Contraceptive conversations: power, discourse and the social construction of contraceptive use during nurse consultations with women in family planning clinics.

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Abstract

This thesis aims to make a significant contribution towards ' *a sociology of contraception'*. It takes as its starting point the lack of a contraceptive *'strand'* within the sociological literature on the body generally, and on women's reproductive sexual health specifically. It takes as its focus the under-researched area of nurse/woman contraceptive consultations in family planning clinics, and explores how contraceptive use is discussed. This is undertaken by utilising Foucault's work on discourse and power, and the body theory work of Turner and Frank.

Using a *'constructivist'* grounded theory approach, incorporating a Foucauldian perspective, 49 consultations between nurses and women were audio taped in two large family planning clinics in the North of England. Interviews with 15 family planning nurses were also conducted.

Three categories were identified from the consultation data: 'Body education', 'Body surveillance' and 'Regimen'. Further analysis resulted in the development of two overlapping core categories: Surveillance and Compliance, within which the three initial categories were placed. In the context of these categories, nurses employ discursive techniques to develop the women into effective users of contraception. It is suggested that these discursive techniques construct the *'Reproductively vulnerable body'* and utilise this concept to encourage women to become involved in self-surveillance and self-care practices and to adhere to a contraceptive regimen - further constructing the: *'Active yet compliant patient'*. The manner in which the Foucauldian notion of *'Productive power'* is utilised within this process is discussed extensively.

The thesis concludes by proposing that the contraceptive consultations result in the construction of a *'contraceptive-using body'*, one that has developed a *'contraceptive habitus'* congruent with Foucault's *'techniques of the self'*. Furthermore, this process also enables the evaluation of Frank's somewhat neglected *'body types in action'* and *'body typology'* work.

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Chapter 1
Introduction and summary

1.1 Introduction

The aim of this thesis is to make a significant contribution towards a *'sociology of contraception'* by exploring the under-researched area of nurse/woman consultations in family planning clinics. It is the lack of a contraceptive *'strand'* within the sociological work on the body generally and on women's reproductive health specifically that serves as a starting point for this work. The thesis therefore engages with the theoretical issues of *the body* in sociology, particularly the literature around the social construction of *the body* and the work of Foucault (1973, 1977, 1981a 1984, 1986) on power, sexuality and discourse, Frank (1991, 1995) and his work on the body and *body use in action* and Turner's (1992, 1995) work on the body's *societal tasks.* It is within this theoretical context that the thesis aims to contribute to a sociological analysis of contraception.

This chapter is in two sections. The first section sets out the background and context of the study. To do this, the professional background of the author is firstly discussed, together with a brief explanation of how this research interest originated from within a sexual health research and teaching role with family planning nurses. This is followed by an overview of the family planning/contraception service in England, with a specific focus on the increasingly autonomous role of nurses working in family planning clinics. This section then sets out how family planning clinics operate, demonstrating how the contraceptive consultations between nurses and women provide an ideal opportunity to make a significant empirical contribution to this under-researched area of women's reproductive and sexual health.

Finally, this first section provides a brief introductory discussion of the related contraception and body literature, to provide the context for a more detailed discussion in subsequent chapters. The few contraceptive consultation research studies within the *clinical* literature are introduced, together with the proposition that this work is based upon certain clinical and medical assumptions that limit its usefulness from a sociological perspective.

Furthermore, it is suggested that the topic of contraception and family planning is significantly neglected within the *sociological* literature on the body, despite many other areas of women's reproductive health being well represented. This literature is outlined briefly to set the scene for a more extensive review in subsequent chapters.

The second section of the chapter provides a chapter-by-chapter summary of the thesis. This will introduce the theoretical context of the study and then foreground the development and implementation of the research design through an introductory discussion of the methodological aspects of the study. The findings will then be summarised, followed by an overview of the key theoretical discussions and conclusions that comprise the last two chapters of the thesis.

Section one: background to the study
Family planning clinics and nursing practice in England

1.2 The author's background

The author is a registered nurse and, for the last ten years, has held a lecturer post in the Nursing school of a University in the North of England. The author's main teaching and administrative role is course leader for the Bachelors degree in Sexual and Reproductive Health. This is a modular course mainly undertaken by nurses, midwives and health visitors who want to work in sexual health or family planning settings. The course includes modules on sexually-transmitted infections, Human Immune Deficiency Virus (HIV) and family planning. The author's clinical background is in HIV and sexually-transmitted infections not in family planning practice. Therefore, because of this lack of clinical experience, teaching contributions to the specialist family planning modules mainly involve the subjects of sexual behaviour research, sexual health epidemiology and health psychology.

Working in sexual health over the years has generated a number of research interests, including a broad interest in sexuality and how this issue is addressed in nursing work, along with an interest in women's reproductive health, particularly contraception. Both these issues have led the author, often via nursing literature, to the sociological literature in this field, particularly the work of Foucault on sexuality, discourse and the body (Foucault, 1973, 1977, 1981a, 1984), and also to many other authors writing about the body and reproductive health, for example Martin (1989) Laws (1990) and Howson (1998, 2001a, 2001b).

Linked closely with these general interests is also a specific one about how nurses work with clients in sexual health settings during one-to-one interactions. Indeed, one of the factors that have enhanced this interest is that over the last few years, nurses working in sexual health have been increasingly involved in one to one counselling with patients. This was particularly evident during the late 1980's and early 1990's, as part of HIV services, where nurses became increasingly involved in conducting pre- and post-HIV test counselling, in fact the author's initial interest in nurse/client discussions originated during a 1994 project involving health advisors in Genito-Urinary Medicine (GUM) clinics.

During this work, which involved teaching counselling skills, it became clear that little was known about how these practitioners managed their discussions with clients. For example, what was said, what was the nature of the discussion, what happened in that private clinical space?

Conducting this work also highlighted the fact that most, if not all of the literature on nurse/client interaction and communication involved ward-based research conducted during care giving in the semi-public environment of a hospital ward or department, for example the work by Gibb and O'Brian (1990), Hunt (1991), Wilkinson (1991) Faulkner (1992), and Jarrett and Payne (1995). Furthermore, this work often explored communication skills (or lack of them) during regular nursing work with ill, often elderly patients, and not as part of a clinic based, medical style consultation.

This GUM project, together with an awareness of a gap in the nursing literature, kindled a growing interest in finding out about the clinical space that nurses were now increasingly occupying, namely individual consultations with clients, a role traditionally the domain of medical practitioners. However, at that point in time the opportunity never arose to explore this further and subsequently research was undertaken by others to explore HIV and GUM counselling, notably Silverman and Perakyla researching HIV counselling (1990) and more recently by Pryce exploring how the sexuality of gay men is reflected in GUM clinics (2000, 2001), although neither of these studies focused on nurses.

Nevertheless, the interest in exploring nurse/client consultations continued and, as more time was spent with nurses working in family planning clinics, it became clear that a growing trend was the increasingly autonomous role of the nurse in one-to-one consultations with women who are using or seeking to use contraception.

This role also involved these nurses in taking on some of the clinical roles traditionally undertaken by doctors. In fact, the work that nurses were undertaking in family planning clinics was often far more advanced and autonomous, involving prescribing and cervical cytology for example, than that performed by their colleagues in GUM. As a result of this, the author began to explore the potential for research within family planning clinics, particularly the role of nurses within contraceptive consultations. This next section, therefore, outlines the structure of contraceptive services in England, particularly illustrating how family planning clinics operate, and providing more detail of how nurses work within them.

1.3 Contraceptive services in England

Although this study is set in family planning clinics, women can obtain contraceptive advice from various other settings. Many women choose to see their General Practitioner or Practice Nurse, at their local surgery, and some women may also obtain contraception from private clinics. However, it is only family planning clinics where contraception is the primary focus of activity. It is extremely rare for General Practice to offer a dedicated contraceptive clinic; clients are seen for contraceptive advice along with the rest of the wide variety of health needs that present during a typical surgery.

This factor alone makes researching contraceptive consultations in General Practice problematic, given that it would be extremely difficult to know when such a consultation would take place. Furthermore, this study is focused upon nurses, and it is often doctors who give the majority of contraceptive advice in General Practice, and although practice nurses are increasingly undertaking this role, they still do not have the same level of autonomy and training as their counterparts in family planning clinics. Additionally, the same issue of access would apply to practice nurses, given that normally they also do not operate dedicated contraceptive clinics.

1.4 Family planning clinics in England

Family planning clinics provide contraceptive advice and treatment free of charge and are part of the National Health Service (NHS) in England and Wales. Alongside General Practice, they provide the principal contraceptive service within the NHS.

In 2002, there were 2.6 million attendances at family planning clinics, involving 1.2 million women, an increase of 4% compared to the previous year (Office for National Statistics (ONS) 2002). Louden et al (1995:11) suggest that there are a number of reasons why family planning clinics are popular:

- Self-referral: clients do not need to be referred by a doctor.
- Predominantly female staff: many women dislike discussing sexual health with a male doctor or nurse; additionally, some methods of contraception could involve an internal examination.

- Some women may find it easier to discuss intimate matters with a stranger rather than with their own General Practitioner (GP).
- Family planning clinics operate flexible opening times (including weekends and evenings).
- A drop-in service is provided in most clinics where no appointment is needed, an aspect that is particularly popular with younger clients.
- There is a perception amongst women that the staff in clinics are more highly trained; unlike practice nurses, family planning staff are required to undertake additional training in contraceptive practice.
- Confidentiality: visits to family planning clinics tend to be more anonymous than a visit to a family doctor.

Furthermore, due to recent policy initiatives - for example the Department of Health *Sexual Health Strategy* (Department of Health 2002) - many family planning clinics now provide non-contraception services, such as cervical cytology and menopause services, thereby attracting many more women. However, the focus of this study is on contraception and, although women may visit a clinic for a variety of contraceptive needs, these visits tend to fall into one of the following four categories.

1. *Commencing contraception*: Women may attend because they are considering starting a contraceptive method. In these cases the nurse helps the woman to choose a method by describing how various methods work and what the particular advantages and disadvantages are for a particular type of contraceptive. This type of consultation will also include a detailed medical history being taken because some medical conditions can preclude the use of certain contraceptives, for example a blood clotting problem or migraines rule out the use of the combined oral contraceptive pill.

2. *Wanting to change methods*: Women may also visit because they are dissatisfied with their current method and are seeking advice on making a change. This consultation takes a similar pattern to women starting contraception, particularly the nurse outlining the other methods, although side effects may be discussed in more detail here to find a method the woman may be able to use more easily.

3. *Obtaining more contraception*: Women also attend clinic to obtain more contraception. For example, women using Depo-Provera will return to clinic every 10-12 weeks for a top-up injection, they may also attend for a 'coil check' or to obtain more condoms. Women using oral contraception also return to clinic for a repeat pill prescription or 'pill check'. Usually these repeat visits will involve a discussion with the woman to check that she is still happy with her method and that she is using it correctly. The range of contraceptive methods used by women who visit family planning clinics is broad, although some methods are more popular than others. In 2002, 43% of women visiting family planning clinics were using oral contraception; 34% were using the male condom (although many women also *'double up'* this method with another method, for example the pill, in case of condom failure); 7% were using an intra-uterine system or device; 8% used Depo-Provera and 6% used a cap or diaphragm (ONS 2002). The remaining 2% includes contraceptive implants (0.6%), spermicidal chemicals (0.4%) female condoms (0.2%) and sterilisation (0.1%).

4. *Emergency contraception*: Women may also visit for emergency contraception. This often follows an episode of unprotected sexual intercourse or a failure of their normal method, for example missed pills, a broken condom or late Depo-Provera. This visit may also involve a pregnancy test and a discussion about exposure to sexually-transmitted infections. In England and Wales, emergency contraception was given on 201,000 occasions during 2002 (ONS 2002).

Table 1 (adapted from information leaflets given to women in clinic) provides an overview of the most commonly-used contraceptive methods, together with explanations of how they work and their respective advantages and disadvantages. It gives an indication of what is discussed in the consultation and provides a helpful reference for the discussion in later chapters.

Table 1: Common methods of contraception

	Contraceptive Injection (Depo-Provera)	Intrauterine System (IUS)	Intrauterine Device (IUD)	Combined Pill (oestrogen and progestogen)	Progestogen only pill (pop)	Condoms
How it works	Releases the hormone progestogen slowly into the body. This stops ovulation and thickens cervical mucous to prevent sperm meeting an egg.	A small plastic device which releases the hormone progestogen is put into the womb. It thickens cervical mucus to stop sperm meeting an egg. It may stop an egg settling in the womb or stop ovulation.	A small plastic and copper device is put into the womb. It stops sperm meeting an egg or may stop an egg settling in the womb.	Contains two hormones - oestrogen and progestogen - which stop ovulation.	The hormone progestogen, taken at the same time each day, thickens cervical mucus to prevent sperm meeting an egg or an egg settling in the womb. In some women it prevents ovulation.	Condoms are barrier methods of contraception. They stop sperm reaching an egg. They are made of latex and fit over the penis.
Advantages	• Lasts for 12 weeks (Depo-Provera or 8 weeks (Noristerat). • May protect against cancer of the womb and some protection from pelvic inflammatory disease • You don't have to think about contraception for as long as the injection works	• Works for five years but can be taken out at any time. • Periods will be much lighter, shorter and usually less painful. • You don't have to think about contraception for as long as the IUS works.	• Works as soon as it is put in. • Can stay in 3 to 10 years depending on type, but can be taken out at any time. • You don't have to think about contraception for as long as the IUD works.	• Often reduces, bleeding, period pain and pre-menstrual tension. • Protects against cancer of the ovary and womb and some pelvic infections. • Suitable for healthy non-smokers up to the menopause.	• Useful for older women who smoke or who cannot use the combined pill. • Can be used when breastfeeding.	• If used according to instructions they are 98% effective. • You only need to use them during sex. • They provide some protection from infection. • Side effects are minimised.
Disadvantages	• Periods may be irregular or stop. • Regular periods and fertility may take a year or more to return after stopping the injections. • Some women gain weight. • Other possible side-effects include headaches, acne, mood changes and tender breasts.	• Irregular light bleeding is common for the first three months and sometimes longer. • May be temporary side-effects such as headaches, acne and tender breasts.	• Periods may be heavier or longer and more painful. • Not suitable for women at risk of getting a sexually transmitted infection.	• Not suitable for all women. • Rare but serious side-effects may include blood clots (thrombosis), breast cancer and cervical cancer. • Can be temporary minor side-effects. • Not suitable for smokers over 35. • Having to take it every day.	• May be minor side-effects. Periods may be irregular, with some bleeding in between, or be missed. • May be less effective in women who weigh over 70kg (11 stone). • Having to take it every day.	• If not used correctly can split, break or come off. • Some people are allergic to the latex. • When removing the condom after sex it is important no sperm is spilt. • They can interrupt sex. • You have to think about taking them with you if you go out.
Comments	The injection cannot be removed from the body so any side-effects may continue for as long as it works and for some time afterwards.	• Women are taught to check the IUS is in place by feeling the threads high in their vagina. • Very useful for women with very heavy or painful periods.	• If fitted after the age of 40 it can stay in until the menopause. • Women are taught to check the IUD is in place by feeling the threads high in their vagina.	• Not effective if taken over 12 hours late or after vomiting or severe diarrhoea. • Some drugs may stop the pill working. • Pill users should not smoke.	• Not effective if taken over three hours late or after vomiting or severe diarrhoea. • Some drugs may stop the pill working but antibiotics do not affect POPs.	• Men who do not always keep their erection may find them difficult to use. • They need to be stored correctly (heat can damage them). • Certain oils (for example, massage oil) can damage condoms).

1.5 Family planning clinic structure

Most family planning clinics in England consist of a large clinic in the centre of town, together with smaller *'satellite'* clinics that operate in local health centres or community centres. Clinics, including satellite clinics, are usually managed by a senior nurse, experienced in family planning practice, who is responsible for the staffing and running of the service, Family planning clinics are also usually part of a Primary Care Trust (PCT). Typically, the larger central clinics are open five days a week and also sometimes on Saturday mornings. These clinics usually offer a service that consists of morning, afternoon and evening sessions, making them popular with employed women. Main clinics also encourage access by offering a mix of appointment and *'drop-in'* sessions where no appointment is required. Waiting times in many clinics can be quite long (20-40 minutes), particularly during *'drop in'* sessions, where clients are seen in order of arrival. The smaller satellite clinics often only open once a week, in an afternoon or evening, and are staffed by nurses who normally work in the main clinic as well.

Clinics keep their own set of records for each client and these are used in subsequent clinic visits to keep a record of the women's contraceptive histories. Other relevant medical and social information from the woman is also stored in these records. Some clinics use computers in the consultations and access women's records in that manner. However, many clinics still operate with written records in the traditional brown medical envelope with a card insert.

1.6 The role of nurses in family planning clinics

Working in family planning clinics requires a professional qualification of Nurse, Midwife or Health visitor (for convenience, the collective term nurse will be used from now on) together with completion of a recognised post-registration course in family planning/sexual health. Typically, these courses take around six months to complete, during which time nurses undertake supervised practice in clinics and complete practical and theoretical assessments. Most of the nurses who work in family planning clinics actually have other jobs, for example practice or school nurse, health visitor or midwife, and work for clinics on a part-time basis, although there is an increasing number of nurses who are employed full time by clinics.

Within the consultation, nurses and doctors work to a set of clinical guidelines or protocols devised by the medical and nursing staff in the clinic. One of their main aims is to ensure safety. For example, certain women cannot take the contraceptive pill because of their age or pre-existing medical condition and therefore the guidelines for contraceptive pill prescribing will set out exactly what the practitioner must address with regard to the woman's medical history and age, in other words they act as an *aide memoir* to ensure that practice is safe and comprehensive.

Over the last ten years, the role of nurses in family planning clinics has increased dramatically. Additional training and professional developments within nursing generally, means that nurses now undertake many of the extended clinical roles previously performed by doctors. For example, many family planning nurses are now qualified to prescribe certain drugs, including oral contraceptives, whilst some are also qualified to perform procedures such as inserting an Intra-Uterine Device (IUD or coil) and cervical smear-taking.

This increasing autonomy means that many family planning clinics now run *'nurse only'* sessions, where no doctor is present whilst many others operate with doctors and nurses working alongside one another, performing very similar clinical roles. In these situations, a nurse would usually only advise the woman to see the doctor if she had not yet been fully trained to prescribe, or if a health issues arose that was beyond the scope of family planning. For example, a woman could report symptoms of a urinary tract infection that required the prescribing of antibiotics.

1.7 Family planning and contraception research

It is probably because this level of autonomous nursing practice has only come about relatively recently that the research into what takes place within these consultations is so scarce, yet even from the brief descriptions above it is clear that the family planning clinic, particularly the contraceptive consultation, provides an interesting environment in which to begin developing a *'sociology of contraception'*. However, despite being an important clinical space where large numbers of women engage with a health professional to discuss sexual and reproductive health matters, research in this area is remarkably scarce. This is particularly true of sociological literature, discussed shortly, but it is also a valid criticism of the clinical literature.

1.7.1 Clinical research

Despite the suggestion by numerous authors that the *client/provider interface* is an important aspect of the contraceptive service that requires far more research (Simmons and Elias 1994, Baraitser 1995, Rasch 2002, Lachowsky and Levy-Toledano 2002), it is an area of family planning practice that has received little attention in the clinical literature.

Only four empirical studies of the nurse/client contraceptive consultation were found in the literature, although none were undertaken in Europe. One, by Candlin and Lucas (1986) was performed almost 18 years ago in the United States whilst another, by Dodge and Oakley (1989) was undertaken nearly 15 years ago, also in the United States. More recently, another was study was performed in Kenya by Kim et al (1998) and the most recent was undertaken in Ecuador, Uganda and Zimbabwe, by Bessinger and Bertrand (2001) However, all of these studies were motivated to explore the consultation in order to improve and assess clinical practice, *not* to problematise or analyse the process in any sociological sense.

Candlin and Lucas (1986) utilised applied linguistics to explore advice giving in contraceptive consultations in a private family planning clinic in the United States. Their aim was to explore how health care professionals gave advice to clients and they chose family planning as an example of providing information to 'healthy' individuals. This study, although looking at contraceptive advice giving did not explore the consultation from a sociological perspective, and was more concerned with the wider linguistic processes involved in giving health information to women in clinical situations. This study also involved a large number of non-nurse '*volunteer workers*' with little medical training, it is unclear how many nurses were involved in the study.

Dodge and Oakley (1989) explored the nurse/client consultation by audio-taping 12 consultations in a family planning clinic. This study aimed to explore the clinical skills utilised by nurses to discuss contraceptive use with women. In this study, Dodge and Oakley were primarily concerned with how nurses could improve contraceptive compliance. A central finding from analysis of the 12 consultations was that nurses did not spend enough time discussing how women planned their future contraceptive needs.

Interestingly, this study did not manage to collect data on how nurses discuss contraceptive methods - for example how they work or what side effects they have - because in the clinics that Dodge and Oakley used, this information was given via video to women in the waiting room, before they saw the nurse.

A much larger study, by Kim et al (1998), analysed 176 audio-taped consultations by nurses and community workers giving contraceptive advice to women in Kenya. These consultations did include providing information to women about how contraceptives worked and what the advantages and disadvantages of different methods were. However, as with Dodge and Oakley (1989), the aims were clinically driven. Kim et al set out to assess the amount and accuracy of information provided in the consultations, in the most part analysing consultations by checklist to assess the accuracy and completeness of the factual contraceptive information given to women. This study is also somewhat limited by the inclusion of non-nurses. Also, due to cultural and socio-economic differences, it is not readily transferable to a western European clinical setting.

Similar criticisms are applicable to Bessinger and Bertrand (2001), who conducted observations of family planning nurse and volunteer contraception counsellor's consultations with women in Zimbabwe, Ecuador and Uganda. The authors observed over 200 consultations but, like Kim et al (1998), were concerned with monitoring the accuracy of the instructions given to women. They also used a check-list to measure whether workers gave women clear instruction on matters such as when to return to the clinic and how to obtain more contraception.

Furthermore, although these four studies were found, they are of limited use for any sociological analysis, given that they all have mainly *clinical practice* aims and objectives. This means the studies focus upon improving practice, rather than analysing or *problematising* the assumptions, discourses and techniques involved within the consultation from a sociological perspective.

What they do illustrate, however, is that within the clinical literature there are certain assumptions, for example that compliance by women is a universally positive outcome in contraceptive counselling and therefore measures to increase it are the key aims of clinical practice.

Such assumptions can be seen to underpin the clinical literature where calls are made for more research into the client/provider interface in family planning practice. See for example, Oakley (1994), Simmons and Elias (1994) and Moos et al (2003). However, these assumptions would not normally precede a sociological analysis.

1.7.2 Sociological research

Contraception is also under-represented in the sociological literature. The extent of a contraceptive analysis within the empirical *body* literature will be discussed shortly. However, it is within the general, often non-empirical, work that contraception is discussed in the greatest depth, although this work often refers to contraception tangentially when discussing such matters as the history of population control, or female sexuality. Given the nature of this study into analysing contemporary contraceptive consultations the social history of contraception will not be covered in detail here, although certain aspects of it will be discussed in subsequent chapters. However, for background and context, it is possible to summarise this literature within three discursive strands.

1. Contraception or family planning is often featured in work discussing the links between social policy and population issues; this work often encompasses an analysis of the historical social concerns about the quantity and quality of the population. Beginning with the Malthusian and eugenics movements through to contemporary social concerns about unplanned pregnancies amongst teenagers, contraception and birth control are often cited either as the solution to, or the cause of, social problems attributed to unchecked birth rates and population growth. See, for example, the work of Searle (1971) and Weeks (1989).

2. Contraception is also closely linked with sexual behaviour and sexuality. The ability of women to access methods to control their fertility continues to be the subject of discourse that celebrates the empowering nature of contraception by enabling women to express their sexuality without the ever present threat of pregnancy (Himes 1963, Atkinson 1986, Hardon 1992). However, running parallel to this is a discursive thread that accuses contraception of creating an environment of promiscuity within which an erosion of sexual morality has occurred. See, for example, the work of Oakley (1976) Mackenzie (1976), Weeks (1989), Finch (1993) and Barret and Harper (2000).

3. A more recent theme is a challenge to the premise that contraception is always emancipatory for women. This discourse argues that contraception has also been instrumental in further medicalising the female reproductive system (Hardon 1992). Some authors also argue that, in order to use contraception, women - not men - often have to submit to medical intervention, expose themselves to potentially dangerous side-effects and bear social and personal responsibility for preventing pregnancy (Kammen and Oudshoorn 2002, Oudshoorn 2002, 2003). Others have also suggested that national birth control programmes, particularly in developing countries, sometimes clash with the freedom of women to choose *not* to use contraception (Hartmann 1987, Germain and Ordway 1989, Whelan 1992, Hardon 1992).

Some of this work and related literature will be revisited and discussed in more detail within later chapters, although none of it explores how these issues are played out within clinical situations. Indeed, the same can also be said for the literature that addresses *the body* in sociology.

During the last decade or so there has been a significant growth of interest in the *sociology of the body* (Hancock 2000, Twigg 2002). This trend includes analysis of the female body, generally, as well as the female reproductive system, specifically. Although this literature will be explored in greater detail in forthcoming chapters, a brief introductory overview is provided here, in order to make the point that contraception seems to be missing from this body of literature, whereas other aspects of reproductive health are addressed quite comprehensively.

For example, work by Martin (1989) and, more recently, by Leysen (1996) and Harding (1997) discusses both how the menopause is represented in medical texts and how it is experienced by women. The pregnant body has been the subject of excellent work by Duden (1993), Stabile (1994) and also Martin (1989). Infertility is the subject of work by Gerson (1989) and reproductive technology and infertility is addressed by several authors, for example Rowland (1992), Raymond (1994) and Harraway (1997). Menstruation and its discourses are also ably covered again in the writings of Martin (1989) but also by the work of Laws (1990) and Grosz (1994). More recently, the issues of female embodiment and cervical cancer screening have been explored, particularly in the work of Bush (2000) and Howson (1999, 2001a, 2001b).

Surprisingly, contraception is absent from this body of literature, yet it seems clearly related to the powerful discourses around pregnancy, fertility, sexuality and the body. Furthermore, the reasons for this absence are difficult to imagine. Perhaps it is because contraception has, until recently, been regarded as empowering for women amongst writers who have chosen to focus on, what for them, seem to be more contentious aspects of women's reproductive health, for example pregnancy and the reproductive technologies, menstruation and the menopause. Whatever the reason, contraception seems to be one aspect of women's reproductive health that has, despite millions of women using it, slipped through the net of the sociological study of the body.

This study aims to redress this and it is suggested that this lack of work presents a clear opportunity to make a significant contribution towards a *'sociology of contraception'*. Furthermore, it is proposed that the family planning clinic provides an ideal clinical space within which to make this contribution, being a key site where women engage with a health professional to discuss issues that clearly involve their body, reproductive health and sexuality.

The next section of this chapter summarises how this research was undertaken and outlines the key findings and subsequent theoretical discussions by providing a chapter-by-chapter overview of the thesis.

Section 2:

Summary of the thesis

This next section provides a summary of the thesis by summarising the key aspects of each chapter. It begins by outlining the theoretical context of the study discussed in chapter 2.

1.8 Theoretical background chapter summary (Chapter 2)

This chapter is structured around four themes: the emergence of the body in sociology; an exploration of what Shilling (1993) describes as '*social constructionist theories'* of the body (particularly the work of Goffman and Foucault); an analysis of Foucault's writings on sexuality and finally, an analysis of the theoretical frameworks for studying the socially-constructed body, developed by Turner (1991, 1992, 1995) and Frank (1991, 1995).

The first section begins by exploring the work of Shilling (1993), Turner (1991,1992, 1995), Nettleton and Watson (1998) and others who set out the various social phenomena they identify as factors driving the recent prominence of the body within sociological work. These numerous factors, which include concerns about the ageing population, the rise of consumerism and growing concerns about the meaning of the body, are discussed here, however, a particular focus is directed toward an exploration of the feminist literature on the body. This involves a more detailed discussion of the work by Martin (1989), Laws (1990) and others introduced earlier (for example Howson 1998, Bush 2000), and illustrates how, for women, the body has always been at the forefront of feminist writing (Birke 1999, Brook 1999). This discussion is closely linked to an exploration of how medical and scientific discourse - and subsequently practice - have been heavily influenced by naturalistic theories relating to the female body.

It is argued that naturalistic views of the body often assume a *biological essentialism* for it, an issue that particularly impacts upon the reproductive health of women by *pathologising* many aspects of women's reproductive anatomy and physiology in a gender-stereotypical manner.

For example, Martin (1989) discusses how the menopause is characterised as a reproductive system that is disintegrating, weak and unstable. Laws (1990) argues that menstruation is often viewed as a process that weakens women, both physically and emotionally.

In the second section, the discussion moves on to explore how a general dissatisfaction with naturalistic descriptions of the body as a pre-discursive, obdurate fact of biology, led sociology to develop alternative, more satisfactory accounts of the body. Central to this are theoretical concepts that describe a *socially-constructed body*; a body subject to change, interpretation and influence by complex social processes, for example, discourse.

This section then moves on to discuss the work of Goffman (1967, 1971) and Foucault (1973, 1977, 1981a, 1984, 1986, 1991). Within this discussion, it is suggested that, although Goffman's work is concerned with the body, to a large extent his work is concerned more with how the body *acts and works* to construct the world *around* it rather than how it is constructed *itself*. It is suggested that the work of Foucault is far more directly concerned with the body itself, therefore providing a more appropriate theoretical context for this study. This section then sets out how, for Foucault, the body and its discursive construction is central to understanding the wider social processes of power, sexuality and government. Subsequently, this section proceeds to explore how the central plank in Foucault's work on the body - discourse - operates through complex discursive practices. It discusses the close links between the body, knowledge and power and, in so doing, traces the shift within Foucault's own views of the nature of power and the place of the body, from his earlier writings replete with repressive and coercive notions of power (Foucault 1973, 1977, 1981a), through to his later work, where power is seen as productive and persuasive, more concerned with developing self-care and self-understanding through *techniques of the self* (Foucault 1984, 1996, 1991).

This later work of Foucault, centred around his writings on sexuality and the body, is therefore discussed extensively in the third section of this chapter. Particular emphasis is placed upon how Foucault uses sexuality to provide two key examples of his later ideas about power; one is how sexuality provides an exemplar of how dominant medical and scientific discourse constructs the body (particularly the female body) and subsequently deploys this discourse as *power/knowledge* (Foucault 1981a).

Secondly, using sexuality as an example, Foucault utilises an analysis of ancient Greco-Roman texts to illustrate his increasing interest in how individuals are transformed into self-caring *subjects*, through the productive power techniques of self-understanding and adherence to regimen; the *'askesis'* (Foucault 1984, 1986).

Finally, this chapter concludes with a section that explores how the socially-constructed body can be understood. This section discusses some of the contentious issues in this area, particularly the epistemological tensions in body theory about what role, if any, is played by the physical or corporeal body in social constructionist frameworks. This section then focuses on two theorists, Turner (1992) and Frank (1991,1995) who, despite incorporating strong Foucauldian dimensions within their work, set out theoretical models by which the body can be analysed as both a socially-constructed *and* corporeal phenomenon. The chapter concludes by asking some broad questions about how the work of Foucault, Turner and Frank could contribute to an exploration of the family planning clinic consultation between woman and nurse.

1.9 Methodology chapter summary (Chapter 3)

This chapter moves on from the questions posed at the end of chapter 2 to set out the methodological aspects of the study. It begins by justifying the employment of qualitative rather than quantitative methods, briefly outlining the general merits of qualitative research - given the intention to undertake an in-depth exploration of the family planning clinic consultation. The selection of a methodology drawn from the social constructivist tradition is then discussed, particularly the links between this research approach and the intention to incorporate a Foucauldian perspective within the methodology. Within this discussion of constructivist methodology, consideration is given to the epistemological tensions within sociological research involving the body discussed at the end of chapter 2, particularly the issue of corporeality and its place in social constructivist epistemology. It is suggested that a *strong* constructivist or an orthodox Foucauldian approach to the methodology could preclude sensitivity to the role of a pre-discursive or material body. Therefore, the selection of a *'weak'* constructivist approach (Longhino 1990, Schwandt 2000) - in other words, a constructivist methodology that allows for the possibility that the physical body can, at least partially, have a role in influencing discourse, as well as being constructed by it, is discussed.

This chapter also sets out the challenges presented by the flexible, changing, sometimes muddled process that is often encountered when employing an emergent qualitative research design. It describes how the adoption of a broad research focus, rather than a specifically-defined research question, brings with it further methodological issues. The discussion subsequently explores how this broad approach provides challenges to the researcher, who can become *'swamped'* by interesting data and has subsequently to decide on the future direction of the research, given that he or she *'cannot study everything'* (Lincoln and Guba 1985: 210).

This chapter then discusses one of the key methodological concerns of the study; that of carefully selecting a methodology that enables the nurse/woman consultation process to be explored in a manner that initially minimises the possibility of influence by extant theory, yet ultimately allows the consultations to be placed in a wider theoretical context. To this end, two constructivist methodologies are subsequently explored. Firstly, a constructivist reading of ethnomethodolgy - *interpretive practice* is discussed; its combination of conversation and Foucauldian discourse analysis is considered as a possible methodology. However, although this approach is considered to have merits, it also has numerous aspects that adversely affect its suitability for this particular study, for example a lack of clarity about data-collection and analysis techniques.

Constructivist grounded theory is suggested as being the most appropriate methodology for use in this study. Constructivist grounded theory is described by Charmaz (2000) and, in practice, differs only slightly from more orthodox approaches to grounded theory, one of the key differences being an encouragement for researchers to include the views of research participants on the emerging theory. In most other respects, constructivist grounded theory utilises the same techniques of simultaneous data-collection and analysis, through the application of the constant comparative method and theoretical sampling described by its main proponents such as Stern (1985) and Strauss and Corbin (1990). Grounded theory also has the merit of being highly emergent in design - an important factor, given the broad research focus of this study. Also, by being explicit about where, and when, extant theory influences data-collection and analysis, it is well suited to managing the potential for bias outlined above. Finally in this chapter, the importance of trustworthiness in qualitative research is discussed.

The methods advocated by Lincoln and Guba (1985) for establishing *credibility, transferability, dependability* and *confirmability*, are outlined and the discussion clearly sets out the manner in which a grounded theory approach can incorporate these important aspects of data-collection and analysis.

1.10 Method chapter summary (Chapter 4)

This chapter describes how the methodology set out in the previous chapter was deployed in the field and is structured around two closely-related (sometimes overlapping) sections. The first section, *'gaining access'* concerns the development of the study and includes negotiating entry to the two family planning clinics, Clinics A and B used in the study. These two clinics are situated in large towns, approximately 50 miles apart, in the local health region. Both Clinics A and B provide the bulk of their family planning service from large *main* clinics in the town centres, which are open six days a week, but they also run several smaller *satellite* clinics, often opening on only one day a week. This first section also sets out how ethical approval was obtained, and describes how the ethical concerns of the study were addressed, particularly the important issues of consent and confidentiality.

The intention to explore the nurse/woman consultation resulted in the selection of data-collection methods which comprised audio-taping the actual consultation and conducting post-consultation interviews with nurses and women. It was decided that the consultation data would be subject to the data collection and analysis techniques that are characteristic of a grounded theory approach; namely the constant comparative approach, aided by theoretical sampling and resultant theory-building. The interviews, guided by emerging concepts from the consultation data, would be both subject to a more informal analysis and used at a later stage to add richness to the theoretical analysis of the consultation process.

The second section, *'entering the field'*, concerns the conduct of the study from the commencement of the fieldwork. This section includes an initial summary of data-collection to provide the context for the subsequent detailed description of the data-collection and analysis process. It describes how a total of 49 consultations undertaken by 20 different nurses with women using a broad range of contraceptive methods, were recorded during data-collection visits to 31 clinic sessions.

In the area served by Clinic A, data were collected from the main clinic and two satellite clinics. In the case of Clinic B, data were collected from the main clinic and one satellite clinic. Also, 14 interviews with nurses were undertaken and 4 interviews with women.

The second section of this chapter then describes how data-collection and analysis were conducted in the field, and outlines how the constant comparative approach was utilised. This discussion also outlines how the increasingly large amounts of interesting data generated from the consultations during the early stages of open coding led to numerous interesting issues emerging that could take the research in various directions. At this point in the study, both the richness of data emerging from the consultations, but also the sense of being overwhelmed with data from an emergent design, became apparent; a decision had to be made on the direction of the study. This involved a practical consideration of the methodological issues outlined in the previous chapter relating to refinement of the focus of an emergent approach. In this case, an initial research focus was adopted, which was; *what is the nature of the nurse-client consultation in family planning clinics?* However, at this point in the study, numerous potentially interesting strands of possible enquiry presented themselves and decisions as to the future direction of the research were required.

Close examination of the data resulted in the emergence of a more precise type of research question, which took shape through attempts to screen out the *specific* interesting areas mentioned above, in a way avoiding the *'brightest lights'* and concentrating on the broader *holistic* question of *'what is going on in these consultations'* and *'what is the purpose of them'*? With these questions in mind, it began to become clear that the consultation, as a *whole,* represented a *process* within which women are helped to use contraception effectively. Many of the interesting issues identified so far were actually *part* of this process.

Attempts began to unpick the way in which the consultations operated as a process that facilitated women to be effective users of contraception. In other words, the simple fact was: *women come to the family planning clinic because they are choosing to use contraception. It is the nurse's role to help them do this. How does this work?*

This analytical process marked a significant move forward in the study and was an important stage in the study: it consisted, basically, of a realisation that the interesting question was not just about *what* took place in the consultation, but about *how* the consultations actually operated, an analytical process which was actually a tortuous, protracted and messy methodological process. However, this analysis did eventually refine the research focus into a clearer question; *how do nurses use the consultation to facilitate the effective use of contraception amongst women?*

This led to several decisions about subsequent data-collection, the main change being the decision to stop interviews with women and concentrate on the process of how nurses utilised techniques in the consultation to help women develop into effective contraceptive users. From this point on, data-collection and analysis concentrated on consultation data and nurse interviews.

However, this decision was also influenced by other less theoretical problems, particularly a number of difficulties relating to the conducting of interviews with women. For various reasons, women were reluctant to be interviewed. These are discussed in detail, but seem to be related to: firstly, women indicating to nurses that they did not have time to stay after the consultation and, secondly, the gender of the researcher. In addition, the data gathered from interviews with women was quite disappointing compared to the consultation and nurse interview data, an aspect that is also discussed further. Furthermore, given the direction that the research was now taking, particularly the decision to explore issues that could include more intimate contraceptive use practices, questions to women could have become increasingly intimate and, hence, increasingly problematic for a male researcher.

This section of the chapter then describes in detail how the constant comparative approach to data-collection and analysis was utilised. In keeping with grounded theory, small segments of data were initially given *open codes,* with names reflective of the particular element of the consultation that they represent. For example: *'side-effects'.* As data-collection and analysis continued, *open codes* were placed in larger, more abstract, *substantive codes*, for example*: 'Coping'.*

This process involved asking questions of the data and testing the fit of codes within these larger codes, an aspect of the data-collection that often saw *substantive codes* change or amalgamate as more data were collected and analysed. Increasingly, as this process continued, theoretical concerns influenced the process involved in searching for patterns and links within the data. In the later stages of data-collection and analysis, *categories* of data were constructed by linking *substantive codes* together in an attempt to develop a theoretical framework that represented the consultation process as a whole. This was a complex process and is described in detail. The final result was the identification of three *categories* from the consultation data; *Body Education*, *Body Surveillance*, and *Regimen*. The following chapter of the thesis then sets out how these categories represent the consultation process.

1.11 Findings chapter summary (Chapter 5)

This chapter begins by presenting a summary of the three categories developed from the consultation data in Clinics A and B. It also provides an overview of the discursive techniques utilised by nurses within the consultation. The second section then presents the findings in more detail, utilising extracts from the data obtained from the 49 consultations in Clinics A and B. The third section discusses the development of an overarching conceptual model that is proposed as a useful theoretical framework for understanding the nurse/client consultation.

The first two sections are structured around the three categories identified at the end of chapter 4 and include extensive use of the data from the consultations to illustrate how the consultation proceeds. This section sets out how the consultation process consists of *micro-power relations* that are geared towards discursively constructing a reproductive system and providing a disciplinary framework within which a woman becomes a person who is knowledgeable about both her reproductive anatomy and physiology and her method of contraception. However, within this framework, the woman is also given heightened awareness of her vulnerability to pregnancy and of her need for contraceptive *protection*.

This *'knowledgeable/reproductively vulnerable patient'* is closely linked to power relations that are operating to develop a woman who is an *'active'* but also *'compliant patient'* - active in the sense that she is encouraged to participate in the process of her contraceptive care yet compliant in the sense that she becomes a woman who complies with a contraceptive regimen.

Her compliance is obtained through productive power relations that do not threaten or coerce, but that persuade, instruct, normalise and monitor. The three categories identified within the consultation data that comprise this process can be summarised as follows.

'Body Education' is about how nurses use discourses of anatomy and physiology to increase women's awareness and understanding of the way their bodies work in relation to their contraceptive method. This aspect of the consultation takes the form of an ongoing teaching process, where nurses utilise techniques of questioning and testing to develop a woman's understanding. Within body education, nurses rely upon medical and scientific discourses to explain the workings of the reproductive system. Within these descriptions, nurses use language that creates the notion of *reproductive vulnerability*; women are made to understand their reproductive system as being under threat of pregnancy and in need of contraceptive protection. Body education comprises of three substantive codes. Nurses explain the *anatomy* and *physiology* of the reproductive system, a process that utilises medical discourse on anatomy and physiology to stress the need for protection. Nurses test women's body knowledge by asking questions about the reproductive system. Nurses also educate women about the impact of contraception upon their body. This centres upon a discussion of the *risks and benefits* of contraception; it also includes the education of women in terms of the need to endure or persevere with contraception in the face of side-effects, an element of the consultation that seems to be about *coping*.

'Body Surveillance' builds upon body education. The consultation process encourages women to be aware of their body, and place it under surveillance. The need for surveillance is linked to the notion of a *reproductively vulnerable* body and of the need to protect it against potential threats, consisting either of pregnancy or of the adverse effects of the contraceptive. However, the process of surveillance is much more holistic than mere observation; it involves the woman becoming closely aware of her body, in order to subject it to discipline as part of adhering to a regimen of contraception. It also involves the woman placing her own body within the monitoring '*gaze*' of the clinic. Surveillance comprises three substantive codes: *Body monitoring by the woman* describes how women, prompted and encouraged by the nurse, observe their body for signs and symptoms, and report these at clinic for the nurse to interpret. *Body monitoring by the nurse* involves measurement and recording of information from women about their past and present health.

Nurses also record measurements taken from the woman's body: for example weight, menstrual cycle and body mass. *Body techniques* involve the elements within the consultation that relate to women being able, not only to monitor their body, but also to examine and manipulate it physically in the context of contraceptive use.

'Regimen' relates to the aspect of the consultation that is about women complying with a contraceptive regimen and provides several key examples of the deployment of disciplinary power within the consultations. An important element of this compliance is the need for women to keep to time when managing their regimen and to adhere to the *'rules'* governing their method. Regimen also entails women being aware of - and possessing - the necessary strategies to deal with regimen failure. Regimen comprises three substantive codes. *Time-keeping* refers to the way in which women are taught to be aware of the importance of time-keeping and time observation. *Threats to regimen* is an aspect that links with body education and surveillance, where nurses ensure that women are aware of the things that can interfere with the efficacy of the regimen. *Dealing with regimen breakdown* involves nurses making sure that women are aware of how to deal with any breakdown in their contraceptive regimen.

Analysis of the consultation data also revealed several overarching discursive techniques employed by the nurses. These techniques were utilised throughout the process of the consultation and can be seen operating within all three categories of Body Education, Body Surveillance and Regimen. Furthermore, although these techniques are employed in a complex and holistic way throughout the consultation, they can be identified as techniques that comprise a number of distinct practices.

- **Concept of the body**; the body in the consultations is clearly defined by medical and scientific discourse. Within these discursive boundaries, the woman is educated about her body. This body is presented to the woman employing the terminology of *reproductive vulnerability* and the requirement for the reproductive system to be restrained and protected by contraceptive methods. The body as an object in need of surveillance was also part of the way in which nurses conceptualised the body, as was the notion of the body being a site for the application of disciplinary techniques.

- **Language;** nurses modify their language when discussing different elements of contraceptive use. A significant example of this is when nurses use scientific, research-based data, in the form of percentages, when mentioning the effectiveness of a method, but then use non-scientific terms such as *'a bit'* or *'a little'* when covering its adverse effects.

- **Questioning and testing,** the use of questions to test women is evident in all three of the categories described above. These questions are quite different from questions aimed at eliciting information and about testing women's knowledge of their bodies and their use of contraception. Questions test women's knowledge about how the reproductive system works and how contraceptive methods function. They are also used to test women's knowledge of their regimen.

- **Interpretation and diagnosis;** as mentioned previously, surveillance is an important part of the consultation. Nurses encourage women to be vigilant and to observe their bodies. Women are taught to look for body changes, symptoms possibly related to side-effects. They are also taught to monitor for signs of regimen failure. Women are also encouraged to report any of these signs to the nurse at the clinic. However, within the consultation data, it is evident that although nurses encourage this 'observation and report process', interpretation of the relevance (or otherwise) and the importance (or otherwise) of the woman's report is mainly the nurse's role.

- **Use of knowledge;** Nurses utilise knowledge as a power technique within the consultation. They do this by using such information about the body and contraception that they posses and the women do not, illustrating the links between knowledge and power. Often, nurses refer to medical texts, anatomical diagrams or models as part of this process. Nurses also collect information from the woman. This information covers the woman's health and body, for example weight, body mass, menstrual cycle that is then used as part of surveillance. It is also used, by the nurse, as part of making normalising judgements about the woman, utilising a knowledge base drawn from other women's information, scientific research and medical texts.

- **Discipline;** an important element of the consultation is the process by which women are encouraged to participate actively in their contraceptive care. The use of contraception requires that women adhere to a regimen. Nurses emphasise this and a significant amount of time is spent encouraging women to adopt a disciplined approach to managing their contraceptive method. This regimen includes the importance of time-keeping when taking contraception, regimens of bodily observation and also strategies to deal with any threat to the regimen that may lead to its failure. Nurses give women written guidelines about the regimen and often refer to the *'rules'* when instructing women. Nurses also encourage women to keep their own contraceptive records and they test women's knowledge about their regimen, and discuss strategies to incorporate this regimen into daily life.

The final section in this chapter describes how further data-analysis was conducted resulting in the identification of two overlapping core categories: '*Surveillance'* and *'Compliance'*. It is proposed that the three categories: '*Body Education'*, '*Body Surveillance'* and '*Regimen'* can be placed in and around the intersection of these two core categories.

A diagrammatic framework is then offered to map out how the contraceptive consultations exist within a network of discursive techniques employed by nurses within the consultation to develop the women into an effective user of contraception: a process that resulted in the development of the: *Knowledgeable yet reproductively vulnerable* and *active yet compliant 'patient'.*

1.12 Discussion chapter summary (Chapter 6)

This chapter discusses the findings presented in chapter 5 and places them in a theoretical context. The discussion is structured around an analysis of the two core categories – '*Surveillance* and *Compliance'* – which, although intended to represent a holistic process, can best be analysed from a theoretical perspective as discrete but closely integrated, categories. The discussion of the findings within this chapter is also enriched by data obtained from interviews that the author conducted with family planning nurses in Clinics A and B.

Firstly, the discussion sets out the value of a Foucauldian perspective on power in providing an analytical framework for exploration of the complex nature of the consultations in the family planning clinic. It is proposed that the power relations and discourse operating within the nurse-client discussion are a detailed example of what Foucault means by the *'micro-power'* relations that operate during the individual engagement of a person with a health care professional; power relations that, by conducting an *'ascending analysis'* can be linked to wider structures of power. The discussion then moves on to propose that the data obtained in this study contributes a detailed insight into the concepts of *productive power.*

Furthermore, the manner in which body education and surveillance involve discursive techniques congruent with Foucault's (1981a) description of *'procedures of exclusion'* techniques and *'the will to truth'* is analysed in this section. Body education is also a key factor in creating a heightened awareness of the need for *reproductive vigilance* amongst women. How this relates to and develops the existing literature on the social construction of the female reproductive system is also explored.

Within the consultation, women are encouraged to monitor their bodies, for either the manifestation of side-effects or signs of pregnancy. It is suggested that the construction of the *vulnerable* reproductive system is a factor in this encouragement. This aspect of the consultation process involves women being taught self-surveillance skills by the nurse. Sometimes, this includes self-examination techniques. It is suggested that these techniques contribute additional dimensions to the literature on other aspects of body examination by women, particularly the work by Howson (2001a, 2001b) on examination and visualisation of the cervix.

It is also clear from the data that the nurse acts as an interpreter of the signs and symptoms that the woman reports at clinic, a process that is reflective of Nettleton's (1994) *dentist judge* - a practitioner who listens to patient reports, but combines examination and a greater medical knowledge in order to judge the importance of signs and symptoms. How nurses use these discursive practices, including *normalisation,* to control this discourse is explored in detail, particularly how they utilise their knowledge of other women visiting the clinic and their greater contraceptive knowledge within the consultation.

Body education and self-surveillance are also closely integrated with the process of encouraging women to comply with contraception. Within the consultation, women are educated about the side-effects of contraception. This is to enable them to recognise and report these signs at clinic. However, nurses also seem aware that side-effects are a potential source of non-compliance, an issue that presents the nurse with a dilemma. The way in which nurses manage this dilemma is discussed theoretically by utilising Foucault's work on discursive procedures. In addition, as nurses often encourage women to be stoical and to persevere with the uncomfortable side-effects of contraception, the work of Frank (1991, 1995) on the body and corporeality is engaged, particularly his discussion of the relationships between the discursively constructed body and the body as flesh.

Lastly, a key element of compliance is regimen. A significant aspect of the consultation involves nurses encouraging and educating women to ensure adherence to their contraceptive regimen. This often includes written instructions and the teaching of the *'rules'* for a particular method. How this resonates with both Foucault's earlier work on body discipline, through rule observance (Foucault 1977) and his later work, on the less coercive regimens for self-mastery within the *techniques of the self* (Foucault 1984, 1986), is explored extensively in the concluding section of this chapter.

1.13 Conclusions chapter summary (Chapter 7)

This chapter presents the conclusions from the study. It is in two sections. Section one draws together the threads of the contraceptive consultation by exploring the way in which the closely integrated processes operating within the categories of 'Surveillance' and 'Compliance' provide tangible, contemporary examples of Foucault's (1984, 1986) *'techniques of the self'*. Comparisons and links are made between the consultation process and the development of body practices and techniques, framed within Foucault's analysis of the Greco/Roman principle of *'askesis'* and *'technologies of the self'*. The relationship between these practices and the formation of a *'contraceptive habitus'* is also explored. Furthermore, the manner in which the reproductive system is discursively constructed as *reproductively vulnerable* builds particularly upon the work of Martin (1989, 1991) and reveals key ways in which the terminology of the contraceptive-using body differs from that of the menstruating, pregnant or menopausal body described in her work.

Body education also adds to the work of Laws (1990) on menstruation. In particular it demonstrates specifically how medical discourses around *'normal'* menstruation are utilised in clinical encounters between women and health professionals.

Although acknowledging that the creation of health risk as a prerequisite to self-surveillance is not a new idea (for example; Lupton 1994, Nettleton 1997, Harding 1997, Howson 1998), it is suggested within this study that there are a couple of interesting additions to this work. Firstly, this study illustrates how self-examination techniques are included within the encouragement to self-monitor. This aspect adds new dimensions to the literature on self-examination, which has previously been dominated by breast examination, whilst also contributing to the debate, discussed by Howson (2001a, 2001b) about whether the ability to visualise and examine the body is a liberating or constraining act.

Secondly, the study demonstrates interesting limitations to self-surveillance. Women are encouraged to self-monitor, but do so under the overarching surveillance activity of the clinic. The clinic, acting as Panopticon, particularly through the use of case-notes, illustrates that surveillance *of* self-surveillance is a key role within the family planning clinic. How this particular issue contributes to the debate about the continuing relevance of Panopticon in contemporary health care is also analysed by exploring the tensions between direct forms of surveillance and the less direct techniques of *simulation* for encouraging compliance with health-care instructions.

The study also provides interesting examples of disciplinary power techniques at work. As with self-surveillance, the concept of disciplinary practices operating in health care is not new, Nettleton's (1994) descriptions of dentistry provides one example and Howson's (1998, 2001a) work on cervical smears another. However, the study does reveal a couple of discursive processes that are not described elsewhere in the literature, particularly the discursive management of side-effects and the notion of stoicism and perseverance, how these add further dimensions to earlier work is presented.

On a wider theoretical note, the study provides the first empirically-based critique of Frank's (1991, 1995) *body types* and *body use in action* typology. The study demonstrates how Frank's body types do not seem robust in providing a framework within which the *contraceptive-using body* can be placed.

Although it is suggested that, if room were made for the *blending* of body types across less *rigid* boundaries, this typology, which has been rather neglected, would be of use in body research, for example, as a tool to explore how bodies may *change* from one type to another.

Frank's other theoretical contribution - his triangular model of the body - proved to be a very useful framework in illuminating the whole process of constructing the *'Contraceptive-using body'*. This study is the first research study to apply this neglected typology empirically, and it is suggested that it provides a useful structure within which to explore the social construction of the body, particularly as a way of exploring how the two, highly Foucauldian, notions of *'discourse'* and *'institution'* fit with the body as a *corporeal reality.* This is analysed by utilising the elements of the contraceptive consultation as an exemplar.

Section two of this chapter discusses the limitations of the study and, integral to this, suggests areas of research that could further develop the understanding of contraceptive discourse, power and the body. Firstly, this section proposes that this understanding can be extended usefully by an experiential account of women's embodied experiences of using contraception, for which this study provides useful frameworks or reference points.

Furthermore, the lack of a contraceptive-user's perspective in this study limits the extent to which *resistance* to power can be explored. This is a widely-cited criticism of Foucault's work on power (Rabinow 1984, Lupton 1997, Macleod and Durheim 2002) and an area where further work would be useful. However, it is suggested that this study provides a background that could form the basis for exploring contraceptive resistance, such as, resistance to regimen and/or surveillance.

Section two also explores the possibility of links being made between the data in this study to wider, social structures that influence sexual health, population control and the health of women. To do this, Foucault's work on Governmentality is discussed and the work of Turner (1992) is engaged, particularly his *'societal task'* model, which is presented as a possible framework to link the micro-processes of power deployed in the individual contraceptive consultations with wider power structures.

Lastly, recent developments in contraception are explored briefly and suggestions are made for future research, particularly with other health professionals providing contraceptive counselling in other clinical settings, also in the areas of newly-developed contraceptive methods for women users and of male contraception.

1.14 Summary

This chapter discusses the background to this study in family planning clinics and, through a brief introductory look at the literature, illustrates how consultations between women and nurses in family planning clinics are an under-researched area of women's health, yet form an important clinical space where issues surrounding contraception, sexuality and reproductive health are discussed. The nature of this consultation is unexplored from a sociological perspective. What takes place within the discussion between nurse and woman in the consulting room is relatively unknown, yet, every year, 1.2 million women experience this aspect of reproductive health-care. This chapter therefore outlines how this study aims to make a significant contribution to the development of a *'sociology of contraception'* by addressing this neglected aspect of women's reproductive health. This chapter also provides a summary of the thesis, through a chapter-by-chapter overview. The thesis will now proceed by exploring the theoretical background to the study in detail.

Chapter 2

Theoretical background to the study

2.1 Introduction

This chapter sets out the theoretical background to the study, exploring and expanding on the literature introduced in the previous chapter. The aim is firstly to discuss the emergence of the body as a focus of sociological study. Secondly, the role that sociology plays in understanding the body will be discussed, particularly from the perspective of the social construction of the body. Within this analysis, Foucault's (1973,1977,1981a,1984,1986) writings upon the body, power and sexuality will be discussed extensively. Thirdly, it will explore the development of analytical frameworks connected with the study of the body, particularly the work of Shilling (1993), Turner (1991, 1992, 1995) and Frank (1991, 1995) and other body theorists, mapping out some of the tensions within the study of the body, particularly the vigorous debate over the role played by the physical or *corporeal* body within these analytical frameworks.

2.2 The sociology of the body

Over the last two or more decades the body has, increasingly, been the focus of sociological writing and is now a well-established field of sociological enquiry (Nettleton and Watson 1998, Hancock et al 2000, Howson and Inglis 2001). However, until this relatively recent period, classical sociology has often been accused of adopting a *'disembodied approach'* towards its subject matter (Williams and Bendelow 1998, Shilling 1993, Turner 1992). Turner (1991) identifies a number of reasons for the failure of classical sociology to provide an overt sociology of the body. As Shilling notes, *'these can all be related to the disciplinary projects taken by the 'founding fathers' of sociology* (Shilling 1993:25).

According to Turner and Shilling, one key reason for this neglect of the body was the very scale of the nature of sociological enquiry. The focus of early sociology was not concerned with the historical evolution of human beings, but in developing theory to explain and understand industrial and political revolutions, the growth in wage labour, and the increasing urbanization and mechanisation of society.

Turner (1991) argues that this necessitated explanations based upon societal factors, for example Marxist theories of class struggle and the forces of production together with the theories of rationalisation (Weber), theories of human embodiment did not figure in this process. Furthermore, sociology has, in the past, focused primarily on issues of order and social change. For example, attempts to understand the complexity of industrial capitalism led to development of theory that focused upon *social systems* rather than the *physical bodies* of those who made up those systems (Turner 1991).

In addition, the physical body is often neglected within sociological theories of human agency which have been primarily linked with consciousness and the mind, rather than the physical body, representing the legacy of the Cartesian distinction between mind and body (Howson and Inglis 2001). As Shilling notes, bodies:

> *'Came to be seen, at best, as an uninteresting condition of social action. The body was usually seen as a passive container, which acted as a shell to the active mind (Shilling 1993:26)*

Therefore, because of this, early theoretical sociology did not show much interest in anthropological or biological views of the body:

> *'It was the mind, rather than the body, which served as the receptor and organizer of images concerned with social stratification'. (Shilling 1993:26).*

Shilling (1993:26) contributes two further points to Turner's analysis. One is that the body is *deliberately* absent from the methodological approaches of sociology, in order to emphasise the importance of *'abstract cognitive inquiry'*. Shilling (1993) adds that this necessitated removing the body from this analysis and, citing Durkheim, states the reason for this was in order to remove emotional prejudices that inhibited scientific notions or explanatory concepts (Durkheim1938, cited in Shilling 1993:26).

The second is the interesting point that the gender of the early sociologists was influential, in other words the fact that the *'founding fathers'* of sociology were men influenced their ability to develop a *'sociology of the body'*. Shilling (1993:9) argues that sociology is a social as well as an epistemological project and, had Marx, Weber and Durkheim been women, then the risks to women through morbidity and mortality in childbirth and infant mortality that occurred through the industrial revolution may have led to a greater consideration of the body.

However, despite outlining these reasons for the lack of a *'corporeal sociology'*, Shilling (1993:27) and, to a lesser extent, Turner (1991) also propose that a sensitive re-reading of classical sociology can actually reveal the presence of the body, albeit in an implicit rather than explicit way.

Shilling refers to this concept as the body having an *'absent presence'* (Shilling 1993:9) in sociology. What Shilling is referring to here is the argument that sociology has adopted what he calls a *'dual approach'* to the body (Shilling 1993:9). In other words, it is possible to claim that, although sociology has not adequately addressed the issues of the body itself, it does concern itself with:

> *'The structure and function of societies, and the nature of human action (which) has inevitably led it to deal with aspects of human embodiment (Shilling 1993:9).*

Williams and Bendelow (1998) agree and discuss how the work of Marx addressed the body in terms of labour and the needs of the organic body. Engels, too, in his studies of working life, described the privations and injuries inflicted upon the physical body that were part of the development of a capitalist industrial society. Indeed, Engels specifically refers to the impact of labour on the bodies of women that often created problems with pregnancy and childbearing. Shilling (1993) also points to the work of Goffman and Foucault as examples of the body being given attention in their respective work on interaction order and disciplinary systems, work that will be discussed in detail later. Williams and Bendelow (1998) also point out that, from a critical re-reading of Weber and Durkheim, the body emerges as a significant element (Durkheim's *'dual nature of human beings'* and Weber's notions of the ascetic body and restraint of desire within the Protestant ethic, for example). What sociology has only recently started to do is to explore the explicit, rather than implicit, place of the body in sociological enquiry (Hancock et al 2000).

2.3 The emergence of the body in sociology

Shilling (1993:30) argues that current sociological interest in the body cannot be explained totally by *'its emergence as a new social problem'*. The body, he proposes, has long been seen as important. However, this importance has, until recently, been a concern of governments. Shilling (1993) identifies concerns over the physical fitness of the population in the United States and Britain, centred around the health of military recruits and issues relating to the malnourishment of the poor.

Both of these issues were linked to wider concerns related to the physical deterioration of the population or *'stock'* and led to programmes of national efficiency that *'were far more to do with the body than with the mind'*. (Shilling 1993:30). These concerns were also closely linked with Eugenics, driven by fears of excessive birth rates among the poor (Searle 1971, Weeks 1989).

According to Nettleton and Watson (1998), there is a consensus in the literature about the reasons for the growing salience of the body. Numerous authors discuss these within their writings on the body (Turner 1991, Shilling 1993, Williams and Bendelow 1998, Hancock et al 2000, Twigg 2002). Broadly speaking, these reasons, although having a degree of overlap, can be presented under a number of discrete headings.

2.3.1 Demographic factors

A major issue for western society is the ageing of the population. This has created a number of areas for debate and analysis relating to the body. Turner (1992) identifies that increasingly ageing populations have serious implications for social policy and health and welfare expenditure, both in terms of the growing illness burden and of the increase in disability.

Work by several authors has illustrated how the older body is conceptualised by society (Featherstone and Hepworth 1989, Featherstone and Wernick 1995, Blaikie and Hepworth 1997). In addition, numerous authors have explored the impact of ageing upon women's bodies. For example Laz (1998) and Woodward (1991) both explore the issue of cosmetic surgery in older women and, along with Fairhurst (1998), discuss the social and economic pressures on women to *'grow old gracefully'*.

Turner (1991) adds that concerns over the ethical implications of medical interventions, such as artificial insemination, cloning, transplant surgery and pharmacological techniques upon the body, also focus attention upon the physical body. Sawicki (1991) and Martin (1989) both point out that this technology is often aimed at women and their bodies, an aspect that will be discussed shortly.

2.3.2 Rationalizing the body: a crisis in meaning

Williams and Bendelow (1998) argue that, as we become more aware of our bodies, we are accompanied by a growing uncertainty over what the body is. Competing theories to explain the body, for example medical and alternative explanations, create confusion, as does the growing use of technology and our ability to mechanically alter and enhance the body.

Advances in transplantation technology have led to greater developments in the ability to control the body (O'Neill 1985). One major effect of this technology has been the rationalization of the body as *machine* both in professional discourse on health and disease but also from lay perspectives of the body (Rogers 1991).

Shilling (1993) points out the potential conflict between the assertions that bodies are on the one hand becoming more individualised yet, on the other hand, regarded as machines, mass produced and identical in structure. However, he adds that the two propositions could be reconciled by:

> *'The individual feeling that the body is their machine which can be maintained and fine tuned through diet, regular exercise and health check up'. (Shilling 1993:37)*

2.3.3 Consumer culture

Accompanying demographic changes have been fundamental changes in social structure. Featherstone (1991) and Glasner (1989) both comment upon the replacement of competitive capitalism based on disciplined labour forces, industrial production and the associated decline of the traditional working class, with a lifestyle increasingly centred upon consumption and leisure. The use of the body in marketing and advertising and the portrayal of women's bodies in particular, has increased debate about the body and it symbolism.

Turner also refers to the rise in *'keep fit, the body beautiful'* (Turner 1991:21) as being inherent parts of consumer culture. Featherstone (1991) supports this notion and Ogden (1992) illustrates the impact of this process on women by research in the United States that revealed only 10% of women have never dieted.

Shilling (1993) develops this discussion, making reference to the *'body as a project'*, meaning that in the affluent West, consumerism has created the notion of the body as being in the process of:

> *'...becoming; a project that should be worked upon as part of an individuals self-identity' (Shilling 1993:5)*

Shilling adds that treating the body as a project, although not necessarily entailing a full time preoccupation, nevertheless does involve an individual:

> *'..being conscious of and actively concerned about the management and maintenance of appearance of their bodies'. (Shilling 1993:5)*

In response to the rise in consumerism, a number of researchers have emphasised the impact upon female bodies. For example, a number of authors explore how the female body has been normalised and commodified within consumer discourses (Dyer 1982, Winship 1983, Kilbourne 1995, Brook 1999) and also the way in which women are portrayed on magazines as glamorous, sexual and domestic with the female body being used as persuasion to consume (Mc Robbie 1996). Smith (1990) argues that consumer discourses often inform women that their bodies are inferior and require improvement; the body as an object to be remedied, with attention required to mouth, hair, teeth and other body parts. Indeed, such discourses are the subject of work that explores the rise of cosmetic surgery among women (Davis 1995, Brush 1998) and also keep fit and body-building (Hall 1996).

However, in response to this discussion, some authors have suggested that consumerism has been instrumental in helping to shape the individualized feminine self, for example by using the many *'masquerades of femininity'* to manipulate social position (Evans and Thornton 1989:67) and allowing women to *'play with identity'* by adopting different roles (Lury 1996:89). However, within feminist literature, consumerism has generally been regarded as a force that has reinforced patriarchy and the representation of the female body in constraining and negative ways (Wilson 1985, Bartky 1990, Bordo 1993). Indeed, it is feminist writings dealing with the body that have made significant contributions to the body within sociological theory and its importance as an object of social significance within studies of power (particularly Patriarchy), relationships and social policy (Sawicki 1991, Davis 1997, Brooke 1999).

2.3.4 Feminist work on the body

Nettleton and Watson (1998) and Davis (1997) propose that the growing *politisation* of the body, particularly within feminist writing, is a key factor in the emergence of the body as an object of sociological investigation. Feminist research is significant in highlighting the importance of the body within sociological debate, particularly in the area of gender inequality, for example, as Brook (1999) points out:

> *'Feminist thinkers have always been interested in the way women's bodies are talked about, classified, disciplined, invaded, destroyed, altered, decorated and more' (Brook 1999: 2)*

Turner (1991) argues that, eventually, feminist criticism and analysis of the subordinate position of women created a much greater sensitivity towards gender, sexuality and biology on the part of social theorists. Davis (1997) illustrates this by highlighting the fact that feminist analysis of female oppression created academic conceptualisations of, for example, patriarchy and, within these critiques, the biological body figured strongly as the source of patriarchy. Shilling (1993) notes that one of the effects of feminist work was to:

> *'....address directly the body's implication in systems of domination and subordination'. (Shilling 1993:32).*

Shilling (1993) and Turner (1991) both point also to the impact feminism had on debates relating to the commodification of women's bodies, for instance in pornography and prostitution. Singer (1990) clearly describes the impact of an increasingly complex society upon women's bodies:

> *'The well managed (woman's) body of the 80's is constructed so as to be even more multifunctional than its predecessors. It is a body that can be used for wage, labour, sex, reproduction, mothering, spectacle, exercise, or even invisibility as the situation demands (Singer 1990:138)*

Ussher (1989, 1992), Davis (1997) and Brook (1999) propose that medical discourse has been fundamental in defining woman's bodies, and that this definition has resulted in women becoming socialised into looking to the crucial biological events in their lives, menstruation, pregnancy and the menopause for their sense of self. Furthermore, they suggest, that it is around these biological events that power relations operate, in fact it is in this context that much of the feminist literature about the body is placed.

Feminist critiques of child development, socialization and gender, as well as studies that explore the effects of male-oriented knowledge that informs medical services and treatment of women's bodies during pregnancy and childbirth, have all added to the emergence of the importance of the body in sociological theory. Work by Kirkham (1989), Young (1990) and Duden (1993) discusses how health professionals use information and technology to control women during pregnancy and childbirth, where access to information is linked to power, and medical technology and scientific discourse are utilised to encourage docility and compliance. Both Arney (1982) and Oliver at al (1996), in research involving invasive tests during pregnancy, refer to the impact of the *'medical gaze'* upon women's obstetric care and treatment and to the effect it has on ensuring compliance with medical interventions and method of delivery. More recently, Root and Browner (2001) explored how pregnant women experience tensions between medical advice and lay notions of maternity care.

Peckover (2002) explored the deployment of power by health visitors when *'policing'* the bodies of children through their mothers. Peckover (2002) argues that health visitors deployed power in ways that encouraged and facilitated women to become *'good mothers'* by monitoring their children's bodies, but were also engaged, in a more regulatory manner, in surveillance of both the physical development of the child and the nature of the care that it received through the use of bodily measurements.

Gerson (1989), Rowland (1992), Raymond (1994) and Harraway (1997) argue that the emergence of new biotechnologies, such as cloning, artificial insemination, in-vitro fertilization and other *'test tube'* techniques are further examples of the impact of medical power upon women's bodies, and that this reflects a continuing trend towards the medicalisation of fertility and women's bodies. Howson (1998, 2001a) proposes that growing surveillance of the health and bodies of individuals has particularly affected women and points to the area of cervical cancer screening as an example of the way in which women's bodies are monitored, codified and medicalised. Howson (2001b) also argues that cervical screening provides an interesting example of encouraging what Armstrong (1983) and Pryce (2000: 104) identify as the *'active patient',* in that women are provided with information and knowledge upon which they are expected to act; in this instance by utilising screening services voluntarily, thus placing themselves under surveillance in the name of improving their health.

Bush (2000) builds upon the work of Howson (1998, 2000a) by exploring the medical discourses and power issues within a study interviewing women attending cervical screening. Bush (2000) describes how the processes of normalisation and obligation operate within the screening programme inasmuch as this invasive medical surveillance is framed within the discourse of it being the right and normal thing to do for women and that women have a duty to their own health to participate. Bush also alludes to, but does not develop further, a brief link to contraceptive regimen in her analysis of interviews with women, in that one respondent remarks upon the prescription of the pill being linked to obligations to participate:

> *'the first time I had it done (cervical screening) was when I was on the pill, I thought they're doing this as a test to see if I'll go through with it, you know..if it puts you off having the pill then you don't really want it' ('Sandra' cited in Bush 2000:13)*

Menopause and menstruation also figure strongly in the feminist literature, for example (Buckley and Gottlieb 1988, Laws 1990, Bransen 1992). Martin (1989), particularly, discusses the impact of machine metaphors upon how women's bodies are conceptualised. Using menopause and menstruation as an example, she outlines how the images of a failing machine, disintegrating systems and a lack of adequate sustenance are used within medical and lay descriptions of the menopause, menstruation and ovulation. Martin also makes interesting links with discipline and authority by proposing that women's bodies are often represented as the undisciplined or transgressing body:

> *'In both medical and popular books what is being described is the breakdown of a system of authority'. (Martin 1989:42).*

Martin (1989), Laws (1990) and Grosz (1994) argue that institutional regimes frequently subject women's bodies to more control than men's, referring to the treatment of women in the workplace, where they are expected to manage and conceal menstruation, pregnancy and menopause. Both Martin's work on menstruation and menopause and Law's work on menstruation draw significantly on historical medical texts to develop their arguments. These texts can be thought of as both originating from and influencing discourses around the body that, in turn, influence dominant thinking and, subsequently, the practices and techniques associated with the body (Sawicki 1991).

More recently Leysen (1996), Wingerden (1996) and Harding (1997) discuss the social construction of both the menopause and hormone replacement therapy (HRT) as the deployment of the medical gaze and a further example of the surveillance of the female body. Harding (1997) claims the growth of HRT is an example of the increased emphasis on women to take care of themselves, to be responsible and to monitor their body for signs of *'deterioration'*. Leysen (1994) and Harding (1997) also argue that this process can be linked to social values around the ageing female body and also the notion of disease prevention, therefore implicit in HRT discourse, are the notions of risk and vulnerability from hormonal decline and the responsibility to be active in absorbing information to enable its early signs to be recognised and acted upon.

2.3.5 Dissatisfaction with Naturalistic theory

A significant factor that influenced particularly feminist, but also other sociological approaches to the body, was a general dissatisfaction with theories of the body from within other disciplines, for example biology, genetics and anthropology, that tend to view the body as an obdurate, pre-discursive object. In general, sociological thinking about the body can be regarded as hostile to these naturalistic views of the body (Williams and Bendelow 1998). However, naturalistic views have been quite instrumental in forming popular and scientific thinking about bodies for centuries (Hancock et al 2000) and, as such, still influence the way in which bodies are regarded today. This is particularly evident within medical discourse, especially where this encompasses women. Naturalistic theory has at its core the notion that the physical body is responsible for creating the world around it:

> *'Naturalistic views hold that the capabilities and constraints of human bodies define individuals, and generate social, political and economic relations which characterize national and international patterns of living'. (Shilling 1993:41)*

Naturalistic theory draws heavily upon biological explanations of the body, and can be linked closely to theories about gender (Williams and Bendelow 1998, Brook 1999). Certainly dominant throughout the eighteenth and nineteenth centuries, naturalistic theory utilises biological *facts* to explain sex and the body, particularly women's bodies.

Naturalistic theory usually placed women's bodies in an inferior position to that of men. Women, their bodies and sexuality were described in terms of frailty, governed by fluctuating hormonal influences, which both gave reason to, and explanation of, the social status and behaviour of women. As Weeks (1989) states:

> *'The assumption that women were dominated by their reproductive systems (women belonged to nature, while men belonged to culture) was implicit in all medical attitudes.' (Weeks 1989:43)*

Laquer (1987) and Martin (1989) argue that biological explanations of female physiology were used to support theories of male dominance. For example, theories relating to menstruation were utilised to deny women access to numerous civil rights (Shuttleworth 1990).

Medicine increasingly identified the reproductive cycle with disease; menstruation was seen as *'being on the borderland of pathology'* (Weeks 1989:43). This medicalization often led to attempts at *'treatment'*, for example ovariotomy and clitoridectomy as cures for, among other ailments, epilepsy, hysteria sterility and insanity. Naturalistic explanations of the body often conceptualised the female body as unstable and unruly and more susceptible to disease than its male counterpart (Jordanova 1989, Schiebinger 1989, Jacobus 1990, Laws 1990)

The key aspect of the naturalistic approach is that it made its claims based upon the natural order of things. Proponents of naturalistic theory were merely describing the rules of nature, so not only did naturalistic theory describe the role of women in terms of sexuality and embodiment, it also stressed the natural, unchangeable and pre-ordained nature of things. This naturalistic approach impacted particularly on the way in which health professionals treated women. Women were seen as being completely defined and limited by their bodies (Martin 1989, Laws 1990, Brook 1999), prisoners to the vagaries and uncertainties of reproductive events and cycles.

Naturalistic theory, therefore, has exerted a tremendous influence over the way in which the female body is seen within the context of health care. Although no longer the pervading powerful influence it was, it can be argued that its influence can still be seen in modern health care, for example in the often negative and mechanistic language utilised in women's reproductive health (Martin 1989, Laws 1990, Sawicki 1991, Brook 1999).

However, although naturalistic theory has tended to be heavily criticised by social theorists, there are some areas where it could be thought of as making positive contributions. Williams and Bendelow (1998) argue that naturalistic theories (when rid of their often racist, sexist, biological reductionist baggage) do at least take the physical *corporeal* body seriously in the way in which it contributes to social relations, an aspect of body sociology that will be returned to later.

Nevertheless, broadly speaking it was the general dissatisfaction with naturalistic accounts of the body that led to the development of theory that explains and understands the body as a *socially constructed,* rather than a naturalistic, phenomenon (Turner 1992, Shilling 1993, Williams and Bendelow 1998, Nettleton and Watson 1998, Hancock et al 2000).

2.4 Social construction of the body

Social constructionists are united in their view that the body cannot be understood purely as a biological phenomenon, although there is considerable debate within this field (Hancock 2000). This debate is concerned with the way in which the physical body is conceptualised within sociological theory, in other words to what extent is the body created by social structures and processes and to what extent does the physical body itself as a corporeal reality influence the world around it. Furthermore, if it is accepted that the physical body has a pre-discursive *corporeal* role, how do we understand the relationship between the two? This issue will be returned to in detail later. However, before that, the work of two of the most influential social constructionists Goffman and Foucault will be discussed.

The body is central to a large part of Goffman's work, particularly his analysis of the problems of the interchanges in everyday life and especially the body's role as a component of action. Williams and Bendelow (1998) propose that Goffman makes several important contributions to the sociology of the body. Firstly, Goffman's (1971) analysis of micro-public order originates from his keen observations of bodies negotiating public space and the skills, rules and values the body needs to develop in order to simply walk along a busy street.

Williams and Bendelow (1998) point out that Goffman's analysis:

> *'reminds us that social order rests upon these micro-public foundations, and that these foundations are in turn dependant upon corporeal competence (body techniques) and know how of the sentient body-subject'. (Williams and Bendelow 1998:57)*

For Goffman, face and body work are crucial to understanding the interaction order and he cites the body and face in several examples of how people manage interactions in social spaces using bodily gestures and glances, for example constantly looking around and glancing at a wrist watch to reinforce the notion of waiting for someone and to dispel the notion that one is *'loitering with intent'*.

Secondly, Goffman's study of embarrassment and stigma are important to the view of the socially-constructed body and are important in the formation of the *'self'* (Williams and Bendelow 1998). In embarrassment, the body clearly gives signs of interactional unease - for example blushing, stammering and other non-verbal behaviour, and it is these processes to which the body is central, and that have so much influence on human interaction.

In his analysis of stigma, Goffman (1967) points out the impact of *'stigma symbols'* or visible signs emanating from the body on social interaction and self-identity. Such symbols, for example physical signs of disease or disability, result in the 'discrediting' of individuals in the eyes of others. Even stigma symbols that are not immediately apparent, but may become visible, influence interaction in that they create a dilemma as to whether or when they are revealed and thus impact upon the *'interactional baseline'* from which a person operates. This also reveals the central role occupied by the body. An excellent example of this is the visible presence of sarcoma lesions, the purple/black skin lesions, often developed by people living with HIV infection, marks that have often been referred to as the stigmata of AIDS.

The third contribution Goffman makes to the sociology of the body is understanding the role of the body in the *'interaction order'* (Williams and Bendelow 1998:61). This is particularly evident in the arena of social class and behaviour.

Goffman proposes that symbols of class status are actually embodied and enacted during social interaction:

> *'These behaviours involve manners of etiquette, dress, deportment, gesture, intonation, dialect, vocabulary, small bodily movements and automatically expressed evaluations concerning both the substance and details of life. In a manner of speaking, these behaviours constitute a social style'. (Goffman 1951:300)*

Within Goffman's analysis, such symbols and bodily behaviours are both symbolic and constitutive of social structures, for example gender inequality is both symbolised and constituted by the bodily act of a man opening a door for a woman (Williams and Bendelow 1998). However, both Williams and Bendelow (1998) and Crossley (1995) argue that, although Goffman's work illustrates the tremendous importance of the physical body to social interaction, it is not concerned centrally with *how* the body is socially constructed, but rather how the body *acts and works* to construct and reproduce the world.

In the main, this is a fair criticism, although in his work on asylums, Goffman (1968) does make some limited references to how the body is constructed when discussing medicine and the *'tinkering trades'* (Goffman 1968:281). What Goffman begins to explore is how the human body is constructed in some medical encounters like a machine and he cites metaphors employed in medical interactions drawing upon engineering, for example as parts of engines can wear out or become blocked, so can the human body. However, Goffman mainly uses this example to go on to discuss how medical encounters mimic interactions with other *'trades'*, for example mechanics and plumbers, and does not significantly develop the construction of the body as machine much further.

Many authors cite the work of Foucault as having the most impact on the social construction of the body (Shilling 1993, Williams and Bendelow 1998, Nettleton and Watson 1998). For Foucault, the body is entirely socially constructed within the overlapping domains of power and discourse. Therefore, to understand the social construction of the body from a Foucauldian perspective, it is necessary to explore how Foucault's writings upon these central issues of power and discourse interlink with the body (Nettleton and Watson 1998).

2.5 Foucault and power

Discourse is the most important aspect of Foucault's work, for Foucault discourses are regarded as *'deep principles'* that incorporate *'specific grids of meaning'* which underpin, generate and establish relations between all that can be seen, thought and said (Dreyfus and Rabinow 1982). As Shilling (1993) notes, the body, for Foucault, is not simply a focus of discourse but is completely constructed by discourse. For Foucault, the body does not exist outside of discourse. Foucault also sees the body as crucial to understanding power; he proposes that the body constitutes *the* link between daily practices on one hand and the large-scale organization of power on the other (Foucault 1981a).

Foucault's analysis regards power as something much more amorphous, intricate and complex than most orthodox or traditional descriptions, such as Mills (1958) Parsons (1967) or Weber (1947), which tend to regard power as an identifiable, top down, mainly oppressive and coercive force. Furthermore, unlike the previously-cited theorists, Foucault's analysis, is not geared towards producing a grand theory of power (McGowan 1994, Driver 1994), but is more closely related to an understanding of the mechanics of power that enable an exploration and analysis of everyday interactions and practices. However, Foucault also proposes that an understanding of how these power relations operate within the most basic interactions and processes of social life can be linked to understanding wider systems of power. In other words, Foucault's work on power, as McGowan states, offers us an *'analytics of power'* (McGowan 1994:96).

In fact, as Driver proposes, rather than formulating a specific theory of power, what Foucault did was to:

> *'pose more modest questions about how power is exercised in particular sites and settings'. (Driver 1994:117)*

However, although Foucault's discussions about power are not intended to produce a *'grand theory'*, this does not mean that Foucault was uncritical about traditional theories of power, or that he did not propose radically different ways of analysing it (Sawicki 1991, Driver 1994:117).

In exploring Foucault's analysis of power and the body it is important both to understand the fundamentally different way in which Foucault defines power and also to explore his rationale for approaching power in this way. It is also important to understand that Foucault's views on the nature of power, power relations, and discursive construction of the body have not been static. Throughout his writings on power and the body, Foucault's ideas have undergone shifts, developments and refinements, particularly to the nature of power and its effect upon the body. However, a first step in this understanding is to look at Foucault's early notions of power and the body, which he developed from his historical analysis of the nature and location of power in modern societies.

Central to Foucault's (1977) writings on power is that, since the Classical Age, the concept of power in the West has undergone significant changes in emphasis and direction. This change is signified by a movement away from a juridico- discursive model of power or *'sovereign power'* to a form of power concerned with fostering and administering life. This change was due to economic and social developments that created a growing concern for the lives and welfare of people, also a growing interest in people's minds, as well as their bodies. This shift was necessary in order to take account of the increasing development of society into more complex, modern, capitalist and industrialised structures. Inherent within this modern society was a need to exercise power, not through brute force, but by means that were more related to surveillance, physical and mental discipline and stimulation (Shilling 1993)

There was a fundamental move within mechanisms of power to control, monitor, organize and optimise, rather than power mechanisms based upon submission and destruction, a move from repression to regulation (Minson 1986, Sawicki 1991, Armstrong 1994). According to Rabinow (1984) and Armstrong (1994) this shift marked a greater concern with the widening of government to matters beyond *'that of the state'* to issues connected with *'economy and social order'*. For Foucault, the body is *the* focus of power. Individual bodies and the collective bodies of the population, therefore, are *the* targets of the discursive practices through which power operates.

Foucault describes his own work as a *'history of bodies'* (Williams and Bendelow 1998), whilst Shilling (1993) notes that central to Foucault's work is a concern with mapping the relations that exist between the body and the effects of power upon it, by exploring how the *'micro-physics'* of power operates in modern institutional forms:

> *'through progressively finer channels, gaining access to individuals themselves, to their bodies'. (Foucault 1980:151)*

According to Foucault, power over the body became divested within a variety of institutions to which were accorded specific technologies of control, for example, crime, health and states of mind (Hewitt 1991). These technologies originally manifested themselves as quite repressive and coercive in nature, Foucault in his writings upon crime and punishment (1977,) identifies the emergence of routine, drill, disciplinary regimes and close observation in penal institutions as replacements for execution and torture and, in his early writings on medicine (1973), describes how medical discourse created whole categories of mental and sexual 'disorders' that were managed by the disciplinary regimes of the asylum and the hospital. Within these power relations, Foucault often refers to the docility of the body. His early writings discuss power and discipline in terms of how they operate to *subjugate* the body, in order to control it. His early analysis of power, therefore, was one that primarily discussed the repressive nature of power and how it was deployed through *'the myriad of power relations at the micro level of society'* (Sawicki 1991:20).

However, Foucault's later writings (1984, 1986, 1991) place a different emphasis upon the role of power and the body. Foucault identifies a movement away from power relations that were coercive and repressive to relations that he referred to as *'productive power'*, in other words power relations operated in ways that sought to control and regulate more by persuasion and normalisation than by coercion (Sawicki 1991). In other words, power became something that exerted a *'positive'* influence on life. It is productive rather than oppressive, although still seeking to regulate and control (Rabinow 1984):

> *'A power that exerts a positive influence on life, that endeavours to administer, optimise and multiply it, subjugating it to precise controls and comprehensive regulations.' (Foucault 1981a:137)*

The mainstay of Foucault's analysis of power is that it needs to be thought of as an amorphous, fragmented, fluid and multi-layered concept, rather than something that has a definite owner and place. Sawicki (1991) provides a useful analysis of this, proposing that Foucault's thinking about power stems from his critique of the Juridico-discursive model of power, which, according to Foucault, involves three basic assumptions (about power):

> *In the Juridico-discursive model,*
>
> 1. *Power is possessed (for instance, by individuals in the state, by a class, by the people).*
> 2. *Power flows from a centralised source from top to bottom (for instance, law, the economy, the state)*
> 3. *Power is primarily repressive in its exercise (a prohibition backed by sanctions)*
>
> *(Sawicki 1991:20)*

Foucault proposes that other forms of power have increasingly supplanted this model and suggests, according to Sawicki, that we need to think about power outside the confines of state, law or class to allow ourselves to locate the forms of power that are obscured by traditional theories (Sawicki 1991). Foucault does not see power as something that was universally produced by institutions, laws or systems of domination (Hewitt 1991); instead, power is something that occurs in all relations:

> *'Power is everywhere, not because it embraces everything, but because it comes from everywhere'. (Foucault 1981a:93)*

To Foucault, power is not something prescribed by and administered by great social institutions, in other words 'top down'. Power is the complex web of discourses and relationships that occur, interconnect and become comprehensive systems:

> *The rationality of power is characterized by tactics that that are often quite explicit at the restricted level where they are inscribed (the local cynicism of power), tactics which, becoming connected to one another, attracting and propagating one another, but finding their base of support and their condition elsewhere, end by forming comprehensive systems.' (Foucault 1981a:97)*

Power, then, according to Foucault, is everywhere. It manifests itself in every interaction, meeting, exchange and relationship between people in every aspect of their lives. Power is something that occurs during specific interactions between specific people and it is these specific interactions that contribute to wider and more global power relations. In other words, as Sawicki (1991) explains, Foucault's analysis of power differs clearly form the Juridico-discursive model in three basic ways:

> *For Foucault,*
>
> 1. *Power is exercised rather than possessed*
> 2. *Power is not primarily repressive but productive*
> 3. *Power can be analysed best by exploring the micro-power relations in everyday events.*
>
> *(Sawicki 1991:21)*

According to Sawicki (1991:22) Foucault's reasoning behind this analysis is threefold. Firstly, in replacing the notion of power as a *'possession'* with a relational model of power as *'exercised'*, we can give an account of how subjects are constituted by power relations. Secondly, by focusing on *'productive power'* rather than on *'repressive power'* we can explore how institutional and cultural practices discursively construct the *'individual'* Thirdly, utilising an *'ascending analysis'* (Foucault 1981a:198), we can explore how power relations at the micro-level of society make possible certain global effects of domination, such as patriarchy. In other words, to understand power and how it operates one must:

> *'Conduct an ascending analysis, starting that is from its infinitesimal mechanisms, which each have their own history, their own trajectory, their own techniques and tactics, and then see how these mechanisms of power have been...and continue to be – invested by ever more general mechanisms and by forms of global domination'. (Foucault 1980:198)*

In order to further understand Foucault's analysis of power, it is important to explore precisely how power over life took form and what Foucault means by his references to discipline, surveillance and discourse.

2.6 Power over life

Fundamentally, Foucault argues that power is principally about power over bodies- individual and social, private and public (Driver 1994). Twigg states that, for Foucault:

> *'Power is capillary. It acts through the micro-technologies of disciplinary regimes as they operate on a day-to-day basis on the bodies of individuals' (Twigg 2002:431)*

Wickham (1986:155), Hewitt (1991) and Deacon (2002) describe how Foucault identifies two central mechanisms around which power over life occurred, two *'poles of development'* that are:

> *'Not antithetical, however; they constituted rather two poles of development linked together by a whole intermediary cluster of relations' (Foucault 1981a: 139)*

The first of these poles, the *'anatamo-politics of the human body'*, centres upon the body as a machine and particularly relates to the individual physical body:

> *'Its disciplining, the optimisation of its capabilities, the exhortations of its forces, the parallel increase of its usefulness and docility, its integration into systems of efficient and economic controls'. (Foucault 1981a: 139)*

The second pole, *'bio-politics'*, is focuses on the population or the *'species body'* and relates to the way in which the population is seen as a sum of bodies:

> *'.... Imbued with the mechanisms of life and serving as the basis of the biological processes: propagation, births and mortality, the level of health, life expectancy and longevity, with all the conditions that can cause these to vary'. (Foucault 1981a: 139)*

Foucault uses the term *'bio power'* to describe the way in which this *'bipolar technology'* is put into practice (Wickham 1986;156, Twigg 2002, Deacon 2002):

> *'Hence there was an explosion of numerous and diverse techniques for achieving subjugation of bodies and the control of populations'. (Foucault 1981:140)*

Particularly, he proposes that the instruments of discipline and regulation were the way in which bio power took form and operated strongly upon the body (Twigg 2002). Central to the deployment of *'bio-power'* was the development of medical power through the *'medical gaze'* (Foucault 1973: 14).

The *'gaze'* or *'regard'* given its most literal translation is a whole system of knowledge about the body. It is based upon the anatomical, physiological and pathological discourses that surrounded the development of medicine. The *'gaze'*, argues Foucault, constructs the body; it is a way of seeing and defining the body that creates a powerful and extensive web of power in which the body becomes enmeshed or, as Armstrong (1983) describes, a system of power in which the body was constructed:

> *'The modern body of the patient, which has become the unquestioned object of clinical practice, has no social existence prior to those same clinical techniques being exercised upon it. It is as if the medical gaze, in which is encompassed all the techniques, languages and assumptions of modern medicine, establishes its authority and penetration an observable and analysable space in which is crystallised...the discrete human body' (Armstrong 1983:2)*

A key aspect of Foucault's work, therefore, is how this *'gaze'* and the resulting power/knowledge are deployed.

2.7 Power, knowledge and discourse

Foucault (1981:94) refers to *'power-knowledge'* to explain how power pervades and influences social relations and interactions by emphasising the importance of discourses (Sheridan 1980, Rabinow 1984, Howarth 2000). It is discourse that Foucault sees as instrumental in creating *'operational policies'* around which gather specific *'practices'*, in other words, common groupings of discourses and techniques. Foucault elaborates upon his meaning here by using medical practice as an example:

> *'Within this definition (of practice) 'medical practices' does not refer just to those actions which occur within and are constrained by medical institutions...it also refers to the knowledge or discourses which keep these actions in place, those knowledges and discourses which are part of the conditions of existence of these actions'. (Foucault, quoted in Phillipps, 1982:58)*

For Foucault, then, discourse is a key concept in the analysis of power. As Driver states:

> *'power, in Foucault's analysis, does not exist prior to discourses and practices, on some other plane or level; rather, it operates through them'. (Driver 1994:116)*

Discourses are the way in which power is created, sustained and employed. However, in Foucault's analysis, discursive practices are subject to change and can operate via differing mechanisms. A central change in Foucault's analysis of discourse was the shift from *'objectification'* to *'subjectification'*. *'Objectification'* was certainly the process that, Foucault argues, takes place within his earlier writings on discourse and power. *'Objectification'* refers to a process by which individuals are discursively created into objects of study, often by being categorised and separated from the norm, for example the development of diagnostic categories such as *'the leper'* and also later, to the development of other, more broad and social categories, the *'homosexual'* and the *'insane'*. Foucault proposes two key discursive practices by which the process of *'objectification'* took place:

'Dividing practices' – modes of manipulation that combine the mediation of a science and the practice of exclusion, for example confinement of the poor, insane and diseased. Dividing practices represent the combination of power and knowledge in order to categorise, control and restrain individuals and groups. These practices led to the development of social practices and institutions designed to physically separate sections of the population - for example the asylum, the leper colony and the prison.

'Scientific classification' – a related, but more oblique, process where science objectified subjects in a number of ways, for instance, the 'speaking' subject in linguistics, or the living body in biology. From this objectification came the *disciplines*, specific areas of discourse related to the particular object or person, for example biology created the *biologist*. Although not as overtly dominating as dividing practices, scientific classification often resulted in the production of subjects that require control, for example *'sexual deviants'*. However, control was often employed more obliquely, for instance through psychiatry or psychoanalysis, rather than by imprisonment.

However, although Foucault does not claim that these practices have totally disappeared, his later writings on power and the body argue that power mechanisms and discursive practices have shifted more from objectifying individuals as categories and classifications to a process that constructs the individual as a person as a *'subject'*, through the process of *'subjectification'*.

Rabinow (1984:7) argues that this shift is representative of the development of Foucault's concepts of power and the body over time, whilst Howarth (2000) points out that the move from *'objectification'* to *'subjectification'* parallels the developments of Foucault's thoughts on power and how he developed his notion of power relations and the body from repressive to more productive techniques. Foucault refers to his attempts to locate and analyse the strands of discourse and practices dealing with the subject (i.e. the person) as ' *the genealogy of the modern subject'* (Rabinow 1984). In other words Foucault was concerned with exploring and analysing the modes by which human beings are made into subjects, a process he calls *'subjectification'* (Rabinow 1984:7)

'Subjectification' - According to Rabinow (1984) and Howarth (2000), this process differs considerably from the previous two modes. *'Dividing practices'* and *'Scientific classification'* are mainly techniques of domination and coercion and, although they both operate through different discursive mechanisms, they share a common theme, in that in the body is passive and docile:

> *'Being either a person in a cell or whose dossier is being compiled' (Rabinow 1984:11).*

Importantly, within the process of subjectification, Foucault argues that, in the process of self-formation, the person is *active,* not passive. Howarth (2000) argues that subjectification is a process within which individuals:

> *'turn themselves into subjects through processes of recognition and self mastery'. (Howarth 2000:80)*

This process has a long and complex history and is closely linked to Foucault's later work on sexuality that will be discussed shortly. However, Foucault's analysis here is generally about identifying the techniques through which a person initiates an active self-formation, which take place through:

> *'operations on (peoples) own bodies, on their own souls, on their own thoughts, on their own conduct.' (Foucault, cited in Rabinow 1984:11)*

Importantly, Rabinow (1984) argues, these practices of self-formation involve a process of self-understanding that is *mediated* by an external authority figure.

Therefore, discursive formations around self-identity consist of discourses related to the understanding of self, but are crucially linked to the discourses of specific disciplines, for example sexuality, where Foucault (1981a) argues that the proliferation of discourses on sex were closely linked to the process of self understanding. However, self understanding obtained through the medium of the *'therapist'*, whose interpretations would be influenced by and framed within the specific discourses of the discipline, for example self-understanding and sexuality may be facilitated within a Freudian psychoanalytic framework.

What can be traced here is a key change in the way discourse is employed within techniques of regulation and control: a change that looks increasingly to individuals to become actively involved in the management of themselves and their bodies, rather than a process that overtly controls a passive, docile individual. Nonetheless, this process may still incorporate elements of discipline and control, but by utilising different, less visible and less coercive means.

An excellent example of this can be seen within the work of Armstrong (1983, 1993), who explores the development of the *active patient* within health and medical practice. Within the power relations of the *'dividing practices'* and, indeed, *'scientific classification'* the patient (the body) was docile, it was a body that was acted upon, surgically operated upon, diagnosed, prescribed to and observed. Armstrong (1993) proposes that, over time, the role of the patient has undergone a significant change. Utilising the historical development of health and medicine, Armstrong (1993) explored the rise of personal hygiene and sanitary practices to explain how the individual person (patient) became an active participant in the practices of health care, as the shift of emphasis in the latter part of the nineteenth century moved from structural sanitation to personal hygiene and developed a range of discourses that incited and encouraged *individual* hygienic practices. What this shift represented was the emergence of health and medical discourses that employed tactics exhorting individuals to act themselves in order to improve their health and prevent disease, a process that Armstrong (1993, 1984) and others (Gastaldo 1997, Lupton 1997, Bunton 1997, Nettleton 1997) argue has become a key element within the disciplines of health promotion and education, where patients are recruited as *'partners'* in disease prevention programmes and begin to use medical and scientific discourse to understand themselves and their own bodies.

It was to this process, by which individuals came to understand themselves, that Foucault's attention turned during his later work. His notion of a move within the dividing practices towards *subjectification* led him to explore how this self-understanding was discursively structured and, importantly, how the power techniques of discipline and regulation operated within it. To this end, Foucault began to look extremely closely at the discursive techniques used within the process of subjectification. Sheridan (1980) and Howarth (2000:80) both describe how Foucault identified *'procedures of exclusion'* that act to control and organise discourse within the development of self-understanding;

Prohibition – simply, we cannot say what we want, when and where we like, and not just anyone can speak of anything. In other words, as Sheridan (1980) illustrates, certain subjects became taboo in certain circumstances. However, some speakers, in some contexts, are allowed to initiate such discourse, for example doctors or teachers may be allowed to discuss sex in an educational context, whereas their patients and pupils will have constraints on their discourse.

Division and rejection – the separation of discourses, based upon assumptions about their relative importance. For example, the importance attached to the words of the doctor compared to the words of the patient.

The true and the false – *'the will to truth'*. This aspect concerns the power of knowledge and the ability to claim to be professing the truth. An example of this is the development of the sciences and the creation of body's of knowledge, supposedly free of human influence, that were empirically proved to be facts, the *truth.* Therefore, other, alternative body's of knowledge were dismissed, denied, even outlawed, because they were labelled as false, untrue. A contemporary example would be the tensions between orthodox and *alternative* medicine.

Foucault then turns to another set of procedures that limit discourse. However, as Sheridan (1980) points out, instead of operating from outside discourse, like the exclusions above, these procedures act from within discourse:

Commentary – is the way in which key primary texts or narratives, for instance religious or scientific texts, come to control and inform discourse Howarth (2000) argues that these texts limit and control the discourse of individuals through only allowing them access to a *'true'* commentary on a subject. For example, the way in which medical texts on anatomy and physiology are stipulated reading to medical and nursing students.

Authorship – not authorship in the traditional sense, but the unifying principle in a group of writings that denotes its significance and importance. A principle that has become less important in scientific discourse, resulting in individual authorship often just being *'a convenient label on a theory or a syndrome'* (Sheridan 1980:125) because of the increasing importance, not of the individual author, but of belonging within a particular and defined group of authors: a discipline.

Disciplines – the 'disciplines' are a system of control for the production of discourse. To belong to a discipline, a proposition must refer to certain body of theory (Sheridan 1980, Deacon 2002). Disciplines are not static but fluid, they are responsible for not only the generation of discourse but also the prohibition of discourse. For example, at a certain point in time, the healing properties of certain herbs and plants belonged to medical discourse but, as scientific medicine developed, these discourses came to be seen as outside the discipline of medicine and, therefore, outside medical discourse.

Foucault then proposes a third set of procedures for the control of discourse, which concern the rules that affect the way they are communicated, and also those who communicate them, which Sheridan refers to as:

Ritual - the qualifications required of the speaking subject, the gestures, behaviour and circumstances that accompany the discourse, in other words the status of the individual dictates their ability to discuss a particular topic with authority or not.

Societies of discourse – the function of which is to preserve discourse by its production in a restricted group (Sheridan 1980), an excellent example being the way in which medical discourse is regulated. For example, until recently medical texts were only available in Latin, restricting both authors and readers.

More recently, powerful systems have been developed to further control and restrict medical discourse. For example, journals, guidelines and techniques are all subject to scrutiny by 'experts' in the field and allowed or disqualified as a result of this scrutiny. In this way, discourses on health are restricted and controlled.

In essence, what Foucault proposes is that power is intimately linked with the development of knowledge, through the formation of discourse. These discourses, operating in differing ways, are instrumental in creating the policies and practices, which manifest themselves in the disciplining of the individual body (anatamo-politics) and the regulation of the population (bio-politics). In other words, as Dreyfus and Rabinow comment:

> *'The body for Foucault is not simply a focus of discourse, but constitutes the link between daily practices on the one hand and the large scale organisation of power on the other'. (Dreyfus and Rabinow 1982, cited in Shilling 1993:75)*

2.8 Discipline and regulation

It is from the bi-polarity of bio-power that Foucault identifies two key processes in relation to the body; discipline and regulation, what Turner (1991) refers to as an interest in the construction of the *'micro-politics of regulation of the body and a macro-politics of the surveillance of populations'. (Turner 1991:23).*

2.8.1 Disciplinary power

Foucault's views on the changes in the way power operates, particularly the way power affects the body, are linked to the development of more complex social structures, particularly economic developments and capitalism (Minson 1986). Foucault links the development of capitalism and the Industrial Revolution with an increase in the way in which bodies were subject to control.

An example of this is Foucault's description of the *'docile body'* in his earlier writings on power (Foucault 1977: 138), that reflected the need to ensure that individuals and groups were organised to contribute to social production and social service:

> *'The human body was entering a machinery of power that explores it, breaks it down and rearranges it. A political anatomy which was also a mechanism of power was being born; it defined how one may have hold over others bodies, not only so they may do what one wishes, but also that they may operate as one wishes, with the techniques, the speed and the efficiency that one determines. Thus discipline produces subjected and practiced bodies, 'docile bodies'. (Foucault 1977:138).*

It was to this end that discipline and surveillance of the body became increasingly prevalent and sophisticated. Foucault gives numerous examples of this, particularly concerning punishment. Driver (1994: 118) explains that, according to Foucault, there was a shift in power away from monarchical regimes towards more *'carceral regimes'*, that represented a change in the way in which power gains hold of human beings. Within the monarchical regime, execution and torture reaffirmed the power of the sovereign. However, the *'carceral'* regime consisted of the replacement of execution etc. with disciplinary institutions designed to produce reformed, docile and obedient individuals, utilising techniques of disciplinary regimes and the close surveillance of personal conduct.

Closely integrated within Foucault's discussions of discipline is the issue of regimen. In his work on medicine (1973) and discipline/punishment, Foucault (1977) was specifically concerned with the growth of examinations, taxonomies, classifications and registers which provided a means for the detailed surveillance and disciplining of the body (Turner 1984). These *'schemata'* facilitated the control of large numbers of people (bodies) within a regimented space (Turner 1991) and occurred in social institutions such as prisons, schools and hospitals. It is these practices that occur within institutional settings that form the discourses of discipline. The aim of these discourses is to provide a means by which bodies can be policed although, in his later writings, Foucault (1984, 1991) developed the concept of power into a process within which individuals increasingly became actively involved in disciplinary regimens and were encouraged to police themselves:

> *'They secure their hold not through threat of violence, but by creating desires, attaching individuals to specific identities and establishing norms against which behaviours and bodies are judged and against which they police themselves'. (Sawicki 1991:67)*

Hewitt (1991) and Nettleton (1994) argue that this process of policing occurs through a process of *'normalisation'*, something that is achieved through the emergence of *'normative judges'*, such as teachers, psychologists, social workers and health professionals. These *'normative judges'* would:

> *'Differentiate, quantify and rank an individual according to his or her ability to conform to the normative prerequisites of disciplinary technology'. (Hewitt 1991:229)*

These technicians applied corrective disciplinary techniques to address deviation. Such techniques, aimed at the body, included such things as exercises, timetables, compulsory movements, drills, regular activities and solitary meditations (Hewitt 1991, Nettleton 1994). Armstrong (1983) uses the example of military discipline and the use of routine drill and the regular surveillance of the parade ground inspection as an example of this, whereas Nettleton (1994) uses the more health-orientated example of dental care and regimens of teeth cleaning.

Foucault (1973) also argues that the medical gaze added the medical profession to these technicians of disciplinary power. However, medical discourse was deployed in the clinic, rather than the barracks, targeting the patient rather than the soldier, but the techniques and practices shared similarities.

Nettleton (1994) and Deacon (2002) describe three inter-related instruments of disciplinary power within medical discourse that *'provide procedures for training, using and thus transforming bodies* (Nettleton 1994:81) which are:

Hierarchical observation – refers to those sites where individuals can be observed - such as schools, prisons or hospitals that serve as *'laboratories of power'* where observation and training can take place. Nettleton (1994: 81) provides an example from dentistry, the *'toothbrush drill'* - a system that specified equipment, technique, regimen (through the identification of timing) and surveillance (through record keeping).

Normalising judgement – the way in which individuals are compared with others. Through the assessment and measurement of actions, norms are established. The norm came to be a crucial part of discipline for Foucault because it was through the norm that conformity was induced by way of correction.

Examination – combines both hierarchical observation and normalizing judgement in a crucially important way. It is the examination that permits, as Foucault notes:

> *' the subjugation of those who are perceived as objects and the objectification of those who are subjected...in this slender technique are to be found the whole domain of knowledge, a whole type of power'. (Foucault 1977)*

The examination linked the formation of knowledge to power; this was achieved in three ways. Firstly, the systematic examination places the individual in a situation of perpetual observation, they become *visible.* Secondly, it introduces individuality into the practice of documentation, through the development of archives and records. Thirdly, the examination, through the techniques of measurement and record-keeping produce a *case* from an individual, a *case* that can be compared to other *cases*, therefore contributing to the knowledge of the whole population. As Foucault remarks:

> *'The examination that places individuals in a field of surveillance also situates them in a network of writing; it engages them in a whole mass of documents that capture and fixes them. The procedures of examination were accompanied at the same time by a system of intense registration and of documentary accumulation'. (Foucault 1977:189)*

2.8.2 Regulatory power

As well as being concerned with the discipline of the individual body, mechanisms of power, according to Foucault are also applied to the population as a whole:

> *'Comprehensive measures, statistical assessments and interventions aimed at the entire social body or at groups taken as a whole'. (Foucault 1981a:146).*

Foucault uses the example of Bentham's Panopticon to illustrate how regulatory power operates (Armstrong 1983). The Panopticon, a hypothetical model prison, was designed to create the ideal disciplinary environment for the control of prisoners. The Panopticon was a central tower from which prisoners in surrounding cells could be constantly observed and monitored, day and night, by someone in authority. In the Panopticon this surveillance and control would be used as a disciplinary tool by way of ensuring compliance with prescribed forms of behaviour.

Foucault uses the Panopticon as an exemplar of disciplinary strategy (Driver 1994) describing the Panopticon as:

> *'a diagram of a mechanism of power reduced to its ideal form...a pure architectural and optical system (abstracted from any) obstacle, resistance or friction'. (Foucault 1977:205).*

In other words, the principle of the Panopticon is seen by Foucault as exemplary because:

> *'it embodies principles and techniques of discipline, surveillance, regulation and control which were increasingly influential within social policy* '(Driver 1994:120)

For Foucault the Panopticon is a metaphor for the regulatory control of the 'social body' or population, which comprised of numerous techniques and practices. For example, Rose (1994) proposes that the emergence of the public health movement resulted from the need to increasingly regulate urban populations.

Armstrong (1983) refers to the *'extended medical gaze'* (Armstrong 1983: 8) when describing this incursion of medical surveillance into the wider community and, in fact argues that this increasing surveillance represents the *'Panopticon writ large'* (Armstrong 1983:9). The emergence of the public health movement and the rise of health promotion and education therefore marked an extension of the medical gaze into the community, resulting in the development of *'surveillance medicine'* (Armstrong 1983:9) and, importantly, it subsumed not only the medically ill but also the well, the healthy, by creating the notion of the potentially ill (Armstrong 1983). This extended role of medicine resulted in the deployment of a range of *policing* activities within the community. Rose argues that this extension was marked by the development of two central *'axes of policing'* (Rose 1994:55) which were:

- **The axis of statistics** – the mapping out of the population as a *'territory to be known'* (Rose 1994:55) through the collection of statistics, for example birth rates, morbidity and mortality statistics which, through the process of collecting and recording information from individuals, could be measured and analysed for variation in the population across time and space. In other words, the origins of the techniques of Epidemiology.

These norms could then be applied to both populations and individuals as a means of identifying appropriate or inappropriate practices, behaviours or deviations, and could be utilised as tools to modify behaviour.

- **The axis of administration** – which sought to invent mechanisms for regulating events within the population. These mechanisms varied widely, from sanitation and planning reform to attempts to change immoral behaviour. Within the axis of administration, medicine became:

  > *'the great adviser and expert.....in that of observing, correcting and improving the social body'. (Foucault 1977, cited in Rose 1994:57)*

  This task involved the development of a *'medico-administrative knowledge'* that created a mass of documentary evidence (Rose 1994: 58) that connected biology, disease, housing, moral habits together.

This documentary evidence plays a key role in the formation of discourse on the body and the population that, in turn, influences the practices and techniques employed for disciplining of the body and regulating the population. According to Foucault, there is no better illustration of this process than the subject of sexuality.

2.9 Foucault and sexuality

For Foucault, sexuality offers the perfect topic to illustrate the techniques and practices related to the discipline of the body, the regulation of the population and the process of *'subjectification'* through the *'creation'* of the *'subject'* (Sheridan 1980, Turner 1992, Shilling 1993). It is within his analysis of the history of sexuality that Foucault provides a number of specific examples of how power operates through discourse upon the body. This contribution to the understanding of power and the body can broadly be separated into two (albeit linked and overlapping) areas: firstly, Foucault's analysis of the medicalisation of the body illustrates itself most clearly within the domain of sexuality. Secondly, Foucault's historical analysis of sexuality sheds further light on how his thinking developed in relation to productive power, the concept of *'subjectification'* and the development of the *'subject'*.

2.9.1 The medicalisation of the body

In his analysis of the *'history of sexuality'*, Foucault (1981a) identifies the impact of modern scientific medicine upon the discourses of sex. Foucault refers to this as the development of the *'scientia sexualis'*, a process that included the body, sex and discourse (Foucault 1981a: 58).

Whilst Eastern culture and discourse were concerned primarily with the *'ars erotica'*, the art of love and pleasure (Foucault 1981a:58), sexuality in Western culture came to be regarded through medical and scientific domains. The *'scientia sexualis'*, refers to the way in which sexuality came under the *'gaze'* of individual practitioners of health and the institutions that they represented. This process was instrumental in generating the discourses within which sexuality specifically, and also the body generally, were framed (Turner 1995, Rabinow 1984).

Foucault does not propose a single unifying strategy to explain the effects of the *'scientia sexualis'* on discourse and power (Sheridan 1980, Rabinow 1984), but instead proposes that discourses developed around four specific areas or *'strategic unities'* (Foucault 1981a: 104) which linked together a host of practices and techniques of power that:

> *'formed specific mechanisms of knowledge and power centring on sex.' (Foucault 1981a: 103)*

Foucault firstly proposes that medicine and science embarked upon a process of the classification and diagnosis of sexual behaviour, which generated medical and scientific discourse. This *'strategic unity'* saw the emergence of a whole catalogue of medically-defined sexual disorders, a process Foucault calls the, *'psychiatrization of perverse pleasure'*; which attempted to define the normal and abnormal in terms of sexual behaviour, along with the development of *'corrective technology'* for the abnormal, for example the emergence of homosexuality as a pathological category to be cured. The three remaining *'strategic unities'* concern particularly the interrelated issues of the body, women, reproduction and the population.

Firstly, the *'hysterization of women's bodies'* refers to the way in which women's bodies were firstly regarded as being saturated with sexuality and the development of medical pathology related to this, and, the relationship between female sexuality and the *social body,* in terms of the role women played in the regulation of fertility. Developing within this process were discourses connected to women's bodies, particularly the way in which medicalisation occurred in areas like menstruation and childbirth and fertility. These discourses also informed the way in which women's bodies were increasingly seen as machines, governed by hormones and cycles, capable of management and of breakdown. The theories that developed around women's bodies significantly influenced how women were treated and managed in health care. This process offers a clear illustration of how science and medicine contributed to the naturalistic theories of the body described earlier.

A 'socialisation of procreative behaviour'; refers to the emergence of incitements and restrictions brought to bear upon the fertility of couples. Foucault describes these incitements or restrictions as social and fiscal measures that sought to create the *'responsibilization'* of couples with a rare reference to birth control:

> *'A medical socialisation carried out by attributing a pathogenic value – for the individual and the species to birth control practices'. (Foucault 1981a: 103)*

This aspect can be thought of as representative of the *'bio-politics of the population'.* Discourses on population growth, eugenics, and birth control all figure in this area. Within these discourses lie the development of social policy in the arena of the family, procreation and birth control. The development of practices aimed at the management of the population originate from discourse in this area, for example strategies to reduce unplanned pregnancy (such as sex education) are driven by demographic and epidemiological information, also services connected with sexual and reproductive health, for example Genito-Urinary Medicine and contraceptive/family planning clinics, play a role in managing the sexual health of the population as well as the individual.

The *'pedagogization of children's sex';* refers to the process by which the sexuality of children became a social and medical concern because of the perceived moral and physical, individual and collective, dangers of sexual activity. For example, the links between sex and a variety of medical and psychiatric disorders, particularly masturbation and insanity provide an excellent example of *'dividing practices'* at work. It was also anxieties around sex that influenced the discourse on parenting and population control, heavily influencing the early family planning movements, and even today can be seen influencing social policy, in the form of teenage pregnancy and related sexual health strategy (Social Exclusion Unit 1999, Dept of Health 2002).

These *'strategic unities'* are central to what Foucault refers to as the *'deployment of sexuality'* (Foucault 1981a:77). In other words, far from the popular notion that sex was totally repressed and hidden away by society and was not discussed or theorised, Foucault claims that the scientific and subsequent social enquiry into sex embodied within the four *'strategic unities'* caused a *'discursive explosion'* around sex (Foucault 1981a:104). The resulting discourses that were generated from this process were linked to how sexuality was defined and constructed, also to how it was regulated (Smart 1985, Williams and Bendelow 1998). The deployment of sexuality therefore concerned the development of social norms, medical practices and social concerns centring on the subject of sex. The regulation of sexuality, therefore, is a key way to understanding how regulation of the body occurs:

> *'A constant, and historically changing, deployment of discourses on sex, and this ever expanding discursive explosion is part of a complex growth of control over individuals through the apparatus of sexuality.' (Weeks 1989: 7).*

It is these discourses that both create and sustain the policies and practices that are the instruments of power (Smart 1985). It is incitement to discourse that serves as the way in which society regulates sexuality:

> *'Sexuality must not be described as a stubborn drive, by nature alien and of necessity disobedient to a power, which exhausts itself trying to subdue it and often fails to control it entirely. It appears rather as an especially dense transfer point for relations of power: between men and women, young people and old people, parents and offspring, teachers and students, priest and laity, an administration and a population' (Foucault 1981a: 103)*

It is the notion of the link between sexuality and power that is important here. It is the discourses around sexuality that, in essence, *define it*, setting the *rules* and the *norms* against which an individual and a population can be judged or compared.

> It is within these discourses that sexuality is regulated (Foucault 1981a); it is around this process of discourse that practices and policies emerged as the apparatus of this regulation. Institutions and individuals working within medicine, the law, and government were simultaneously involved in generating these discourses and practising within them.

In other words, the deployment of sexuality can be thought of as a process by which discourses upon sexuality were framed in the context of the medicalisation of both sex and the body, which then, in turn, influenced the training and practices of those individuals and institutions. This practice was influenced by dominant theories and ways of thinking (i.e. *procedures of exclusion*) that subsequently came to be represented in clinical guidelines, procedures, manuals, descriptions of technique, and bodies of knowledge. These practices are then put *into* practice at the micro level through the interface between institutions and individuals, the most obvious example of this being the engagement of client and practitioner within the clinical encounter or consultation.

2.9.2 Sexuality, Discourse and 'Subjectification'

In addition to the medicalisation of the body, Foucault's writings on sexuality provide specific examples of the relationship between discourse, power/knowledge and the construction of both the body and the creation of the *'subject'*. Foucault identified the process of *'confession'* as a key site for the expansion of sexual discourse, and the deployment of power. The confession became a central process in the *'will to truth'* about sex (Rabinow 1984). Within the religious confession, Foucault identifies a greater exhortation for the disclosure of not only minute physical details about sex but also confession of thoughts, feelings and even dreams of a sexual nature. These confessions were then subject to interpretation and prescription, in the nature of penitence by the confessor.

However, as a number of authors indicate, Foucault proposes that this model developed historically into a more medical and social process, as a key part of the deployment of sexuality within the *'scientia sexualis'* (Sheridan 1980, Rabinow 1984, Shilling 1993, Weeks 1989). A key site for the confession became the medical consultation.

Within this process, Foucault points to several discursive practices that exemplify the concept of power/knowledge,

Through a clinical codification of the inducement to speak – This process illustrates the requirement of the *'patient'* to tell all, however insignificant, because it may be important to the observer. In other words, the patient places himself or herself within the *'gaze'* of the confessor/practitioner.

Through the postulate of a general and diffuse causality – sex as the underlying cause of everything. The most discrete event, the simplest malady was attributed to a sexual aetiology. Here, links were made between behaviour and bodily disease, and sex was linked to all manner of ills. The clearest example of this are the relationships drawn between the bodies of women, sex and hysteria.

Through the principle of latency intrinsic to sexuality – sex as a means to self-understanding. The need to uncover, not only what the individual was hiding about sex, but to bring subconscious issues around sex, hidden to the individual, out into the open.

Through the method of interpretation – The confessor's role was to interpret the confession; increasingly this interpretation was through scientific discourse as a form of scientific validation. Sexuality was something to be interpreted, by the confessor, the expert. The patient provided the information but it was the confessor/practitioner who made the interpretation, the judgement upon its meaning and importance.

Through a medicalisation of the effects of the confession – the confession and its effects were recodified as therapeutic operations. Sex was placed under the rule of the normal and the pathological. Instead of spiritual rationale (i.e. sinful acts) and penance (i.e. prayer) as explanatory and consequential techniques, diagnosis (disease) and prescription (treatment) became the outcome of the interpretation.

2.9.3 The *'Practices of the self'*

It is within Foucault's later writings on sexuality (Foucault 1984, 1986, 1991) that he begins to develop his thoughts on *'subjectification'* and the body. It is within these later writings that we can trace the development of Foucault's analysis of the relationship between power and the body. It is these later writings that map out the shift Foucault identifies within discourse, from 'classification' and 'objectification' to 'subjectification' described earlier. However, curiously, his thoughts upon this are drawn from a historical analysis of Greco-Roman texts that discussed body management, health techniques and sexuality, behaviours which he terms; *'the practices of the self'* (Foucault 1991:11).

In the second, and in particular, the third volume on the History of Sexuality, Foucault (1984, 1986) discusses the ancient Greek concept of *'askesis'* to illustrate how *'subjectification'* involves the linking together of bodily practices and self -awareness that enable and individual to conform to the *'ethical and aesthetic criteria of existence'* (Foucault 1986:67) and explains that individuals are required to *'cultivate themselves'* and carry out:

> *'certain modifications: through the exercise of abstinence and control that constitute the required askesis, the place allotted to personal knowledge becomes more important. The task of testing oneself, monitoring oneself in a series of clearly defined exercises' (Foucault 1986:68)*

However, it is extremely important to recognise that these practices are not something that an individual invents for him or herself; Howarth (2000) argues that, although the practices of the self represent an example of techniques that subjects engage in as *'agents'*, the practices themselves originate from the culture and social groups within which the subject is situated (Howarth 2000: 80) and, what is more are taught to others by experts versed in these techniques. In his description of the practices of the self, Foucault identifies a numbers of elements that together formed a comprehensive discourse on self-cultivation,

The *cura sui* – the philosophical doctrine that one should make oneself into the object of care. Foucault acknowledges that this care often refers to cultivation of the soul, but adds that the well-being of the physical body was intrinsic to this and provides several examples of this, particularly the link between diet, exercise and sexual activity (Foucault 1986).

The *epimeleia* – The development of a habitual process in daily life where attention to self-care is given:

> *' there is the care of the body to consider, health regimens, physical exercises, meditations on notes the recollections of truths that one knows but that need to be more fully adapted to one's life'. (Foucault 1986:51)*

The *mia chora* – the meeting of philosophy and medicine. Foucault proposes that this meeting created the requirement to have knowledge of the body along with the habit of self-care:

> *'educating oneself and taking care of oneself are interconnected activities' (Foucault 1986:55)*

The increased medical involvement with self-care brought about an increased interest in the body, particularly careful examination and observation of the body for signs of illness.

It is through this writing, in his later work, that Foucault provides much clearer examples of what he means by productive power, although, typically, he chooses to utilise historical texts that precede the period of industrialisation to do this.

At the heart of Foucault's analysis of power, then, is the issue of sexuality. He argues that the *'apparatus of sexuality is of central importance to modern plays of power'* (Foucault 1981a:82) and that the issue of sexuality is inextricably linked to discipline and control of the individual body, along with surveillance and regulation of the population. It is around sexuality that a proliferation of discourses upon sex occurs (Sheridan 1980). It is around sexuality that Foucault provides most of his clearest examples of the relationships between discourse, power and the body and it is entirely within the context of sexuality that Foucault develops his thoughts on subjectification and the development of the self as a result of *'productive power'*.

Foucault's discussions on sexuality also draw strongly upon his analysis of a disciplinary society, a society of surveillance and control (Driver 1994), and he uses his analysis of sexuality as a way of illustrating clear examples of the way in which bio-power operates.

Sex, argues Foucault, is the pivot of two axes along which the whole technology of life developed:

> *'Sex was a means of access both to the life of the body and the life of the species'. (Foucault 1981:146)*

However, because of his untimely death, Foucault was unable to continue with what was obviously a key concern in his writings on power and the body, that of the notion of productive power and the process of *'subjectification'*, particularly in the arena of its relationship to the individual and the *'anatamo-politics of the body'*, and also to the wider issue of population within *'bio-politics'*. Despite this, it is clear that his work continues to inform thinking around the sociology of the body and his influence can be seen extensively throughout many of the attempts to develop analytical tools with which the body can be further understood.

2.10 Analytical frameworks of the body

As the body has become more significant in sociology and as more analysis has been directed towards it, so the debate about how a sociology of the body should proceed has become an important element in sociological research (Shilling, 1993, 1999, 2001, Turner 1992, Nettleton and Watson 1998, Williams and Bendelow 1998, Howson and Inglis 2001). This debate, briefly mentioned earlier, centres on both the ontological and epistemological frameworks of approaches to the human body (Turner 1992, Nettleton and Watson 1998), and is a highly-contested domain (Hancock et al 2000)

Turner (1992) and Nettleton and Watson (1998) propose that, within the social sciences, there is an ontological tension between foundationalist and anti-foundationalist perspectives on the body and, although there are different approaches and schools, sociological approaches to the body can be roughly divided along this philosophical line.

Foundationalist frameworks assume that the body has some sort of pre-discursive or *corporeal* existence that impinges on our experiences of the body (Nettleton and Watson 1998) and, according to Turner, consist of theoretical frameworks that are:

> *'Concerned to how the biological conditions of existence impinge upon everyday life and macro organization of human populations'. (Turner 1992:48)*

On the other hand, anti-foundationalist frameworks maintain that the body is purely a product of discursive processes or contexts (Nettleton and Watson 1998) and are concerned to:

> *'Conceptualise the body as a discourse about the nature of social relations, or comprehend the body as a system of symbols, or seek to understand the body as a social construction of power and knowledge in society, or perceive the body as an effect of social discourse'. (Turner 1992:48)*

Both Nettleton and Watson (1998) and Shilling (1993) argue that these tensions are reflected in the debate between *social constructionists,* who argue, along Foucauldian lines, that the body is socially created and is contingent upon the discursive and social context in which it resides and *anti-constructionists,* who argue that the body exists independently of its social context (Nettleton and Watson 1998). From an epistemological standpoint the debate is, as Turner identifies:

> *'For those who oppose the idea of the social construction of reality, the body exist independently of the forms of discourse which represents it; for their opponents, the body is socially constructed by discursive practices'. (Turner 1992:49)*

Turner also poses the question of whether these two epistemological standpoints always have to be mutually exclusive. In other words, is there some way in which a theory of the body can be constructed that, on one hand, recognises the social construction of the body but, on the other, also gives regard to the body as a thinking, feeling and doing subject, or do body researchers have to make an epistemological choice?

In reality, it seems that often they do not. As Nettleton and Watson (1998) identify, within the sociological literature, much of the debate has focussed upon the *extent* to which to which the body is socially constructed and how theory can be developed that takes account of both social structure and individual embodied action, although, from a purely Foucauldian perspective, the idea that the body exists prior to, or outside of, discourse would be unacceptable.

Nevertheless, it was to this end that Turner (1984) set out his early work theorising the body, which he has subsequently developed and refined (Turner 1992). Turner's work also influenced Frank's (1991) theoretical work on the body, which provides both an elaboration of Turner's work and an alternative theoretical framework.

Both are concerned with theorising the body in a way that addresses the ontological and epistemological issues mentioned above (Nettleton and Watson 1998, Hancock et al 2000, Howson and Inglis 2001). Turner, particularly, is concerned with the dangers of *'epistemological fundamentalism'* (Turner 1992:57) and calls for methodological pragmatism within sociological research and the body:

> *'The epistemological standpoint, theoretical orientation and methodological technique which a social scientist adopts, should be at least in part determined by the nature of the problem and the level of explanation which is required'. (Turner 1992:58)*

In other words, arguing:

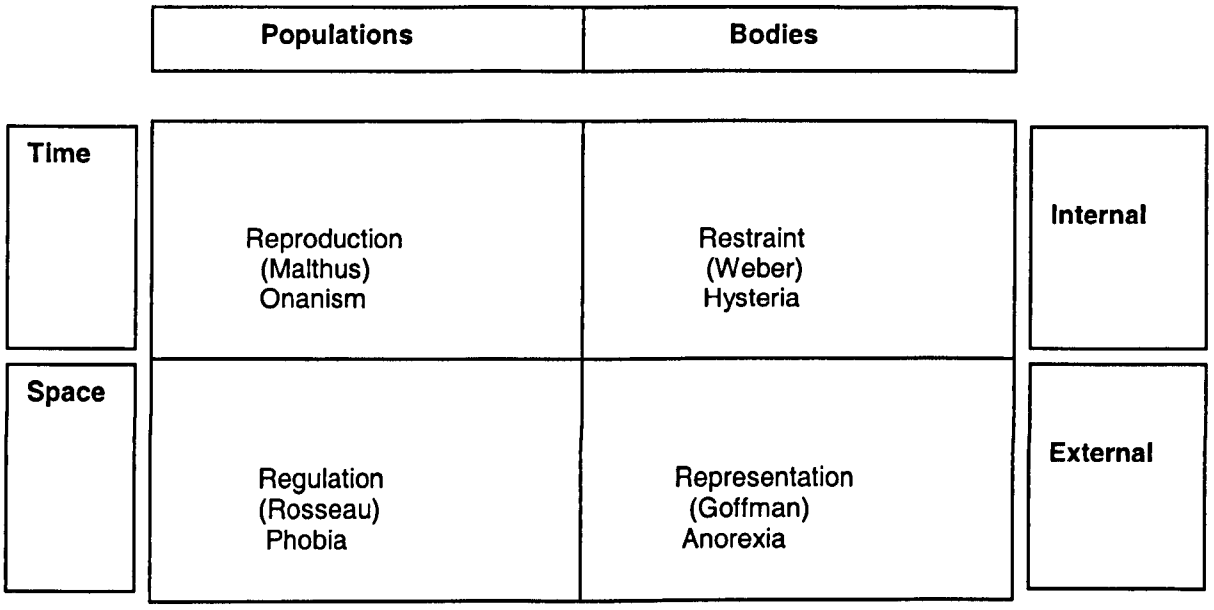
> *'That if we wanted to study the social representation of, say, the reproductive organs, it makes sense to think of the body as a representation of power and to utilise Foucault. However, if we wanted to study the effects of a missing limb, psychological research may be more appropriate' (Turner 1992:61).*

However, calling for pragmatism in this way does not address the concerns to develop a way of linking social constructionist views of the body with a corporeal, at least partially pre-discursive, body. Therefore, in addition to calling for pragmatism, Turner sets about trying to provide an analytical framework which combines a foundationalist ontology of the body (an organic, pre-social body which exists beyond discourse) with a socially constructionist epistemology, where the body is also a product of power/knowledge (Williams and Bendelow 1998).

2.11 Turner's Societal task model

Turner's (1984, 1992) attempts to provide a framework for analysis of the body is clearly influenced by Foucault, particularly as it addresses both the body singular - the individual, and bodies plural - the population (Williams and Bendelow 1998). A detailed explanation will follow. However, in a brief description of his model that he originally outlined in 1984, but subsequently utilises again in 1992, Turner suggests that bodies are set certain tasks by society. On an individual level these tasks are to do with the internal practice of restraint and, externally, concern the way in which the body represents itself. On a wider population level, the body's tasks are to manage reproduction of themselves over time and to manage the distribution of themselves in space. He also allocates certain theorists to each domain and suggests that each domain has its own representative illness. Turner (1984,1992) then provides a diagrammatic framework to illustrate his descriptions (Fig. 1).

Figure 1: Turners (1984, 1992) Societal task model



2.11.1 The body

Turner (1984, 1992) proposes that the body can be thought of as being divided into internal and external space. The external body is concerned with the representations of the body in social spaces and their regulation and control. Turner mentions the importance of consumer culture here, with increased emphasis upon the externality of the body, its shape, its adornments and how it looks. In other words, the issue here is, as Turner points out, one of representation.

The internal body is related to the body's internal structures, its organization and its maintenance. The central issue here, for Turner, is one of restraint. Turner refers to the work of Weber and the management of desire to illustrate this, but what seems to be important here is the idea that the body requires 'restraint' in the interests of social organisation. Along with Weber, the work of Foucault on disciplining the body would be highly relevant here.

Another Foucauldian aspect to Turner's model is the way in which the concept of '*anatamo-politics'* links with the internal and external aspect of the body. The need for discipline and management is concerned with the internal body, but could also be seen as increasingly related to the external representation of the body, for instance in the field of diet, exercise and physical attractiveness, especially, though not exclusively, of women.

2.11.2 Population

Further influences of Foucault can be seen in Turner's inclusion of the population issue in his model:

> *'Rather than looking only at bodies in the singular, we might think a la Foucault of bodies in the plural (Turner 1992:58).*

Turner suggests that the two issues or 'problems' of the population are the ones of:

- Reproduction (time):

> *'Populations have to be reproduced through time through the control of sexuality within the household and within the family'. (Turner 1992:58)*

- and Regulation (space):

> *'With the growth of urban congestion and the social problems of city life, much social theory had revolved around the problem of social regulation'. (Turner 1992:58)*

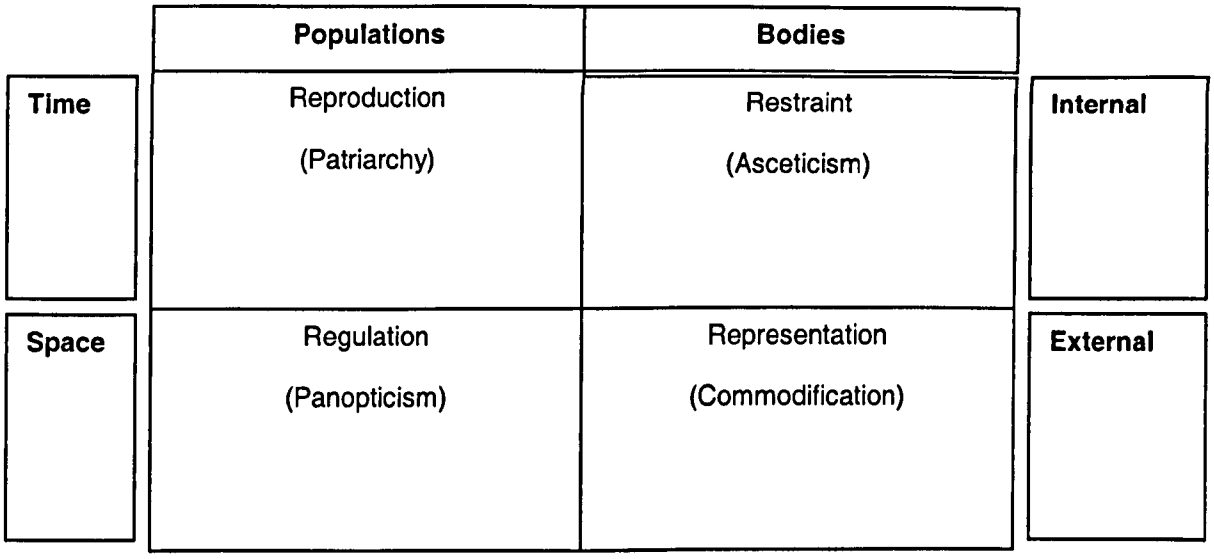
The issue of populations, particularly with their regulation, clearly links with Foucault's *'bio-politics of the population'*: the surveillance of and development of techniques to measure and regulate the *'social body'*. Turner also seeks to allocate a dominant social theorist to each specific social task. For example, Malthus and his work on the natural and moral necessity to control populations and the birth-rate for the management of population growth is placed alongside the regulation of populations over time. Malthus, however, did not advocate contraception as a means of doing this, even though some limited methods were available; on the contrary, Malthusian principles advocated sexual restraint and delayed marriage as regulatory mechanisms.

Goffman's work on impression management for the external representation of the body and how bodies are categorised, labelled and stigmatised is placed within the realm of representation. Rosseau's work on the problems of urbanisation for the regulation of populations in space is allocated to the regulation of populations in space. Rosseau's theories centred on the moral dangers of urbanisation, particularly to women, and argued for increased regulation and policing of urban areas. Lastly, Weber's work on the control of desire, aestheticism and the moral regulation of the interior body is placed alongside restraint.

Furthermore, adopting the Foucauldian view that all illness is social illness (Williams and Bendelow 1998), Turner (1992) added four paradigmatic types of illness to represent each of the societal tasks of the body. Onanism (masturbation) was a disease that was regarded as harmful to the development of healthy children, and was viewed as a consequence of failing to achieve Malthus's ideal of sexual propriety. Masturbation was regarded scientifically as resulting in both physical and emotional maladies that reduced the quality of semen, therefore producing inferior children that subsequently diluted national efficiency, a key concern of the early eugenics movement (Weeks 1989). Hysteria was the signature illness of the female body and was linked to the hormonal instability of the female body and the requirement to regulate it medically. Anorexia can be regarded as the classic affliction of the aesthetic presentation of the body, whilst phobia, particularly agoraphobia, the fear of social spaces, was seen as a natural consequence of Rosseau's depiction of the dangerous urban environment.

Frank (1991) elaborated upon Turner's model by proposing that the institutional sub-systems of reproduction, restraint, representation and regulation could also be defined by the concepts of patriarchy, asceticism, panopticism and commodification (figure 2). This is also a further reference to Foucault's work, particularly the reference to surveillance and control through *Panopticism*, but also through the connection with regimen and asceticism and the link between discourse and patriarchy.

Figure 2: Turner's societal task model (After Frank 1991)



Williams and Bendelow (1998) acknowledge that Turner's analysis of bodily order has a number of merits, being the first attempt systematically to integrate diverse theories of the body into a coherent framework. However, it does suffer from a number of limitations.

For example, it is not clear how this model provides a way forward in the epistemological debate about corporeality. It seems that Turner is making the point that body research requires pragmatic use of appropriate epistemologies and methodologies pertinent to the particular societal task for the body under scrutiny, but this does not provide a framework for exploration of how the body is both corporeal and socially-constructed.

Furthermore, it seems that Turner's model clearly sets out both the individual and societal importance of the body, but he does not provide a mechanism to demonstrate how they are linked. For example, he describes regulation of the population (bodies plural) in space and restraint of the internal body (body singular) but does not suggest a way in which they are linked or influence one another.

Frank's (1991) critical reflections upon Turner's work highlight these limitations. Frank's main concern is that Turner's model is primarily functional in nature, understanding the body as a *'problem of government'* for society, and that Turner's model:

> *'Invites the reader to view the body from the perspective of society, societies tasks, its problems of government'. (Frank 1991:43)*

Frank's critique of Turner's approach to the body is that it is concerned with a societal level of understanding. In other words, Turner's model views the body as being problematic for society, rather than the body being a problem for itself; a system problem rather than an action problem (Williams and Bendelow 1998).

Turner's model, according to Frank, is fundamentally a *'top down'* approach to the body, rather than bottom up. Frank uses a linear model to explain this:

> *'If the theoretical objective is to move from body to self to society, Turner's typology would represent the final, societal level of theorizing'. (Frank 1991:48)*

Frank (1991) proposes that his elaboration of Turner's typology (fig 2) does go some way towards addressing these problems. For example, he argues that not only is reproduction a social problem with regard to populations, it is also a task of bodies themselves to work out the terms in which they will and will not reproduce. In other words, Frank is proposing that, with modification, Turner's typology can be utilised to explore the body from the perspective of its *'own'* rather than *'socially-defined'* problems, but then goes on to propose that even this amendment is unsatisfactory:

> *'Ultimately it is only bodies which reproduce themselves. Society can set conditions for this reproduction, but it cannot itself reproduce bodies'. (Frank 1991:44)*

Thus, Frank sets out to describe a general theory of the body that, he claims, starts with a more phenomenological rather than a functional orientation (Williams and Bendelow 1998).

2.12 Frank's '*body use in action*' model

As with Turner, the work of Foucault can be clearly seen within Frank's typology of the body. However, unlike Foucault, Frank (1991) takes the physical body seriously by exploring the notion that, although influenced by discourse, the body can exist beyond discourse and actually exert a reciprocal influence upon discourse by its very *'corporeality'*.

Instead of asking the question *'what are society's tasks for the body?'* Frank (1991:48) proceeds from the opposite viewpoint, that bodies have *'problems'* that they face themselves:

> *'Bodies alone have tasks. The theoretical problem is to show how social systems are built up from the tasks of bodies, which then allows us to understand how bodies can experience their tasks as imposed by a system', (Frank 1991:48)*

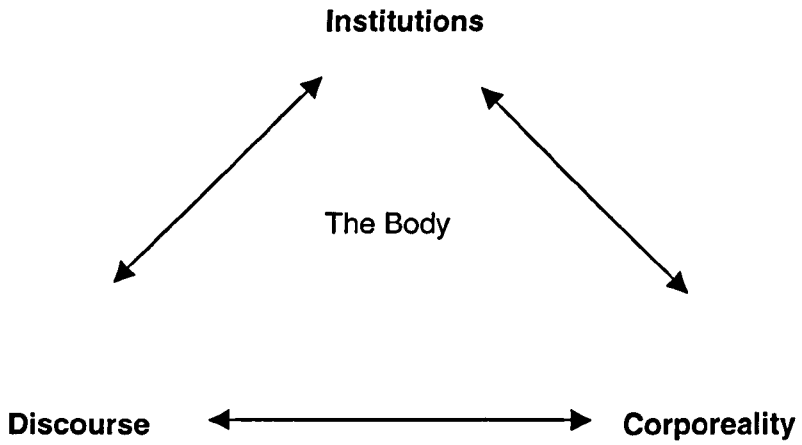
Frank utilises the phrase *'body techniques'*, originally used by Mauss (1973) to describe historically and culturally contingent, technically efficient, body actions, proposing that:

> *'Theory needs to apprehend the body as both medium and outcome of social 'body techniques' and society as medium and outcome of the sum of these techniques'. (Frank 1991:48)*

Frank proposes that, although body techniques are socially given, individuals may modify them (but rarely make any up for themselves). Furthermore, it is also possible for body techniques to be enabling as well as restricting. Techniques are therefore resources for bodies as much as they are constraints on them (Frank 1991). Frank does not elaborate upon this in detail, but the idea of enabling techniques links quite closely with Foucault's conception of the *techniques of the self*, which are, indeed, enabling, yet simultaneously constraining, by the adherence to a strict regimen.

Further echoes of Foucault can be seen in Frank's typology of the body. Frank (1991) offers a neat triangular framework, comprising discourse, institution and corporeality, within which the body can be placed conceptually (Fig. 3)

Fig. 3: Frank's triangular framework



Within this framework, bodies exist among discourses and institutions. *Discourses* being the mappings of the body's possibilities, these mappings provide the *'normative parameters'* governing how the body can understand itself. These discourses are *'instantiated'* in ongoing practice (Frank 1991:48) in other words discourses are put into practice by individual and institutions.

Institutions, for example the church, the school or the clinic, are fixed places, but are related to discourse in a mutually constitutive way, as Frank states:

> *'Institutions are constituted in and through discourses, and discourses are instantiated and modified in institutional sites'. (Frank 1991:48).*

Again, with echoes of Foucault, Frank remarks that:

> *'The point of a sociology of the body is not to theorise institutions prior to bodies but to theorize institutions from the body up'. (Frank 1991:49).*

Frank, however, adds a third dimension to his typology, that of *Corporeality*, or the fact that the body exists as flesh and blood, capable of change but ultimately restricted by the physical constraints of that flesh. It is within this third dimension, corporeality, that Frank's work marks a movement away from Foucault.

Within Frank's framework the *corporeal* body has a role: existing beyond discourse, it also *influences* the *development* of *Discourses* and *Institutions* rather than merely being *constructed* by them. Frank uses the following example of the ascetic fasting practices of medieval holy women to explain how this relationship between the physical body, discourse and institutions works.

In order to attain a spiritual state, medieval women would fast, following a dietary regimen originating from historical discourses about diet and fasting within the domain of female spirituality (discourse) which, in turn, would influence and contribute to the church (institution) and its development of dietary regimens and ascetic practices. However, the limitations of these practices are fundamentally affected by the physical body of the woman. How much starvation can a body endure, for how long etc. In other words, the physical body (corporeality) has to significantly influence embodied actions and practices.

It is within this triangular framework that Frank seeks to describe his typology of body use in action (Williams and Bendelow 1998). It is also within this framework that Frank provides what could be termed a *third way* within the constructionist/anti-constructionist debate, in that Frank provides a framework in which the construction of the body by institutional and discursive practices is acknowledged, whilst recognising that the physical reality of the body also has a contribution to make, an approach clearly congruent with Nettleton and Watson's (1998) remark that most body research seems to reflect this notion.

Frank's (1991) work on analytical frameworks did not stop with this triangular model, however, he also went on to develop a further framework that centres upon his notion of bodies having problems for themselves, rather than being set tasks (as with Turner's framework), problems which require the development of *body techniques.* Frank therefore suggests that the body confronts four central questions that it must ask itself as it undertakes action when presented with the requirement to act (Frank 1991, 1995, Shilling 1993, Williams and Bendelow 1998):

- **Control** – How predictable and controllable the body's performance will be. Whilst we may know what we want the body to do, it retains some contingent will of its own. It is this issue of control that must be resolved.

- **Desire** – the body must constitute itself on a dimension of desire according to whether it is lacking or producing desires. In other words, is the body complete or incomplete; efficient of inefficient; does it require something to fulfil itself?

- **Relation to others** – whether the body relates to itself as monadic, closed in on itself, or in an open, dyadic, manner involving mutually constitutive relationships with others.

- **Self-relatedness** – whether the body consciously relates to itself, particularly its own surface, or whether it dissociates itself from its own corporeality.

From these four questions, Frank (1991:77) claims that four types of *body use in action* originate, which he terms the *'disciplined body', the 'mirroring body', the 'dominating body'* and the *'communicative body'*. As the body responds to the questions of control, desire, relation to others and self-relatedness, the four types of body use emerge. Shilling (1993) and Williams and Bendelow (1998) describe how these body types address those questions:

- **The disciplined body** – The problem of control for the disciplined body is resolved by regimentation. Regimen ensures predictability, with regard to *desire* the disciplined body is regarded as lacking. The disciplined body is monadic, closed in; it is isolated in its performance. It is also dissociated from itself; for example, the ascetic, is in but not of, the body. The theorist, therefore, of the disciplined body is, as Frank states, Foucault.

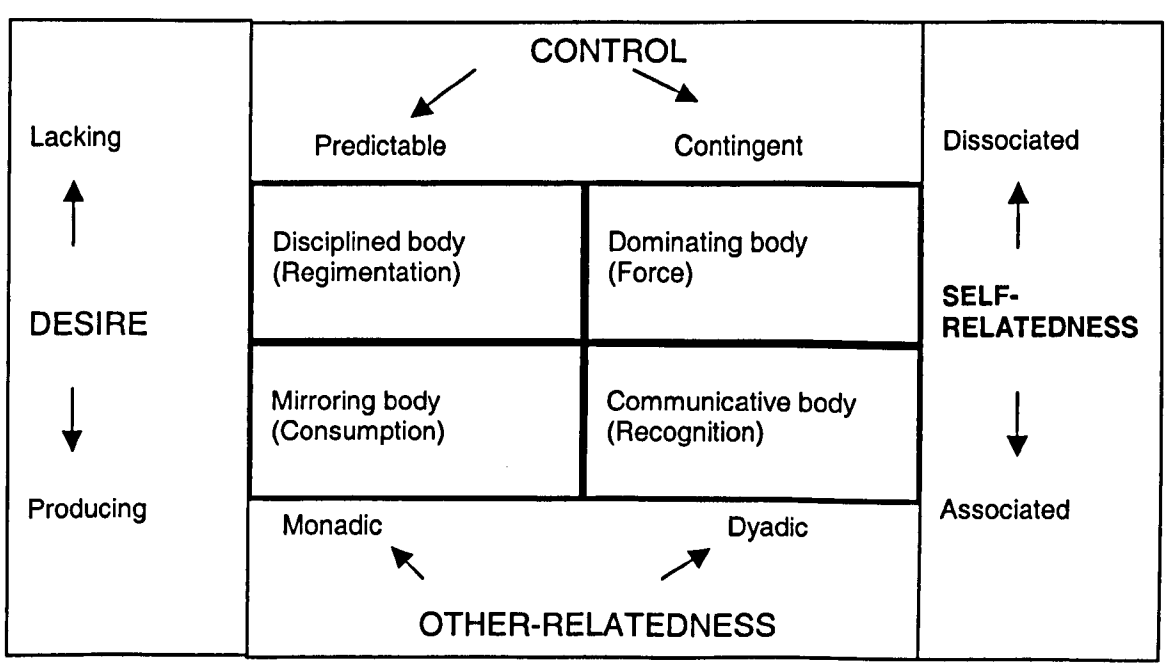
- **The mirroring body** – is predictable, not through discipline but by 'mirroring' all that is around it via consumption. The mirroring body is constantly producing *'superficial desires through consumption'* (Shilling 1993: 96). The mirroring body is monadic: external objects are viewed purely in terms of their use for the mirroring body. The mirroring body is also closely associated with its own surface, but in a narcissistic manner.

- **The dominating body** – As Frank argues, is impossible to theorise without giving weight to masculinity and lack. When a dyadic other-relatedness is combined with a sense of lack the body turns to *'domination as its expressive mode of relating to others'.* (Williams and Bendelow 1998:63). The world of the dominating body is warfare, by definition contingent, and one where the body must be dissociated from itself to absorb and inflict punishment on others.

- **The communicative body** – this body type is *'less a reality than a praxis'* (Frank 1991:79) or a *'future possibility'* (Shilling 1993:97), more difficult to define in an empirical way than the other body types. As Frank explains, the nature of the communicative body is that it is a body in the process of creating itself. Frank uses the example of the performing arts, also the caring practices of medicine to illustrate the communicative body. The communicative body produces desires, but for dyadic expression rather than monadic consumption. The communicative body is also closely related to itself, being comfortable in, rather than being alienated from, itself.

The dimensions of action problems and types of body activities can be seen in Figure 4. In the centre are the four body types, disciplined, dominating, mirroring and communicative. Surrounding these body types are cells that represent the four central questions of desire, control and 'self' and 'other' relatedness.

Fig. 4: Frank's typology of Body use in Action



Frank's typology, then, as Williams and Bendelow (1998) propose, regards the core problems of the body not as problems of order, implying a *looking down* on bodies, but as bodies experiencing their own problems. Frank's typology can be seen as a model that builds *up to* Turner's typology of the problems of bodily order:

> *'Bodies can be seen as the foundation as well as the product of both discourses and institutions'. (Williams and Bendelow 1998:65)*

However, Frank's typology has also been accused of the same functionalism as that levelled at Turner. Shilling (1993) argues that, although Frank addresses the concept of agency more strongly than Turner, the kernel of Frank's argument revolves around the action problems that bodies have to overcome. There is no sense, according to Shilling, of *why* people should adopt particular relations to their bodies or *how* individuals are able to change between styles of body usage, or what wider *historical conditions* could influence their adoption of certain styles over others.

If one takes Frank's model as described above, then this is fair criticism. However, Frank's typology does not stand alone as an analytical framework in the way that Turner's does. Frank, by way of his triangular model of discourse, institution and corporeality, does provide an additional model by which analysis of how body types can emerge, and does, in fact, attempt this in his example of the fasting and aesthetic practices of medieval women. This aspect of Frank's work does seem to be neglected, with no attempts to utilise it as an analytical tool within the sociology of the body literature, with author's favouring other forms of enquiry, for example more phenomenological approaches (Howson and Inglis 2001).

Furthermore, although he is critical of the theoretical positions of Turner and Frank as not adequately addressing the role of the physical *lived* body in understanding human agency, Shilling (1993) does remark that Frank's theoretical approach can be seen as complementing Turner's, and that combining the two:

> *'may be a useful way of deriving the principle problems facing social systems and the action problems facing individual bodies'(Shilling 1993:98).*

2.13 Summary and conclusion

This chapter has set out the theoretical background to this study. It has illustrated how the body has increasingly become the focus of sociological inquiry, an issue that is particularly true within the area of women's reproductive health. It has also set out how, particularly for the study of the female body, social constructionist approaches have been particularly valuable in challenging some of the harmful effects of naturalistic descriptions of the body. However the chapter has also set out some of the tensions within body research, particularly the debate over the role of the corporeal body within social constructionist frameworks.

Foucault's (1981a,1984, 1986) work, on the one hand, provides an excellent theoretical framework for the exploration of issues around sexuality and reproductive health. His work particularly offers the analytical tools, for example his discussions of discourse and techniques of power, for analysis of the micro-relations that exist in clinical situations, particularly the interaction between practitioner and patient.

However, there is also a need to proceed cautiously when using Foucault, lest one become limited, for example, by his unwillingness to recognise the issue of corporeality. This is perhaps where the work of Turner (1992) and, particularly Frank (1991,1995), proves helpful. Turner's point about epistemological pragmatism is helpful, but Frank offers a clear framework for analysising the body that incorporates many of the facets of a Foucauldian analysis (discourse and institution for example) whilst also leaving room for the corporeal. Furthermore, his descriptions of body types provide an interesting framework to test out in empirical body research; how reflective are they of body actions for example.

Many facets of a woman's visit to a family planning clinic and subsequent consultation with a nurse are related to the issues of the body, power, sexuality and medicine and could be further understood by utilising analysis drawn from the work of Foucault, complemented by the work of Turner and Frank.

Attending the family planning clinic is a process that concerns women with their body and its reproductive capacity. The consultation concerns the use of contraceptive methods within a discussion between the nurse and the woman, with a view to enabling the woman to control her fertility and prevent unplanned pregnancy.

However, this control can only be achieved if women use a contraceptive method correctly. Additionally, the consultation is a space where the women engage with a clinic and, therefore, engage with medical and health discourse. It is also a space where women consult a health professional, therefore entering into a relationship where micro- power relations exist and operate.

Family planning clinics operate within the dual domains of providing services for the individual, but also providing a wider role in terms of social policy linked to birth control. This requires the woman also to engage with an institution that has a role beyond that of her individual needs and requirements. It has a wider social role in the surveillance of the population and the reciprocal role of both contributing to and being informed by the discourses surrounding family planning and contraception.

As has been previously discussed, little research has been conducted into the consultation between nurse and woman in the family planning clinic environment and none of this previous work has explored either the power relations that operate or the way in which the body is conceptualised. With regard to women's reproductive health, research has been conducted that explores the body in relation to menstruation, menopause, pregnancy and cervical screening, but no work has taken in the issue of contraception.

There is no empirical *sociological* literature that explores what takes place in the contraceptive consultation; this study is designed to address this. Given this lack, it seems appropriate to begin to explore this area from as broad a point of view as possible and not, at present, to set any clear research aims or questions beyond asking the question *'what is the nature of the nurse/woman consultation in the family planning clinic'* and in what particular ways can this understanding make a contribution to the theoretical literature explored in this chapter? The next two chapters therefore set out how research methodology and methods were designed and employed to address this question.

Chapter 3

Methodology

3.1 Introduction

This chapter sets out the methodological aspects of the study. It begins by justifying the employment of qualitative rather than quantitative methods, briefly outlining the general merits of qualitative research. The selection of a methodology drawn from the social constructivist tradition will then be discussed, particularly by setting out the links between this research approach and the intention to incorporate a Foucauldian perspective to the methodology. Within the discussion of constructivist methodology, however, consideration is given to epistemological tensions within sociological research on the body, particularly the issue of corporeality. It is suggested that a strong constructivist or strictly Foucauldian approach to methodology would preclude sensitivity to the possibility of a pre-discursive, material body. The employment of a 'weak' constructivist approach is presented as a way of addressing this issue.

Consideration is also given to the issue of research questions in qualitative research studies. The flexible, changing, sometimes muddled process that is integral to qualitative research is discussed. The merits and difficulties that are connected to an emergent design are explored in relation to the broad aims of this particular study. This discussion includes the requirement to carefully consider the selection of a methodology that enables the consultation process to be explored and understood in a manner that minimises the possibility of bias from extant theory, yet ultimately allows the placing of the consultations in a wider theoretical context.

Two constructivist methodologies are subsequently discussed in relation to their appropriateness for use in this study. Firstly, a constructivist reading of ethnomethodolgy, *interpretive practice,* is discussed; its combination of conversation analysis and Foucauldian discourse analysis is considered as a possible methodology. However, although this approach is considered to have merits, it also has numerous aspects that adversely affect its suitability for this particular study.

Grounded theory is suggested as being the most appropriate methodology for use in this study. It has the merit of being highly emergent in design and, through the employment of constant comparative methods of data-collection and analysis, is well suited to managing the potential for bias outlined above. The unique way in which data-collection and analysis takes place within grounded theory is described, emphasising throughout the particular strengths that this approach has both in general terms and, specifically, in relation to this particular study.

Finally, the importance of trustworthiness in qualitative research is discussed. Lincoln and Guba's (1985) criteria for establishing *credibility, transferability, dependability* and *confirmability* are used as a framework to demonstrate how grounded theory enables these important issues to be addressed.

3.2 Qualitative research

Given the major concern to gain an in-depth understanding of the consultation process between nurse and woman, it was decided to employ a qualitative rather than quantitative approach in this study. Qualitative researchers *'stress the socially-constructed nature of reality and the intimate relationship between researcher and what is studied'* (Denzin and Lincoln 2000:8). Furthermore, qualitative research, according to Rossman and Rallis (1999), has attributes that particularly enable the exploration of complex social situations in that it:

- *Takes place in the natural world*
- *Uses multiple methods that are interactive and humanistic*
- *Is emergent rather than tightly prefigured*
- *Is fundamentally interpretive*

(Rossman and Rallis 1999:9)

These characteristics enable the researcher to *'secure rich descriptions'* of the world and also, through the techniques of interviewing and observation, *'capture the individual's point of view'* (Becker 1996:122). Qualitative research therefore enables the researcher to explore and analyse aspects of social life, for example complex social situations, that are not measurable in any traditional positivistic sense.

3.3 Philosophical elements of qualitative research

Qualitative research actually consists of *'a complex, interconnected family of terms, concepts and assumptions'* (Denzin and Lincoln 2000:2) and is a broad term used to describe *numerous* approaches to the study of social phenomenon (Bryman 1984, Guba and Lincoln 1994, Marshall and Rossman 1999).

It is, therefore, important to acknowledge that, within the *'umbrella term'* of qualitative research, there are numerous ontological and epistemological differences between the various strands of qualitative enquiry. Denzin and Lincoln (2000:19) maintain that it is important that qualitative researchers are clear about the philosophical basis upon which their work is based, given that this world-view or *'paradigm'* is instrumental in guiding the whole research design, suggesting that a paradigm is effectively a *'basic set of beliefs that guide action'* that can be visualised as a *'net'* containing specific beliefs about:

1. *Ontology:* what is the nature of reality?

2. *Epistemology*: what is the nature and grounds of knowledge?

3. *Methodology:* how do we know the world or gain knowledge of it?

(Denzin and Lincoln 2000:19)

Guba (1990) maintains that the characteristics of a paradigm are reflected in the way they respond to these three questions and also identifies that the choice of paradigm is intricately linked to the development of the research design.

3.4 Ontology: the nature of reality

The notion of what constitutes reality is important for research, given that all research aims to *'communicate ideas and understandings about the world'* (Lincoln and Guba 2000:167). Given the intention within this study to incorporate a Foucauldian perspective, an ontological stance based on a constructivist notion of reality seems the appropriate way of proceeding. The *'Constructivist'* sees reality in the terms of *relativism*: there is no *real* beyond local and specific *constructed* realities (Lincoln and Guba 2000:168).

This stance on the nature of reality is clearly reflected in Foucault's work: for Foucault, everything is discursively constructed, discourse is the way in which *'reality'* is shaped. Additionally, because discourse is subject to perpetual shifts in emphasis and meaning across time and space, this necessitates the view that, from a Foucauldian perspective, there is the potential for *numerous* constructed *'realities'*; in other words *reality,* for Foucault, is *relativist.*

This can be seen most clearly within Foucault's management of the subject of *'truth'* and its relationship to the nature of reality. According to Lincoln and Guba (2000:177) positivist, post-positivist and critical theorist stances on *'truth'* are *'foundationalist'*. In other words, the *'truth'* can be uncovered by investigation although, for critical theorists, the *'truth'* is located not in some external reality but in the *'specific historical, economic infrastructures of oppression, injustice and marginalisation'* (Lincoln and Guba 2000:177). The *'truth'* for Foucault is not an issue of the *'real'* being discovered in some way, the truth is a discursively constructed, fluid and contested issue, linked clearly to power and knowledge. For example, for Foucault, anatomy is not in any sense a *'reality'* waiting to be discovered by dissection and the microscope in order to reveal the *'truth'* about itself, it is constructed within the discourses of medicine and science, a discourse *claiming* to represent the truth about the body as a tactic of power, particularly power engaged in the *'will to truth'* (Foucault 1981, 1984); t
he discursive procedures operating to elevate certain discourses (truths) above others, for example lay or alternative body discourse.

Similarly, Foucault's analytics of power are clearly located within the constructivist paradigm. The critical theorist stance regards power as vested in social institutions and infrastructures (for example Marxism), institutions that can be revealed by investigation, illuminating their effect upon the individual and society, therefore enabling enlightenment and the possibility of social change. For Foucault, power is amorphous and *'capillary'* (Twigg 2002:431) and is neither possessed by individuals or institutions, nor fundamentally oppressive or restrictive. Power operates through discourse operating at the *'micro-level'* and is productive rather than coercive. Discourses also *'compete'* for primacy through the various discursive *'procedures of exclusion'* that operate within the mechanisms of power/knowledge (Sheridan 1980, Howarth 2000).

Constructivists are, therefore, in essence, *anti-foundational* (Lincoln 1995, Schwandt 1996), refusing to adopt *'any permanent, unvarying standards by which truth can be universally known'* (Lincoln and Guba 2000:177). Research conducted within the constructivist paradigm recognises the locally *'constructed'* nature of reality and attempts to explore and describe the social construction of that reality rather than *'uncover'* any form of objective reality (Best and Keller 1997, Lincoln and Guba 2000).

3.5 Epistemology: social constructionism and the nature of knowledge

Epistemology refers to the question: *'what is the nature of knowledge?'* (Guba 1990:18). Schwandt (2000:190) argues that social enquiry cannot be thought of as *'atheoretical'* in that, as researchers are engaged in generating and interpreting data to explore the meaning of what others are saying and doing they:

> *'inevitably take up theoretical concerns about what constitutes knowledge and how it is to be justified'* (Schwandt 2000:191).

Social constructionists begin with the assumption that knowledge is not discovered, found or interpreted, but is constructed. Knowledge arises from our attempts to invent concepts and models that make sense of our experiences (Schwandt 2000). Additionally, this construction occurs within *'a socio-cultural and historical backdrop'* (Schwandt 2000:197). Furthermore, with strong echoes of Foucault, Potter (1996; 98) suggests that, *'the world is constituted in one way or another as people talk it, write it and argue it'*, a stance supported by Denzin (1997), who argues that *discourse* is the material practice that constitutes knowledge. Moreover, because discourse cannot be wholly understood without acknowledgement of the particular historical, cultural, ideological context in which it occurs and since these conditions are eminently changeable, socially-constructed knowledge must be equally as fluid (Denzin 1997).

3.6 Ontology, epistemology and tensions within body research

The philosophical issues outlined so far, particularly the issues of foundationalist and anti-foundationalist, closely reflect the debate around body research and sociology discussed in the previous chapter. In that debate, the status of the physical body is contested (Hancock 2000, Williams and Bendelow 1998).

Foundationalists see the body as having a pre-social existence, in other words a *'corporeal'* reality prior to discourse, whereas anti-foundationalists regard the body as discursively constructed and do not take into consideration the existence of the body as some form of physical reality. This issue can create dilemmas for body researchers, in that there seem to be two almost irreconcilable positions here, particularly if one adheres *rigidly* to the tenets of a philosophical position that presupposes the *complete* social construction of reality, how can the physical body be incorporated or even acknowledged?

Turner (1992) tries to develop some way out of this situation by suggesting that an approach that avoids the divisions outlined above is required. He does this by arguing for a methodology for body research that combines both foundationalist and anti-foundationalist views, arguing that there are *'clearly organic foundations to the body'* but that at the same time, there is also *'no reason to doubt the proposition that the body is socially constructed'* (Turner 1992:26). Turner's typology of bodily order, discussed in Chapter Two, is his way of approaching this issue. However, Shilling (1993) is critical, arguing that Turner's model does not offer any *practical* way of exploring how the physical body shapes and influences discourse as well as being constructed by it.

Of more help is Turner's appeal to be *'epistemologically pragmatic'* about body research (Turner 1992: 61) when, moving away somewhat from his ideas of uniting different epistemologies, he argues that researchers should adopt the epistemological stance most closely related to the object of their study, helpfully using the example of the study of the reproductive organs as a justification for the use of social constructionist epistemology and methodology. Turner (1992:61) also advises against *'foreclosing conceptual options prematurely'*, suggesting that some form of flexibility is important.

The dangers of becoming trapped, by remaining strictly within the boundaries of complicated theoretical perspectives, are highlighted by Denzin and Lincoln (2000), who argue that there is a risk of it blinding the researcher to the,

> *'enduring issues, shared concerns and points of tension that cut across the landscape of the (qualitative research) movement ' (Denzin and Lincoln 2000:205).*

Patton (1986) and Atkinson (1995a) share this view, with Atkinson commenting that,

> *'In practice it is rare for the researcher to confine themselves to narrowly defined methods, while eschewing all interest and influence from other quarters. The realities of social research are not properly served by attempts to fit the social world into the Procrustean bed of so-called paradigms...nor should we use the rhetoric of paradigms to erect a technicist view of qualitative research that fetishes method' (Atkinson 1995a:121).*

Marshall and Rossman (1999:3) are supportive of this, pointing out that qualitative research, although being *'guided'* by a set of beliefs, needs to incorporate a flexible and broad approach to its study of social phenomena. They also suggest that qualitative research in practice is *'messy'* and rarely proceeds in a manner that reflects a smoothly theoretical process (Marshall and Rossman 1999:8).

Indeed, as mentioned earlier, Nettleton and Watson (1998) identify that much of the sociological literature on the body does attempt some form of epistemological flexibility or pragmatism, often discussing to what *extent* the body is socially constructed, a standpoint that assumes at least some pre-discursive place for the physical body: an issue that is foremost in Frank's (1991) attempt to reconcile discourse, institution *and* corporeality in his typology of the body.

Such flexibility has also been reflected in attempts to *'moderate'* social constructionist approaches. Schwandt (2000:198) describes the emergence of *'weak constructivism'* as a means to develop some sort of sensitivity to pre-discursive reality and cites Longhino (1990) as *'steering a middle ground'* by:

> *'Arguing for a social epistemology, in which ideological and value issues tied to socio-cultural practices, are interwoven with empirical ones in scientific inquiry' Schwandt 2000:199).*

In other words, this adopts a stance where the social construction of knowledge can allow for the existence of some form of empirical reality: for example, with the body, recognition that flesh and blood are reality, but that the interpretations placed upon that reality are socially constructed. This is definitely a stance that Foucault could not accept and it would be difficult to incorporate this into a strictly Foucauldian methodology, but it is clearly congruent with Turner's (1992) and Frank's (1991) attempts to map out frameworks for body research, who both, nevertheless, still retain a very Foucauldian *feel* to their work.

Weak constructionism does seem to provide a way through some of the difficulties outlined so far. It still assumes a socially-constructed reality, but leaves room for the possibility of some sort of empirical reality that places constraints on, or influences socially-constructed realities. At the very least, it offers the chance to conduct research that utilises a constructivist approach, but one that remains sensitive to other possibilities. This is in contrast to pursuing a rigid Foucauldian methodology, which would preclude such flexibility.

Given this, along with the discussion above about the need to be pragmatic, flexible and not necessarily constrained by *strict* adherence to the ontological and epistemological doctrines of paradigm, the most appropriate way of proceeding would appear to be to adopt a *'weak'* constructivist approach, incorporating a Foucauldian perspective. Adopting a weak constructivist approach allows for discussion of areas in the study that may challenge or divert from strong constructivist concepts of reality and knowledge. Furthermore, it enables a Foucauldian analysis to be utilised in the study without the restrictions imposed through the adoption of a purely Foucauldian methodology.

Having reached this decision the challenge is to develop a research design that incorporates methods of data-collection and analysis that firstly, originate from within the constructivist tradition and, secondly, are flexible, rigorous and trustworthy. This next step in the research process, once the theoretical and philosophical stance of the study has been justified, is often referred to as determining the *strategy of inquiry* (Marshall and Rossman 1999, Denzin and Lincoln 2000).

3.7 Strategy of inquiry: the issue of research questions

According to Denzin and Lincoln a strategy of inquiry:

> *'Comprises a bundle of skills, assumptions and practices that the researcher employs as he or she moves from paradigm to empirical world....and connects the researcher to specific methods of collecting and analysing empirical materials' (Denzin and Lincoln 2000:22).*

This aspect provides *the* link between the theoretical paradigm and the specific data-collection and analysis methods that are to be employed (Simmons 1995).

This stage of the research process traditionally involves a focus on the development of the research question or questions, which are connected to decisions about data-collection, in other words deciding,

> *'What information most appropriately will answer specific research questions, and which strategies are most effective for obtaining it' (Le Compte and Preissle 1993:30).*

However, the process of moving from a broad conceptual position to a research question in practice is not as straightforward as many texts seem to claim. Yin (1989:28) describes it as a *'logical sequence that connects the empirical data to a study's initial research question and, ultimately to its conclusions'.* Marshall and Rossman (1999:29) suggest the use of a *'metaphorical funnel'* as a tool for developing a set of research questions. The large end of the funnel represents the broad theoretical/philosophical focus of the research. Further down, as the funnel narrows, so the focus narrows to more specific theoretical and conceptual issues, connected to the broader theoretical starting point. Finally, as the funnel narrows to its smallest point, the specific research questions are articulated.

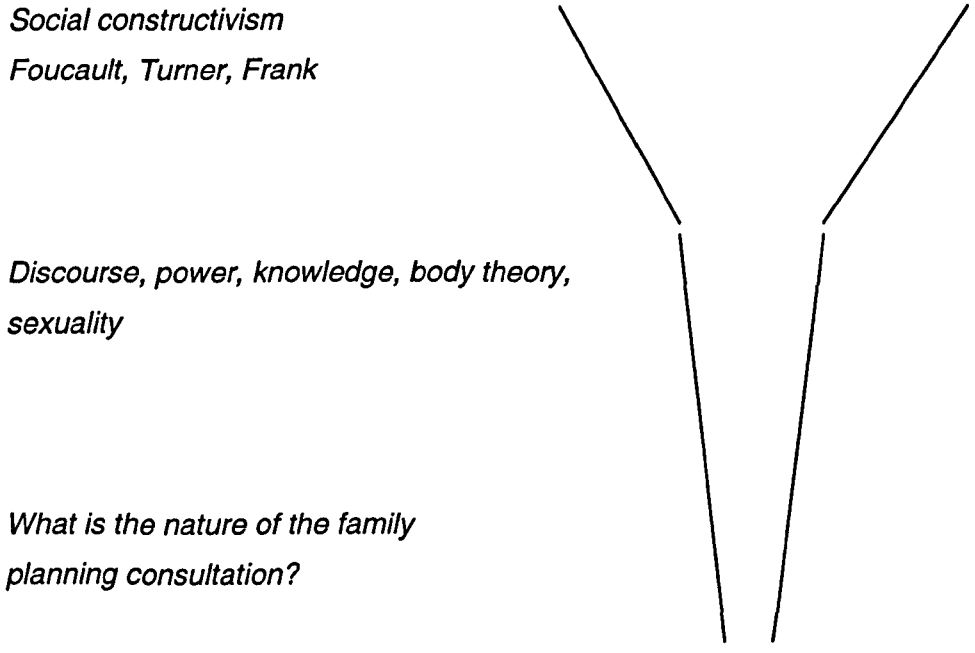
This seems a neat and tidy process on paper but, in practice, qualitative research rarely progresses this logically or straightforwardly and, according to some authors, *should not* proceed this smoothly. Numerous reasons are suggested in the literature to explain and justify how qualitative research can actually become a *'frenzied, twisting and continuously changing endeavour'* (Lincoln and Guba 1985:211). One of the reasons for this is the need to be pragmatic when conducting qualitative research: everyday situations in the *natural world* are not controllable in the way laboratories are, requiring qualitative researchers to be flexible and adaptive to the situations they encounter in the field. Another reason is linked to the nature of qualitative research itself, in that, because it aims to be flexible, exploratory and emergent rather than prefigured, it by necessity proceeds, during the early stages at least, with a degree of *'ambiguity and uncertainty'* (Patton 1990:62).

Patton (1990:62) goes on to maintain that the two issues of *natural world* research and the exploratory nature of qualitative methods necessitate an certain *'open-ended'* aspect to research questions, particularly at an early stage in the design and implementation of the study. Furthermore, both Bryman (1988) and Lave and Kvale (1995) maintain that defining rigidly-focussed research questions at an early stage in a project can preclude the discovery of material not directly related to the questions.

In fact, Lincoln and Guba (1985:224) point out that the qualitative researcher normally *'starts with a focus'* and that, as the study proceeds this focus *'may very well change'*, they then go on to caution that the *'naturalist claiming a fully developed initial design would be suspect'*. Lincoln and Guba (1985:226) therefore propose that, in qualitative research, a design *'emerges'* as the study progresses from the starting point of a *'focus'*, rather than a set of prefigured research questions.

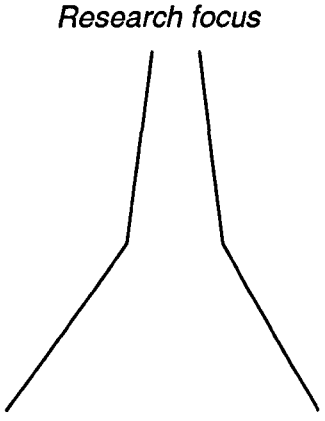
Given the discussion in the previous chapter and within the theoretical discussion in this chapter, it is clear that this study lies within the ontological and epistemological domain of social constructionism. There is also a requirement, eventually, to develop the broad questions about power, body theory, sexuality, discourse and contraception, posed at the end of Chapter Two, into more focused research questions but, in doing this, it is important that the study should retain the *'flexibility that is the hallmark of qualitative research'* (Marshall and Rossman 1999:38). At this point, therefore, the research design follows the advice of Lincoln and Guba (1985) and, in terms of research questions, does not move beyond defining the *focus* of the study as *'what is the nature of the nurse/women contraceptive consultation in the family planning clinic'?* To this extent, the funnel described by Marshall and Rossman (1999) can, at least, be used to illustrate how the focus of the study emerged from the broader philosophical and theoretical domains of constructivist ontology and epistemology (figure 5).

Fig. 5 The conceptual funnel



However, by using the funnel in a way not envisaged by its proponents, but one suggested by Phillips and Marsh (1984), it can provide a metaphor to illustrate how qualitative research with a *focus* can actually lead to a broadening, rather than a narrowing, of the area for inquiry, although this requires the funnel to be turned upside down. As utilised above, the funnel demonstrates how a research study can become focused upon one particular situation, that serves as a lens through which the broader theoretical and conceptual issues can be studied. However, when the result is a rather broad, undefined research question, it is interesting to note that the funnel may thereafter become inverted. In other words, the broad and flexible research question may well lead to the emergence of numerous interesting areas for further inquiry, an outcome depicted in Figure 6.

Fig. 6 The *inverted* funnel (after Phillips and Marsh 1984)



Lincoln and Guba (1985:210) argue that this result is almost inevitable, due to the emergent nature of qualitative research, describing how, in the early stages of field-work, the researcher is *'plagued'* with a broad range of evidence that may open up numerous interesting avenues to explore, and is then faced with the issue of re-focusing the inquiry, *'since one cannot study everything'*. This aspect of research design is obviously a challenge to the researcher. Decisions often need to be taken that affect the direction of the study. However, the literature does not provide a great deal of clear direction on this matter, an aspect that will be discussed in more detail in the following chapter.

3.8 Strategy of inquiry: constructionist methodology

Although only a broad research focus has been identified at present, it is still clear that this study is striving to do two main things. Firstly, it is aiming to provide a detailed understanding of the consultation process between nurse and woman in the clinic. Secondly, it is also attempting to test out the work of Foucault (1973, 1977, 1981a, 1984), particularly his analytics of discourse, sexuality and power, and the body theory work of Turner (1992, 1995) and Frank (1991, 1995).

It is, therefore, important that a methodology be selected that provides the opportunity to collect and analyse data in a manner that enables both of these aims to be achieved. However, it is also important that this methodology minimises the possibility that the theoretical background to the study unduly influences attempts to describe the consultations, whilst, at the same time, allowing the opportunity to place the family planning consultation into a wider theoretical context.

Social constructionists employ a range of research methodologies within their research designs. For example, sometimes using narrative or biographical techniques to understand how individuals construct their worlds (Tierney 2000). However, when exploring social situations and interactions two of the most frequently used approaches are grounded theory, to be discussed shortly, and various adaptations of speech and language analysis, such as, content analysis, discourse analysis and semantic network analysis (Lincoln and Guba 1985, Denzin and Lincoln 2000). These latter methods concentrate mainly on the intricacies of speech and language during social interaction and often involve highly detailed analysis of vocal and verbal data. Since this study is not primarily concerned with this type of analysis, these types of methodology were not explored in great detail. However, a methodology incorporating discourse analysis, but claiming to offer a broader and less language-focused approach, was considered. Ironically this approach originates from within the ethnomethodological tradition, a methodology not usually the preserve of constructionists.

3.9 Constructivism, Foucauldian discourse and Ethnomethodology

Ethnomethodology has, traditionally, been concerned with the question of *how* social reality is constructed, but Gubrium and Holstein (2000) suggest that it has also now turned to the questions of *'what is being constructed'* as well as *how*, remarking that questions for ethnomethodologists are increasingly asking:

> *'What is being accomplished, under what conditions and out of what resources' (Gubrium and Holstein 2000:488).*

Gubrium and Holstein (2000) suggest that a useful social constructionist methodology can be derived from a novel use of ethnomethodological practices, particularly the combination of speech/ conversation analysis techniques with Foucauldian discourse analysis, proposing that such an ethnomethodological approach improves social constructionism's *'analytical acuity' (Gubrium and Holstein 2000:487).* They call this combination *'interpretive practice'* and describe a process that, they claim, engages both the *how* and the *what* of social reality, an approach to research that is concerned with illuminating how people construct their experiences *in conjunction* with how institutional life informs this activity.

In practice, traditional ethnomethodological research has been concerned with naturally-occurring talk within social interactions. Gubrium and Holstein (2000;492) refer to this as a concern with *'discursive practice'*, in other words the language and speech practices utilised in everyday conversational interactions.

Ethnomethodologists study the process of conversations and language to understand how they act locally to construct meaning and *'reality'*. To do this they often employ detailed analytical methods to study talk minutely (Potter 1997) and explain how, through this *'conversational machinery'*, reality is constructed (Gubrium and Holstein 2000: 492). The methods of inquiry most often employed in ethnomethodological research, therefore, are conversation analysis and (non-Foucauldian) discourse analysis. This approach has been employed within health-care settings to study health professionals talking to patients, but is mainly utilised within studies that are interested in how information is given or received, or whether patients and professionals communicate effectively, where, for example, patients are undergoing counselling in a health clinic (Silverman and Perakyla 1990), Silverman et al 1992) or consulting a family doctor (Ruusuvouri 2001).

However, this particular approach is criticised by numerous authors for concentrating too much on the detail of talk and conversation and neglecting wider social, cultural and historical factors and, according to Lynch (1993) and Maynard (1998), has the potential to reduce all social life to recorded talk and conversation sequencing.

An alternative stance within ethnomethodology that addresses this criticism is Foucauldian discourse analysis. Gubrium and Holstein (2000) identify numerous similarities between Foucault's work on discourse and power and the principles underlying the ethnomethodological practices of conversation and speech analysis. For example ethnomethodologists proceed from a standpoint in which:

> *'Social order is not externally imposed by proverbial social forces, it is achieved through locally produced practices of mundane reason' (Gubrium and Holstein 2000:491)*

Additionally, for ethnomethodologists, social life and locally produced practices are seen as *mutually constitutive.* Both of these aspects are clearly reflective of Foucault's description of discourse and productive power. For Foucault, individuals are subjectified through localised discursive practices. Power is not in an external position to this process, rather, it operates through these practices. Furthermore, for Foucault, discourse is both simultaneously the product and creator of *'meaning'*, *'reality'* and *'truth'*.

Where Foucault adds to the ethnomethodological project is through the provision of a wider historical, social and cultural dimension to the local practices of discourse, allowing more extensively for an analysis of the *whats* as well as the *hows* of social interaction than speech or discourse analysis. Gubrium and Holstein (2000:494) use the term *'discourse in practice'* (as opposed to the term *discursive practice* used earlier) to describe Foucault's use of discourse. Foucault's work does not specifically aim to analyse or describe localised talk or conversation. It aims to use localised practices as examples of how the discourses of power/knowledge are simultaneously constructed and employed in everyday life: *discourses in practice.* For Foucault, these localised discursive practices are *the* way, by conducting an *'ascending analysis'*, by means of which the social construction of reality can be understood (Foucault 1980:198).

Nonetheless, although Foucault's work adds this dimension, he is often criticised for not providing clearer examples of how his thoughts on *'new technologies'* operate in everyday processes (Atkinson 1995b), being accused of having the reverse of failings of conversation analysis, by focusing on broad, historical discursive development at the *expense* of localised discursive practices.

Gubrium and Holstein (2000) propose that *interpretive practice* bridges the gap between conversation analysis and Foucauldian discourse analysis, thereby ameliorating the limitations of both approaches. This works by using both methods to offset the alleged limitations of the other. For example, conversation analysis in its description of *'discursive practice'* lacks a broader social context, which Foucault provides, and Foucault's alleged lack of specific localised examples in *'discourse in practice'* is provided by the detailed study of speech in a specific situation. Interpretive practice, therefore, claims to be able to bring the two different aspects of conversation analysis and Foucauldian discourse analysis together within a constructionist ethnomethodology.

According to Gubrium and Holstein (2000:499), the key to utilising an *interpretive practice* approach is *'analytical bracketing'*, meaning that, throughout the study, the researcher moves constantly between an analysis of the data from a *'discursive practice'* perspective to one of a *'discourses in practice'* perspective. Gubrium and Holstein (2000:501) claim that this approach tempers the Foucauldian urge to interpret everything as an *'artifact'* of discourse by the use of *'a more interactionally sensitive analytics of discourse'* (Gubrium and Holstein 2000:501).

At first glance, this approach seems reasonably suited to this study. What *interpretive practice* attempts to provide is a method that contains the analytics of Foucault, but does not wholly accept his world-view and can be utilised to explore and understand social interaction. It also acknowledges that the world cannot be understood purely by analysing speech and conversation at specific localities without some sort of external theoretical reference point. However, there do appear to be a number of areas within the *interpretive practice* approach that lack clarity.

Furthermore, there are aspects to interpretive practice that, given the focus of this study, seem to limit its usefulness:

- It is a little inaccurate to accuse Foucault of not considering the intricacy of localised discursive practices and language. In his later work, particularly within his writings on subjectification and the techniques of the self, his attention turned quite specifically to the manner in which words and language with specific nuances were employed. A clear example of this is his analysis of body practices in Greco-Roman culture.

- It is also not entirely clear how the switching between Foucauldian analysis and the traditional conversation analysis inherent within *'discursive practice'* guards against ultimately conducting a Foucauldian analysis. Everyday speech for Foucault *is* the way in which discourse is put into practice; it is not clear how a detailed analysis of speech and language processes changes this view.

- Gubrium and Holstein (2000) themselves point out that analytical bracketing is difficult to achieve, but do not offer any concrete suggestions as to how it can be done, beyond offering metaphors such as *'skilled juggling'*, *'changing gear'* or *'changing trains'*. Problems in doing this make it difficult for the researcher to ensure that one analytical focus does not unduly influence the other, a point highlighted by Denzin (1998). They do not provide a detailed description of how to proceed through data-collection and analysis, indeed pointing out that even the question of the side of the *'discourse in practice'*, *'discursive practices'* divide on which to commence data analysis is a contentious and unclear one.

- When aiming to understand a complex social process, how important is a detailed analysis of speech? In *interpretive practice,* it appears that there could be a tendency for analysis of speech and language to gain ascendancy, with a Foucauldian analysis providing just an interesting backdrop. Although Gubrium and Holstein (2000) claim it would not, Maynard (1998) suggests that over-reliance on one idiom is a possibility.

- It is not clear how sociological theory, other than that of Foucault, is incorporated into an *interpretive practice* approach. It aims to provide a *softening* of Foucault by using conversational or speech analysis, not by the use of other theoretical explanations of broader social processes.

- Finally, it also seems to be a very rigid constructionist approach to research. There does not seem to be any room in *interpretive practice* for individuals to have a chance to explain what they mean themselves. Their speech is analysed for them, without any opportunity, it appears, to comment on the researcher's interpretation of it.

Given these concerns, although this approach does seem potentially useful in some settings, it was decided to look more closely at one of the other commonly used constructionist methodologies: grounded theory.

3.10 Grounded theory

Ryan and Bernard (2000:768) remark that *'grounded theorists want to understand people's experiences in as rigorous and detailed a manner as possible'* and, in order to do this, grounded theory provides the researcher with a *'set of guidelines'* from which to build explanatory frameworks. These frameworks provide a detailed conceptual picture of a particular social situation, helping the researcher to understand how *'the social phenomenon being studied really works'* (Ryan and Bernard 2000:783). Such explanatory frameworks can also be utilised to *'specify relationships among concepts'* (Charmaz 2000:510), thereby providing a rich account of how the various processes within social situations are linked or integrated. This approach is clearly congruent with the aim to understand the contraceptive consultation in this study.

Additionally, grounded theory enables a conceptual framework to emerge in a manner particularly faithful to the data pertaining to the situation under investigation, but it also allows the researcher to make gradual links with the wider empirical literature. These two particular attributes of grounded theory provide a useful way of addressing the potential conflict between the two broad aims of the study and are attributes that arise from the unique way in which data-collection and analysis occur within a grounded theory approach.

Strauss and Corbin (1990) describe grounded theory as a research process in which theory is:

> *'Inductively derived from the study of the phenomenon it represents, that is, it is discovered, developed and provisionally verified through systematic data collection and analysis of data pertaining to that phenomenon' (Strauss and Corbin 1990:23).*

Stern (1982) outlines that grounded theory differs from other research approaches in number of key ways,

- Theory is induced directly from data, not from other studies (although the empirical literature is often utilised in the later stages of the study to enrich categories).

- Data is compared with other data, utilising *'constant comparative'* analysis.

- The emerging theory is developed by questions asked of the data and informs the direction of sampling to obtain further data (theoretical sampling).

- Data-collection and analysis occur concurrently.

Grounded theory, initially developed by Glaser and Strauss (1967) but since being adopted and adapted by numerous proponents, is a method of research that consists of *'systematic inductive guidelines for collecting and analysing data to build middle range theory'* (Charmaz 2000:509). Middle-range theories attempt to describe, explain and predict everyday situations (Moody 1990) and, according to Glaser and Strauss, can further be defined as being either, *'substantive'* or *'formal'*, substantive theory,

> *'Is developed for a substantive or empirical area of sociological inquiry, such as patient care, race relations, professional education, delinquency or research organisations' (Glaser and Strauss 1967:32).*

Whereas formal theory is,

> *'Developed for a formal or conceptual area of sociological inquiry such as stigma, deviant behaviour, formal organisational, socialisation, status congruency, authority and power, reward systems of social mobility' (Glaser and Strauss 1967:33).*

Utilising these definitions in the context of the research focus outlined earlier, it is apparent that this study is aiming to develop substantive theory, the understanding of the consultation process, whilst also testing out some formal sociological theories, particularly Foucault's analytics of power and discourse, and the body theory of Frank (1991) and Turner (1992).

In providing a step-by-step guide to the collection and analysis of data, grounded theory, it is suggested, provides an ideal research approach to achieve these two aims. It will enable a detailed understanding of the processes within the family planning consultation to be presented, whilst offering measures to restrict undue influence of this activity by the related theory and literature. This is primarily achieved through being clear about the role of literature and theory throughout the collection and analysis of data.

3.10.1 Managing 'a priori' knowledge in grounded theory research

One of the attributes of grounded theory is that it enables the development of explanatory frameworks that are, certainly at the start of the process, grounded in the data rather than being representative of preconceived concepts and theories created from the '*a priori*' knowledge of the researcher (Chenitz 1986), an issue that is clearly relevant in this study. However, this aspect of grounded theory creates vociferous debate over the role of '*a priori*' knowledge within grounded theory, particularly the role of published literature.

This debate is linked to wider debates about grounded theory, tensions that arise from within the *'scientific'* origins of the approach. One of the most substantive criticisms of grounded theory is that it is imbued with positivism (Guba and Lincoln 1994). Charmaz (2000:511) argues that many of the key proponents of grounded theory have regarded the approach as a method to expose some form of *'objective, external reality'*, uncovered by a neutral observer who utilises the methods of grounded theory in a *'reductionist, objectivist manner'*. In this orthodox application of grounded theory, the research should not be foreshadowed by *a priori* knowledge (including published literature) lest it interfere with the objectivist stance of the researcher and influence the resulting descriptions of reality.

However, in many other, more recent, interpretations of grounded theory, the approach to prior knowledge is subject to a more flexible and encompassing stance. Strauss and Corbin (1990) and Chernitz (1986) recognise that the researcher is likely to come to the study with knowledge of the literature pertinent to the focus of the research. Strauss and Corbin (1990:41) use the phrase *'theoretical sensitivity'* to refer to the prior knowledge of the researcher, and that furthermore this sensitivity plays an important role in the intuitive aspects of data analysis. Chernitz (1986) adds that, in order to identify specific areas for research, some degree of *a priori* knowledge must be assumed. Nonetheless, Strauss and Corbin (1990) do warn that although *'a priori'* knowledge informs the intuitive process of data-analysis and collection, the researcher must be wary of its influence on the development of codes and categories within the data, particularly in the early phases of the study. As the work progresses, however, the dangers of prior knowledge both lessen and, in fact, become important in later stages of data-analysis by informing the researcher's attempts to direct further data-collection and to conceptualise categories within the data (Strauss and Corbin 1990).

Charmaz (2000) remarks upon the fact that grounded theory creates such tension and debate, her main point being that grounded theory should be regarded not just as a prescriptive and rigid methodology for developing theoretical explanations of reality, but should be considered as a *'set of tools'* for understanding empirical worlds through the use of grounded theory methods as *'flexible strategies rather than formulaic procedures'* (Charmaz 2000:510). She goes on to propose that grounded theory offers researchers from numerous traditions, including the constructivist tradition, the opportunity to *'tell stories about people, social processes and situations'* (Charmaz 2000:522). In suggesting this Charmaz, like Turner (1992), argues for *'pragmatism'* in the use of grounded theory as an approach to exploring social situations (Charmaz 2000:515). Indeed, she suggests that grounded theory can be adapted to suit various epistemological positions and describes a version of grounded theory that she refers to as *'constructivist'*.

3.11 Constructivist grounded theory

Upon close inspection, constructivist grounded theory does not differ a great deal from more traditional forms of grounded theory. In terms of the procedures of data-collection and analysis there is little difference.

Charmaz's (2000) main point appears to be that the *'objectivist grounded theorist'* claims to provide a 'window on reality' whereas the constructivist approach recognises the locally *constructed* nature of the emerging theory. In other words, the key difference is the ontological stance taken by the researcher, and that this stance influences some of the nuances of the approach. Charmaz (2000: 524) proposes that *'constructivist'* grounded theory differs from *'objectivist'* grounded theory in four main ways:

- It does not claim to be as generalisable as *'objectivist'* grounded theory; it is more concerned with how participants construct localised realities.

- It is less concerned with over-complex conceptual diagrams, arguing that these can sometimes detract from the holistic view of a situation or process. It also tries to avoid the use of *'scientific labels'*, for example, *'axial coding'* in order to distance itself from the positivist leanings of grounded theory.

- It relies more on the *intuition* of the researcher to look for meaning in the data than with more 'objectivist' applications of grounded theory

- It allows for the participants to add their own interpretation of the emerging theory, either to enrich the conceptual frameworks being developed or enabling the theory to be understood further, by participants commenting upon it.

It is tempting to argue that most of this seems like *'splitting hairs'* and that many grounded theory approaches, not overtly claiming to be constructivist, adopt the approaches outlined above. Furthermore, one could also argue with many of the charges Charmaz levels at *'objectivist'* grounded theory, particularly the alleged lack of intuitive data-analysis. However, the last of the four items above is interesting and appears to offer another aspect to grounded theory, that of testing out emerging theory with the participants who contributed to it, as a way of enriching understanding of the situation under investigation.

In essence, the very description of a *'constructivist grounded theory'* does reinforce the central point that Charmaz (2000) makes in her argument: that grounded theory should be regarded as a set of tools to be used flexibly and imaginatively by researchers from various traditions who are keen to explore and understand complex social situations. Therefore, one should not have to agree with every premise of *'constructivist'* grounded theory in order to utilise aspects of it within a research study. In other words, be pragmatic. This aspect will be returned to during the discussion of the methods employed in this study, particularly concerning participants' interpretations, but, prior to this, the specific merits of grounded theory will be discussed, with particular reference to how this approach to data-collection and analysis suits the purpose of this study.

3.12 Data collection, analysis and theory development

In grounded theory, data-collection, analysis and theory development occur concurrently in a process that is more *'cyclical than linear'* (Glaser 1978:2). Although grounded theory does not specify data-collection methods, Ryan and Bernard (2000) propose that the data most often traditionally associated with grounded theory is that of interview transcripts, although other forms of data are not precluded. Grounded theory provides the researcher with a number of procedural steps to take that incorporate simultaneous collection and analysis of data. One of the key features of grounded theory is that analysis starts early, as soon as the first data have been collected (Strauss and Corbin 1990). The first stage of this is initial or open coding.

3.12.1 Open coding

As soon as they are available, transcripts are analysed. Sandelowski (1995) suggests that this often starts with the researcher simply underling key phrases when proof-reading scripts. These are then scrutinised line-by-line to identify phenomena within the data. These segments of data are named by the researcher, usually in the form of descriptive labels that describe the specific activity or issue to which they pertain. Stern (1985) suggests that the terms used are closely reflective of the language within the data, a technique also referred to as *'in vivo'* coding by Strauss and Corbin (1990).

This iterative process helps to focus the researcher on the data. Strauss and Corbin, (1990) suggest that such an approach to data-analysis, as well as starting the process of building ideas inductively, keeps the researcher focused on the data and restricts the potential for imposition of extant theories on the data, a strength also identified by Chernitz (1986) and Charmaz (2000).

3.12.2 Memoing

Grounded theory relies upon a constant comparative approach to data (Strauss and Corbin 1990). The researcher constantly asks questions of the data that are being collected, beginning the process of suggesting and developing links between the open codes in an attempt to develop larger, more substantive categories. An integral aspect to this process is *'memoing'*. Memos usually take the form of either notes or diagrams, written by the researcher either to guide the process of collecting further data, for example, a note that identifies an interesting emerging issue requiring further data, or a more analytic memo that relates to developing ideas of how codes may be related or linked. Strauss (1987) proposes that as the study progresses *'memoing'* will become more analytical.

3.12.3 Category development and formation

The next step in grounded theory is to start utilising the process of memoing and constant comparative analysis to develop larger categories from the data. In this process open codes are tentatively placed into larger clusters, sometimes referred to as *'axial coding'* (Ryan and Bernard 2000:783). During this process, analytical memos that suggest links between open codes can be tested and used to develop more abstract substantive categories. Commonly, during this aspect of the research, categories may be developed and subsequently changed or subsumed within other categories as the study proceeds. Therefore, as data collection and analysis continue, the researcher builds a conceptual framework of the process under investigation. A key part of this development is the purposive collection of data to add further density to the emerging categories. Within grounded theory, this further data is obtained through *theoretical sampling*. It is at this stage that the researcher may, utilizing theoretical sensitivity, use prior knowledge of the literature to aid this intuitive process (Chenitz 1986, Strauss and Corbin 1990), something that may be reflected in the labels attached to emerging categories.

3.12.4 Theoretical sampling

When utilising grounded theory, it is impossible to say how many participants or incidents will need to be sampled at the outset of the study. Indeed, Stern (1985) states that sampling continues until the researcher:

> *'Is satisfied that a conceptual framework is developed that is integrated, testable and explains the problem' (Stern 1985:153).*

Theoretical sampling can take numerous forms. It could be the collection of data from a new situation or groups of participants. It could be used to hone and sharpen interview questions, collecting more data from previously sample participants, or it could be collecting more data from the same, or a similar, situation (Strauss and Corbin 1990).

Morse (1995) proposes that grounded theorists use the criteria of *'saturation'* to mark the end of their research. In other words, any new data collected continues to fit within the categories that have been developed. Strauss and Corbin (1990:188) suggest that the following criteria for saturation be used,

- No new data appear to further dimensionalise a category.
- The category development is dense.
- Relationships between categories are established.

3.12.5 Core category formation

This stage of the process concerns identification of one or more categories that link the substantive categories together, to form a theoretical framework. Core categories, according to Strauss (1987:111), represent the *'underlying story'* of the study. An important aspect of this stage of theory development is the use of negative case analysis, to test out categories. For example, looking for instances in the data that do not fit. Grounded theory, at this stage, often takes on a diagrammatic form, with the emerging theory presented by mapping out the various categories and their relationships to one another. The objective is, therefore, to produce a conceptual framework that seems to explain the phenomena under investigation.

The conceptual framework is the objective of grounded theory; therefore, its robustness is of vital importance. In grounded theory, as in all research studies, it is important that the researcher can demonstrate that the findings are trustworthy. This next section discusses procedures that are designed to help establish trustworthiness in qualitative research. Throughout this discussion, links will be made to how these are achieved when using grounded theory.

3.13 Establishing trustworthiness

One of the most frequent criticisms directed at qualitative research is that it is sloppy, *'merely subjective'* and above all lacks rigour (Lincoln and Guba 1985:289). These charges are often made by researchers from the positivist tradition, claiming that only *'scientific'* research provides results that are valid, true, reliable and objective citing the various measures for demonstrating these values within their methodology (Denzin and Lincoln 2000, Janesick 2000).

Given its position on the status of reality and knowledge, as discussed earlier, the concepts of objectivity, validity and truth are incongruent with constructivist ontology and epistemology. However, as Marshall and Rossman (1999:191) state, *'all research must respond to canons of quality'* and, as Lincoln and Guba point out, it is important for researchers to be able to demonstrate the trustworthiness of their work by being able to:

> *'Persuade the audience that the findings of an inquiry are worth paying attention to, worth taking account of' (Lincoln and Guba 1985:290).*

Lincoln and Guba (1985:300) point out that the positivist concepts of internal and external validity, reliability and objectivity do not translate into the constructivist paradigm. They therefore propose four alternative measures to demonstrate trustworthiness in qualitative research: *'credibility'*, *'transferability'*, *'dependability'* and *'confirmability'*.

3.13.1 Credibility (for internal validity)

Lincoln and Guba (1985) identify a number of techniques that qualitative researchers can employ to demonstrate the credibility of their findings:

- *Negative case analysis*
- *Member checking*
- *Triangulation*
- *Peer debriefing*

Negative case analysis, or *'revisiting hypotheses with hindsight'* (Lincoln and Guba 1985:309) is an important element of ensuring credibility and is a key aspect of grounded theory. Stern (1985) argues that the data is required to be rich enough to enable identification of clear categories that are true, testable and account for the whole of the phenomenon they are intending to illustrate. An important aspect of the constant comparative method within grounded theory is that the researcher tests the 'fit' of the data into the emerging framework by looking for negative instances where the data may appear to contradict or further dimensionalise codes and categories. As Hutchinson explains:

> *'The grounded theorist looks for contradictory data by searching out and investigating unusual circumstances and occurrences. If such data do not fit what has already been found, they will not be discarded but will contribute to the richness of the theory in development' (Hutchinson 1986:116)*

Another element of ensuring credibility is member-checking. Member-checking involves the use of research participants to check out the researcher's interpretation of the data. Lincoln and Guba (1985) argue that this process is one of the most crucial in establishing credibility, emphasising the importance of the researchers ability to:

> *'Purport that his or her reconstructions are recognizable to members as adequate representations of their own realities' (Lincoln and Guba 1985:314).*

Member-checking can be formal - through arranged presentations and discussions with participants or informal, for example through opportunistic discussions with participants during field-work (Lincoln and Guba 1985:315).

Although they add a cautionary note, to the effect that the researcher must not attempt to reconstruct an average or typical position in the light of conflicting member-checking comments, lest it come to represent '*no-ones reality*', neither is the researcher bound to honour all of the criticisms of members, but he or she is bound to *consider* them (Lincoln and Guba 1985:316). It is also interesting to note that the issue of member-checking resonates quite closely with the use of research participants' views to shed further light on emerging theory described by Charmaz (2000), although this aspect of *'constructivist grounded theory'* can also be seen as another frequently used method to demonstrate credibility, triangulation.

According to Denzin (1978), triangulation involves the use of multiple or different data sources, different methods, investigators or theories within the research design. The rationale is that gaining data from different perspectives will enrich understanding of the particular phenomenon under investigation. In large studies, the use of multiple investigators is a common form of triangulation but, within smaller qualitative studies, this technique is more often employed by the use of different methods of data-collection (Lincoln and Guba 1985), such as the combination of interviews with observation or questionnaire.

The value of method triangulation is that it enables researchers to explore situations from different perspectives, collecting data that add richness to the description of the phenomenon, whilst simultaneously demonstrating, through the use of different methods, that their descriptions and interpretations are supported by more than one type of evidence. The techniques of theoretical sampling within grounded theory are particularly well-suited to triangulation. By using the constant comparative approach to data-collection and analysis further data can be obtained, through theoretical sampling, from other sources by utilising other methods, for example adding depth and richness to observational data by conducting interviews.

Peer de-briefing involves the discussion of the research project with others in order to generate searching questions pertaining to the study. This can take numerous forms, but presentation of *'work in progress'* at seminars and meetings, discussions with colleagues working in related fields and with an adviser/supervisor can all serve to generate probing questions about methodology, method and findings etc. Janesick (1998) adds that allowing another person to read through and comment upon interview transcripts or field notes can also be useful.

3.13.2 Transferability (for external validity)

This aspect refers to how generalisable the findings of the study are. Unlike the positivist researcher, who can use statistical analysis to demonstrate external validity, the qualitative researcher can only:

> *'Set out working hypotheses together with a description of the time and context in which they were found to hold' (Lincoln and Guba 1985:316)*

Marshall and Rossman (1999) propose that responsibility for assessing transferability actually lies more with other researchers, who may wish to test out or use the framework in other research settings. Kennedy (1979) suggests that the qualitative researcher's first task is clearly to articulate the findings as they relate to one specific group, in order to enable other researchers to apply these to other groups. Hutchinson (1986) suggests that this view is compatible with the tenets of grounded theory, in that a quality core theory, whilst clearly being relevant to the population studied, may have applicability to a different or wider population. Indeed, Strauss and Corbin (1990) point out that the value of grounded theory is that further research in other settings will enrich not debunk the theoretical framework. Ultimately, Lincoln and Guba (1985:316) argue that, in the *'strict sense, external validity for naturalistic research is impossible'* and that the researcher's task is to provide a *'thick'* description that incorporates the *'widest possible range of information'* in order to:

> *'Provide the data base that makes transferability judgements possible on the part of potential appliers' (Licoln and Guba 1985:316).*

Sandelowski (1986) echoes this view and identifies that for transferability the qualitative researcher's task is to provide sufficiently rich descriptions and contextual information to inform the work of others.

3.13.3 Dependability (for reliability)

Positivist notions of reliability assume an unchanging world, where reality is measurable and that any inquiry could be replicated (Marshall and Rossman 1999), an ontological and epistemological stance that is at odds with the constructivist belief that the world is socially constructed, and that reality is relative to specific situations.

To address this, Marshall and Rossman (1999) suggest that, in qualitative research, the researcher's task is to account for,

> *'The changing conditions in the phenomenon chosen for study and the changes in design created by an increasingly refined understanding of the setting' (Marshall and Rossman 1999:194).*

Grounded theory seems well placed to undertake this task (Stern 1985, Brink 1989). The process of constant comparative data analysis and theoretical sampling demonstrates clearly how an emergent approach to the development of theory is both influenced by and responsive to changes occurring in the study setting, an aspect that has already been explained earlier, when discussing credibility. Indeed, the link between *dependability* and *credibility* is remarked upon by Lincoln and Guba (1985) who suggest that:

> *Since there can be no validity without reliability (and thus no credibility without dependability) a demonstration of the former is sufficient to establish the later' (Lincoln and Guba 1985:317)*

This makes the point that if sufficient evidence exists as to the quality of the research, in terms of its credibility, it must, therefore *be* dependable. However, Lincoln and Guba do go on to add that other measures may also establish dependability, for example by auditing the research process, an issue that links strongly with establishing confirmability.

3.13.4 Confirmability (for objectivity)

Confirmability, according to Koch (1994:978), can be defined as the requirement to *'show the way in which interpretations have been arrived at via the inquiry'.* Strauss and Corbin (1990) suggest that one way in which this can be approached by grounded theorists is by being explicit about the procedures they have used throughout the research process, thereby enabling judgements to be made about their findings. Lincoln and Guba (1985) suggest that the techniques employed to establish credibility, transferability and dependability together form the basis for establishing confirmability.

They also suggest that providing an *'audit trail'* that enables the progression from raw data to conclusions to be traced is a useful process in providing evidence as to how the researcher conducted the study and made decisions regarding, for example, data-collection, and category formation (Lincoln and Guba 1985:319) a technique that is also seen as valuable by Sandelowski (1986) Koch (1994) and Marshall and Rossman (1999).

In grounded theory research, the step-by-step manner in which data-collection and analysis proceeds, in addition to the use of memoing and theoretical sampling, are all techniques that lend themselves to establishing an audit trail. Agreeing with this, Koch (1994) suggests that a research diary or file, in which field-notes and memos about decisions regarding the collection and analysis of data are kept, is good practice in qualitative research.

3.14 Methodology summary

This chapter has demonstrated how a qualitative approach, adopting a *'weak'* constructivist methodology incorporating a Foucauldian perspective, is the most appropriate way to address the focus of the study. This approach will enable the strengths of Foucauldian analytics to be utilised whilst remaining sensitive to other theoretical positions, particularly the issue of corporeality. Using a grounded theory approach is logical, given these requirements.

Grounded theory offers the best possibility for a detailed exploration of the processes involved in nurse/woman consultations, whilst also allowing for incorporation of wider theoretical perspectives in a manner that, through the procedural techniques of data-collection and analysis, demonstrates that the theory is enriching rather than driving understanding. The notion of a *'constructivist'* grounded theory is also taken into consideration, particularly the concept of research participants adding understanding to the theoretical framework as a way of enriching and furthering understanding.

Grounded theory incorporates many of the measures suggested by Lincoln and Guba (1985) as being important in establishing trustworthiness, therefore ensuring that the findings that emerge through the development of a conceptual framework are robust and that they provide an accurate account of the consultations.

The challenge for the researcher now is to put the methodology into practice *in the field*. The next chapter will therefore describe how this methodology was applied to the study of nurse/woman consultations in family planning clinics

Chapter 4

Method

4.1 Introduction

This chapter sets out the methods employed within the study. It discusses in detail how the methodology outlined in the previous chapter was employed in the field. In doing this, however, it is important to recognise that writing up the process of social research is often difficult to do in a traditional, linear way. Consideration in this respect must be given to the earlier discussion about the flexible, changeable, frequently muddled nature of qualitative research. Some comfort is drawn from Burgess (1984) who, when, referring to neat and tidy accounts of qualitative research, remarks:

> *'Such presentations are nothing short of misleading....the reality is that social research is not just a question of neat procedures but a social process...infinitely more complex' (Burgess 1984:44).*

As such, many of the methods of social research that appear on paper in a logical, linear manner actually often happen concurrently, or even happen without seeming to follow a logical pattern at all! Given this aspect of qualitative research, it seems that the best way to describe the conduct of this study is to use a framework that follows the traditional steps of the research process, beginning with the first moves towards entering the field, progressing through to the gathering and analysis of data, leading to the eventual presentation of the main findings and conceptual frameworks, which are discussed in the next chapter.

This chapter is, therefore, structured around two closely related (sometimes overlapping) sections. The first section, *'Gaining access'* concerns the development of the study and includes: negotiating entry to the two family planning clinics used in the study; the selection of data collection instruments, and the closely integrated issues of obtaining ethical approval and ensuring that ethical considerations were addressed within the research design. The second section, *'Entering the field'*, concerns the conduct of the study from the commencement of the fieldwork. This section includes an initial summary of data-collection, to provide the context for a detailed description of the data-collection and analysis process.

It also describes how the constant comparative approach was utilised, and how theoretical sampling was conducted. Refinement of the research focus into a more specific research question is also discussed, particularly how the dilemmas created by emergent designs, as set out earlier, were addressed. The discussion also describes the practical steps that were taken to establish trustworthiness.

Section one: Gaining access

4.2 Selecting the study settings

Given the focus of this research study, which is to explore the nurse/woman contraceptive consultation, gaining access to a clinical area where such consultations take place was clearly of central importance. Family planning clinics provided the obvious choice of setting, for several reasons. As outlined in chapter one, although contraceptive advice is available to women in several health care settings, family planning clinics are the only clinical area where this is the prime focus of activity. Therefore, the first step in this direction was to select a family planning clinic to approach.

Given the author's role in family planning education, consideration was given to the potential impact this could have on the study. Marshall and Rossman (1999) identify that, in qualitative research, the researcher *is* the research instrument and therefore a fundamental element in the collection and analysis of data. The immediate question was: should the study take place locally, where the author is known, or should data be collected from settings where the researcher would not meet former students from family planning courses, but where research participants would, nevertheless, be aware of the author's background in sexual health work? Several aspects were considered at this point, leading to the decision to seek local settings:

- The author is known by the potential research participants and, importantly, has a good working relationship with the clinic managers, who are key individuals or *'gatekeepers'* controlling access to the clinics. Numerous authors describe how these individuals and a researcher's relationship with them can affect the success of otherwise of a study (Burgess 1984, Lincoln and Guba 1985, de Laine 2000).

- Although the author is involved in teaching family planning nurses, this does *not* involve clinical contraceptive teaching, but entails broader topics, for example sexual health research and health promotion theory. Therefore, potential participants might not feel as threatened as they would if the author were a clinically-trained teacher of contraceptive advice, able to pass judgement on their clinical knowledge and skills. Given the author's role, however, it was felt that a very important aspect of the study was how the study was presented to nurses in clinic when negotiating access.

- Consideration was also given to practicality. Marshall and Rossman (1999) point out that all research has practical aspects that, to some extent, impose limitations. In this respect, the clinics where the author was not known were outside the boundary of a Regional Health Authority and, given the considerations of time, funding and travel, using these clinics would present numerous travel and resource problems.

4.3 Unfolding the design

The emergent nature of qualitative research, according to Lincoln and Guba (1985:210), necessitates that the research design *'unfolds, cascades, rolls and emerges'* as the study progresses, yet they, and Marshall and Rossman (1999:56), both recognise that some sort of logical, concise and *'do-able'* plan is necessary for presentation to individuals who control either access to research settings or funding. They suggest that researchers do this by devising a proposal that is broad enough to be flexible, yet focused enough to provide enough detail about the aims of the study for individuals in the position of *'gatekeepers'*. Clearly, individuals in a position to approve the study would need to know, among other things, what was intended in the study, who would be used as research participants and what data would be collected from them and how.

To address this, a research proposal was developed. Firstly, the study's aim was broadly defined as exploring the *'nurse/client interaction with an emphasis on understanding communication between the two about contraceptive use'*. It was felt that this broad aim added clarity beyond the more vague *'what is the nature of the nurse/woman contraceptive consultation in the family planning clinic'*, but remained broad enough to encompass the numerous elements that may emerge during the study. It is also, very importantly, accurate and not deceptive.

At this stage, another issue that required clarification was whether or not this study would be seeking to collect data from clients under the age of sixteen. This issue was given considerable thought, given that the issue of young teenage sexuality is very high on the sexual health policy agenda, reflected particularly in the Department of Health's Sexual Health Strategy (Dept of Health 2002). The outcome of this deliberation was that the study would only collect data from the over 16's, the rationale for this consisting of several issues, some practical and some methodological:

- This study is not about teenage sexuality; it concerns contraceptive consultations. In consultations with under 16's, health professionals have to spend time establishing competence for consent and asking questions that try to ascertain if any type of abuse is taking place. All this occurs before any contraception is discussed. It was felt that these issues would detract from the main focus of the study.

- It was also highly unlikely (later to be borne out in fact) that ethical approval would be granted for this type of research with the under 16's, particularly as the inclusion of this age group was not an *essential* requirement of the study.

- Meetings with staff in the clinics indicated that this could be problematic; some nurses remarked that there was a risk that seeking permission to tape record and interview very young clients could frighten them away from clinic visits in future.

Given the decision to exclude under 16's from the study, attention turned to how women would be sampled for early data collection. There were also some other exclusion criteria decided upon at this stage, that will be discussed shortly.

Lincoln and Guba (1985) argue that, in emergent designs, there can be no prior specification of the sample. Additionally, qualitative research does not seek to select a statistically representative sample from which to generalise. Closely influenced by the research focus and methodology, the initial concern was to collect data from suitable sources, in order to begin the process of data-analysis.

To do this, the approach to sampling was based upon the principle of what Lincoln and Guba (1985:202) refer to as *'purposeful sampling'*, incorporating a *'continuous adjustment or focus of the sample'* as the study progresses, a method of sampling that is clearly congruent with a grounded theory approach. Lincoln and Guba (1985:202) suggest that, initially, *'any sample unit will do as well as another'* as a starting point. The early approach to sampling in grounded theory, then, is somewhat a blend of the sampling techniques Miles and Huberman (1994:28) call *'purposive'* and *'convenience'*. In other words, an initial attempt is made to sample a typical case. A convenient family planning clinic session would provide the opportunity to do this, although the purposive selection of women attending for contraception would also be required. In the later stages of grounded theory, of course, data-collection is guided more and more by theoretical concerns arising from the constant comparative approach to data-analysis (Strauss and Corbin 1990), an issue that will be explored in detail in the second section of this chapter. However, at this stage, the intention was to try to collect data from suitable women over 16 years of age who were visiting the clinic for contraception.

4.4 Data collection instruments

Given the intention to explore the consultation process, it was decided that data would be collected from the actual consultation itself and also from the nurse and woman afterwards. An early decision on data-collection was the use of interviews to collect data from the nurses and women separately, after the consultation had ended, an aspect that will be discussed in detail shortly. However, a more difficult decision concerned how to collect data from the consultation itself and a number of methods were considered at this stage. This next sub-section describes this process which, in reality, overlapped somewhat with the presentations of the research in clinic undertaken as part of negotiating access.

4.4.1 Data collection from consultations

The intention to study the nurse/woman consultation meant that getting as close to that process as possible was a key priority. With regard to gathering data from the consultation itself, three potential data-collection methods were considered; direct observation, video recording and audio-taping, each providing the researcher with an opportunity to collect valuable data, yet each having its own distinct advantages and disadvantages, requiring careful consideration.

4.4.2 Direct observation

Silverman (1993:30) maintains that direct observation by the researcher is often the best way of answering the question; *'what is going on here'?* He continues by arguing that observational research enables the researcher, among other things, to, *'see things through the eyes of participants',* enabling the researcher to observe the norms, values and actions of the participants at first hand. Secondly, observation allows the researcher to see the non-verbal behaviour of the participants as well as hearing their conversation (Angrosino and Mays de Perez 2000). Indeed, observation has been used as a technique in family planning settings, although its use has been limited to observers using checklists to assess the amount and accuracy of information imparted by counsellors (Fisher 1992, Simmons and Elias 1994, Bessinger and Bertrand 2001).

However, there are disadvantages to observation as a data-collection tool. Silverman (1993) points to the possibility of observer bias, arguing that observation cannot be regarded as completely objective. One researcher may well record different impressions to another when viewing similar circumstances (Werner and Schoepfle 1987). Indeed, Sacks (1992) maintains that recordings, unlike field notes made by observers, provide accurate records of the data for scrutiny by others.

Furthermore, consideration needs to be given to the impact that the observer's presence has on the situation being studied. Most authors recognise that the observer's presence can often interfere with the situation under investigation (Angrosino and Mays de Perez 2000). Furthermore, although this may vary in different contexts, it would be safe to assume that the more intimate the subject, the greater the possible effect. Indeed, Simmons and Elias (1994) highlight this as a particular problem in contraceptive and sexual health counselling research.

Given the focus of this research and taking the points above into consideration, a decision was taken to explore less intrusive methods of data-collection. This decision rests upon three factors closely related to the specific area of research, factors that also arose frequently during preliminary discussions with nurses working in the clinics:

1. The intimate nature of the consultation: women may not disclose personal information with a third-party present, for example.

2. The gender of the researcher (male), in a female/female consultation, would be problematic, particularly if intimate information was required (highly likely) or if a physical examination were necessary.

3. Practicality: many of the consulting rooms are too small for observational research.

4.4.3 Video recording

A less intrusive form of data-collection, but a method that also captures the non-verbal context of the consultation, is the use of video recording. With video, the researcher captures the visual image in a similar way to observation, but without the observer's presence being necessary. The videotape also addresses Sacks' (1992) concern of a data record and is regarded as being a more complete record than the observer's written record (Hanson 1994). Video has been employed in numerous settings, sometimes involving intimate health issues, such as a study of Midwife/mother post-natal home visits (Lomax and Casey 1998) and even vaginal examinations during labour (Bergstrom et al 1992), However, no literature on the use of video within family planning clinics was found, although the technique has been suggested (Simmons and Elias 1994).

However, criticisms similar to those made about observation are also levelled at video recording. The main charge is that, like the observer, the camera is a distraction and will affect the behaviour of the participants, a view not shared by some authors, who claim that the camera is soon forgotten (Vuchinich 1986, Vihman and Greenlee 1987), although others claim that the camera has a significant impact on participants' behaviour (Gottdiener 1979, Hanson 1994).

Sacks (1992) also points to the technical difficulties encountered when using video, such as camera positioning: with no operator to move the camera, can all the participants be included? The cost of video equipment must also be taken into account.

Had this study been focussed primarily upon conversation analysis, these difficulties could have been addressed or accounted for, but, given the focus of the study, capturing non-verbal behaviour is not regarded as important enough to pursue this level of data-collection. Therefore, reasons similar to those used to justify the rejection of observation informed the decision not to employ video in this study; it may be intrusive, affect the behaviour of participants and there would also be technical and cost difficulties. Additionally, given the confidential nature of the clinic service, nurses expressed the view that using video would adversely affect the willingness of women to participate, a view that seems quite reasonable.

4.4.4 Audio-taping

The use of audiotape is one of the most frequently used methods for collecting data in qualitative research (Silverman 2000). Audiotapes give the researcher a detailed record of the phenomena beyond that obtainable by observation and note-taking alone; furthermore, tapes can be replayed by the researcher to increase understanding (Sacks 1992). Intrusion, by the use of microphones and cassette recorders, is still an issue when using audiotapes and it would be incorrect to argue there is no effect on the participants. Audiotapes, however, are regarded as a far less intrusive medium than video, particularly when modern equipment is used, often requiring only the presence of a small microphone (Roter 1991, Ong et al 1998, Riddle et al 2002). Audiotapes are also the main way in which data has been collected in research exploring interactions between health-care professionals and patients, for example, Gillotti et al (2002) and Rosser and Kaspeski (2001), as well as in the family planning setting, by Dodge and Oakley (1989) and Kim (1998).

Audio-taping, whilst less intrusive than video or observation, also suffers from similar criticisms, particularly the effect on the participants. It is probably less likely than other methods to inhibit client disclosure, although this remains a possibility. The main impact is likely to be the effect on the health professional.

Some authors comment on the fact that, when recorded, practitioners adopt *'best practice'* due to their awareness of the tape (Kirkham 1989, 1993, Simmons and Elias 1994), although Kirkham (1993) adds that this may not always be a problem, and in fact may, paradoxically, add interest in terms of finding out what practitioners actually feel that *'best practice'* is.

Audiotapes are also accused of presenting data that is *'incomplete'* (Silverman 2000), lacking the non-verbal data captured during observation and filming. Sacks (1992:26) agrees to some extent, but argues that, in research data, the idea of completeness may actually be *'an illusion'*. Furthermore, he adopts a pragmatic view when he suggests that *'one gets started where you can and maybe gets somewhere'* (Sacks 1992: 26) adding that it would often be *'great'* to see and study everything, but in many cases, for various reasons, one cannot.

However, to collect data, some form of instrument has to be used. In Chapter One the lack of data from *'inside'* the family planning consultation was discussed, along with the argument that, in order to really understand the consultation process, this form of data is crucial. Audiotapes were, therefore, judged the most acceptable form of data-collection, being the least intrusive, least technically problematic and most cost-effective instrument of data collection. Additionally, audiotape equipment is very portable and is easier to set up than video, an issue that is important, given that, in many clinics, numerous consulting rooms are used, necessitating the moving of equipment around a building. Importantly, it was also the method of data-collection most acceptable to the clinic staff.

4.4.5 Data collection from Interviews

From the very early conception of the study, interviews with women and nurses were considered as a data-collection tool, being the most extensively used and, arguably, most effective way of acquiring information from people in social research (Burgess 1984, Fontana and Frey 2000). Burgess (1984) points out that interviews are often used to accompany other research methods, such as observation. However, as the planning phase of the study continued, consideration was given to the precise manner in which interview data would be used and, consequently, to what type of interview was to be used.

Given that the plan was to record the actual consultation, it was decided that the interviews would be designed in such a way that they enabled participants to discuss the consultation from their perspective. This approach is reflective of the use of respondent interviews advocated by Charmaz (2000) within her description of constructivist grounded theory. The early intention, therefore, was to interview nurses and women after the consultation had taken place, in order to shed further light upon the ongoing analysis of the consultation. Used in this way, interviews would also provide a method of triangulation as a means of enhancing the credibility of the study. Furthermore, in order to gain data that were as accurate as possible, interviews would be tape recorded and subsequently transcribed.

Most research texts separate the interviews used in social research into two types: structured and unstructured. However, these texts elaborate on this, by pointing out that the range of approaches to interviews is far broader than this, particularly in relation to unstructured approaches (Burgess 1984, Lincoln and Guba 1985, Fontana and Fey 2000). Structured interviews tend to use closed questioning and a pre-planned, often quite rigid, series of pre-established questions, furthermore, the interviewer has very little flexibility to explore other avenues that emerge during the interview. Given the exploratory and emergent nature of qualitative research, unstructured approaches are generally used (Fontana and Fey 2000). However, Burgess (1984:102) maintains that most social researchers actually utilise *'semi-structured interviews'*, rather than completely unstructured ones, particularly through the use of interview guides consisting of more flexible, open-ended questions. Utilising this approach, the researcher is still able to allow respondents to articulate their own views clearly, but is also able to explore unanticipated, yet interesting avenues with new, unplanned and responsive questions. Lincoln and Guba (1985) also add that semi-structured interview guides should be flexible and that as a study progresses, interview questions may change to follow particular themes that emerge from previous data collection. The flexibility of semi-structured interviews in this way is clearly congruent with theoretical sampling in grounded theory: as concepts emerge, interview questions can be amended or added to enable further data, pertinent to the emerging theory, to be collected.

Before fieldwork commenced, the early intention was to collect data in *triads*. In other words, to collect data from the consultation and then from interviews with the specific nurses and women concerned. The aim was to use the consultation tape to inform the subsequent interview, in addition to using a number of open questions set by the author in advance. It was envisaged that, as the study progressed, questions could be changed and developed to further illuminate emerging concepts in the consultation data. To this effect, two semi-structured interview schedules were devised for both nurse and woman interviews (appendices I and II), with the intention of other questions emerging from prior analysis of the consultation data. Guided by the advice of Burgess (1984), the interview questions were tested with the author's supervisor and two female colleagues (one of whom taught on the family planning course) resulting in some minor amendments.

Also, at this stage, the author was aware that gender might be an issue in interviews, particularly with female clients. Several authors remark on the impact that gender differences can have on interviews (Oakley 1981, Weston 1998). This is an aspect of data-collection that will be discussed in the second section of this chapter, along with a wider description of how this early plan actually played out when fieldwork commenced. However, once the methods of data-collection had been selected, the next step was to approach local family planning clinics, in order to seek permission to conduct the study.

4.5 Negotiating access

There are six main clinics in the local region (a large health region in the north of England) serving six cities/towns; a central *pool* of nursing and reception staff resource each clinic. Each clinic also runs smaller *'satellite'* clinics, based in local health centres using staff from this *pool*. These satellite clinics may only operate one evening or afternoon clinic a week and are often staffed by a single receptionist and nurse. The intention was to use more than one town and more than one clinic in each of those towns in order to add breadth to the data, and also to enhance the credibility of the study by limiting the possibility of merely reflecting *local* nursing practice in any findings. However, it was decided to seek permission in one area first, and then, using that experience, subsequently to approach another clinic, in another town.

One of the smaller clinics was selected initially. A number of reasons determined this choice, one being that the size of the clinic meant that organisation the data-collection would be simpler. Another reason was that the senior nurse and clinic manager had expressed interest in the project during informal discussions. However, during these discussions, it became clear that a locality manager (not a nurse) and *not* the clinic manager (as had previously been thought) controlled access to the clinic: she was therefore the *'gatekeeper'* described by Burgess (1984) whose permission was required. At this point a number of things happened concurrently as part of negotiating access:

1. A meeting was arranged with the clinic nurses and locality manager, all of whom had been sent a copy of the research proposal.

2. The relevant forms for local ethical approval were obtained.

3. Indemnity insurance from the University was arranged.

At the meeting, the research study was presented to the nurses in clinic and the locality manager. During the discussion, numerous points were raised, the need for confidentiality, the type of data-collection instrument to be used, and other practical issues concerning consent and confidentiality, that will be discussed in detail later. During this presentation the manager also asked *'what do you expect to find'?*

Although the exploratory nature of the study was outlined in the proposal, Marshall and Rossman (1999) maintain that qualitative researchers are often asked these questions, and identify this as a problematic area for qualitative researchers when *'pitching'* a research project to either a potential funder or individual controlling access. Given the emergent nature of most qualitative research, this is a difficult question to answer. The honest answer is probably *'I don't really know'.* However, this particular response did not seem appropriate, therefore, the exploratory nature of the study was emphasised, although a broad aim of wanting to explore how nurses and women discuss contraception in clinics was also given, reflecting closely the aims of the study in the proposal.

What was helpful at this stage was the opportunity to clarify that the study was *not* aiming to assess clinical practice or to measure the accuracy of the contraceptive advice given by nurses. At this point the fact that the nurses knew the author was helpful, in that they were aware that the author was *not* trained in the *clinical* aspects of family planning, therefore assertions that the study was *not* intending to assess clinical practice could be made and believed. The issue of someone critiquing the quality of their clinical practice seemed to be the most keenly held reservation of the nurses at this meeting. The knowledge that the research was from a sociological perspective and would look at the *process* of the consultation, not the *content* from a clinical quality angle, seemed to be very helpful in alleviating the concerns of the nurses.

The meeting ended positively and the manager gave her verbal agreement that the study could proceed, indicating she would confirm this in writing. Two months passed and no letter arrived; telephone calls to the manager were not returned, and a letter remained unanswered. Eventually, a second letter was answered, three months after the meeting, which indicated that permission to use the clinic would not be granted after all.

Quite what precipitated this is unclear. The letter hinted that the nurses had expressed second thoughts about the study; the manager also expressed concern that the forms for ethical approval had been obtained (not completed or submitted-obtained!) prior to her written approval of the project. A response was drafted and sent, thanking the manager for considering the project, also indicating the author's willingness to discuss these matters further. No reply was received.

This of course was a setback: several months, whilst not completely wasted, had passed without much progress being made. Nonetheless, going through this process had resulted in the development of a research proposal, and the drafting of research ethics forms: a useful exercise. Furthermore, the presentation and discussions with the nurses had been a learning experience. Solace was also taken from Marshall and Rossman (1999), who point out that qualitative researchers often experience difficulties gaining access, and must remain confident in their approach and be persistent.

However, the issue of gaining access to a clinic remained, therefore another clinic in a different town was selected for an approach. On this occasion, a larger clinic (Clinic A) with five satellite clinics was selected, with more nursing and clerical staff. Furthermore, this was a clinic where access *was* through the Clinic Manager.

4.5.1 Clinic A

This clinic is situated in the centre of a large town in the north of England. During 2001 14,982 women attended this clinic, 11, 484 of these women were *'first contacts'* (Office for National Statistics 2002). In the main clinic situated in the town centre sessions ran every weekday in the form of a combination of morning, afternoon and evening clinic sessions. Some required appointments, but the majority were *'drop-in clinics'*, where no prior appointment was necessary. Five satellite clinics were also run, but provided a more limited service. For example, one clinic only opened for one evening, another only ran on one afternoon per week.

The request for access to Clinic A followed a similar pattern to that used with the first clinic. The initial reception by the manager was positive and the author was invited to present the study at a meeting attended by all the staff in the clinic. The issues and concerns raised during this meeting were extremely similar to those voiced at the earlier meeting. Confidentiality, data collection methods, and consent procedures were raised, as was the concern that clinical skills were under review. The tactic used earlier to address this latter issue was used effectively, although one aspect of this discussion turned to what the author would do if any dangerous or harmful practice were to be discovered: could the individual nurse be identified and, if so, would the manager be informed? The author's response to this specific point will be discussed shortly, as part of the ethical considerations section.

This presentation to staff went well, with most nurses openly expressing interest in participating. As before, the manager gave verbal permission for the study to proceed, but this time, within a week, confirmed this in writing. Following this permission, approval was sought from the Local Research Ethics Committee (LREC) to carry out the study.

4.5.2 Clinic B

Shortly after gaining permission to undertake the study in clinic A, a second clinic was approached. Clinic B was situated in a town approximately fifty miles away from clinic A. This clinic was very similar in size and structure to Clinic A, in that it consisted of a main clinic with other smaller satellite clinics, staffed by a pool of nurses (who, of course, were different to those at clinic A). 16, 111 women visited Clinic B during 2001 of who 9,334 were *'first contacts'* (Office for National Statistics 2001). Clinic B offered a similar pattern of morning, afternoon and evening clinic sessions to clinic A; it also offered appointment and *drop -in* services.

On this occasion, the author was invited to discuss the study with the senior nurse (also the clinic manager). The presentation resulted in tentative approval from the manager, who seemed even keener when she became aware that another clinic was also participating. The reason for this never became clear, although it could be that she felt reassured that another area was happy with the study, or it could be related to her not wanting to be left out. The manager subsequently invited the author to present the study at a staff training day taking place, quite fortuitously, in three weeks' time.

During this staff presentation, it was interesting to note that very similar issues were raised to those expressed by nurses in Clinic A. They mentioned the importance of confidentiality and informed consent; they also were reassured by the non-clinical nature of the study. One nurse did express concern that data-collection may make the clinic session more protracted, by way of the having to deal with the consent form and switch on the tape (although she subsequently participated), and was partly reassured by the author that any procedures that disrupted the clinic would be reviewed, although one of her colleagues did come to the author's rescue by saying that the consent form and tape activation would *'only take a minute'.* During this clinic presentation, nurses also asked if the study would include under-16's, expressing the view that this could affect the attendance at clinic by very young clients,

Unlike gaining access to Clinic A, Clinic B procedure required the submission of a research proposal to the research governance group within the Primary Care Trust (PCT) before access could be granted. This permission had to be gained before the LREC would consider a research study. This process involved another meeting, to discuss the study with the lead person in the PCT for research, a senior nurse.

At this meeting, two issues seemed important. One was that the research should not interfere significantly with the running of the clinic; the other was: *'were the clinic staff happy to participate'*? The author was able to provide verbal reassurance to this effect, but also arranged for a letter of support to be written by the clinic manager. This letter accompanied the submission of the research proposal to the PCT research governance group, at which no presentation was required. Permission to proceed was granted by letter, and submission to the LREC could therefore proceed. However, unlike the LREC for clinic A, the LREC for clinic B required researchers to attend the meeting, in order to answer questions about their study.

This next section discusses the ethical aspects of the study. It is structured around the generic ethical issues that concern all researchers, although during this discussion the specific local issues encountered through dealing with two LREC's will also be highlighted.

4.6 Ethical considerations

All research studies have ethical dimensions that require detailed consideration by researchers (Parahoo 1997). This section describes how the ethical dimensions of the study were addressed and uses a framework of ethical principles drawn from the literature. This framework is adapted from the International Council of Nurses' (ICN 1996) ethical principles for nursing research, which were heavily influenced by the ethical code of practice set out in the 1978 United States National Commission for the protection of human research subjects (cited by Christians 2000). It is also reflective of other suggested frameworks, for example, the principles of biomedical ethics, set out by Beauchamp and Childress (2001).

4.6.1 Autonomy/respect for persons

The central element of respecting autonomy in research is the issue of informed consent. Subjects must agree voluntarily to participate: furthermore, participation must be informed by the participant knowing the duration, methods, possible risks and aims of the research (Christains 2000). Several aspects affected how the issue of consent was addressed in this study: one was a requirement of the LREC, the other was the need to recognise the specific issues around gaining consent from clients and nurses.

LREC guidance for both clinics recommended that a *'patient'* information sheet be used, based upon the form recommended by the Medical Research Council (MRC), a copy of which is provided in appendix III. This information sheet describes the study to potential participants, particularly stressing the voluntary nature of participation in the study, although it is clearly more suited to medical or pharmacological research, for which it was originally intended.

Consideration was also given to any exclusion criteria that would be applied when seeking consent from women attending the clinic. Although the intention was to have the broadest possible inclusion criteria, in order to allow theoretical sampling, four other exclusion groups were identified in addition to the lower age limit of 16 yrs of age:

1. Women with a learning disability.
2. Women who would require an interpreter in the consultation.
3. Women who were victims of sexual assault or abuse.
4. Women who were unable to read the information sheet.

Consent procedure (clients)

All eligible women over the age of 16 attending the clinic for contraception were given the information sheet to read by the clinic receptionist. Women would often have 20-30 minutes of waiting time during which to read the sheet. The researcher was always in the clinic to answer questions women may have had about the study. When women were called into the consultation, the nurse asked the woman, in the privacy of the consulting room, if she had read the sheet and if she would agree to participate.

As indicated in the information sheet, the woman had the option to decline totally or to agree to audio-taping and interview. If the woman agreed, a consent form for taping the consultation was signed and dated (see appendix IV) and the nurse recorded the consultation. Interview consent was recorded on a separate form completed by the researcher (appendix V), a copy of which was stored with the woman's clinic notes, whilst she retained one herself. The consent forms utilised were based closely upon the ones required by the LREC's.

The LREC for Clinic B initially questioned this process and two members of the committee suggested that the researcher, not the nurse, should be the person who seeks consent. However, it was successfully argued that, because the author would have to approach women either in the waiting room or on the corridor before entering the consulting room, the privacy of the consulting room and the relatively non-partisan approach of the nurse was, on balance, the best way to proceed.

Consent procedure (nurses)

As described earlier, the research study was presented to nurses during a preliminary meeting. They were also given copies of the proposal to take away and read. During orientation visits to the clinics, nurses were asked if they were willing to participate. If they were, the particular clinic sessions they were staffing were identified and used later to plan for data-collection. Nurses only gave formal consent at this subsequent visit, which was preceded by telephone call, and a consent form was signed prior to participation (appendix VI). Nurses were also aware that they could withdraw at any time, without giving a reason. Nurses were also asked if they would be willing to be interviewed and consent was obtained separately for this.

4.6.2 Beneficence / non-malificence

Any research study should benefit either the individual participants or Society in general. It should also be conducted in a manner that ensures the well-being of participants and protect them from harm. Although this study did not include any physical experiments or procedures, this did not mean that the potential for harm was absent. Christians (2000) and Parahoo (1997) both point out that the potential emotional harm research that participants could experience also requires recognition. This was partly addressed by the procedure for obtaining informed consent discussed above, also through ensuring privacy and confidentiality, which are to be discussed shortly. However, it was also recognised that there was a concern in this respect relating to the possibility of participants becoming distressed during data-collection procedures, therefore this was addressed in the following three ways:

- Participants were made aware that they could withdraw from the study at any time, without giving a reason. Audio-taping during the consultations could also be interrupted or stopped, by either nurse or woman, at any stage.

- Any interviews with women would be conducted in clinic, where trained nurses were available to give advice and support to participants.

- The researcher's contact details were given to all participants, to enable them to discuss their participation in the study at a later date, if they so wished.

A related area of concern was the issue of the author's ethical responsibility to the women taking part in the consultation. What would happen if the author came upon examples of poor practice or even occasions of abuse or negligence? Interestingly, this issue did not occur in any communication with either LREC, but was raised during the clinic A presentation mentioned earlier. This dilemma is addressed by the work of De Laine (2000:122), who uses the phrase, *'whose side are you on'* as a researcher. She argues that researchers do have some ethical responsibility to *'gatekeepers'* who have granted them access, but also points out that keeping the confidence and trust of the participants in a study can be crucial to its success. Therefore in research studies, some issues may arise that create a conflict of interest. In the case of bad practice in consultations, the author would be faced with the ethical responsibility to report this, in order to protect clients, conflicting with the duty of confidence to research participants (nurses).

De Laine (2000:117) does not really provided any concrete answers to this, beyond suggesting that the researcher draws upon personal and professional values, and does what feels *'right'* or *'good'*. In the absence of clear guidance, the author decided that it would only be in cases where serious harm or abuse was encountered that disclosure to the Clinic Manager would occur. The author felt that, in this instance professional duty to clients (women) outweighed the confidential role of researcher. This was made clear to nurses in the study, who agreed that this was reasonable. Fortunately, no issue arose during data-collection that created a dilemma of this nature. It was also re-emphasised that the study was not aiming to assess the quality of clinical practice and that if any practice issues were described in writing up, individual nurses, indeed, clinics would not be identified.

4.6.3 Privacy and confidentiality

Christians (2000) points out that some researchers actually question whether any research data can be truly considered confidential, simply because there will always be someone able to recognise the slightest clue from carefully anonymised data. Nevertheless, given the intimate nature of family planning and sexual health, confidentiality was an important issue in the design of this study. As part of the informed consent procedure outlined earlier, potential participants were made aware of the measures taken to ensure that information collected during the study would be treated confidentially. These measures were also a key part of the formal ethical approval process and can be summarised by the following procedures:

- All identifying material would be removed from transcripts. Participants would only be referred to as either a number or letter in any data. The names of individual clinics would also be removed from data.
- Data was stored on a password-protected computer, registered under the Data Protection Act.
- Individuals or clinics would not be identified in any published reports or scholarly papers.
- The woman's General Practitioner would not be informed of her participation in the study.

This last point did create some discussion with the LREC for clinic B. However, it was successfully argued that as the clinic, on the grounds of confidentiality, does not inform the General Practitioner of the woman's visit, it would be inappropriate for the researcher to do so.

4.6.4 Justice

Christians (2000:140) proposes that justice concerns the *'fair distribution of both the benefits and burdens of research'*. This includes numerous issues, from the overuse of research subjects to the provision of unfair advantages to individuals if they consent.

The issue of over-research was dealt with by the LREC. Fortunately, women attending family planning clinics are not a particularly over-researched group, and furthermore, no prior research in Clinic A or B had been conducted that involved collecting data in the manner advocated within this study.

However, an interesting issue occurred concerning the aspect of providing advantage to research participants during fieldwork in Clinic A. At one particularly unproductive clinic, the author bemoaned the fact that there were hardly any women consenting to be taped. The receptionist offered to tell women, when she gave out an information sheet, that if they agreed to be taped they could see the nurse earlier. The receptionist was trying to be helpful and had not realised how unethical this was, disadvantaging women who did not want to participate. This offer, however tempting at the time, was of course, declined.

4.6.5 Veracity/accuracy

The aspect of veracity and accuracy concerns the issue of the researcher being truthful, both in the description of the study when obtaining consent and in the analysis of data and the presentation of findings. Christians (2000) maintains that,

> *'Data that are internally and externally valid are the coin of the realm, experimentally and morally' (Christians 2000:140).*

In other words, the researcher has an ethical duty to research participants to undertake research that is trustworthy. If this is not done, it at best wastes the participants' time; at worst it represents them fraudulently.

The particular procedures to ensure trustworthiness within the research design were not queried by either LREC, although the author did have to manage some concerns expressed about qualitative methods in general. In the presentation to the LREC for clinic B, one member, a consultant physician, questioned the validity of qualitative research altogether, arguing that it was subjective and not transferable. The author felt that this was not the time for an extremely robust defence of qualitative research, but did point out that often more quantitative work follows initial qualitative research in areas where not much is known.

Furthermore, the point that within grounded theory the emerging conceptual framework can be utilised, tested and modified by other researchers in other settings was also explained. This seemed to satisfy the committee and verbal approval was given, followed shortly by letter.

A further methodological query was posed by the LREC for Clinic A. Some weeks after the study had been submitted, a curious letter was received stating that, in order for the study to be considered, a *'lay-man's guide to grounded theory'* must be provided. The letter also contained an attempt (which was inaccurate) to set out what the Committee thought that grounded theory was. A short paper was drafted and returned, which clearly must have been acceptable, given that a letter was received shortly afterwards indicating that approval had been granted.

Receipt of this letter meant that all the necessary permission required to commence data-collection in clinics had been obtained. The next section describes how fieldwork was undertaken in Clinics A and B, but it will begin with a summary of the data collected throughout the total duration of the study.

Section two: Entering the field

4.7 Summary of data collection

In keeping with a grounded theory methodology, data were collected and analysed in a gradual manner, over a period of around twelve months, from clinics A and B. This process will be described in detail shortly, however, prior to this, an overall summary of data-collection will be provided, in order to give the subsequent discussion some context.

4.7.1 Consultations

A total of 49 contraceptive consultations, undertaken by 21 different female nurses (no male nurses are employed in either clinic) were recorded in this study during data-collection visits to 31 clinic sessions. 28 consultations involving 12 nurses, were recorded in Clinic A (including two satellite clinics). 21 consultations, undertaken by 9 nurses were recorded in Clinic B (including one satellite clinic). Nurses' ages ranged from 26-54 years of age.

Recruitment of nurses to the study was quite successful. In Clinic A, out of 14 regular nurses only 2 declined to participate. One other nurse was being trained and would have a supervising nurse in the consultation with her. It was felt that data-collection would have been unfair in this situation. In Clinic B, 9 out of 12 regular nurses agreed to participate. One declined, another was on study leave during data-collection and the third was on long term sick leave.

A broad range of clinic sessions were visited for data-collection. Table 2 illustrates the specific types of clinics visited, the number of data-collection visits made and the number of consultations taped at those clinics.

Table 2: Clinic visits and data collection

	No's of clinics attended / numbers of consultations taped				
Clinic type	Morning appointments	Morning drop in	Afternoon appointments	Evening appointments	Evening drop in
Main clinic A	**2 / 3**	**3 / 5**	**2 / 3**	**2 / 3**	**2 / 4**
Clinic A satellite 1	**N/C**	**N/C**	**3 / 4**	**N/C**	**N/C**
Clinic A satellite 2	**N/C**	**N/C**	**N/C**	**2 / 1**	**3 / 5**
Main clinic B	**2 / 4**	**3 / 5**	**1 / 2**	**1 / 3**	**2 / 2**
Clinic B satellite 1	**N/C**	**3 / 5**	**N/C**	**N/C**	**N/C**

Key: N/C = No clinic of this type/time

A broad range of contraceptive consultations were recorded with women who's ages ranged from 17 – 36 yrs. Table 3 sets out the main reason for the woman's visit to the clinic and the woman's age, which was obtained by nurses recording her year of birth on the consent form, although on two occasions this was forgotten.

Table 3: Consultations recorded

Consultation No.	***Reason for clinic visit***	***Age***
Consultation 1	Repeat pill/smear	29
Consultation 2	E/C - missed pill	21
Consultation 3	Coil check	33
Consultation 4	Repeat condoms	24
Consultation 5	Repeat pill/smear	19
Consultation 6	Re-commence pill	36
Consultation 7	Depo-Provera	26
Consultation 8	E/C – missed pill	22
Consultation 9	E/C – Unprotected sex	17
Consultation 10	Repeat pill	18
Consultation 11	Repeat Depo-Provera	32
Consultation 12	Repeat pill	23
Consultation 13	New pill	20
Consultation 14	E/C – new Diaphragm fit	21
Consultation 15	Pill user -? change to coil	24
Consultation 16	Repeat Depo-Provera	20
Consultation 17	Repeat pill	22
Consultation 18	New Coil	20
Consultation 19	Repeat pill/smear	25
Consultation 20	Repeat pill	18
Consultation 21	E/C – condom failure	27
Consultation 22	New pill	21
Consultation 23	Repeat pill	19
Consultation 24	Repeat pill	22
Consultation 25	E/C – missed pill	24

Consultation 26	E/C – missed pill	N/R
Consultation 27	Coil check	N/R
Consultation 28	Repeat Depo-Provera	19
Consultation 29	New pill	17
Consultation 30	Coil check	29
Consultation 31	E/C – missed pill	22
Consultation 32	New coil	39
Consultation 33	Repeat pill	19
Consultation 34	Diaphragm	21
Consultation 35	Coil removal – start pill	27
Consultation 36	Consider pill/diaphragm	34
Consultation 37	Repeat pill	27
Consultation 38	Depo-Provera	25
Consultation 39	E/C- missed pill	19
Consultation 40	Coil check	29
Consultation 41	Coil check	26
Consultation 42	New Depo-Provera	19
Consultation 43	Repeat pill	26
Consultation 44	Coil check	24
Consultation 45	New pill	20
Consultation 46	E/C- condom failure	23
Consultation 47	Repeat Depo-Provera	20
Consultation 48	E/C – missed pill	19
Consultation 49	Repeat Depo-Provera/ ? implant	32

Key E/C = Emergency contraception N/R = Not recorded

4.7.2 Interviews with nurses

15 interviews with nurses were undertaken. 9 interviews were conducted in Clinic A (this included 3 nurses who were re-interviewed) and 6 in Clinic B (including 1 nurse re-interviewed). For confidentiality reasons, nurses were allocated an identifying letter from A to K in transcripts; this also denoted the order in which they were interviewed.

4.7.3 Interviews with women

4 interviews were conducted with women, 3 in Clinic A and 1 in Clinic B. The reason for this small number is related both to the direction that the research took and to recruitment difficulties, aspects that will be explained in the forthcoming discussion.

4.7.4 Measures to enhance trustworthiness

Numerous procedures, drawing upon the techniques outlined by Lincoln and Guba (1985) were undertaken to ensure the trustworthiness of the findings in this study. These will be expanded upon in the forthcoming discussion, but table 4 provides a summary.

Table 4: measures to enhance trustworthiness

Member-checking	*Presentations to participating nurses and other family planning nurses.*
Peer de-briefing	*Discussions with supervisor* *Discussion with colleagues* *Seminar presentation* *Conference papers*
Triangulation	*Theoretical sampling;* • *Nurse interviews* • *Multiple clinics* • *Multiple nurses* • *Range of contraceptive methods*
Audit trail	*Memos* *Field notes* *Interview guide amendments* *Data analysis notes* *Drafts of early work*
Negative case analysis	*Constant comparative approach* *Memos* *Theoretical sampling*

4.8 Experiences of data-collection

4.8.1 Consultation taping

On the whole, the practicalities of data-collection progressed quite smoothly, although certain practical problems did occur relating to the use of tapes early in the study. On one occasion, the microphone was situated too close to the computer keyboard, resulting in the crashing of keys obscuring the discussion. Similarly, when positioned too close to the blood pressure cuff, talk was obscured when this equipment was used. The importance of being present in the clinic was also demonstrated when a nurse came out halfway through a consultation to ask the author to turn the tape over!

Taking an extension lead for mains-powered equipment also proved valuable, given that in many of the consulting rooms the electric socket by the nurse's desk is in use. Furthermore, the importance of making sure that individuals are able to correctly use equipment given to them by the researcher was forcefully made when an apparently successful evening clinic visit, with consent to record given by four women, ultimately yielded a blank tape because the nurse had pressed *'play'* instead of *'record'* during all four consultations!

Similarly, the recruitment process clearly showed the value of involving the receptionists in the study and, on the whole went well, occasional glitches occurred. For example, in Clinic A one consultation with a fourteen-year old was inadvertently recorded, in another a young man attending for condoms was taped, and in Clinic B, in one of the satellite clinics, a woman attending for a smear was taped. None of these tapes were used in analysis. With regard to the exclusion criteria, no cases of women attending as a result of assault or rape were encountered, or of women requiring interpretation. One incident occurred of a woman giving the receptionist the information sheet back, remarking that she was unable to read, which although considered as part of the inclusion criteria was a thought provoking incident for the author; how many women who could not read and, feeling too embarrassed to admit this, subsequently gave consent? This is difficult to assess, but the fact that women subsequently signed a consent form is reassuring, to some extent.

4.8.2 Interviews with nurses

Interviews with nurses provided some very interesting data that added to the understanding of the consultation data. Some nurses were actually re-interviewed as a result of changes that were made to the interview schedule, in response to analysis of the consultation data, an aspect that will be explored in detail later. On the whole, these interviews were enjoyable to perform, with nurses seeming genuinely pleased to be able to talk about what they do, resulting in most of the interviews lasting well over an hour. Generally, the questions asked during interviews generated rich answers, and the author was quite satisfied that these interviews were effectively conducted. The main problem with the nurse interviews was finding time in a busy clinic schedule to conduct them, an issue that had an impact on the nature of the study and will be discussed later in this chapter.

4.8.3 Interviews with women

Interviewing women was difficult, for a number of reasons. Although the nurses interviewed were all female and the author male, the nature of the questions meant that this gender difference did not appear to hinder the process. However, this may have been the case with women clients. Even though the initial questions were about their experience with the nurse, the author gained a sense of guarding against the interview straying too far into the women's personal contraceptive use, which is hardly surprising. Nevertheless, the literature is fairly scarce about gender influences on interviews, even though feminist researchers raised the issue over twenty years ago as a significant power issue in social research (Oakley 1981). Fontana and Frey (2000) cite the example of even Babbie's (1992) classic text, the *Practice of Social Research,* as citing gender only three times. The general feel from what literature there is on this matter is that, for sensitive issues, interviews that generate a feeling of reciprocity and intimacy tend to obtain the richest responses (Oakley 1981). Reading between the lines, many authors imply that women interviewing women is the best way to achieve this (Oakley 1981, Weston 1998) and, although this may be challenged, it does seem particularly relevant when matters close to sex and sexuality are involved.

However, this was not the only reason why interviews with women were difficult. Initially, the aim was to explore their experiences of the consultation that had just ended. Questions were devised that asked about this. During the interviews, it seemed that women wanted to say how pleased they were about the consultation, that they always felt able to ask questions and always understood the nurses' instructions. They didn't feel rushed or judged by the nurse and they felt respected. In short, apart from saying that waiting a long time was a problem, getting women to talk about the consultation in any depth was difficult. The reasons for this could be numerous. For example, perhaps the author's gender was a factor, or women may not have wanted to criticise the nurse. Alternatively, their positive comments could be genuine, or they may have wanted the interview to be quick. Furthermore, perhaps it was the author who was making a routine everyday aspect of women's lives into a more significant event than it actually was. In reality, it was probably a mixture of all of the above. The impact these difficulties had on the study will be explored in detail later, when data-collection and analysis are discussed. However, prior to that, the first steps in beginning fieldwork in both Clinics A and B will be described.

4.9 Orientation to the clinics: entering the field

Prior to any data-collection, some time was spent becoming familiar with clinic routines. This began in Clinic A with the author spending time observing the clinic process and talking to clinic staff. Lincoln and Guba (1985:251) use the term *'prior ethnography'* to describe the time a researcher spends becoming orientated to the research setting, pointing out that this time is well spent, because it helps to *'diminish the obtrusiveness'* of the researcher, whilst also providing the *'informational orientation'* to increase the effectiveness of the formal fieldwork (Lincoln and Guba 1985:251).

These visits enabled a more detailed understanding of the consultation process to be obtained. An important element of this was spending time talking to nurses about how they worked through the consultation, included talking about how nurses used the clinical protocols that guide their practice. The visit to the main Clinic A also included becoming familiar with the computerised consultation system that nurses used. The computer takes the place of written records in this clinic; the system is based upon the paper protocols, but is set out as a computer process.

What seemed clear at these visits was that nurses did have views about how the computer and clinical guidelines influenced their practice, issues that were reflected in questions on the initial interview guides. A subsequent visit to Clinic B enabled a similar orientation to the consultation process. No computers are used in Clinic B (the clinic will be computerised in 2004. Therefore, only written records are used. They also use clinical protocols that are very similar to those used in Clinic A.

Although the geography of the buildings was somewhat different, both clinics operated in a very similar way; women entered the clinic and were greeted by a receptionist; who recorded details and asked the nature of their visit. Women were then asked to sit in the waiting area of the clinic. Both Clinics A and B shared their waiting areas with other clinics, for example podiatry and maternity clinics. Women were then called by number through to see the nurse. Occasionally, some women needed to be seen by a doctor after they had seen the nurse. This would occur if the woman needed a pelvic examination or a coil fitting, for example; procedures nurses are not trained to do. However, most women left the clinic after seeing the nurse. Evening clinic sessions were also observed. These ran in the same way, except that the waiting room was exclusively for the family planning clinic.

These visits, as well as helping the author to become less obtrusive, enabled a number of practical issues to be identified and addressed prior to formal data-collection. The visits enabled identification of a quiet, private room in which to conduct interviews and also helped the author to find the best place to spend time during the clinics that was both accessible to clinic staff and one that did not interrupt the running of the clinic. Furthermore, clinic visits were also useful in that they enabled observation of the clinic reception procedure. The opportunity to see what happened to women from the moment they walked into clinic was extremely useful, particularly as the reception procedure was a crucial event in the recruitment of women to the study.

On entering either Clinic A or B, a woman would see the receptionist, who asked her about the nature of her visit. If the woman had visited the clinic before, the receptionist would also obtain her clinic notes. The receptionists, therefore, were key people in the consent procedure and it was important that they were familiar with the workings of the study. Fortunately, in Clinic A and B, many of the receptionists had attended the staff training days where the study was first presented. However, it became clear that spending time with receptionists proved valuable in terms of the smooth running of the fieldwork.

Since the receptionists were the first contact with women attending the clinic, they were the practical *'gatekeepers'* to the clinic and played a number of key roles, particularly in the sampling and consent procedures. Firstly, they would be able to identify which women were attending for contraception (some women attend just for a cervical smear, not for contraceptive advice). Secondly, they would know the age of the woman (LREC permission only allowed over-16's to participate). Thirdly, they would provide the first verbal introduction to the research study that the woman heard.

This last point was the subject of some discussion and thought. Receptionists often asked: *'what shall I say when I give the sheet out'?* Prior to these orientation visits, this, very simple, yet important aspect had not been considered. The decision was taken that, to ensure women did not feel pressured in any way, and to ensure uniformity, a standard phrase would be used, which was: *'There is a research study taking place in the clinic today, would you please read this leaflet before you see the nurse'.*

Establishing this phrase helped the receptionists whilst also guarding against receptionists unduly encouraging women or, on the other hand, describing the study in a more negative light.

It also became clear, during observational visits, that the first women into clinic were often called through to see the nurse within a few minutes of arrival. This meant that they would have little or no time to read the information sheet; it was women who attended after these first women who had a twenty-minute or so wait. On this basis, it was decided that receptionists would not give out information sheets to the first women coming into the clinic.

As mentioned earlier, these orientation visits also enabled the author to discuss the study further with nurses working in the clinic and to seek their consent to participate. This generated a list of names and clinic sessions that provided a helpful guide with which to plan fieldwork.

However, nurses were not formally consented at this point. It was felt that written consent would be best obtained during a fieldwork visit (which had been pre-planned with the nurses concerned), to enable them to have time to change their mind about participation when telephoned prior to the visit (although none did).

4.10 Data collection (initial concerns)

As outlined in the previous chapter it is impossible, when utilising grounded theory, to predict how many participants or incidents will be required at the outset of the study. With grounded theory, very soon after the first data are collected and analysed, sampling is driven theoretically by the requirements to explore and test emerging concepts (Stern 1985, Chenitz 1986); it is only when the researcher is satisfied that the categories which emerge are saturated that data-collection ceases (Strauss and Corbin 1990).

However, data-collection had to start somewhere and, to this effect, a 3-hour afternoon *'drop-in'* session in Clinic A with two nurses who had agreed to participate was selected. Every eligible woman over-16 seeking contraceptive advice was given an information sheet (except the very first clinic arrivals) to read in the waiting room, before seeing the nurse.

This initial fieldwork did not go well. At this clinic, not one out of 24 women who had been given information sheets consented to participate in the study. No data was collected at all.

Discussing this with the two nurses involved after the clinic was useful; one of their main comments was that several women had said they did not mind being taped, but would not or could not spare time for an interview. Their impression was that women were mainly reluctant to be interviewed because it would entail prolonging their clinic visit, although it is impossible to say if this was a polite excuse or not. Nevertheless, the early signs were that conducting interviews with women would be problematic.

Another clinic session, with the same nurses, was attended, this time a 2-hour evening clinic. At this clinic, one woman consented to be taped and interviewed, although the nurse concerned could not be interviewed that day because of family commitments. Nevertheless, the consultation was taped and an interview with the woman was undertaken. The nurse was interviewed three days later. A further 2-hour evening clinic was also visited, this resulted in no data collection.

Even at this early point in the study, it was becoming clear that collecting data in *triads* was proving very difficult and, in retrospect, was based on slightly naïve and unrealistic plans. Firstly, the idea of listening to tapes before interviewing women about the consultation they had just had was problematic, given that as the consultation ended, the woman was immediately available for interview. On the occasions where women had consented, the interview was conducted just using the initial interview guide; the tape of the consultation could not be played back until later. Furthermore, as fieldwork progressed, it became clear that there was also a problem with interviewing nurses directly after the clinic had ended, as they had paper work to complete and the clinic had to be closed shortly after the consultations ended. Interviews had, therefore, to be arranged with nurses at other more convenient times, meaning they were far less likely to be able to recall the *specific* consultation that had been taped. Indeed, two further nurse interviews were conducted on this basis, again just using the original interview guide.

At this stage, there was some frustration that, due to the manner in which consent was sought from women (taping and interview combined), consultation data that could have been collected were being missed because women were not willing to stay for interview.

At this point, some comfort was drawn from the knowledge that qualitative researchers often experience these types of problems and that the unpredictability of field work requires a flexible response to these issues (Burgess 1984, Lincoln and Guba 1985). It was evident that some re-thinking had to be done to manage this problem. This rethinking marked a key moment in the future direction of the study.

It was decided to amend the consent and data-collection procedures, in an attempt to collect at least some consultation data. This involved instigating a *two-stage* consent procedure for women attending the clinic, that allowed them to consent to their consultation being taped, *without* having the need to consent to interview afterwards. This change in procedure meant that adjustments were required to the patient information sheet to set out clearly that women could agree to the taping of the consultation *without* the need to stay for an interview. This change shifted the focus of the study from the initial idea of having *triads* of data on *specific* consultations to a less rigid approach to the collection of data. At this early stage, it was decided firstly to collect as many tapes of consultations as possible to obtain some data, taking the opportunity to interview women when it occurred and conducting interviews with nurses that sought their views on the contraceptive consultations *in general,* rather than on any one specific consultation. This amended approach also enabled several consultation tapes to be listened to, transcribed and initially coded before further interviews took place.

The change to the consent procedure provided positive results immediately. In the first clinic where this procedure was used, six consultations were taped during an evening session, although only one interview with a woman was possible. However, this adaptation had resulted in some tangible data to work with. It was now possible to gain an insight into what was taking place during the consultation between woman and nurse. At this point, data-collection commenced in Clinic B, using the two-stage consent procedure, one clinic session was attended that resulted in two consultations being taped, one woman interviewed and one nurse interview conducted.

Three further interviews with nurses from Clinic A, and two from Clinic B had also been arranged, at later, more convenient dates, and several clinic sessions had been identified for future data-collection visits. However, at this point it was decided that some time working with the consultation data would take place prior to these interviews.

4.11 Data-collection and analysis

As indicated above, this early data collection resulted in six consultations being taped from Clinic A and two consultations from Clinic B. Additionally, three women had been interviewed and also four nurses. The first act was simply to listen to the tapes of the consultations and interviews, this being the first time the author had been able to listen to what actually occurred in the consulting room. The next act was to transcribe the tapes into text. For this, a member of the university clerical staff was employed, although the author transcribed two consultation tapes and one nurse interview personally and subsequently always listened to tapes when reading transcripts for the first time, to check accuracy. A further task when reading the transcripts was to remove any identifying information and to store the tapes in a locked drawer and transcript data on a password-protected computer.

From the outset of the study, it had been intended to use interviews to shed light upon the emerging theoretical framework derived from the consultation data. To this end, consultation and interview data were managed differently. The consultation data were analysed using the constant comparative method with the subsequent coding and categorising procedure outlined earlier, in the methodology section. In doing this, interview questions would then be guided by memo writing, as part of this emergent approach. Therefore, in keeping with this concept, the interview transcripts were subjected to more informal analysis, that mainly involved looking at the descriptions, experiences and rationale provided by respondents in relation to the consultation data.

4.11.1 Consultation data analysis

In keeping with grounded theory, data analysis commenced as soon as these first consultation tapes had been transcribed. According to Glaser and Strauss (1967), the process of open coding involves a line-by-line examination of the transcript. However, later advocates of grounded theory argue that this technique is time-consuming and tedious, particularly with large amounts of data (Chenitz 1986, Strauss and Corbin 1990, Charmaz 2000). They go on to add that line-by-line may be appropriate for initial data, but that later analysis takes place on a segment-by-segment basis. In practice, however, there was a need to use a combination of these two approaches. For example, even in later transcripts, particularly interesting and rich sections of text required a line-by-line analysis.

However, throughout data-analysis, consideration was also given to the position taken by Charmaz (20000), namely that it is important to remember that minutely examined lines of text are also part of a holistic process. A helpful technique in doing this was to listening again to the original tapes, and to read through transcripts. Indeed, having the notion of holism at the back of the mind during early data-collection proved extremely helpful during the next stage of the study: how to manage the large amount of interesting data that was revealing numerous potential avenues of inquiry. In other words, the data was acting in the way described earlier by Phillips and Marsh (1984) raising a multitude of new research questions in the manner of an inverted funnel: an issue that was becoming more problematic as data-collection continued, adding a further seven consultations.

4.12 Refining the focus of the study: *the inverted funnel*

It was during this stage, involving reading and listening to the consultation data, along with the early stages of open coding, that the term *'plagued'* by a vast array of interesting data, used by Lincoln and Guba (1985:210), took on a concrete meaning. The data during this early phase of the study generated all sorts of tempting issues, interesting questions and hypotheses. It seemed as though every section of data provided enough material for a whole research study, guided by new research questions. This was a difficult time in the data-collection and analysis process; not seeing the wood for the trees did spring to mind here. To give a flavour of this stage, some key examples of early notes and memos are offered to illustrate the types of issues that were vying for attention:

- Sexually Transmitted infection (STI): how do nurses introduce the possibility of the woman contracting an STI within the consultation process? How do they phrase questions to women who are attending for contraception and not expecting to discuss their risk of STI's? There were instances in consultations where women had practised unsafe sex, but nurses did not always explore the risk that those women had taken and had not discussed safer sex. Why was this? Do women feel that this visit is only for contraception, rather than for wider sexual health needs?

- Teaching women how their method of contraception works seems important. Is this an aspect of all consultations? Do nurses feel that this is important? How and why is it done?

- How does the computer influence the consultation and how does this compare with consultations conducted using paper records? Consultations seem to be driven by the computer programme. There were instances where women were diverted back from certain issues because of the procedure of the consultation. There were also some interesting comments by nurses about their thoughts on the computer during interviews. What do women feel about the computer during the consultation?

- Clinical protocols: How do nurses adapt and use the clinical protocols as part of their practice? The consultations are constructed around these guidelines. Some interesting views were also expressed on them during interviews, particularly how some nurses valued them as helpful *aide-memoir* whilst others felt they needed to be utilised quite flexibly. In Clinic B, nurses use slightly different clinical guidelines and use written, rather than computer record systems, in clinic. Does this affect the consultation?

- Some of the instructions to women seem quite complex. How do nurses help women understand these?

- Side-effects seem important. How do nurses help women who are experiencing side effects whilst ensuring they continue to use contraception?

- Attitudes to sexuality: how do nurses manage their own personal attitudes to the sexual behaviour of the women they see in clinic alongside their professional practice? Do women feel that they are being judged during consultations?

- Does the age/intelligence of women affect the consultation? Do nurses amend their strategies for younger women or as they perceive women to be more or less well-educated?

As indicated in the previous chapter, little concrete advice is given to researchers at this stage, apart from the acknowledgement that emergent designs do generate data that could potentially take the researcher in numerous directions and the assertion by Lincoln and Guba (1985:210) that, because of this, *'one cannot study everything'*. Also, the appropriateness of qualitative research being a *'frenzied, twisting and continuously changing endeavour'* in which the researcher must learn to accept *'ambiguity'* was becoming increasingly apparent (Lincoln and Guba 1985:203). This was an important early stage in the study. Decisions had to be made as to what particular focus the study would take, a process which involved weeks of thinking, re-reading transcripts and mulling over the various interesting directions the study could take. Several considerations influenced this process, some of them methodological, some more practical.

It was very helpful at this stage to do two things. One was to reflect upon the broad aim of the study, which was to explore *'the nature of the nurse/women contraceptive consultation'*; the other was to try to look at the consultation data obtained up to that point in as holistic manner as possible, with this overall focus in mind. Doing this over time resulted, gradually and in a fragmented, messy way, in the emergence of a sharper focus to the study. By looking at the data in this way, a more precise type of research question began to form, which took shape by trying to screen out the *specific* interesting areas outlined above, in a way avoiding the *'brightest lights'* and to concentrate on the broader, *holistic* questions of: *'what is going on in these consultations'* and *'what is the purpose of them'*? With these questions in mind, it began to become clear that the consultation as a *whole* represented a *process* within which women are helped and encouraged to use contraception effectively; many of the interesting issues identified up to this point were actually *part* of this process. It also seemed likely that pursuing one of these specific issues could seriously detract from understanding the *entire* consultation process.

Examining the data in this light, combined with re- invigorated open coding, attempts began at unpicking the way in which the consultations operated as a process that facilitated women to be effective users of contraception. In other words, the simple fact was: *women come to the family planning clinic because they are choosing to use contraception. It is the nurses' role to help them to do this, How does this work?* This thought process marked a significant move forward in the study.

Going through the process of coding, memo-writing and intuitively looking for links, gradually began to reveal how women are trained, encouraged, prepared and helped to use a method of contraception by nurses during the consultation.

This realisation was an important stage in the study. It consisted, basically, of a realisation that the interesting question was not just about *what* took place in the consultation, but *how* the processes in the consultation actually operated, a thought process which, although described above in a rather neat way, was actually a tortuous, protracted and messy process. However, this process did eventually refine the research focus into a clearer question; *how do nurses use the consultation to facilitate women to use contraception effectively?*

It also would be disingenuous to claim that this question emerged purely from a process of methodological analysis. The fact that the early intention to collect data *'triads'* to analyse *specific* consultations had become impractical, combined with the difficulty in obtaining interview data from women, were both difficulties encountered in the field that influenced this decision. Problems encountered in fieldwork can often influence the direction of qualitative research, according to many authors (Burgess 1894, Lincoln and Guba 1985, Marshall and Rossman 1999). The researcher's task, in these circumstances, is to respond flexibly to these methodological issues and practical difficulties by amending the research design (Marshall and Rossman 1999). Therefore, at this point of the study, several decisions about data-collection were taken that informed further fieldwork:

- Refining the research question did not affect the continued collection of consultation data. The intention was to keep collecting and analysing this data as before, although the objective was to now look closely at developing conceptual frameworks to explain the way in which nurses facilitated effective contraceptive use.

- Nurse interviews would continue. Increasingly, the focus of these interviews would be guided by questions designed to explore issues emerging from consultation data. This led to the development of a modified interview guide (appendix VII) to be used in subsequent nurse interviews.

Additionally, plans were made to re-interview the three nurses who had been interviewed so far. Interestingly, this change meant that because interview times and dates were negotiated, nurses had far more time for interview than they would have had after a busy clinic. Many of these interviews were carried out during lunchtimes, or after work, in the nurse's other place of employment. As a result of having more time, far more interesting data was gathered.

- Interviews with women would not continue. This decision was not taken lightly, but was taken for a variety of reasons. The nature of the study was moving towards exploring the *general* process of the contraceptive consultation and how nurses used various processes to help women to use contraception. Initially, Interviews with women were intended to enable exploration of the *specific* consultation of which they had been part. It was clear that women contraceptive user's views on this process could be helpful, but it was felt that this would be more appropriate for future research, an issue that will be re-visited later when discussing the limitations of the study.

- The change in focus of the study also meant that refinements would have to be made to the initial questions designed to ask women about the consultation, such as; *'did you feel that the nurse allowed you to ask questions'* and *'did you understand the information the nurse gave you'*? As will become clear from the data to be presented, this could entail interview questions becoming increasingly focused upon quite intimate aspects of contraceptive use. Given the author's gender, it was considered that this line of enquiry would, as highlighted earlier in this section, become even more problematic. This, combined with the point made earlier about the focus of the study becoming more about the consultation *process* and nurses views on it, augmented by the lack of really satisfying data emerging from these interviews described earlier, led to the decision to stop seeking interviews with women at this stage and to concentrate upon the consultations and nurse interviews. The information sheet given to women was amended to reflect this.

4.13 Open coding

As discussed in the previous chapter, open or initial coding, is the first step in data analysis in grounded theory. The intention, as data-collection and analysis continued was to use the open codes firstly to construct more substantive codes, that could eventually be condensed into larger categories as shown in Table 5.

Table 5 Open codes to category

<table>
<tr><td>Open codes</td><td rowspan="4">Substantive codes</td><td rowspan="8">Category</td></tr>
<tr><td>Open codes</td></tr>
<tr><td>Open codes</td></tr>
<tr><td>Open codes</td></tr>
<tr><td>Open codes</td><td rowspan="4">Substantive codes</td></tr>
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To start this process, consultation transcripts were printed, leaving space at the right hand margin for notes and memos. These were subsequently coded into open codes, given naming labels closely associated with that particular activity in the consultation. Table 6 provides an example of this, from an extract taken from a consultation in Clinic A where a nurse is discussing the contraceptive pill with a woman. The open codes allocated to segments of data are included in the right-hand margin (the complete transcript of this consultation is presented in appendix VIII). The open codes developed during this stage of data-collection remained virtually unchanged throughout the data-collection and analysis process, although additional codes were generated as more data were collected.

Table 6: extract from consultation 6 (Clinic A)	**Open codes**
Nurse: what we suggest you do is start your pill from whatever date your period starts and from then on you are sort of protected.	*Instructions on use* *Protection from pregnancy*
Woman: the last day…?	*Women questioning*
Nurse: no, the first day of your period, so whatever day of the week that is and you carry on for all your 21 pills. We suggest you take it at the same time everyday. It doesn't matter what time of day it is, it's whatever suits your lifestyle. It's best if you get up at the same time in a morning and are able to remember to take it with your first cup of coffee at breakfast.	*Awareness of menstruation* *Being aware of time* *Instruction in use* *Fitting into lifestyle*
Woman: yes	*Affirming understanding*
Nurse: What we suggest you do is take it at the same time everyday within a few hours	*Awareness of time* *Instructions on use*
Woman: I tend to do that	*Confirming compliance*
Nurse: That's great. This is the leaflet we will be giving you to go through. The pill is over 99% effective, but that depends on how well you take it, if you forget to take it and go messing around with the times, then it is not so effective. Also when you are taking other medications such as antibiotics that can cause changes in the gut, it can affect absorption erm..so we suggest you use some other form of contraception like condoms or whatever for seven days, and again if you have got diarrhoea or sickness use something. We also advise you to use condoms for sexually transmitted diseases, infections that….	*Giving written information* *Contraceptive % efficacy* *Danger of non compliance* *Interference with contraception* *Education about physiology* *Timing of pill taking* *Requirement for protection/STI's*
Woman: I use condoms as well	*Affirming compliance*
Nurse; Lovely, great and so we can provide them for you (the pills). So it's over 99% effective, erm..slight disadvantages you might gain some weight, feel a bit sick, some breast tenderness because of the hormones there it can affect you, so give it chance to get into your system..	*Contraceptive % efficacy* *Informing of side-effects* *Minimising side-effects* *Education about hormones* *Giving it time to settle*
Woman: Right	*Confirming understanding*
Nurse: now one thing, if you forget to take your pill, hopefully you are not going to because, you know, you're wanting to use it as a form of contraception and the best way to make it effective is to take it regularly.	*Maintaining protection* *Timing of pill taking* *Efficacy of contraception*
Woman: Yes	*Affirming understanding*
Nurse: So here's just a little run down…more than twelve hours late you take the last pill you've remembered and leave any earlier one in your pack, and you must use extra contraception for seven days, and if there is more than seven pills in your pack when you've finished this pack leave the seven-day normal break…but if you find you missed one or two more than twelve hours late and you've only got six pills left don't have your seven day break, start your next pack straight away, because the hormones need to be kept up. But if you're less than seven hours late…sorry twelve hours late if you say take it in the morning and then at teatime you then think 'oh' I've forgotten it this morning you're in twelve hours, just take that pill and the you'll take the next one next morning.	*Awareness of time* *Missed pill* *Extra precautions* *Maintaining protection* *Adjusting regimen* *Time-keeping* *Explaining hormones* *Maintaining protection* *Amending regimen* *Time awareness* *Amending the regimen*

4.14 Memo-writing during open coding

Memos and notes were made extensively during this period. As described by Glaser and Strauss (1967), they took various forms. Some memos asked questions about how certain codes could be linked together, indicating the very early and tentative steps towards developing larger categories later. For example, from the previous extract, it was noted that nurses provided a lot of information to women about their reproductive system, generating memos; *was this education linked to encouraging them to use contraception and, if so, in what way?* And: *time seems important to contraceptive use, is this reflected in other consultations?* Also*: How do nurses address this?*

Memos also helped to guide theoretical sampling. For example, one of the early memos during data analysis from Clinic A was, *are the consultations at Clinic B any different?* The extract from clinic B consultation 16 data in table 7 illustrates how similar the consultations in both areas were. Very similar patterns were emerging from consultations using computer and written records; there was no real evidence in the consultations of major differences in the way in which consultations with women proceeded. This extract also provides an example of early attempts to check out questions prompted by other memos, for example, *are open codes equally applicable to different contraceptive methods*? Early signs from the data suggested that they were, but this was a constant question asked of the data. Table 7 is presented as an example of this, being drawn from a consultation for Depo-Provera at Clinic B.

Table 7 Consultation 16 (clinic B)

Consultation data	Open codes
Nurse: do you know..roughly how long you have got between injections? Do you know what the time limits are? We usually give women an appointment at 11-week intervals, 12 weeks if you like, but it's important, absolutely imperative that you don't actually exceed that 12-week barrier, and if you do use additional precautions because you would be at risk of pregnancy OK.	Time awareness Testing women's knowledge Stressing importance of compliance Risk of pregnancy Need for protection
Woman: Yes	Affirming understanding.
Nurse: And you've been happy with this, the only bleed you've had is a couple of days ago? You've been made aware that you can have some bleeding problems initially when you start the injection?	Menstruation questions Checking previous education Awareness of menstruation.
Woman: I didn't think I could to be honest.	Woman's lack of knowledge

Nurse: It tends to happen you know, when you've had your top-up injections, girls that have been on it some time, don't tend to bleed at all, they might have a spotting here and there from time to time, but with the fist injections you can have some menstrual disturbance. If you do have some problems you can come back and have the injection earlier OK?	Education about method. Passage of time Menstruation education Education about side-effects Amending the regimen
Woman: That's fine, yes.	Affirming understanding
Nurse: OK then, do you want to take that with you to help you read about it, that's your information sheet, OK, Bye.	Giving written information

The above extracts from consultations are excellent examples of the manner in which all the consultations proceeded. Memos were written extensively during this initial open coding to inform further consultation data-analysis. Memos were also used to add to, replace or sharpen the focus of the questions in the nurse interview guide, for example:

- In consultations, education of women about how their method of contraception worked, how effective it was or how their body worked (mainly the reproductive system) seemed common. An early memo also picked up that nurses often quoted percentages when explaining how effective a method was. Questions were developed to ask nurses, for example, about how they educated women about contraceptive methods and the reproductive system. Nurses were also asked if they felt this education was an important aspect of their role.

- Side-effects were also discussed. Nurses made women aware of what side-effects could occur with their method. Interestingly, it was also noted that nurses did not use percentages (as they did for efficacy) when discussing how common side-effects were. Nurses also routinely asked women if they had experienced any side-effects if they were already using contraception.

- Helping women to be aware of the passage of time was a recurring theme. Nurses always discussed time and how important it was in using a method. This could be time in hours, weeks, months or even years. Nurses were subsequently questioned about this in interview, for example, asking if they felt that women using contraception needed to be aware of certain timings in order to use it properly and how they helped with this.

- This also created a set of questions that sought nurses' views on how they managed the issue of side-effects in the consultation.

Data-collection and coding continued in both clinics but, at this stage in the study, as around 25 consultations had been recorded the first real steps towards developing, what at first were more substantive codes, but what were eventually to become larger categories, began.

4.15 Substantive code and Category development

As data-collection and open coding continued in both Clinics A and B attempts at placing data into more substantive codes commenced. In keeping with the methodology, this was an iterative, gradual process that relied on flexibility and the constant testing and questioning of the data.

The formation of these larger, more abstract, substantive codes and categories involved different intuitive skills from those used in open coding. Their formation relies more heavily upon the researcher's ability to make intuitive links between the open codes and, from this, to develop larger codes and, subsequently, larger categories that provide a more theoretical description of the phenomena. This stage of data-analysis also begins to incorporate and integrate the prior theoretical concerns of the researcher (Strauss and Corbin 1990, Charmaz 2000). However, during this process, the researcher has to be aware of the importance of both checking for the accuracy and completeness of substantive codes and categories, through negative case analysis and theoretical sampling, and constantly to be prepared for these codes to change or amalgamate (Strauss and Corbin 1990). This is a time-consuming process, that, as Lincoln and Guba (1985:210-211) identify, proceeds not just through time allocated for research, but also through time *'usually devoted to sleep or meals'* often involving expanding a great deal of *'mental energy'*. Consequently, it is a messy and complex process that is difficult to articulate clearly on paper, Nevertheless, several examples of how this process of analysis proceeded will be given.

4.15.1 Developing substantive codes

What was useful at this stage was to try to cluster seemingly linked open codes into larger substantive codes. For example, there were numerous open codes that linked with nurses educating women about their body, particularly the reproductive system, that were formed into a substantive code: *anatomy education.* Similarly, a process by which nurses taught women about how hormones, menstruation and their method of contraception worked, initially called *method education* was, in the light of further data analysis and collection, eventually renamed: *physiology education.*

Linked with this, memos were generated that asked questions of the data, for example: *are substantive codes discrete or do they overlap?* As a result of these questions, data were re-examined to explore this possibility, leading to the eventual condensing of the above two substantive codes into one: *anatomy and physiology education.*

The employment of a constant comparative method sometimes resulted in the fragmentation of substantive codes rather than their condensation; a particularly clear example of this was the issue of side-effects. Throughout the consultations, nurses discussed the side-effects of contraception with women. Initially, these open codes were placed in a substantive code simply entitled: *Side-effects.* However, further data collection, analysis and memo writing led to the emergence of questions about whether placing these open codes under this broad heading accurately reflected the complexities of the consultation. Close inspection and testing of this data subsequently fragmented *Side-effects* into three new substantive codes, more reflective of the consultation: *Risks and benefits, Putting up with side effects* and *Normalising side-effects.* Additionally, because of this, some side-effect open codes seemed better placed in *Anatomy and physiology education.* However, driven by the constant comparative approach, subsequent data-collection and analysis resulted in two of these newly formed substantive codes: *Putting up with side effects* and *Normalising side-effects* being reunited, condensed this time under a new, seemingly more accurate name: *Coping.*

Another key area where data-analysis led to the development of two substantive codes from one was the substantive code entitled: *Body monitoring.* Initially, this substantive code was where the open codes concerned with monitoring the woman's body were placed. However, as data-analysis continued and memos were written, for example: *are women also taught to monitor their body themselves,* it became clear that this substantive code could be separated into two. It remained the case that women's bodies were monitored, but the woman performed some of this monitoring *herself* after instruction by the nurse, for example monitoring and reporting side-effects such as changes in menstruation or headaches. Nevertheless, a substantial amount of monitoring was still undertaken *directly* by the nurse, for example weighing, taking body mass measurements and recording health information. Consequently two substantive codes were identified from *Body monitoring*: *Body monitoring by the nurse* and *Body monitoring by the woman.*

The issue of side-effects can also be used to illustrate how negative case analysis contributed to enriching emerging concepts. As described above, two separate substantive codes were developed to account for side-effect education: *Risks and benefits*, and *Coping.* However, within the substantive code *Risks and benefits* were open codes that reflected how nurses used percentage figures to explain the effectiveness of methods, but did not use percentages to explain how frequent side-effects were likely to be, instead they used language to minimise side-effects. The two open codes formed as a result of this were: *% effectiveness of method* and *Minimising side-effects.*

This aspect of the data generated a memo; *do nurses always do this in relation to efficacy and side-effects?* As data-collection and analysis continued, this question was asked and in one consultation a negative case appeared to exist. A nurse used a percentage to described how frequent side-effects were. However, subsequent line-by-line analysis of this consultation revealed that the context in which this percentage was used was crucial. In this consultation, the nurse was counselling a woman who was considering changing methods because she was suffering from quite bad side effects on her current method, the nurse used percentages in this specific context to describe how much *less* side effects were on a new method compared with her *current* one. This illustrates one of the strengths of grounded theory, in that it challenges the researcher constantly to ask questions of the data.

In this case, the negative instance served to enrich the substantive code *Risks and benefits* by the inclusion of a new open code: *% side-effects when comparing method.* It also enriched the subsequent theoretical analysis of the consultation process, to be presented later in Chapter Six.

The constant comparative method also resulted in seemingly small adjustments at the time, but ones that had a significant bearing on discussion later. One example of this was the changing of a substantive code name from *Time-management* to *Time-keeping.* This simple name change resulted from a constant stream of memos questioning the data about; *is it telling the real story?* It also resulted from discussing the data with interested colleagues and the author's supervisor, a technique advocated for helping to establish credibility (Lincoln and Guba 1985). As more consultation data were analysed, it became clear that women were not being prepared to *manage time*, but were being taught the importance of *keeping time* as part of using a contraceptive regimen. Several aspects of the data contributed to this realisation, but perhaps the most influential was the frequent use by nurses of the term *'rules'* about contraceptive time regimens in consultations.

Theoretical sampling also played a key role in dimensionalising and, ultimately, ensuring saturation of these substantive codes. This occurred through ensuring that data was collected from a range of clinics sessions in areas A and B and from a range of nurses. It also meant that sampling continued until a broad range of contraception methods had been included in the data. The extent of this process was illustrated in tables 2 and 3, presented earlier. As this process continued, numerous substantive codes were tentatively constructed; many were amended at this point and some, as will be described shortly, were changed completely in the light of further analysis. However, at this point in the data analysis, 14 substantive codes were constructed from 112 open codes. Table 8 is offered as an example of how open codes were linked to form the substantive code: *Time keeping.*

Table 8: substantive code: Time keeping

Open codes	*Substantive code*
Timing of pill-taking	Time-keeping
Timing of Depo-Provera injection	
Timing of smear test	
Timing of coil change	
Timing of condom use	
Timing of emergency contraception	
Timing of menstruation	
The pill rules	
Written time regimens	
Effectiveness times	
Awareness of time	
Timings for diaphragm use	

The other substantive codes at this stage were:

- Contraceptive history-taking
- Safety-checking
- Body-monitoring by the nurse
- Body-monitoring by the woman
- Body awareness
- Risks and benefits
- Anatomy and physiology education
- Health-advising
- Threats to regimen
- Amending the regimen
- Body techniques
- Adhering to instructions

Theoretical sampling was also undertaken by adapting the interview guides to reflect emerging issues in the consultation data. As further interviews with nurses were conducted, new questions that explored their views on emerging themes were asked. For example, nurses were asked about how they managed the issue of side effects in the consultation, how important time-keeping was in using contraception, and exploring their use of the term *'rules'*. The interviews also served a useful purpose in checking out the emerging themes within the data, with nurses acting as a form of method triangulation in enriching, understanding and enhancing the credibility of the emerging theory.

4.15.2 Member-checking and peer-debriefing

At this point in the study the opportunity was taken to check out some of the emerging themes with participating nurses and with other groups of family planning nurses. This aspect was helpful in lending credibility to the eventual findings and is a strategy encouraged by numerous authors (Lincoln and Guba 1985, Denzin and Lincoln 2000). It was also a positive process in that it helped the author to talk through ideas about the data by sharing what was actually quite a lonely process.

Two events enabled this to happen at this point. The first was when the author was invited to discuss the progress of the research at a staff meeting of Clinic A. During this meeting, the lists of open codes were shown and explained to participating nurses along, with questions such as: *is there anything missing?*

A similar method was used with nurses during the last few weeks of their six-month family planning course, during which they had been on clinical placements being training to conduct consultations. What was very reassuring, after questions had been answered to clarify the meaning of some open codes, was that no omissions were pointed out. When asked: *are these a fair reflection of a breakdown of what you do in the consultation*?, both groups of nurses replied that they were.

Finally, two nurses from both clinics were spoken to, informally, almost 18 months after they had been involved in the consultations that were taped. The purpose of this discussion was to ask them if they had been conscious of the tape, and how this had influenced their discussions with women. Although both nurses said that they were nervous at the start and aware of the microphone, they did remark that, after a while they *'forgot about it'* and that they *'just did what they always do with women'*. These comments are, to some extent, reassuring as they add to the credibility of the consultation data, although there is no way of checking whether or not they are being completely truthful.

4.16 Theoretical sensitivity

The aim during open coding and the early stages of data-collection and analysis was to concentrate on the data and to resist the temptations to impose extant theory upon this process of analysis (Strauss and Corbin 1990, Charmaz 2000).

However, during later stages, particularly during the formation of substantive codes and larger categories, and in keeping with grounded theory (Stern 1982), theoretical concerns began to influence the process. Some examples are:

- As data analysis continued, memos became more theoretically influenced. For example, later memos might ask questions about the discursive techniques utilised by nurses. This was particularly evident when exploring the language that nurses were using to describe the reproductive system, memos were written that explored how the reproductive system was constructed as vulnerable to pregnancy and data examined for this.

- The names of substantive codes began to show theoretical links. For example, the use of the Foucualdian term *body techniques* emerged from memos written testing the data for evidence that nurses were teaching women to observe and examine their body. Similarly, the work of Armstrong (1983) and Frank (1991) influenced memos testing the data for ways in which nurses instructed women to become involved in self-care practices.

- The decision to form two separate substantive codes from the single *Body-monitoring* was influenced by theoretical sensitivity. Awareness of Armstrong's notion of the active patient was influential, as was Foucault's description of surveillance. The decision to form the two substantive codes: *Body monitoring by the woman* and *Body monitoring by the nurse* reflected a sense that both direct surveillance of, and self-surveillance by, the woman were important aspects of the consultation.

- The substantive code *Amending the regimen* was also influenced by Foucauldian writings on discipline and power and subsequent examination of the data to test out memos such as: *how do nurses use the instructions and rules about contraception with women to help use a contraceptive regimen?*

- Another theoretical concern was linked to broad questions about discourse and power, leading to questioning the data about*: do nurses use their knowledge as a power technique in the consultations. If so, how does this link with instructing women about using their contraception effectively?*

4.16.1 Category formation and development

As more and more substantive codes were constructed from the open codes and as data-collection and analysis continued, attempts were made to explore how the substantive codes could be developed into a larger category or categories. To a great extent, this aspect of the data-analysis process mirrored that described earlier entailing weeks of thinking, memo-writing and testing out hypothetical links within the data. It also involved incorporating theoretical concerns into the writing of memos and testing of the data.

Almost immediately, it was realised that there was no single overarching category within which all the substantive codes could fit. They were all clearly linked to the process of the contraceptive consultation, but they also seemed to represent different elements of this process. Furthermore, at this stage, links between different elements of the consultation were emerging, helping to illustrate the process by which nurses facilitated effective contraceptive use by the women visiting the clinic.

During this phase of the study, as data collection continued, it was becoming clear that fewer and fewer new open codes were being elicited from the consultations, whilst the substantive codes appeared to be saturated and quite robust. This eventually led to a decision to stop data-collection, after 49 consultations had been recorded from a range of consultations that demonstrated a wide sampling of different nurses, a broad range of contraceptive consultations and a good number of different clinics.

This stage overlapped with attempts at exploring how the substantive codes could be placed into larger categories. As with the substantive coding earlier, this process involved a protracted and complex process of intuitive attempts to see larger patterns within the data, accounting for the numerous themes within the consultation. It resulted in numerous experiments with the data and a constant process of memo-writing to test the fit of the emerging framework. It also resulted in yet more amendments, amalgamations and separations within the substantive codes as well. Again, during this process, it was helpful just to listen to some tapes and read a few transcripts of consultations, following the advice of Charmaz (2000) in remembering that the aim is to explore a holistic process. Many ideas were tested out; some only required visualising in the mind, some only cursory sketches to be rejected, whereas some lasted for a longer period of time.

As a result of this analysis, four categories were tentatively identified as a representative framework within which the substantive codes could be placed. Table 9 illustrates these and their respective substantive codes.

Table 9: the 4-category framework

Substantive code	Category
Contraceptive history taking	*BODY SURVEILLANCE*
Safety-checking	
Body-monitoring by the nurse	
Body-monitoring by the woman	
Body awareness	*BODY AWARENESS AND MAINTENANCE*
Risks and benefits	
Anatomy and physiology education	
Health-advising	
Threats to regimen	*MANAGING CONTINGENCY*
Amending regimen	
Time-keeping	*ADHERANCE*
Body techniques	
Adhering to instructions	
Coping	

This initial 4-category framework was subject to a great deal of further analysis because, although it represented a move forward, it still did not intuitively feel right or finished. This was mainly due to continued analysis of the component substantive codes, to test their integrity and saturation. As this process proceeded and substantive codes were amended further, clearer links began to emerge that slowly began to crystallise into a stronger sense of how the consultation could be theorised. A key factor at this stage was the realisation that certain substantive codes required amalgamating or adjusting, and that this analysis drove further amendments and changes to the existing 4 categories. This process led to a much clearer sense of the consultation process as a whole, it also led to the amendment of the four category framework above to a three category model to be presented briefly in this chapter and in detail in the following chapter.

The following are examples of the analytical processes and subsequent code and category amendments that reflect this part of the data analysis process:

- The deconstruction of the category *Body awareness and maintenance* – further thought and analysis led to re-allocation of open codes (and hence the amendment or deconstruction of the respective substantive codes) from this category into either the substantive codes: *Body-monitoring by the woman* or *Anatomy and physiology education.* This was driven by memos suggesting that, on reflection, the woman was becoming more aware of her body, either through education or by the nurse teaching her to observe her own body. This change also highlighted a link between the education of women about their bodies and the process of monitoring it. Similarly: *Safety-checking* and *Contraceptive history-taking* did not stand up to tests aimed at distinguishing them from *Body monitoring by the nurse.* The result of this was the creation of a new category: *Body Education,* to replace *Body awareness and maintenance.*

- Safety-checking – This substantive code was also deconstructed. Further analysis revealed that this substantive code was actually about either *Body Surveillance* or *Body Education.* Therefore, relevant open codes were placed within either: *Anatomy and physiology education* or *Body-monitoring by the nurse.*

- *Adhering to instructions* – This substantive code was deconstructed completely. It was quite large and, as analysis continued it became clear that it could be dimensionalised into codes that dealt either with managing contraception through time-keeping or the following of instructions to check the body physically. Therefore these component open codes were better placed in: *Time-keeping* and *body techniques.* Furthermore, some open codes from*: Adhering to instructions* were placed in the substantive code*: Amending the regimen.* This was subsequently renamed*: Managing regimen breakdown.* This development seriously threatened the very existence of the category *Adherence* and eventually led to a new category which seemed better to reflect the process described by the data: *Regimen.*

- The one category that survived this reconfiguration process and, was actually strengthened by the inclusion of the substantive code *Body techniques* - previously situated within the now deconstructed category: *Body Awareness and Maintenance* - was *Body Surveillance.* This new category seemed to represent far more clearly how the clinic placed the woman, either directly or vicariously - through self-monitoring or self-examination - under surveillance.

This re-framing of substantive codes and categories illustrates how the process of constant comparative analysis continued right through data analysis. This subsequent, detailed analysis finally resulted in the amendment of the whole framework into a far more satisfying form. The analytical process that guided this was complex but can best be explained by stating that it occurred through a mutually-constitutive process of re-looking at the substantive codes and, simultaneously asking the questions: *what is the nature of the process of the consultation? How are these segments of the data linked with this?*

Help was also gained by testing out some of these conceptual links during discussions with other interested groups and individuals. A paper presented at the British Sociological Society medical sociology conference (in 2003) stimulated some useful discussion. One ex-family planning nurse remarked that everything presented was *'absolutely true'* of her experiences in clinics, another remarked that it closely matched her experiences of emergency contraception prescribing. The discussion also explored the issue of whether the three categories that had been identified reflected consultations covering all methods of contraception. It was difficult to answer this question without presenting the whole of the findings chapter, where it is clear that they do. Therefore, in order to help this understanding, a table was drafted to provide a brief summary of how each of the three categories from the consultation data maps with the common methods described in Chapter 1. This table, presented in appendix IX, is best read after the following chapter.

The findings from the consultation data were also presented and discussed with a group of experienced family planning nurses, two of whom had been involved in the study and four of whom had not (one of whom was, somewhat embarrassingly, from the clinic approached originally where access had been denied). Additionally, a conference paper drawing from data analysis so far was presented at a sexual health nursing conference. Both these presentations were useful in allowing the author to voice ideas to others and to discuss emerging ideas.

It was reassuring that, during these presentations the emerging understanding of the contraceptive consultation was not subject to significant challenge. In subsequent discussions, many family planning nurses in the audience also remarked that they could identify with the overall *story* that the data was telling.

The final substantive codes that emerged from this process of analysis were:

- Anatomy and physiology education
- Risks and benefits
- Coping
- Body-monitoring by the nurse
- Body-monitoring by the woman
- Body techniques
- Time-keeping
- Threats to regimen
- Managing regimen breakdown

These substantive codes were then reconfigured within *three* categories developed from the initial four, restructuring that had been influenced in part by further modification of substantive codes and by the subsequent reflection and analysis this entailed. The following chapter presents this framework of three categories namely: *Body-education, Body-surveillance* and *Regimen*, which are offered as a conceptual framework representative of the contraceptive consultation. It also discusses the relationships between the open codes, substantive codes and their respective categories. Using extracts from the consultation data, it illustrates how these categories are linked and how, conceptually they represent the process of the contraceptive consultation.

However, data analysis did not stop at this stage. The next chapter also describes how the conceptual framework was refined further, leading towards the emergence of two overarching and overlapping *core categories,* within which the three categories described above can be placed.

4.17 Method summary and conclusion

This chapter has set out how the methodology described in Chapter 3 was employed to gain access to and to collect data from contraceptive consultations in 5 family planning clinics in 2 different areas. 49 consultations, conducted by 20 nurses were audio-taped during 31 clinic visits. 15 interviews with 11 nurses were also undertaken.

This chapter has also described how data were collected from the consultations and nurse interviews and has set out in detail how a step-by-step constant comparative approach was utilised to construct conceptual frameworks from the consultation data. The role that theoretical concerns played in later data-analysis was discussed. Within this discussion, the measures taken to enhance the trustworthiness of the findings were also described. The discussion outlined how the problems encountered during fieldwork conducting a flexible and emergent research design were managed, particularly the refinement of the research focus. The chapter concludes with the emergence and brief description of a three-category conceptual framework grounded in the consultation data.

As mentioned above, the next chapter sets out the three category conceptual framework in detail and, using extracts from consultation data, illustrates how each of the three categories are linked within the contraceptive consultation process. However, in keeping with a grounded theory approach, data analysis did not stop at this stage and the next chapter also describes how this further analysis was conducted, in order to further condense these three categories into two core categories.

A further chapter (Chapter 6) follows, involving an in-depth theoretical analysis of this conceptual framework. It is within this theoretical chapter that the discussion and analysis are enriched by the use of data obtained from the nurse interviews.

Chapter 5

Findings from the nurse/woman consultations

5.1 Introduction

This chapter sets out the findings from the consultation data collected from the family planning clinics A and B. It firstly gives a summary of the findings, that includes a description of the development of the three categories: ***Body education***, ***Surveillance*** and ***Regimen*** from the consultation data. It also provides an overview of the power techniques utilised within the consultation. The second section presents the findings in more detail, utilising extracts from the consultation data. The third section discusses the development of an overarching conceptual model that is proposed as a useful theoretical framework for understanding the nurse/woman consultation.

The consultation process consists of power relations that are geared towards discursively constructing a reproductive system and providing a disciplinary framework within which a woman is developed into a subject who is both knowledgeable about both her reproductive anatomy and physiology and method of contraception. However, within this framework, the woman is also given a heightened awareness of her vulnerability to pregnancy and of the requirement for protection. This *'knowledgeable/reproductively vulnerable patient'* is closely linked to power relations that are operating to develop a woman who is an *'active'*, but also *'compliant patient'*: active in the sense that the woman is encouraged to participate in the process of her contraceptive care; compliant in the sense that the knowledgeable, vulnerable and active *'patient'* becomes a woman who complies with a contraceptive regimen, not because of power relations that threaten or coerce, but because of power relations that persuade, instruct, normalise and monitor. The consultation process presents clear examples of productive power operating through techniques and relations that, although able to be described under discrete headings, are closely interlinked to form a holistic process with which the woman engages when she visits the clinic.

5.2 Summary of findings from the consultations

One important element in the consultation is the way in which women are made more aware of their bodies. Nurses utilise medical and scientific discourses to educate women about their reproductive anatomy and physiology and, in particular utilise the discourses of risk, vulnerability and the need for protection and restraint of the reproductive system when discussing the threat of pregnancy.

This knowledge and awareness about the reproductive system that is gained from the nurse in the consultation, plays a key role in development of the woman as an *'active patient'*, a person who places her body under surveillance and is aware of the need to be vigilant and to report adverse body signs and symptoms at clinic. Closely connected to surveillance is the development of the *'compliant patient'*. In the consultation power relations can be seen that encourage and facilitate compliance with a contraceptive method. This compliance involves the nurse in instructing women about the requirement to be disciplined in following a contraceptive regimen. In addition, this process includes making women aware of how to recognise a failing regimen and teaching them how to take action to rectify any breakdown in contraceptive compliance.

Analysis of the consultation data enabled this complex process to be explored. Data analysis revealed that, although the consultation process was a holistic one, certain key elements could be identified and described. Utilising the approach of open coding, continuous data-collection and development of substantive codes and ultimately larger categories set out in the previous chapter, three overlapping and integrated categories emerged from data-analysis. These were named: *'Body Education'*, *'Body Surveillance'* and *'Regimen'*.

5.3 Summary of *'Body Education'*

This aspect of the consultation relates to the ways in which nurses use discourses of anatomy and physiology to increase women's awareness and understanding of the way their bodies work in relation to their contraceptive method. This aspect of the consultation takes the form of an ongoing teaching process, where nurses utilise techniques of questioning and testing to develop a woman's understanding. Within body education, nurses rely upon medical and scientific discourses to explain the workings of the reproductive system.

Within these descriptions, nurses use language that creates the notion of *reproductive vulnerability*; women are made to understand their reproductive system as being under threat of pregnancy and in need of contraceptive protection. This element of the consultation contains a number of closely-linked themes that were identified within the process, described in the previous chapter, of open coding and the subsequent development of broader *'substantive codes'* (Strauss and Corbin 1990). The substantive codes generated from data analysis formed different elements of a process by which women are educated about their bodies, in particular their reproductive systems, also about how contraceptive methods impact upon the body. The substantive codes were given names that reflected the nature of the open codes from which they were generated. Nurses explain the ***anatomy*** and ***physiology*** of the reproductive system, a process that utilises medical discourse on anatomy and physiology to stress the need for protection. Nurses test women's body knowledge by asking questions about the reproductive system. Nurses also educate women about the impact of contraception upon their bodies. This centres upon a discussion of the ***benefits*** and ***risks*** of contraception, and includes the education of women about the need to endure, or persevere, with contraception in the face of side-effects, an element of the consultation that seems to be about ***coping***. Collectively these substantive codes were amalgamated into the category ***Body Education***, a term that seems best to fit this element of the consultation.

5.4 Summary of '*Body Surveillance*'

Body surveillance builds upon body education. The consultation process encourages women to be aware of their body, and to place it under surveillance. The need for surveillance is linked to the notion of a *reproductively vulnerable* body and of the need to protect it against potential threats, consisting of either pregnancy or the adverse effects of the contraceptive. However, the process of surveillance is far more holistic than mere observation. It involves the woman becoming closely aware of her body, in order to subject it to discipline, as part of adherence to a regimen of contraception. It also involves the woman not only in placing her own body under surveillance, but also in placing herself within the monitoring '*gaze*' of the clinic.

Three inter-related substantive codes emerged out of the open codes generated from the data: ***Body-monitoring by the woman***: this relates to how women, prompted and encouraged by the nurse, observe their bodies for signs and symptoms and report these at clinic for the nurse to interpret. ***Body-monitoring by the nurse***: reflects how, within the consultation, nurses measure and record information from women about their past and present health. Women also have measurements taken from their body by the nurse for example: weight, menstrual cycle and body mass. ***Body techniques:*** this comprises the elements within the consultation that relate to women being able, not only to monitor their bodies, but also physically examine and sometimes manipulate it, in the context of contraceptive use.

5.5 Summary of '*Regimen*'

This aspect of the consultation is about women complying with a contraceptive regimen and provides several key examples of the deployment of disciplinary power within the consultations. One important element of this compliance is the need for women to keep to time when managing their regimen and to adhere to the *'rules'* governing their method. Regimen also entails women being aware of, also possessing the necessary strategies to deal with, regimen failure. It involves women being aware of the factors that can interfere with their method: for example, being late taking a pill or incorrect timings of diaphragm use. This theme also builds upon the notion of reproductive vulnerability and plays a key role in the development of the *'knowledgeable/reproductively vulnerable'* woman and the *'active/compliant'* woman. Collectively, these elements of the consultation were amalgamated into the substantive codes: ***Time-keeping:*** this refers to the way in which women are taught to be aware of the importance of time-keeping and time observation. ***Threats to regimen***: this links closely with body education and surveillance. Nurses ensure that women are aware of the factors that can interfere with the efficacy of the regimen. ***Dealing with regimen breakdown:*** this involves nurses making sure that women are aware how to deal with any breakdown in their contraceptive regimen. This includes knowing how to amend the regimen and use additional protection because of the lapse in contraceptive protection. Collectively, these three substantive codes were linked with the category: ***Regimen.***

Tables 10, 11 and 12 illustrate the development of the three categories from their respective open and substantive codes.

Table 10: *'Body Education'*

OPEN CODES	SUBSTANTIVE CODE
Explaining menstruation	*Anatomy and Physiology education*
Explaining reproductive hormones	
How method works biologically	
Need for protection	
Vulnerability of reproductive system	
Biology of side-effects	
Explaining fertility	
Testing women's body knowledge	
Need to restrain the reproductive system	
Testing women's body knowledge	
Description of physical barrier function of method	
Dispelling myths about anatomy	
Anatomy of cervix	
Anatomy of reproductive tract	
Anatomy of urinary tract	
Anatomy of coil insertion	
Using anatomical models	
Using anatomical diagrams	
Diaphragm anatomy	
Pros and cons of method/s	*Risks and Benefits*
Control of menstruation	
% Efficacy of method	
% side-effects when comparing methods	
Ease of method use	
Disruption of menstruation	
Minimising side effects	
Interference with lifestyle	
Side-effect descriptions	
Coping with side-effects	*Coping*
Normalising symptoms	
Comparing with other women	
Living with side-effects	
Problems with method	
Lesser of two evils	
Perseverance	
Giving it time to settle	
Inevitability of side-effects	

Table 11: *'Body Surveillance'*

OPEN CODES	SUBSTANTIVE CODE
Monitoring severity of side-effects	*Body-monitoring by the woman*
Monitoring frequency of side-effects	
Monitoring time of menstruation	
Reporting symptoms/changes in menstruation	
Observing for pregnancy	
Nature of last period	
Observing for side-effects described by the nurse	
Client recording menstrual cycle	
Menstrual cycle at time of sex	
Nurse interpreting reported symptoms	
Taking BP	*Body-monitoring by the nurse*
Weighing	
Body mass index	
Comparing to norm	
Interpreting symptoms	
Referring to case notes	
Height	
Urine testing	
First day of last period	
Making women aware information is recorded	
Last sexual intercourse (day/hour)	
Recording regimen failure	
Pregnancy tests	
Observing pill taking	
Previous pregnancy	
Reminding women of information in notes	
Contraceptive history	
Migraines	
Deep Vein Thrombosis	
Circulation problems	
Health problems (family)	
Past medical history	
Checking coil threads	*Body Techniques*
Breast examination	
Condom technique	
Inserting diaphragm	
Anatomical models	
Diagrams/leaflets	
Practicing	
Comparing to tampon use	

Table 12: '*Regimen*'

OPEN CODES	SUBSTANTIVE CODE
Timing of pill-taking	*Time-keeping*
Timing of Depo injection	
Timing of smear test	
Timing of coil change	
Timing of condom use	
Timing of emergency contraception	
Timing of menstruation	
The pill rules	
Fitting into lifestyle	
Written time regimens	
Effectiveness times	
Awareness of time	
Timings for diaphragm use	
Missed pills	*Threats to regimen*
Danger of non-compliance	
Which pill missed	
Late pill	
Efficacy of pill	
Interference with pill	
Testing woman's knowledge of threat	
Condom failure	
Incorrect fit of diaphragm	
Timing of missed pill	
Which pill missed	
Missed Depo injection	
Late Depo	
The pill rules	*Dealing with regimen breakdown*
Amending/adjusting the regimen	
Reporting regimen breakdown to clinic	
Giving written information	
Need for pregnancy test	
Risk of S.T.I.'s	
Travel/event management	
Aware of emergency contraception	
Testing knowledge for breakdown	
Being aware of time of breakdown	
Abstinence	
Condom '*backing up*'	
Take extra pill	

5.6 Discursive techniques within the consultation

Analysis of consultation data also revealed several overarching discursive techniques that are employed by the nurse. These techniques were utilised throughout the process of the consultation and can be seen operating within all three categories of *'Body Education'*, *'Body Surveillance'* and *'Regimen'*. Furthermore, although these techniques are employed in a complex and holistic way throughout the consultation, they can be identified as techniques that comprise a number of distinct practices. How these techniques are employed within the consultation will be illustrated in detail within the next section of this chapter. However, a brief introduction can be provided here.

- **Concept of the body**: In the consultations, the body is clearly defined by medical and scientific discourse. Within these discursive boundaries the woman is educated about her body, which is presented to the woman utilising the terminology of reproductive vulnerability and the requirement for the reproductive system to be restrained and protected by contraceptive methods. The body as an object in need of surveillance was also part of the way in which nurses conceptualised the body, as was the notion of the body being a site for the application of disciplinary techniques.

- **Language**: nurses modify their language when discussing different elements of contraceptive use. A significant example of this is when nurses use scientific, research-based data, in the form of percentages, when mentioning the effectiveness of a method, but then use non-scientific terms, such as *'a bit'* or *'a little'* when covering its adverse effects.

- **Questioning and testing**: the use of questions to test women is evident in all three of the categories described above. These questions are quite different from those aimed at eliciting information. This questioning is about testing women's knowledge about their body and about their use of contraception. Questions test women's knowledge about how the reproductive system works and how contraceptive methods function. They are also are also used to test women's knowledge of their regimens.

- **Interpretation and diagnosis:** as mentioned previously, surveillance is an important part of the consultation. Nurses encourage women to be vigilant and to observe their bodies. Women are taught to look for body changes and for symptoms possibly related to side-effects, also to monitor for signs of regimen failure. Women are also encouraged to report any of these signs to the nurse at the clinic. However, within the consultation data it is evident that, although nurses encourage this 'observation and report' process, interpretation of the relevance (or not) and the importance (or not) of the woman's report is mainly the nurse's role.

- **Use of knowledge:** Nurses utilise knowledge as a power technique within the consultation. This is by using information about the body and contraception that they posses and the women do not, and illustrates the links between knowledge and power. Often, nurses refer to medical texts, anatomical diagrams or models as part of this process. Nurses also collect information from the woman. This information includes the woman's health and body information: for example; weight, body mass, menstrual cycle - which is then used as part of surveillance. It is also used, by the nurse, as part of making normalising judgements about the woman, utilising a knowledge base drawn from other women's information, scientific research and medical texts.

- **Discipline:** One important element of the consultation is the process by which the woman is encouraged to participate actively in her contraceptive care. The use of contraception requires that women adhere to a regimen. Nurses emphasise this and a significant amount of time is spent in encouraging women to adopt a disciplined approach to managing their contraceptive method. This regimen includes the importance of time-keeping when taking contraception, regimens of bodily observation, also strategies to deal with any threat to the regimen that may lead to its failure. Nurses give women written guidelines about regimen and often refer to the *'rules'* when instructing women. Nurses also encourage women to keep their own contraceptive records and to test women's knowledge about their regimen, and also discuss strategies for incorporation of this regimen into daily life.

5.7 Findings from the consultations

The following sections present the findings from the nurse/woman consultations, utilising extracts from the consultation data to illustrate the discursive strands within the three categories: Body Education, Body Surveillance and Regimen in more detail.

5.8 *'Body Education'*

Body education consists of three linked discursive themes - those of anatomy and physiology, discussion of the risks and benefits associated with contraception and the notion of the woman coping and/or persevering with the adverse effects of contraception - that together, helped to construct a powerful image of the woman's reproductive system as vulnerable and in need of protection.

5.9 *'Anatomy and Physiology education'*

It seems clear from the data that part of the consultation involves increasing women's awareness and understanding of how their body functions. However, This process is confined to explanations using anatomical and physiological discourses and is limited, in the main, to the reproductive system. The notion of the body within the consultation is one surrounded by medical and scientific explanation and rationale. Descriptions about the anatomy and physiology of the body are linked to explanations about how contraceptive methods worked. The consultations often incorporate a teaching process or lesson, with the nurse as teacher and the woman as student. This teaching process can be seen within other aspects of the consultation, but is clearly evident when nurses were involved in educating women about their bodies. The *'lesson'* includes the nurse providing information about the anatomy and physiology of the woman's body, supported by explanation and rationale (sometimes with the help of visual aids, in the form of anatomical models or diagrams) and the use of testing and questioning techniques to check understanding.

One of the approaches that nurses use in body education is adoption of a specific discursive technique when discussing how contraception works, or, indeed, may fail. This technique utilises both anatomical and physiological terminology, combined with the notions of control, restraint, vulnerability and protection. This first extract refers to the notion of the ovaries *'waking up'*, almost as if the contraception is placing the woman's reproductive system in a state of suspended animation.

Here, the nurse is trying to help the woman to understand the need to keep the hormones from the contraception in her body. The nurse emphasises this notion by creating the image of the requirement to keep the ovaries in stasis. The importance of this is illustrated by the description of the ovaries starting to function, with the implied risk of pregnancy:

> *Nurse: so that the pill is out of your system. Which means the hormones in a few days will be out of your system anyway because your period will start and your ovaries will start to wake up again and start functioning' (Consultation 12)*

This second extract uses an explanation based more on restraint. Stating that contraception is preventing the body from *'releasing'* an egg. Additionally, contraception is preventing the *'risk'* of pregnancy. The nurse also mentions that the woman is giving her body the *'chance to release another egg'*, giving the impression that the woman has lost control of her body, placing it in a vulnerable state:

> *Nurse: well, you're really giving your body chance to release another egg and put your self at risk of pregnancy (Consultation 1)*

Here, the notion of restraint is utilised again to explain that the role of this method was to prevent the sperm from reaching the egg. It is also used to describe the role it plays in *'stopping'* the *'releasing'* of an egg. Again, it also implies the role of contraception in protecting the body:

> *Nurse: it works by thickening the mucus from your cervix so it makes it difficult for the sperm to pass through and reach the egg. It also thins the lining of the uterus or your womb and in some women it stops the ovaries from releasing an egg, (Consultation 36)*

In this next extract, the nurse refers to the absence of body functions to replace the lining of the womb:

> *Nurse: it stops you from ovulating because of the progesterone (*hormone*) so if you're not ovulating and even in the off chance that you did ovulate there's nothing for the egg to attach to you because you're not replacing the lining of the womb (Consultation 15)*

Furthermore, the notion of maintaining protection is mentioned, with the need to keep hormones (from the contraception) at functional levels, an understanding that nurses use later to ensure compliance with a regimen:

> *Nurse: because the hormones need to be kept up (Consultation 6)*

Nurses also link the understanding of hormonal control and protection with the reduction of vulnerability to pregnancy. In this extract, a nurse explains how the continued hormonal presence of a contraceptive provides *'cover'*:

> *Nurse: There's no normal cycle, so you are contraceptively still covered (Consultation 9)*

The concept of *'cover'* continued in another extract, where a nurse instructs a woman when to start contraception in order to be safe. This extract also illustrates the introduction of time as an issue:

> *Nurse: if you start it on the first day of your period then you'll be covered straight away (Consultation 29)*

Another nurse explains to a woman about the dangers of letting the hormonal protection drop:

> *Nurse: you would actually be at risk of pregnancy (Consultation 16)*

This next extract shows how the nurse uses a hormonal description to illustrate the role of contraception has in restraining the reproductive system, stopping the *'release'* of an egg:

> *Nurse: It allows your hormones to come into play and produce an egg, because this is the way it works, it stops you from producing an egg (Consultation 29)*

The notion of *'covering'* the reproductive system by taking extra *'precautions'* with condoms was also evident:

> *Nurse: You'll need to take additional precautions with condoms for a while to make sure you're covered (Consultation 24)*

Also, in this extract the function of contraception in protecting the reproductively vulnerable body is demonstrated explicitly when a nurse explains the pill to a woman:

Nurse: this pill is going to protect you...against pregnancies (Consultation 26)

Nurses also use physiology and the concept of absorption when discussing the contraceptive pill with women. These explanations are intended to demonstrate to women the need to keep the pill in the body in order for it to work. Use of the term *'you'* may also send a message that the woman has a responsibility to ensure that this happens. This aspect of body education also reveals how nurses utilise body education as part of preparing women to deal with contraceptive regimen and regimen breakdown. For example:

Nurse; ..'cause if you vomit the pill back up or it passes straight through it won't get absorbed (Consultation 13)

The effect of other medication, particularly antibiotics, on pill effectiveness is also mentioned frequently:

Nurse: antibiotics, they alter how you absorb things in your gut, and you don't absorb it properly (Consultation 26)

In addition, diagrams, supportive texts in the form of leaflets and, occasionally, anatomical models are sometimes used by nurses to reinforce body education. Women are often given leaflets works to take away from the clinic describing how their method works. This helps to continue the woman's learning beyond the consultation:

Nurse: I'll give you a leaflet on that (Consultation 1)

Nurse: This is the leaflet we will be giving you to go through (Consultation 6)

In this next extract, a nurse uses an anatomical model when explaining use of the diaphragm. The model is a large, coloured plastic representation of the internal anatomy of the pelvic area in a cross section; within the womb there is a model foetus.

The nurse uses this model to reinforce a number of things; firstly, she remarks upon the foetus as the *'thing'* the woman wants to prevent. Use of this powerful description at the start of the teaching process clearly focuses the woman's attention on the key issue at stake. Another interesting aspect of this model is that the plastic foetus is removable and, therefore, creates a powerful image of the womb with and without a pregnancy, to reinforce the nurses' instructions:

> *Nurse: if you'll just let me get the model out...this is the pelvic organs and this pink blob there is your uterus and the thing there (*indicating the foetus*) is what you are wanting to prevent' (Consultation 14)*

This anatomical model is also used to illustrate how problems can occur by orientating women to the anatomical proximities within their reproductive system. This next extract sees the nurse use anatomy as a prequel to discussing the need for an internal examination, to fit the diaphragm properly. The nurse uses the model to illustrate where the urethra, *'pipe'*, is situated:

> *Nurse: but sometimes they are fitted too uncomfortable and they irritate your bladder. That's the pipe that takes the urine from you bladder to the outside as you can see, where the diaphragm rests on very close to that'*
>
> *Woman: Yes*

The nurse then again utilises the terminology of protection and risk. She mentions the need for the cervix to be covered and she identifies the dangers of *'sperm swimming round'* if it is not used correctly:

> *Nurse: they can tell by how far your cervix is back, what size diaphragm you'll need to make sure the cervix is covered. The fit is really important because if that is too big you'll get a lot of pain just up here. If it is too small it'll be wiggling around and you would get some sperm swimming around (Consultation 14)*

The use of testing questions seems to be one way in which nurses attempt to create the vigilant *'active patient'* in the consultations. This will be illustrated later in the context of regimen and body surveillance, but nurses also use this approach to check and test women's body knowledge.

Nurses use questions to probe how much women know about the manner in which their body can interfere with their contraception. The questions appear to serve two main purposes in the consultation. Firstly, they reinforce the teacher/student relationship between nurse and woman. Secondly, they reinforce the need for knowledge retention by the woman, because she is aware that further testing will occur in future consultations. It is clear that nodding and feigned understanding will not suffice. These next three extracts, with women using the pill and coil, show how probing the questioning can be:

Nurse: so there are actually three things that reduce the effectiveness of your pill, do you know what any of those are?

Woman : erm.... diarrhoea and sickness

Nurse: sickness and diarrhoea are classed as one yes..

Woman: erm...medication

Nurse; yes, antibiotics, that's the second one, theres a third one, do you know what it is?

Woman: No..no..

Nurse: its late or missed pills (Consultation 17)

And,

Nurse: And are you aware of the sorts of things that can interfere with the effectiveness of your pill?

Woman: yes

Nurse: Can you give me any examples?

Woman: such as erm..antibiotics..?

Nurse: do you know anything else?

Woman: er...you'll say it and I'll probably say oh yes that's it!

Nurse: sickness and diarrhoea.

Woman: right yes (Consultation 13)

The role questions have in making women aware of risk is evident in this next extract, where a nurse is discussing the coil with a woman. She is using questions to test the woman about her knowledge of the coil.

It also demonstrates the link between body education, questioning and risk. The nurse, having asked the woman if she knew about times in her menstrual cycle that are particularly high risks of pregnancy, states:

> *Nurse: After your period...your uterus can contract..can't it? So it's a high-risk time (Consultation 3)*

5.10 *'Risks and benefits'*

As part of body education, nurses also use a strategy of discussing the benefits and risks of particular methods with women, such as discussing contraceptive effectiveness, ease of use of a method in comparison with its drawbacks, side-effects or impact upon daily life. Nurses seem to be aware that there is no such thing as the *'perfect'* contraceptive and this aspect of body education is about preparing women for this reality. An extract from the data, which seems to sum this up, is taken from a consultation with a woman who is having difficulty using a variety of methods. The nurse informs the woman that part of taking contraception is always about dealing with adverse effects. Contraceptive choice is about choosing the *'lesser of all evils'*:

> *Nurse: It's a shame 'cause you've tried a number of different methods and there's not really a good one that suits you. The problem is, it's a case of choosing the lesser of all the evils really with contraception (Consultation 14)*

This next extract illustrates the notion of weighing up the pros and cons of contraception. This extract also illustrates how nurses introduced 'vulnerability to pregnancy' into discussion about the merits or drawbacks of a particular method:

> *Nurse: Erm.....a lot of the chemical methods of contraception do have weight gain and possible side-effects erm..... its a case sometimes of weighing up gains and losses, and gains erm... apart from a coil, they're mostly chemical matters, erm... like the pill, the mini pill might be less likely to make you gain weight, but that's almost the same effect as the Depo, so again you could, by then your going into the rounds of your more likely to get pregnant, so you've got to weigh up the pros and cons. The pill's got the advantage of you're not likely to become pregnant on it but you have the disadvantage that you've got to remember to take it and if your memory's not so good for taking pills, then are you risking your pregnancy? (Consultation 36)*

Explaining side-effects often involves nurses in educating women about the effects of hormones from the contraceptive and about the effect upon their body. For example:

> *Nurse: you may gain some weight because of the hormones, so give it chance to get into your system to see whether...(Consultation 6)*

> *Nurse: it has two hormones in it, oestrogen and progesterone, it tends to be oestrogen that makes women feel a little bit sick (Consultation 9)*

Woman: Why, exactly, do they make you gain weight?

Nurse: Because of the hormones

Woman: Oh right

Nurse: There's hormones in them (Consultation 36)

Nurse: it might just be withdrawal from the hormone in that week 3 (Consultation 10)

Taking a holistic view of the consultation process, it is evident that Body Education is closely linked with the two other categories: Body Surveillance and Regimen. Women need to have prior knowledge in order to monitor their bodies effectively. However, nurses appear to recognise the potential impact upon compliance that graphic descriptions of side-effects can have. Nurses, therefore, seem to be faced with a dilemma: it is important that they encourage and enable women to take their contraception properly. Part of this involves women being vigilant for side-effects, therefore nurses must make women aware of the potential adverse effects of the method they are using. However, this information could affect the acceptability of the method and, therefore, compliance. In order to manage this dilemma, nurses appear to utilise specific discursive techniques that place a different emphasis upon the effectiveness of contraception and the side-effects that it may create. This technique involves the application of scientific and research-based language when discussing effectiveness and the use of other language when mentioning side effects - language that uses adjectives that minimise the symptoms. The following two extracts illustrate the use of statistics when explaining effectiveness:

> *Nurse: Asking how effective the pill is, it is over 99% effective (Consultation 6)*

> *Nurse: what did we say, 36 hours ago...? This, for you, will be around 98.8% effective.....(Consultation 14)*

In addition, when mentioning how effective a method is, nurses also use the opportunity to remind the woman that effectiveness is linked with correct compliance:

Nurse: provided you use it with a spermicidal cream it's actually between 92 and 96% effective (Consultation 14)

Nurse: if used correctly it can be 98% effective, (Consultation 15)

For side-effects, nurses use language that seeks to minimise and normalise them. The following five extracts illustrate this. Use of the prefixes *'some'*, *'a bit'* ' and *'a little'* prior to a symptom contrasts with the quite strident use of effectiveness statistics mentioned earlier:

Nurse: it can make you feel a little bit dizzy and a bit sick (Consultation 8)

Nurse: it has two hormones in it oestrogen and progesterone, it tends to be oestrogen that makes women feel a little bit sick and a little bit ill' (Consultation 9)

Nurse: a very small chance of feeling a little bit queezy..erm (Consultation 9)

Nurse: you'll get a bit more cramp than usual (Consultation 14)

Nurse: you may gain some weight, you can feel a bit sick er.. breast tenderness because of the hormones, so give it chance to get into your system to see whether...(Consultation 6)

A further example of scientific and non-scientific language can be seen in this following extract, taken from a consultation with a woman who is contemplating a coil. The nurse is responding to the woman's concerns about the safety of the procedure. She uses body education and statistics in her description of the merits:

Nurse: it actually reduces the lining of your womb so it is actually good for women with heavy periods and it reduces them to such an extent that it reduces them to practically nothing, that coil is as effective as being sterilized, its 99.8% effective

Woman; is there any chance of it perforating the womb?

But, when responding to this question, the nurse does not use any statistical information about adverse incidents related to coil fitting, instead she reverts to very reassuring language that minimises the risk:

> *Nurse: When you come and have a coil fitted, that's always a small..... It's absolutely minute, the risk is very, very small, but it's still classed as a risk (Consultation 15)*

There is one interesting exception to the use of statistics when discussing side-effects. In this extract, the nurse refers to percentages when discussing nausea:

> *Nurse: but only 6% of women feel sick on this one compared to 40% on the other, so you should be absolutely fine (Consultation 9)*

However, the nurse is using a percentage here to compare a new method with an old method. In this consultation, a woman is thinking about stopping a method having become unable to cope with the side-effects. The nurse is discussing a switch to a different pill. This exchange illustrates two things. One is that statistical information is available in respect of side effects. For instance, nurses could say to women that 40% of women feel sick with this method, but they don't. Secondly, it reinforces the earlier point of statistics and research being used to reinforce compliance, because in the above extract, the nurse is using the information to encourage the woman to take up a new method.

A similar process occurs in this following extract. The nurse is exploring the contraceptive pill with a woman. When covering side-effects, the nurse uses *'research says'* to reinforce to the woman that getting pregnant can present her with as great a risk of thrombosis as does the contraceptive method she is contemplating (the hidden agenda being, of course, that this risk would also be accompanied by a pregnancy). In doing this, the nurse presents the woman with something akin to a *'catch 22'* situation:

> *Nurse: You know there are risks, risks to taking the pill? Have you heard of them, blood clots, thrombosis very small risks erm..research says you've just as much risk if not more of having one during pregnancy... literature I mean usually if you look at the literature what it says is a pain in the calf if you, another sign could be, I know this is going to sound awful, but coughing up blood, extremely painful headaches, chest tightness, chest pains..bad chest pains they're all signs of ,of, you know, blood clots...embolisms...but you need to be aware of them, but as I say you've not much risk..that would be a very small risk..*

The nurse then refers to other women taking the pill:

> *...You've got to think that there are a lot of women on the pill that are quite happy* (Consultation 29).

The nurse uses a couple of strategies to encourage the woman in this last extract. The first is the use of language that minimises the risks; secondly, the nurse uses the comparison of *'other women'* as a normalising technique. The woman is asked to compare herself with other women - *'you've got to think'*. In making this comparison, the nurse is asking the woman to place herself in, or outside, that group of *'other women'* who are quite happy with the pill. Another example of this approach is evident in this next extract. A nurse is discussing Depo-Provera with a woman who is worried about the injection:

> *Woman: I had to have an injection once, where my bra was, and it was horrible*

The nurse then refers to other women as being able to manage the injection, thereby placing the woman in a position of having to compare herself with these *'others'*:

> *Nurse: Oh yes I'm not saying you won't feel anything at all. It can vary. They say relax when you have it done...but you know nobody will say you never feel anything...people keep coming back for more so it can't be too bad erm... (Consultation 28)*

5.11 *'Coping'*

Allied to the strategy of using different types of language to discuss side-effects is the notion of coping and perseverance. Where women do report side-effects nurses employ an approach that is used either to encourage women to cope with adverse symptoms or to persevere with a method, with the reassurance that things will improve. Running through this aspect of the discussion was the sense that part of contraception, indeed, part of being a woman, is stoicism in the face of bodily problems.

These next two extracts demonstrate how the nurse checks whether or not the woman is able to cope with a change in menstruation as a result of a new pill. The nurses also stresses the points of *'perseverance'* and *'coping'* in the exchanges:

Nurse: OK, so you've recently changed to Revenuer from Microgynon, any problems

Woman: Apart from its making me, making me heavier

Nurse: The periods are heavier than they were?

Woman: I've got a lot of pain here

Nurse: Do you need to take anything for your pain?

Woman: No

Nurse: You've not done, how much more serious are they since taking Microgynon are they lasting long or is it just that the bleedings heavier

Woman: Well, its about the same but its just a bit heavier

Nurse: Are you managing to cope with it?

Woman: Just about

Nurse: Are you happy to persevere with this one .....?

Woman: I'll stay on it a bit longer

Nurse: Yes....OK that's fine, sometimes it does just take erm... a couple of packets of the same pill before you actually warm to it a little bit, it can take a while once you've changed over...

Woman: I think I'm on the last one now, yes

Nurse: So it's taken all six really to settle things down. OK, so your periods are regular but there just a little bit heavier, you probably find it does settle down, any other problems with your general health, no usually quite fit erm..... Do you know the first day of your last period was (Consultation 38*)*

Similarly in this next extract*:*

Nurse: So are your periods are they all right?

Woman: Quite heavy.....As I say if I'm, if I get pain it's just 2 pains and then it goes away sort of thing.

Nurse: Right, but so they are copeable with...

Woman: Oh yes

Nurse: Yes, so a bit heavy, slightly painful but you can cope with them (Consultation 3)

This following extract illustrates the extent to which women proceed through a process of trying to find a method with which they can live. This woman's story indicates a long period of trying different methods, linked by long periods of forbearance:

Woman: I was prescribed the combined pill after the birth of my son, whose nearly 6 now erm.... I took that for about 12 months after that, erm... but I wasn't particularly happy with it I tended to put weight on and got lots of headaches erm.... so I decided then to try, we thought we'd try the mini pill

Nurse: Yes

Woman: But I wasn't happy with that either, so then we went onto think about erm.... the coil

Nurse: Was that partly because of the 3-hour limit on the er..... you know you have to with taking the mini pill, you've got to be no more than 3 hours late, was that a problem

Woman: No, no, no it was just the, well I tended to gain weight with it and the headaches with the combined pill as well

Nurse: Right, right

Woman: So erm..... I decided to give the coil a try

Nurse: Stop all hormonal

Woman: Yes

Nurse: And try the coil

Woman: Yes

Nurse: And have you been happy with it

Woman: Erm... initially.....

In this last extract, the woman mentions *'we'*, presumably referring to her discussions with nurses at previous clinic visits. The extract also illustrates how the nurse attempts to use questioning to find out if the woman has a difficulty with time keeping.

It is also evident that hormones have been used to explain many of the side-effects that the woman experienced and that she decided to *'stop all hormonal'* and try the coil. It is also clear that this woman's search for an acceptable method is not over, given her final remark.

Women also indicate that they had sometimes received advice from other health professionals about coping. In this extract, the woman has discussed the pill with her Health Visitor, who provided an explanation, upon which the nurse subsequently elaborates:

> *Woman: and they gave me the pill and I got really severe itching for the first 4 months*
>
> *Nurse: Right ...OK*
>
> *Woman: after I had taken one pill it made me itch for a week...but the Health Visitor said that pills are like that*
>
> *Nurse: No that's right, but what it sounds like, what happens, cause it is about hormones, and those hormones will actually change the chemical balance of your vagina, if that's upset then it can actually erm...bring on that itchiness, that itchy feeling.* (Consultation 15)

The theme of perseverance occurs again in relation to Depo-Provera:

> *Nurse: And you are happy with this...have you been made aware that you can have some bleeding problems, initially, when you first start taking the pill injection..?*
>
> *Woman: I didn't think you could, to be honest, I didn't think you could have a period..*
>
> *Nurse: It tends to happen that you know, when you've had your top up injection, girls that have been on it quite some time, don't tend to bleed at all, they might have a day spotting here and there, but with your first injection sometimes you can have menstrual disturbance...(Consultation 16)*

And:

> *Nurse: with any of the side effects they're not to bad if you persevere for 2 or 3 injections they can often settle down ... ..with the Depo injection periods can be irregular, which for the first few months can be a nuisance, but is not too bad, but they, you, know if they persevere things can often settle down* (Consultation 28)

Also with contraceptive implants:

> *Nurse: you can get a little bit irregular in the beginning but it er...usually settles (Consultation 49)*

Another extract indicates how, in previous clinic visits, a woman has been encouraged to persevere in the face of side-effects and makes a remark that suggests she thinks that being stoical in response to the symptoms was a positive attribute. She feels *'proud'* that she has managed to persevere with the side-effects from her 'marina' coil (a coil that releases progesterone):

> *Nurse: are you happy with it ?*
>
> *Woman: no, not really*
>
> *Nurse: why is that?*
>
> *Woman: It made me feel sick and I'm really quite proud of myself. I mean I could have had it removed but they talked me out of it really...(Consultation 30)*

Finally, this next extract illustrates how a woman is determined to continue with her coil, partly because it caused so much pain when inserted. For her, stoicism and coping are strong reasons to continue:

> *Woman: it gave me such a lot of pain going in it was unreal, erm... but er.... I mean it was that painful I said its in, its staying in and its never coming out erm.... and so obviously when its first gone in you have that bleeding which is a bit irregular*
>
> *Nurse: And then it settles....?*
>
> *Woman: Yes (Consultation 41)*

5.12 *'Body Education'* summary

It seems clear from the data that, within the consultation, women are taught about how their reproductive system works. Nurses utilise medical and scientific discourse to do this, but they also utilise the discourses of risk, vulnerability and protection as adjuncts to their anatomical and physiological descriptions of the reproductive system.

Body education seems to serve a number of purposes. It is aimed at equipping women with the necessary information about their body to enable them to understand how their method works, how it can fail, also what potential problems it can cause. It is also related to helping women to understand the vulnerability of their reproductive system to pregnancy and to engender a realisation of the need for protection. The body education that nurses include in their discussions with women is also a means to an end. It is closely related to the process within the consultation that develops the woman into the *active patient*, a women capable of monitoring her body effectively as well as understanding it. Within the data, there were many examples that illustrate this. Women are expected to apply this understanding of the body to themselves as they use their contraceptive method. Nurses require women to be vigilant of their body and to place it under surveillance.

5.13 '*Body Surveillance*'

By entering the clinic, the woman places herself within a system of surveillance. This is undertaken directly by the nurse, but also by the woman herself. The consultation data reveals a process that builds upon the body knowledge that the woman is given, a process by which nurses engage in developing a woman who not only understands her body, but also monitors it, observes it, and places it under surveillance.

As with body education, body surveillance represents a holistic process, but one comprised of elements that can be discretely identified. Firstly, women are encouraged to monitor their bodies closely and to report any bodily changes, cycles and symptoms at clinic: *Body monitoring by the woman*. Closely allied to this is: *Body monitoring by the nurse*: an aspect of the consultation that involves collaboration by women and nurses in the collection and recording of a mass of body information from the woman about her health and lifestyle. Women are also subject to measurements and records being taken from and of their bodies. For example, weighing and body mass calculations. Thirdly, women are encouraged and taught: *Body techniques* related to their contraceptive use. For instance: self-examination and the development of physical techniques to utilise certain methods, such as the diaphragm, coil and condom.

5.14 *'Body-monitoring by the woman'*

Women are made aware, sometimes directly, that they are part of a process of surveillance and that *they* have a responsibility to be vigilant because *they* are often best placed to do this:

> *Nurse: because the best person to pick up any problems is yourself, er... by getting to know what's normal for you and you can pick up any changes, erm...(Consultation 1)*

> *Nurse: it's what's normal for you... so you can pick it up (Consultation 3)*

One of the most significant body monitoring issues concerns the menstrual cycle. Women are encouraged to monitor and report upon the timing, regularity, nature and any changes in their periods linked to their contraceptive method. As with body education, nurses use questions to gather information on women's menstruation. A particularly important and frequent issue is the precise time and duration of menstruation. The following extract illustrates the necessity for the woman to have monitored her periods precisely. The nurse also adds her own interpretation of the woman's cycle being *'good'*:

> *Nurse: And periods, what are they like?*
>
> *Woman: Regular, not particularly, I was never heavy before, I'm slightly heavier now, but not particularly heavy*
>
> *Nurse: So are they regularly every 28 days?*
>
> *Woman: Erm.... 28 to probably 3, it's usually on the day or 2 or 3 days after*
>
> *Nurse: So that's pretty good isn't it and the length of time?*
>
> *Woman: 5 to 6 days*
>
> *Nurse: Right that's good, and the first day of your last one?*
>
> *Woman: It was last Sunday which was the 24th (Consultation 33)*

Not only are women expected to be accurate about menstruation, but also their calculation techniques are required to be in tune with those of the clinic. This next extract is an example of a nurse checking out how a woman calculates her menstruation. The nurse refers to *'we'* meaning how the clinic measures time, which is different to how the woman had been calculating time. At the end of the exchange, the calculation that is recorded and used is the clinic version:

Nurse: And how long do they last your periods?

Woman: Erm.... 3 days

Nurse: So do you think you started on, maybe, the Sunday the 13th do you think, something like that?

Woman: That should be all right, yes

Nurse: And you have a period every month do you, pretty spot on or more or less?

Woman: Erm... usually every 28 days, 24 days

Nurse: From the beginning or are you counting from the end?

Woman: From the end

Nurse: Yes, well we always count actually from the beginning, so your pretty ...about 27 days, thank you. (Consultation 49)

It seems that one purpose of encouraging women to monitor menstruation is to create a sense of vigilance that enables the woman to detect any potential problems and thus bring these observations to the clinic. In other words, women are used as a surveillance mechanism by the clinic. Often, surveillance information provided by women is from memory but, occasionally, women write it down, providing their own version of their medical record. This next extract is an example of this:

Woman: It's just my coil check, but also I've not had a period since the 4th December

Nurse: Oh

Woman: So, and I've been I mean I've got my chart, jotted it down each, you see I've been up and down a lot

Nurse: Right lets have a look

Woman: I mean I'm usually about 5 week I've been going and I've gone to 7, so

Nurse: Right so we'd better sort that out, so no period at all for 7 weeks

Woman: No, like I say the November one I had a lot, like October/November ....(Consultation 44)

This last extract, as well as providing an example of the woman actively participating in the recording of information, demonstrates how that information is used by the nurse. Although the woman has been vigilant, it is clear that the nurse takes over from then on, firstly by asking for the information, then making it clear that the clinic, *'we',* had better *'sort it out'.* From this, it seems that women are expected to participate in monitoring and observing their body, but this stops at interpretation and solution. Another example of this can be seen in this next extract, where the nurse proposes a *'hormone hiccup'* to explain unusual bleeding and, additionally, asks the woman to keep a written record of her menstruation:

Nurse: are your periods regular?

Woman: I've been coming on my period every 2 weeks

Nurse: have you?

Woman: yes

Nurse: so you've had a bleed every 2 weeks

Woman: yes

Nurse: how long's this been going on, a couple of months?

Woman: yes, a couple of months

Nurse: Have you lost a lot of weight?

Woman: no

Nurse: right, it might simply be a hormone hiccup that...make a note of it in your diary every-time you have a bleed OK? we can discuss that at a later date if it doesn't settle down. (Consultation 21)

A related incident is demonstrated in the following extract, where a woman is encouraged to record menstruation in her diary. In fact the nurse actually provides a pen for the woman to record it during the consultation:

Nurse: right, you know you're last period, do you know the last day?

Woman: If I count back, I should really have put a dot in my diary.... Yes, lets have a look, what date are we on now? I always come on on the Sunday...so it'll be 4 weeks back won't it, the 25th march..

Nurse: do you want to borrow a pen to put a dot on?

Woman: yes, thank you (Consultation 19)

Part of the nurse's role in encouraging vigilance of menstruation is in helping the woman to distinguish between normal and abnormal bleeding:

Nurse: Is it continual bleeding, or does it ease off

Woman: I don't know how to describe it really, it's not like proper, proper blood you know it's like a brownie like discharge

Nurse: Like the end of a period

Woman: Yes. It's not like a proper period (Consultation 8)

Body-monitoring can sometimes become quite complex. For example, if a woman is taking emergency contraception, a number of issues need to be taken into consideration. Women need to be aware of the impact their previous hormonal contraception has upon their menstrual cycle when receiving the additional hormones in emergency contraception, distinguishing particularly between a false and *'proper'* menstrual bleed. This next extract is an example of this. In it, the woman is informed that the bleed that she may experience is not a *'proper'* period and receives a medical rationale for this. In other words, women may monitor bleeds, but it is the nurse, not they, who defines it as a *'proper'* menstrual bleed or otherwise. As before, the use of the collective *'we'* indicates that the clinic's judgment is applied in the context of interpretation:

Nurse: now I want to make you aware of the fact that when you've take the treatment (emergency contraception) you can have, a day or two afterwards you can have a bit of spotting (bleeding) or what we call a withdrawal bleed, now that for you is not going to be your next period, even though it might last a couple of days.

Woman: I didn't know that

The nurse then elaborates upon her description, taking the opportunity to further the woman's body education:

> *Nurse: You didn't know that?..., that's only because you are early in your cycle, if you were in the second part of your cycle we would say, yes, it probably would be your period. OK, but because you're so early in your cycle your next periods due first week in June OK, and that's probably expecting to come OK, so come back to us to get some more pills ready to start with your next proper period in June. (Consultation 25)*

Women are also required to monitor their menstrual cycle after receiving emergency contraception, given it could indicate unsuccessful treatment and therefore, pregnancy. These next two extracts involve women receiving emergency contraception after a condom failure. In them the nurse asks the women to *'come and tell me'* or *'come back and see us'*. In addition, in the first extract, the nurse has already interpreted the potential menstruation information that the woman will report:

> *Nurse: your next period..because having emergency contraception you'll get your period a bit earlier and some women can have their period up to a week late. If you're more than a week late though and your period still hasn't come, come and tell me and you need to have a pregnancy test.*(Consultation 14)

> *Nurse: If you don't have your period as normal after the second pack of pills come back and see us* (Consultation 9)

The following extract demonstrates the link between body education and body surveillance quite well. At an earlier clinic visit the woman had previously been made aware of the widening of the cervix during menstruation. The extract shows how the woman has used this information to attend clinic for a coil removal, using her knowledge to time her appointment. This timing serves a dual purpose. It is less painful to remove a coil during menstruation, whilst for the clinician, the wider cervix also makes the procedure easier to perform - an example of body monitoring serving the interests of the woman and the clinic:

> *Woman: It was last Sunday which was the 24th.*
>
> *Nurse: So you're on your period at the moment.*
>
> *Woman: Yes...the reason I've booked in for today is I'm wanting to have it taken out*
>
> *Nurse: Oh right, oh...that's fine that is the right time (Consultation 35)*

Another important element of body-monitoring is how women are encouraged to monitor the side-effects of contraception. Body education has introduced the possibility of side-effects. Now women are asked to report their experiences and observations. One nurse actually pre-warns a woman of what is to be expected of her by giving some sample questions about side-effects that she will be expected to answer at later clinic visits. The nurse emphasises the importance of this vigilance, utilising the *'we'* of the clinic to stress that it is for the woman to report exactly how this contraception will affect *her* body:

> *Nurse: bloatedness breast tenderness erm...irregular bleeding..also one of the things you'll be asked on depo is have you got any leakage of breast milk, that doesn't happen very often, ...we ask you about any abdominal pains, any headaches, nausea...its hormonal contraception so we can't say how it will affect each person (Consultation 28)*

Another example of the 'report and interpret' process can be seen in side-effect monitoring. It is the role of the nurse to make the distinction between real side effects and *normal* body processes. This next extract reveals how a woman is monitoring pain. She had reported the location and timing of the pain to her doctor. The nurse agrees that the pain is *'just'* her cycle and moves on. The pain has been attributed to the 'normal' pain that women experience, not to contraception, and is not, therefore, of consequence:

> *Nurse: Yes, so a bit heavy, slightly painful but you can cope with them*
>
> *Woman: Yes, painkillers takes it off, I don't need anything else*
>
> *Nurse: Right OK, erm.... and you've not got any abnormal discharge or lower abdominal pain or anything to worry about*
>
> *Woman: No, sometimes half way through, you know, the middle of the month I get a bit of pain in my side but I mentioned it to Doctor once and she says its just your ovaries*
>
> *Nurse: It's just your cycle*
>
> *Woman: yes.. (Consultation 3)*

In this next extract, a woman has been vigilant and is reporting symptoms for the nurse to interpret. However, the woman prefaces her report with: *'I don't know if it's me being silly'*, indicating that she has noticed the symptoms but is hesitant to interpret them as meaningful. She also returns to the notion of her *'being silly'* at the end of the description.

The woman waits for the nurse to mention pregnancy. It seems that this is what the woman thought, but she wanted to leave the nurse to make this interpretation of her symptoms. This woman has been monitoring the nature and timing of her menstruation closely and accurately along with her weight for years, and attends clinic as a result of this vigilance. Yet, in the consultation, the woman is self - depreciating and may well be aware of what the symptoms mean, but still leaves the act of interpretation to the nurse. It's the nurse decision as to whether she is being *'silly or not'*:

> *Woman: Right I don't know whether its me being silly or not and worrying but erm.... I, you see, a while ago, my periods were really, really irregular, they were all over the place, but they've sorted themselves out over the past couple of years and now they come dead on time like they supposed to but I'm a week late and I've eaten loads and erm.... I've put a bit of weight on that I don't usually do. I can never put weight on you see, and I've put a bit of weight on, and 'cause I'm really worried, I don't know whether I'm being silly or not.....*
>
> *Nurse: What, with worrying about pregnancy?*
>
> *Woman: Yes (Consultation 42)*

Nurses sometimes use the fact that the woman is body-monitoring to undertake further body education, thereby refining and adding to the woman's skills and knowledge. In this following extract, a woman reports pain on her left side and the nurse uses her anatomical knowledge to provide an explanation. The nurse also mentions that this is *'fascinating'*, presumably referring to information about the body, with which the woman agrees:

> *Nurse: do you suffer from constipation (woman's name)..?*
>
> *Woman: er....sometimes*
>
> *Nurse: Yes, because the side you're pointing to and the place you are pointing to, that's where your bowel erm...comes down the side before you actually open your bowels*
>
> *Woman: oh yes...*
>
> *Nurse: And sometimes, if you've had constipation that's where you can often get aches and pains 'cause it all blocks up so it can actually be related to your bowels rather than periods*
>
> *Woman: oh I didn't realise that*
>
> *Nurse: Fascinating, all this, isn't it? (Consultation 27)*

The notion of 'normal' versus 'abnormal' symptoms can be seen in this next extract. Are the headaches *normal* or a side-effect? In this extract, the woman reports and the nurse uses questioning to make a judgement. This extract also illustrates the way in which women are required to refine their observations between clinic visits in order to provide more detailed information later. In this extract the nurse attributes the headaches to *'hormones'*, but doesn't say if they are from the contraception (and, therefore, the consequence of a side-effect: abnormal). The nurse also ensures that the woman leaves the clinic in a heightened state of vigilance:

> *Nurse: Are you getting headaches?*
>
> *Woman: Well, not too bad, last week and the week before*
>
> *Nurse: Right, is it when you first started taking your pill, after a break or...*
>
> *Woman: It's in the break*
>
> *Nurse: In the break?*
>
> *Woman: Yes*
>
> *Nurse: And is it every single time?*
>
> *Woman: No*
>
> *Nurse: Does it affect your vision at all or balance or anything like that?*
>
> *Woman: No*
>
> *Nurse: It might just be the withdrawal from the hormone in that actual week, keep your eye on it, and if it doesn't get any better, or if it gets worse or..(Consultation 10)*

Being vigilant and observing the body, then, seem to be requirements for women attending the clinic and mark a significant element in the process of using contraception. The nurse encourages body-monitoring, but this vigilance appears to be limited to observation by the woman within a framework of reproductive anatomy and physiology. Women are used by the clinic as observers of their own bodies - an extension of the clinic process of surveillance - but their role is often limited to that of 'reporter', the role of interpretation and diagnosis mainly being assumed by the nurse.

However, Body surveillance does not always rely on the woman as an active observer. Within the consultations, nurses also measure and record a mass of information about the woman, thereby conducting a more direct form of surveillance.

5.15 *'Body-monitoring by the nurse'*

This category of body surveillance also includes another substantive element of activity within the consultation: the collection and recording of *body data* by the nurse. This data is either measured from the woman's body by the nurse in the consultation, then recorded in the woman's clinic notes, or it is information that the woman provides about her body which is similarly recorded. This includes self-report information from the woman - for example: the date of last period - or the nurse measuring height, weight, blood pressure and using charts and tables for example, the use of the body mass index. As the nurse takes and records the information it is compared to previous recordings in the woman's records. This way, ongoing surveillance of the woman's body is practiced. This aspect is usually the most regimented part of the consultation and numerous examples of this can be illustrated from the data. The following extract is highly representative of this part of the consultation:

> *Nurse: I need to weigh you in a minute and take your blood pressure, but we'll check that.*
>
> *Woman: Yes, I'm pretty sure that's gone up since last time, I'm partial to cakes.*

The woman has been monitoring her weight and indicates that it may have increased, but doesn't categorically state it has increased; she leaves that for the nurse to measure and make a judgment. The woman feels the need to provide a reason for weight gain, which she does in the form of an attempt at informal conversation: *'I'm partial to cakes'* to which the nurse responds briefly, but then immediately, brings the discussion back to questioning the woman about her body:

> *Nurse: Aren't we all, absolutely, right. When was the last day of your period?*
>
> *Woman: The 16th erm... oh what are we now*
>
> *Nurse: July now, so 16th June and your periods are all right*
>
> *Woman: Yes, they're fine*

Nurse: No missed periods or bleeding in between your periods

Woman: No.

Nurse: Heavy periods or

Woman: No I'm fine.

Nurse: Lets weigh you know shall we?

Woman: Shall I take my shoes off?

Nurse: Please.

Woman: Yes.

Nurse: 54.5 kilos .....I'll just see what you were last time

Here, the nurse is able to access the data recorded at the previous clinic visit for a comparison. The woman's weight has increased and the nurse explores this:

Woman: Yes

Nurse: You were 52 last time and the time before that you were 52 as well, so you're right you have put a little bit on, just 21/2 kilos. Do you feel you've been eating more?

Woman: Yes, er I used to be a picky eater but recently I'm getting quite, I don't know, I can eat anything and everything and clean my plate every time. I used to always leaves loads and never really eat an awful lot, but as I'm getting older I've started eating more I think

The nurse then justifies the weight gain by attributing it to the effects of the pill, but also indicates that the woman's weight is under surveillance: *'we will keep an eye on your weight'*, and will be checked next time the woman comes to clinic:

Nurse: Sometimes the pill can increase your appetite, we will keep an eye on your weight next time you come, all right erm lets just check your blood pressure

Woman: Yes no problem.

Nurse: Will you just straight, turn your arm round and straighten it for me

Woman: Yes

Nurse: That's fine 120/66

Woman: Is that what it should be?

Again, the nurse is able to refer to previously-recorded information from the woman for comparison, which, as indicated above, can be compared to *'normal range'* blood pressure and be regarded as *'fine'*.

> *Nurse: I will just compare it to last time, but that is within the normal range erm.... where are we, 120/70 last time so it's not very much different is it? (Consultation 1)*

The stored information provides the nurse with a broad base of data to draw upon in the consultation. It is also used as a constant reminder that the woman is under long-term surveillance by the clinic, sometimes over years, as these next extracts indicate:

> *Nurse: You've actually since '97, put 3lbs on and you were on Microgynon* (a brand of oral contraception) *then (Consultation 41)*

> *Nurse; your weight and your blood pressure, your weights been fairly constant and your blood pressures very good..(Consultation 19)*

> *Nurse: actually you've lost a kilo since your last visit which is 2 pounds difference (Consultation 17)*

Another example of measuring and comparing with norms is the body-mass index. On the wall in each room in the clinic is a body index chart. This enables patients to be placed on a continuum running from underweight to obese (coded as coloured areas on the chart), with green labelled *'normal'*. The following extract demonstrates how the nurse combines body education, measurement and a statistical index to show a woman that she is normal and *'healthy'*. In doing that, the nurse also demonstrates that the woman's measurements are being compared to those other women and placed upon a ranking scale of normality and health:

> *Nurse: No, if you're on the pill we tend to weigh you every time erm.... 63 kilograms, just under 10 stone OK how tall are you*
>
> *Woman: 5 foot 4 and a ¼...*
>
> *Nurse: Right erm.... I've rounded it up to 5 erm.... and that makes your body mass index 23 on the chart*
>
> *Woman: Yes*
>
> *Nurse: The green one's the healthy band, so that's absolutely fine, you're in the green band, this is healthy, this is under weight, this is overweight*
>
> *Woman: Oh, right*

Nurse: So you're fine, OK (Consultation 3)

The recording of menstruation is also important; nurses often have to help women to calculate this precisely, sometimes by providing a calendar. For example:

Nurse: ...your details, when was the first day of your last period. The calendars behind you if it helps at all...(Consultation 8)

Nurse: what was the day of your last period, there's a calendar here if it helps..(Consultation 9)

Nurse: When was the first day of your last period, we've got a calendar here to give a helping hand, Tuesday the 18th to Thursday the 27th..lovely (Consultation 2)

Nurse: are your periods regular?

Woman: yes...you're going to ask me my last one...

Nurse: I am

Woman: oh!!!

Nurse: Do you want a calendar?

Woman: yes, what date are we on? (Consultation 20)

Women are frequently asked questions about their health history and previous contraceptive use. The nurse proceeds through a checklist to obtain this information and records the data as she progresses thorough it into the woman's clinic notes. These records help to build a comprehensive store of information about the woman; this is updated at subsequent clinic visits. It is also used to monitor changes in the woman's health status. This process reveals the extent to which women need to be aware of their health and also the health of their close family. In conjunction with body measurements, this adds to the sense of surveillance the woman is under from the clinic. The following extract is typical of this question and answer process, and also provides a further example of the integration of body education and interpretation into the consultation by the nurse. The woman is also made aware that the records held are incomplete:

Nurse: I just need to check your medical records since you were last here.... any changes in your medical or your family history erm .....Rubella..... entry we haven't got that filled in

Woman: Erm.. I think so, was that something at school, that you had at school, I should think so I had everything at school

Nurse: Don't if you're not sure

Woman: Was it an injection that one

The nurse uses body education to justify her concern about Rubella; she also advises the woman that it may be *'worthwhile'* checking if she has had it in the past:

Nurse: Erm we'll leave it, the significance of erm women being immunized against Rubella is to protect them in pregnancy

Woman: Yes

Nurse: Erm you know it may be worth while checking out to see if you have been given the Rubella injection

Woman: Yes I will do

Nurse: So you don't suffer from Migraine, Headaches?

Woman: No

Nurse: No allergies?

Woman: No

Nurse: No epilepsy?

Woman: No

Nurse: No heart problems?

Woman: Nothing with me, no

Nurse: OK, nothing you know your on treatment for?

Woman: No

Nurse: Nothing in the past, no other diseases, no jaundice?

Woman: No

Nurse: Thrombosis or bleeding disorders?

Woman: No

Nurse: OK and your family history, I got that your dad had a heart attack and your mum has angina?

Woman: Yes

Nurse: And is there anything else different?

The nurse then adds her interpretation of the data into the consultation: *'nothing really significant':*

Woman: Erm no, I don't think so, mum just been diagnosed of having a Hiatus Hernia is it, she's got one of those, but that's about it I think

Nurse: OK that's fine, so there's nothing really significant to change then (Consultation 1)

As well as actually recording information during the consultation with the woman present, nurses sometimes mention explicitly that they are recording something that the woman has said, thus further emphasising to the woman that she is under observation and that records are being made, for example:

Woman: I've recently been to GU Med (Genito-Urinary Medicine clinic) and been checked out for everything so its nothing infectious..

Nurse; I'll just record it (Consultation 20)

Information was also utilised as a tool for *policing* women's behaviour. In this next exchange, the nurse praises the woman for her efforts to stop smoking but reminds her that this information will be recorded, for use next time she returns to clinic:

Nurse: do you smoke?

Woman: I used to

Nurse: Oh, well done, how long have you stopped

Woman: about a week

Nurse: I'm going to write that down (Consultation 21)

Nurses use both the fact that they hold information on women and the fact that women are aware of this in a strategic way in the consultations. Often nurses will mention that they are consulting this information in their discussions with women, making the woman aware that the nurse holds and can access this information. When referring to the information, the nurse reinforces this by using the words *'I'* and *'me'* before looking at the woman's records:

Nurse: let me just have a look at what your comments say..(Consultation 24)

Nurse: OK, what I am going to do is get your details up on screen...(Consultation 10)

Nurse: I've just picked up that you had a smear in '98 (Consultation 3)

Nurse: Now...let me just get your history up (on the computer)..now that's your medical history here (woman's name) (Consultation 29)

In this next extract the nurse asks the woman a question to which she already has the answer. The nurse makes the woman aware of this; *'I know'* she remarks when referring to the woman's records:

Nurse: Right dear..have you gone back on the pill as well?

Woman: Yes, the pill

Nurse: That's fine..I know.....looking back through your notes you've had it from here and then I was just looking and it said, will start again.(Consultation 47)

This exchange indicates a couple of power issues. Firstly, it makes it clear that the woman's answers are prone to checking by the nurse. It also gives the impression to the woman that the nurse is in a powerful position, already knowing information about her. This process can also be seen in other consultations:

Nurse; its Microgynon (contraceptive pill) you're taking isn't it...you've been on it for some time as well haven't you..?(Consultation 17)

Nurse: so since May you haven't been using anything at all? (Consultation 8)

Nurse: so this is the first time you've had a coil check since it was fitted...is that 2 years?

Woman: yes..about 2 years (Consultation 3)

Nurse: So it was a whole new thing for you, you'd been actually on the mini pill before hadn't you?

Woman: Yes (Consultation 2)

Women also sometimes mention that they are aware they are being monitored. In this extract, a nurse is discussing smoking with a woman. The nurse refers to *'comments'* - meaning the section of the notes that record miscellaneous information from previous visits in order to check up on the woman's efforts to cut down her cigarettes. The woman joins in by commenting about what was previously recorded, showing that she is aware of the surveillance process. Interestingly, the nurse refers to *'3 ish'* rather than 3, indicating that she may not believe the woman's smoking information:

> *Nurse: right let me have a look at what your comments say...how's the smoking going, you were down to 3 a day, have you managed to cut that down any further?*
>
> *Woman: no*
>
> *Nurse: it's difficult isn't it..so if we put you're smoking at 3 then, we've still got 10 in there, so it's 3 ish...*
>
> *Woman: last time I came there was 50 in there. (Consultation 25)*

5.16 *'Body techniques'*

One element of the body surveillance theme, that is closely linked to body monitoring and that demonstrates links with body education is the way in which nurses develop the skills of body examination and physical techniques with women. Broadly, body techniques can be separated into those practices that are designed to enable women to use a method correctly and those practices that are about checking the body for problems related to the method, for example side-effects.

One example of body techniques can be illustrated from consultations with women who are using, or who are about to use, the coil method. Once a coil has been inserted into the uterus, two small threads protrude through the cervix for a few millimetres. These threads help with removal, but their presence also indicates that the coil is still in place (coils can be accidentally expelled during menstruation).

In all coil consultations, nurses address the issue of the woman examining herself to check the threads. The woman in this extract is informed that she will be taught to feel for the threads. The nurse stresses the importance of the woman performing the procedure in order to detect any problems and of returning to clinic *'immediately'*:

> *Nurse: we teach you to feel for your piece of string and if you feel any more plastic then come back immediately, erm...(Consultation 32)*

The importance of practising is also emphasised to women using the coil. This next extract is a good example of the link between body education and body technique. During this consultation, the nurse shows the woman a leaflet with a diagram of the coil in the uterus, as a visual aid when teaching her what the check for:

> *Nurse: ...it fits in the uterus these thin threads just coil through the cervix, just feel around, don't panic if you can't, it just takes a bit of practice.(Consultation 18)*

Where women had been using the coil for a number of years, a check was made at subsequent consultations to ensure that self-examination was still being performed:

> *Nurse: You check the thread?*
>
> *Woman: I've not had a problem, is it once a year?*
>
> *Nurse: Yes, generally, once its settled, we always say come back sooner if.... you know, your worried (Consultation 32)*

In this next extract, a woman appears to be experiencing difficulty with examining herself to check for the threads:

> *Nurse: That's great....do you check it yourself in between time, do you feel for the threads?*
>
> *Woman: No, no*

The nurse then adds that it is a good idea to do it for the woman to feel reassured, and then returns to asking the woman again:

> *Nurse: OK, it is quite a good idea erm.... for re-assurance just to make sure you can feel, have never tried to feel for the threads?*
>
> *Woman: No*

Nurse: No?

The woman is still sounding reluctant. In this difficult moment, the nurse falls back on body education. The nurse also *ups the stakes* in this extract by adding in the term *'higher risk'*. She also adds in a question to test body knowledge relating to uterine contraction:

> *Nurse: Erm.. and just after a period, during your period you uterus can contract, cant it, so if its going to be exposed its a higher risk time, so the time to check you coil is just after a period*
>
> *Woman: Right*

This moment is followed by more detailed anatomical information. The nurse introduces two more elements into the discussion at this point: the coil itself and a diagram of the uterus and vagina:

> *Nurse: Usually you can't feel the coil, you can check for the threads erm.... I'll just get a picture of it erm....so when the coil is fitted the, all that goes inside your uterus, right and its just the two threads hang through the cervix so by checking it if you feel that you can feel the threads, you know that it's still there, but also you shouldn't be able feel the, the nobbly bit end there, the hard bit, if you feel that it's dislodged, so you should be able to feel the threads, but not the hard bit*
>
> *Woman: Oh, right (Consultation 3)*

The use of the coil and diagram appear to be a further tactic in reinforcing the woman's need to examine herself. The medical diagram, along with the device itself, is used to medicalise what the woman may have regarded as an intimate procedure. The nurse also introduces the concept of risk into the discussion, increasing the importance of the procedure.

Another example of how nurses use anatomical diagrams and models to encourage body techniques can be seen whilst women are using the diaphragm method. The clinics have scale models of the pelvic region, showing reproductive and urinary anatomy, which are often used in consultations. In this extract, a number of things occur during the nurse's description. Firstly, the nurse uses the model to reinforce the importance of technique, mentioning the proximity of the bladder.

The nurses also checks that the woman is paying attention: *'can you see?'* She also brings in the potential dangers of poor technique by remarking that its barrier protection will be incomplete sperm will *'swim around it'*. Another interesting element to this discussion is how the nurse uses a tampon metaphor for insertion:

> *Nurse: That's a typical diaphragm they come in various sizes from 65mm up to 95 mm.... It's actually fitted by squeezing it together and inserting it into your vagina like you would a tampon and it's used in conjunction with spermicidal cream which we give you as well. So a couple of strips on both sides OK and you insert it into your vagina.. You fit it like this, if I can just show you the model, you fit just like you would a tampon. If just flicks itself into place, can you see it's covered all the cervix there and it fits under the pubic bone there. The fit is really important because if that is too big you'll get allot of pain just up here. If it is too small it'll be wiggling around and you would get some sperm swimming around it, but sometimes if they are fitted too uncomfortable it will irritate your bladder.*

The use of the tampon example seems to be related to both the woman's ability and experience of examining herself, but it also serves as an example of the techniques involved. The tampon example seems to be an attempt to use the woman's knowledge of menstruation and sanitary practices as a way of encouraging and explaining this technique, reassuring the woman that is it no different:

> *Nurse: Do you actually use tampons?*
>
> *Woman: Yes I do*
>
> *Nurse: OK so you're comfortable at inserting and pulling things out, so you're technique will be OK, if your comfortable at touching yourself you shouldn't actually have any problems with using the diaphragm. (Consultation 14)*

Continuing the teaching theme, women are expected to practise their techniques. The tampon example occurs here in the context of any discomfort that the woman may experience, building on her earlier experience of tampon use and on how, with practice, this technique improved. The nurse also mentions teaching in this extract and reassures the woman that it *'sounds complicated'* but that she will soon be versed in the technique:

> *Nurse: we're actually going to give you a practice cap to start off with, because of the technique of putting them in and taking it out as well, can you remember when you first started using tampons, it was really uncomfortable?*
>
> *Woman: yes*
>
> *Nurse: and you hadn't got it up far enough?*

Woman: yes

Nurse: and it doesn't take long before you become very au fait with popping them in and out?

Woman: yes

Nurse: and equally there is a little bit of a technique to get used to using it...getting it out is a little bit more difficult...it sounds complicated and it's a difficult thing to teach someone to do but once they get doing it, you'll pop it in and pop it out with no trouble whatsoever. (Consultation 14)

Body technique also includes condom use. In this consultation, the woman disclosed condom breakage when attending for emergency contraception. The nurse instructs her about condom use:

Nurse: The thing you need to remember, when you are putting on a condom to expel all the air from the teat when you roll it on and its really important...'cause if there air when you start having sex the air pressure going to build up and that's when you have your burst condoms..that's really important 'cause otherwise you're going to have to keep coming back (Consultation 26)

Some body techniques are related to side-effects and body-monitoring. For example, women using hormonal contraception have an additional risk of developing breast cancer. Therefore, breast awareness and examination formed part of encouraging women to examine their bodies. Nurses often ask women if they were aware of this. In this extract, the nurse reinforces the point that the woman's knowledge of her own body is important - *'the best person to pick up changes is you'*. She then teaches the woman how to examine herself visually and physically, which she also reinforces with written information - *'a leaflet'*. The nurse also mentions the importance of making this examination into a *'habit'*, thereby attempting to encourage the woman to introduce this examination into her life:

Nurse: Erm the other thing, do you check your breasts, or are you aware?

Woman: Erm I don't really, I know I should do but I don't

Nurse: OK I'll give you a little leaflet about that erm...It is a good idea to get into the habit of being breast aware and checking them erm about once a month because the best person to pick up any problems is yourself er by getting to know what's normal for you and you can pick up any changes erm so you need to look at your breasts er look in the mirror, look for so, hands by your side and behind your head like that, look for any creasing of the skin puckering of the nipple just anything that looks different for you, and then you need to feel your breasts.

a good place is in the bath or shower erm but when you feel your breasts, don't use your fingertips, use the flats of your fingers

Woman: Right (Consultation 1)

The nurse also links with body education by explaining the connection between menstrual cycle and breast tissue, again reinforcing the point that constant vigilance will enable the woman to be aware of her normal body and to detect and act when the *'out of the ordinary'* is detected. This explanation to the woman also includes the previously-described notion of the woman as 'vigilant' and 'active' in detecting changes, but these changes are interpreted by the nurse, who *'checks them out'* to interpret their importance:

Nurse: Erm I mean breast tissue, breast vary at different times in your cycle you probably notice that anyway erm but it's anything out of the ordinary for you, you need to get it checked out. Most things turn out to be nothing anyway but they need checking out (Consultation 1)

The nurse then continues to teach the woman how to examine her breasts, emphasising the problems that incorrect technique can cause, particularly picking up normal irregularities rather than abnormal ones. This, presumably, is intended to prevent the woman detecting and becoming anxious about insignificant changes, but it could also be to prevent women attending clinic too frequently with false alarms:

Nurse: Erm.... feel all the areas of breast tissue, you know if you start say at the nipple and work all the way round in a spiral till you felt all areas of the breast and always finish off under the arm pits to make sure there's no lumps or thickness there, but when you feel your breasts use the erm.... don't use your fingertips, use the flats of you fingers because breast tissue irregular and if you use your fingertips you'll pick up all sorts of irregularities, so use the flats of your fingers (Consultation 1)

The link with time and menstruation is also important. Women have to be aware of the best time to conduct examinations. Again, in this extract, the nurse mentions the difference between abnormal and normal tissue detection:

Nurse: Depending on what time of the month you do your breast examination you might find that your breasts feel a little bit lumpy and that could be at around period time, you're probably better off doing a few weeks later

Woman: Yes.

Nurse: Do your examination a couple of weeks away from your period and you'll probably find that's a lot better (Consultation 20)

In this following extract, the nurse reinforces her teaching on breast examination by stressing the importance of being *'aware'*, referring to the importance of vigilance in early detection. Also, a leaflet is given, in order to continue the reinforcement of the information after the consultation has ended:

Woman: Right

Nurse: And just feel for anything that is different or unusual for you or notice anything that's unusual and make sure there's no discharge from the nipple.....It just pays to be aware that's all, all right? so I'll just give you that little leaflet, OK? (Consultation 21)

5.17 *'Body Surveillance'* summary

This aspect of the consultation illustrates clearly the way in women place themselves under surveillance when visiting the clinic. Within the consultation, women are taught and encouraged to become active in monitoring their bodies for any changes. Sometimes, they are also taught how to examine and manipulate their bodies, in order to manage a contraceptive regimen actively. The role of body education can be seen clearly as part of this process. Women also contribute to the wider surveillance duties of the clinic by providing a range of information about their bodies. This information is recorded and utilised for comparison purposes at future consultations. Body surveillance, then, plays a key role in the development of the *'active patient'*. It also links with the development of the woman as a compliant contraceptive user, a woman who, through monitoring her body closely, becomes disciplined, a woman who can adhere successfully to a regimen.

5.18 *'Regimen'*

Regimen describes a process by which nurses ensure that women are aware of the need to discipline themselves in order to comply successfully with their contraception. Regimen is clearly linked with, and draws from, the processes involved in both Body education and Body surveillance. Regimen includes making women aware of the need to keep to time and to act within the *rules* governing their particular method of contraception.

In addition, Regimen involves women becoming aware of factors that could potentially threaten their contraceptive cover and in developing the ability to recognise and manage regimen breakdown.

5.19 *'Time-keeping'*

Time is an important consideration when using contraception and nurses spend a considerable amount of time in the consultation reinforcing the need to comply with a regimen that relies on time keeping, which is often strict. As before, the concepts of 'risk', 'vulnerability' and *'failure'* was utilised to make the point:

> *Nurse: You know you've only got 2 hours, so if you start at 6 in the evening, your next pill's got to be around 6 in the evening, you've only got 2 hours, otherwise your risking user-failure, you're likely to get pregnant*
>
> *Woman: Oh, you're saying it's got to be the same time every day*
>
> *Nurse: Its got to be at the same time, combined pill you've got 12 hours in which to take it, you take it every day, but you've got that 12 hours window, with the mini pill you've only got 2 hours (Consultation 36)*

Time keeping is very closely linked with women being able to comply effectively with contraceptive regimen and nurses use various strategies to encourage women to do this. Time-keeping in the consultations covers awareness of time - down to the hour in some cases - but time awareness also includes monitoring days, months or, sometimes, years. Nurses make sure that women are aware that time-keeping is an important consideration and they make express links with time and the concept of 'risk' and 'vulnerability' in the consultations:

> *Nurse: it's a very dangerous time to miss any pills (Consultation 29)*
>
> *Nurse: You missed Mondays pill altogether?...which puts you at risk OK? Now the fact that you missed Tuesdays as well and it was the first of seven pills at the start of your packet makes it a bit more risky as well (Consultation 26)*

The issue of time varies according to the method the woman used. For example the coil requires the woman to be aware of its three to five year 'lifetime' and also the need for a monthly check of the threads. Women using Depo-Provera need to be aware of the passage of months. However, for women using the contraceptive pill or the diaphragm, time-keeping is a matter of hours.

For all women, then, an awareness of the passage of time and the importance of time-keeping is an important aspect of using their contraceptive method. In the consultations, nurses alert women to the dangers of not adhering to time, often prefacing discussions around 'timing the regimen' with warnings about the link between time and effectiveness. The notion of time being linked to continued protection is evident:

> *Nurse: OK erm so you should start it on the first day of your period, you need to take it at the same time each day.....and if your more than 12 hours late you are not protected erm (Consultation 1)*

Also, the effectiveness of the pill is emphasized in conjunction with a warning that this is clearly dependant upon correct management of the regimen. Effectiveness is linked to the warning not to '*go messing around*':

> *Nurse: if you forget to take it and go messing around the times then it is not as effective. (Consultation 6)*

Time-keeping is also subject to questioning by nurses, aimed at establishing the woman's compliance with regimen:

> *Nurse: You don't forget to take your pill?*
>
> *Woman: No*
>
> *Nurse: do you take it around the same part of the day?*
>
> *Woman: late morning (Consultation 20)*

Also,

> *Nurse: do you take your pill at a regular time of the day?*
>
> *Woman: yes (Consultation 23)*

The nurse also backs up timing advice with written information that the woman could take away:

> *Nurse: That's great. This is the leaflet we'll be giving you to go through. (Consultation 17)*

In this next extract, the nurse goes through the Pill leaflet with a woman. The leaflet contains a *'flow-chart'*, or prescribed regimen for taking the Pill effectively:

> *Nurse: There's a little-flow chart that tells you what to do, and how to use your pill and it tells you about antibiotics and sickness in it as well and it just reminds you how to take it er and as we said starting on the first day of your period you are protected straight away, you take all 21 pills, have a 7 day break and restart it on the 8 day and your period if you remember comes in the 7 day break*
>
> *Woman: Yes*
>
> *Nurse: And it's really important not to make that 7-day break any longer otherwise.....?*
>
> *Woman: Your messing up your cycle again aren't you?*

The nurse then reinforces the need for accuracy again by referring to the concept of risk drawing upon body information about the reproductive cycle. Employing the example of poor time-keeping giving the body chance to *'release an egg'*:

> *Nurse: Well you really giving your body chance to release an egg and put yourself at risk of pregnancy, so you mustn't make that 7 days any longer (Consultation 1)*

Nurses also reinforce time-keeping by encouraging women to think about including their contraceptive regimen in other daily habits, for instance meal-times or upon waking. In this extract, the nurse uses two strategies that seem to be an attempt to marry the needs of the clinic with the notion of the method fitting in with the woman's daily life. she uses the clinic *'we'* when suggesting taking the pill at the same time twice in the exchange, but at the same time also includes statements that also refer to the woman having a choice to fit the pill into her *'lifestyle'*:

> *Nurse: No first day of your period, so whatever day of the week that is and then you carry on for all your 21 we suggest that you take it at the same time everyday, it doesn't matter what time of day it is, it's whatever suits you in your lifestyle, it's best if you get up at the same time every morning and are able to remember to take it with your first cup of coffee at 8 O'clock in the morning with breakfast*
>
> *Woman: Yes*
>
> *Nurse: Then you can erm or if you find it better in the evening is the best time for you, that's fine what we suggest you do is just take it at the same time every day within a few hours*
>
> *Woman: I tend to do that now (Consultation 6)*

This following extract demonstrates the link between body-monitoring and time-keeping. The nurse links the woman's monitoring of her menstruation with her pill-taking regimen referring to the woman as having a *'good routine'*:

> *Nurse: the first pill out of the packet should be on the same day of the week so you always take the last pill out of the packet on the same day of the week and the same number of days later you always start your period. You've already said you period starts on a Friday, so you've got a good routine (Consultation 17)*

However, there appear to be limits to the ability of women to develop a good routine. In this next extract, the nurse uses a technique to draw the woman away from trying to modify the regimen against the *ideal* regimen prescribed by the clinic. The nurse discusses starting the pill and mentions that *'we like'*, indicating the clinic preference, but the woman questions this:

> *Nurse: when any body first goes on the pill we like them to start on the first day of their period, so if you time it that you see someone before your next period you'll be alright, we know then if you start on the first day of your period that you're covered straight away for contraception and it saves any mix up*
>
> *Woman: what about starting second day..I know that sounds a bit stupid*

The nurse, although indicating briefly that this would be OK, quickly adds that *'we usually say first day'*. The nurse then distracts the woman onto another issue, that of side-effects and adds a question, possibly to restore the balance of power in the consultation:

> *Nurse: No...second days OK, but we usually say first day...you know there are risks...risks to taking the pill..?*
>
> *Woman: yes*
>
> *Nurse: have you heard of them...?(Consultation 29)*

Another element in time-keeping was the inclusion in consultations of the *'Pill rules'*. The Pill rules relate to time schedules for taking contraceptive pills effectively and form a large part of the information on time-keeping given to women. The use of the word 'rules' is interesting here. Nurses *could* use the terms *advice* or *guidelines,* but use a more authoritarian phrase instead, for example:

Nurse; its important that you follow the pill rules (Consultation 9)

And also:

Nurse: There are rules when you are on the pill, take this leaflet. I'll just briefly go through them. What we say is, if you start the pill on the first day of your last period then you're covered straight away for contraception, you take 21 pills, you have seven clear days and then you start your next packet on the first day of your next period..if you've taken these pills correctly you're also covered on your pill free week... these are the rules...are you very good at taking pills...remembering when to take them...?

Woman: yes (Consultation 29)

In this next extract, a nurse questions a woman's compliance and follows up with a checking question about the Pill rules:

Nurse: you're quite good at taking the pill aren't you?

Woman: yes, I'm very good at taking it every morning

Nurse: no missed pills...you're positive, are you aware of the pill rules?

(Consultation 17)

Time is every bit as relevant – if not more so – where nurses are discussing and providing emergency contraception to women, for example after a broken condom or missed pills. Emergency contraception is given in the form of two pills. The second pill has to be taken exactly twelve hours after the first. For example:

Nurse: Remember, that 12 hour gap is really important (Consultation 26)

Nurse: you need to take one pill tonight and the other pill in the morning exactly 12 hours later (Consultation 21)

*Nurse: so (*woman's name*) it's two tablets divided into two separate doses that you take twelve hours apart. Note what time it is when you take it, 'cause then you take the second tablet twelve hours later, so its up to you to decide, its 3.06 (Pm) if you have your first tablet now it would mean setting the alarm for three in the morning or thereabouts, you can make it a bit user friendly, if you wish and have it a seven or eight o'clock tonight and then have it when you get up in the morning, but just remember you do need to take that second tablet twelve hours later (Consultation 25)*

In another case of emergency contraception, the importance of the passage of time is clearly evident. The nurse actually uses the phrase *'time is ticking on'* as a way of reinforcing the importance of time both, not only for the woman to start the treatment, but also for her to remember to take the second pill:

> *Nurse: there just 2 tablets and they're taken 12 hours apart erm.... because you know time is ticking on you'll have one 12 hours later which you'll probably still be up probably, well I'm sure you will because its important to take the second*
>
> *Woman: OK*

The nurse then provides the woman with a leaflet to give her further information and reinforcement about the regimen:

> *Nurse: So you'll take the 2nd one about half past 11 tonight, that's the leaflet dear about it, telling you a bit more*
>
> *Woman: Thank you (Consultation 48)*

Time was also an issue with the use of the diaphragm. In this next extract time is important prior to using the method and the nurse indicates that the woman needs to *'pop it in'* in case sexual intercourse takes place, requiring time management to also be anticipatory. Furthermore, the woman needs to be vigilant with regard to the passage of time after intercourse, in order for the method to be effective and to *'kill all the sperm'*:

> *Nurse: OK... and you insert it into your vagina when you might anticipate having intercourse, for example you might go to bed at night or have a bath and pop it in just in case you do have intercourse with your partner that evening, if you don't you haven't lost anything and you just take it out in the morning when you get up. If you have had intercourse, you need to leave it in for a minimum of six hours afterwards for the spermicide to actually kill all the sperm that are around (Consultation 14)*

The language the nurse uses implies ease and simplicity: *'pop it in', 'just in case', 'haven't lost anything', 'just take it out,* but what the nurse is recommending is a detailed time-keeping strategy for the woman to follow. The woman has to anticipate intercourse, insert the diaphragm and remember the passage of time after intercourse, in order not to remove the diaphragm too soon. Presumably, she would also have to manage time in order to be in a suitable place to do this.

Concerning Depo-Provera, time-keeping is included when nurses question women. This next extract demonstrates how the nurse reinforces time-keeping to ensure effective compliance. The use of *'imperative'* adds the need to observe time. The nurse also uses the terms *'barrier'* and *'limits'* to indicate something beyond which the woman must not go:

> *Nurse: Do you know roughly how long you've got, erm..between injections, do you know the time, limits? We usually give the woman an appointment at 11 week intervals, 12 weeks is ok, buts its absolutely important, imperative that you don't exceed that 12 week barrier. (Consultation 16)*

With Depo-Provera, nurses ensure women adhere to time by being quite insistent upon their making an appointment before leaving the clinic. In this following extract the nurse refers to the woman having the knowledge, *'you know'*, to reinforce the need to return to clinic:

> *Nurse: now you know you're next jab is due on the 5th October, so if you want to make an appointment today (Consultation 11)*

The nurse in this next extract is similarly insistent, buts adds a contingency plan in case there are no appointments:

> *Nurse: if you just make an appointment for 8 weeks time, no later than 8 weeks, if she can't fit you in for 8 you need it for 6 or 7 (Consultation 16)*

For women using a coil method, as well as checking the threads at certain times in the menstrual cycle, time-keeping can be also be measured in years. Women are required to have their coil checked annually at the clinic:

> *Woman: it's just a coil check*
>
> *Nurse; when did you have it fitted?*
>
> *Woman: March last year (Consultation 40)*
>
> *Nurse: right now..when did we actually fit this...lets have a look, yes, July 99, '99 so err...*
>
> *Woman: That's 2 and a half years isn't it? (Consultation 32)*

5.20 *'Threats to Regimen'* and *'Dealing with Regimen breakdown'*

There are strong links between time-keeping and how nurses help women to recognise and deal with any threats to the effectiveness of their contraceptive method:

> *Nurse: now one thing, if you forget to take your pill...here's a little run down...*(Consultation 6)

One important element to most consultations is the nurse ensuring that women were aware of how to manage any breakdown in their regimen. This takes many forms that vary according to the method of contraception the woman is using. However, an encompassing theme is the need to recognise threats to the regimen and to act accordingly.

One of the main strategies that nurses use for this is, as before, questioning techniques that test the woman's knowledge. Sometimes, this questioning is quite intensive, and particularly for women who use the contraceptive pill, contingency management is one of the most complex areas of regimen management. This next extract reveals how intense the questioning can be:

> *Nurse: do you know what to do if you.....?*
>
> *Woman: Miss one?*
>
> *Nurse: Yes, or if you're late in taking one*
>
> *Woman: I was told I could take it within a certain period, so many hours*
>
> *Nurse: Do you know that?*
>
> *Woman: I've got a leaflet at home*
>
> *Nurse: Can you remember?*
>
> *Woman: I think its quite a big gap isn't for this one*
>
> *Nurse: 12 hours*
>
> *Woman: Is it 12 hours?*
>
> *Nurse: Yes.....So if you're more than 12 hours what do you do?*
>
> *Woman: I never have been, but I'd get the leaflet out and read it*

Nurse: If you're more than 12 hours late take the tablet that you've missed and er...

Woman: You'd be a day out

Nurse: And use condoms for 7 days, and then what you've got to consider is how many tablets you've got left in the packet, if you've got more than 7 then you can have your usual 7 day break, if you've got less than 7

Woman: You keep going..?

Nurse: Yes, without a break (Consultation 43)

Several elements of this exchange are interesting and illustrate the nature of the power relations that are operating. Firstly, the nurse continues to question the woman after she has given the right answer. She also ignores the woman's attempt at rationalising the regimen as being *'a day out'* by continuing her point. It seems that it is the nurse's role to interpret the disrupted status of the regimen. The woman also indicates that she has retained - and would consult - the instruction leaflet she has been given; she also stresses that she has never missed a pill anyway, simultaneously indicating that she has kept the information and that she is reliable pill-taker. From this exchange and others it can be seen that women who attend the clinic whilst using the contraceptive pill can expect to have their knowledge tested. In this woman's case, she never actually missed a pill, but she still underwent the testing. This testing, irrespective of the woman's compliance, seems to be one way that nurses encourage vigilance and compliance. A further example of this is the inclusion of testing questions when women visit the clinic for a repeat prescription of pills:

Nurse: ...what do you do if you forget to take it?

Woman; take it in the morning

Nurse: take it as soon as you remember, but use condoms as well, give it a couple of days to get back into your system (Consultation 23)

Nurse; on late pills how long have you got each day to remember to take it...are you aware of that? (Consultation 13)

Nurse; how long have you got..each day, to remember to take your pill?
(Consultation 17)

Nurse: You know what to do if you miss some?

Woman: Yes (Consultation 39)

Often, when discussing missed pills, missed Depo-Provera or broken condoms, the nurses added questions that are designed to test the woman's awareness of emergency contraception:

Nurse; you know about emergency contraception...you know that you've got 72 hours to take it (Consultation 1)

And also:

Nurse: OK do you know about emergency contraception?

Woman: er yes...

Nurse: within 72 hours...?

Woman: yes (Consultation 22)

Furthermore, as this next exchange demonstrates, women realise that they need to be prepared when they attend clinic. In this following extract, the woman is attending for emergency contraception after a condom failure and knows that time is important. Here, we can see a good example of the links between body-monitoring, awareness of time and the use of body information in the management of contingencies. The woman knows what information is required of her and she has recorded it:

Nurse: so what time did you have intercourse then, did you say last night or was it Monday?

Woman: 3 O'clock in the morning

Nurse: 3 O'clock in the morning. OK that's fine.

Woman: I wrote the time down, because I thought..I bet she asks me and I like, don't know. (Consultation 25)

The *'pill rules'* also re-occur within discussions relating to regimen breakdown, as these next two extracts illustrate. The nurses both stress, that if you are within the time limits for the regimen, you have *'no problem'* but outside the 12-hour rule problems occur:

> *Nurse; there is a 12 hour rule and if you have a look through this, this explains, if you're more than 12 hours late, if you're less than 12 hours late, no problem if you're less than 12 hours late, take it as soon as you remember and just carry on as usual erm...if you missed more than one pill, ...use extra precautions for 7 days (referring to condoms). (Consultation 29)*

And also:

> *Nurse: You have to follow these rules though if you're more than 12 hours late (Consultation 13)*

The concept of maintaining protection when there is a breakdown in regimen can be seen in these next three extracts. Women are made aware of the need to use *'additional precautions'*, in the form of condoms, if their regimen is interrupted. Nurses often gave women condoms for that purpose as they left the clinic:

> *Nurse: now in addition to taking two together you have to take precautions for the next 7 days (Consultation 17)*
>
> *Nurse: now in addition to taking two together you have to take precautions for the next 7 days (Consultation 17)*
>
> *Nurse: do you need any condoms just in case you get it wrong? (Consultation 45)*

Also, in this next extract, a nurse suggests abstinence from intercourse as a strategy when discussing what a woman should do if she is late for her Depo-Provera injection:

> *Nurse: and if you do you use additional precautions, you either use condoms or abstain from intercourse until you can get a top up injection (Consultation 16)*

In addition, part of dealing with regimen breakdown utilises the process seen earlier in Body monitoring, that of the woman's vigilance leading to an attendance at clinic so that the nurse can interpret the nature of the problem. This can be illustrated using these two examples from the data.

In the first extract, a woman has attended for emergency contraception but, as the nurse is recording the woman's medical details, it becomes clear she is already taking the contraceptive pill. Firstly, in this extract, the woman is questioned about her management of the regimen:

> *Nurse: I'll stop there because I want to know if you're taking the contraceptive pill you think you need emergency contraception?*
>
> *Woman: Right..er I er...I ..er...on Friday night, I forgot to take one and I ended up taking it later*
>
> *Nurse: right OK, how many tablets have you had, how many pills are left in your pack at the moment?*
>
> *Woman: Well I missed that one (presumably the woman shows the nurse her pill packet)*

The nurse then uses this opportunity to revisit the pill rules and to teach the woman about the regimen. The nurse also asks the woman to use some of her body knowledge to understand the nurse's rationale by using the phrase: *'if you think about it'*. This phrase could be also be regarded as a mild chastisement for the woman, who has misinterpreted the pill rules. The woman then indicates that she wasn't sure and had attended clinic for a judgement, which the nurse gives:

> *Nurse: OK..I'm just going to fill you in on the effectiveness of the contraceptive pill..provided you have a minimum of 7 consecutive pills OK without having any late pills or sickness it would be perfectly safe for you to miss 7 further consecutive pills, as if its your pill free week, 'cause that's what you do really, if you think about it, you actually miss that 7 days to have a withdrawal bleed, so you are or you will be still contraceptively covered because you can theoretically miss 4 pills mid cycle without it actually effecting...*
>
> *Woman; yes...I wanted to know if I needed to take it or not*
>
> *Nurse: In my opinion I don't believe that you do (Consultation 9)*

In this last extract, the nurse is required to decide if the woman is, indeed, reporting a late pill or not. The nurse uses the term *'not classed as a late pill'* in this exchange, therein referring to the clinical criteria defining late.

This following exchange is another example of the questioning technique used by nurses to explore the detail of an incident involving regimen failure:

Nurse: which pills have you missed then?

Woman: It happened Tuesday, but I did take Mondays, and then I took them on Tuesday about...

Nurse: you took them both together?

Woman: Yes, about 3 o'clock

Nurse: Right..OK...the fact that you took it at 3 is OK. Tuesdays pill is not classed as a late pill, 'cause you're actually having the 12-hour window (Consultation 26)

Nurses occasionally have to manage situations where women have developed their own techniques for managing regimen failure, one that does not follow the *'pill rules'*. In this extract, a woman has misunderstood what to do with a missed pill. The woman has been using a strategy that she tries to explain to the nurse:

Nurse: OK you do have a 12 hour window period, if you like, to remember to take it, so if you miss it that night you have until 11 O'clock to take it...do you do that?

Woman: No, not really, 'cause the only time I'd really notice I'd missed it is when I come to take it that night and I'd think ohhh! I've not taken Mondays...

Nurse: So you take two together?

Woman: no, not really, I just sort of miss that day completely, so I'd say if I'd come off the pill on Thursday I'd come off on Friday and work it that way, so that's not the right way then?

Nurse: No, its not so good that (Consultation 17)

5.21 *'Regimen'* summary

This section demonstrates that keeping to time is an important element of taking contraception and nurses use a variety of approaches to encourage women to be aware of this issue. Time-keeping is closely linked to the following of regimen in contraceptive use, thus developing the *compliant patient*. The importance that nurses attach to time can be seen in the strategies that are adopted in explaining what can be quite complex time schedules.

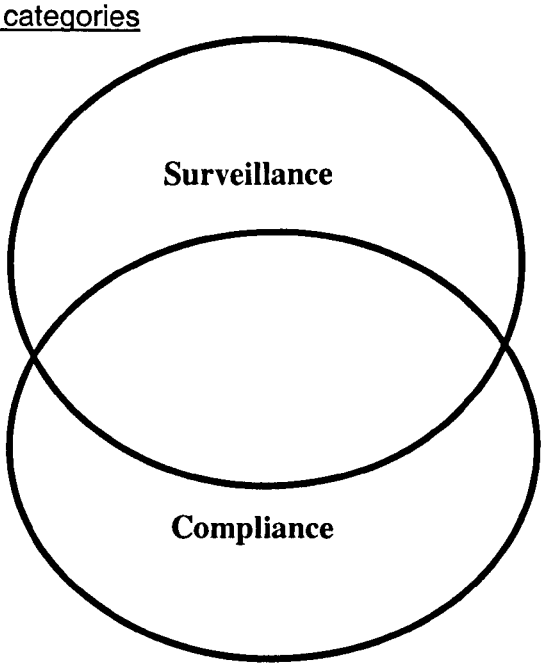
Nurses use the concept of 'rules' to help women to manage their contraception. They also use women's *body knowledge* and *body surveillance* to help explain the importance of time-keeping. Nurses also encourage women to try to integrate contraceptive time-keeping into their daily life, although this encouragement is tempered by the need to stay within the 'rules'.

Regimen also continues the theme of creating the *'active patient'* within the consultations. Women are expected to learn strategies that are often quite complex in order to prevent the breakdown of their contraceptive regimen. As with managing time the use of rules was evident in nurses' advice to women. The management of regimen breakdown also demonstrates how women are required to build on body knowledge and body surveillance in order to manage threats to the effectiveness of their method. It is also evident from the data that the woman's knowledge in this area of contraceptive use is subject led to regular testing during visits to the clinic.

5.22 Core Category formation

Additional analysis of the data was undertaken in order to establish whether or not there was any overarching *core category* that could be considered representative of the three categories; Body education, Body surveillance and Regimen. Careful analysis of the data, from the open codes through substantive codes to the development of categories, leads to the possibility of the categories from the consultation existing in and around the intersection of two core categories: ***'Surveillance'*** and ***'Compliance'*** (Fig. 7).

Fig 7: Core categories



Broadly-speaking, the category *'Surveillance'* reflects those elements of the consultation process that are to do with how the clinic, acting through the nurse, encourages and facilitates the woman to place her own body under a vigilant and knowing gaze. This category also includes the way in which the clinic places the woman under its surveillance through the maintenance of an archive, medical records, and also through measurements, information and behaviours relating to the woman and her body.

The other category *'Compliance'* consists of the elements that are to do with ensuring the woman adheres effectively to her contraceptive method. As part of ensuring compliance, the consultation includes encouraging women to adhere to regimens where there is a need to keep time, and also to manage any breakdown, or *contingency,* that could threaten the effectiveness of the contraceptive method. This category is about the deployment of *disciplinary power in order to create* compliance with regimen.

A more detailed testing of this two-core category framework reveals that, in most instances, the open and substantive codes integral to the three categories can be placed clearly within the intersection of these two core categories, on account of their dual role of contributing to both the development of surveillance and the maintenance of compliance. The main exception to this was the open codes that comprise a significant section of the substantive code *'Body monitoring by the nurse'.* These open codes seemed better suited to a position outside the intersection of the core categories, within *'Surveillance'* only. This additional analysis can be seen for the respective categories: Body Education, Body Surveillance and Regimen in Figures 8, 9 and 10 respectively.

Figure 8: 'Body education' codes within 'Surveillance' and 'Compliance'

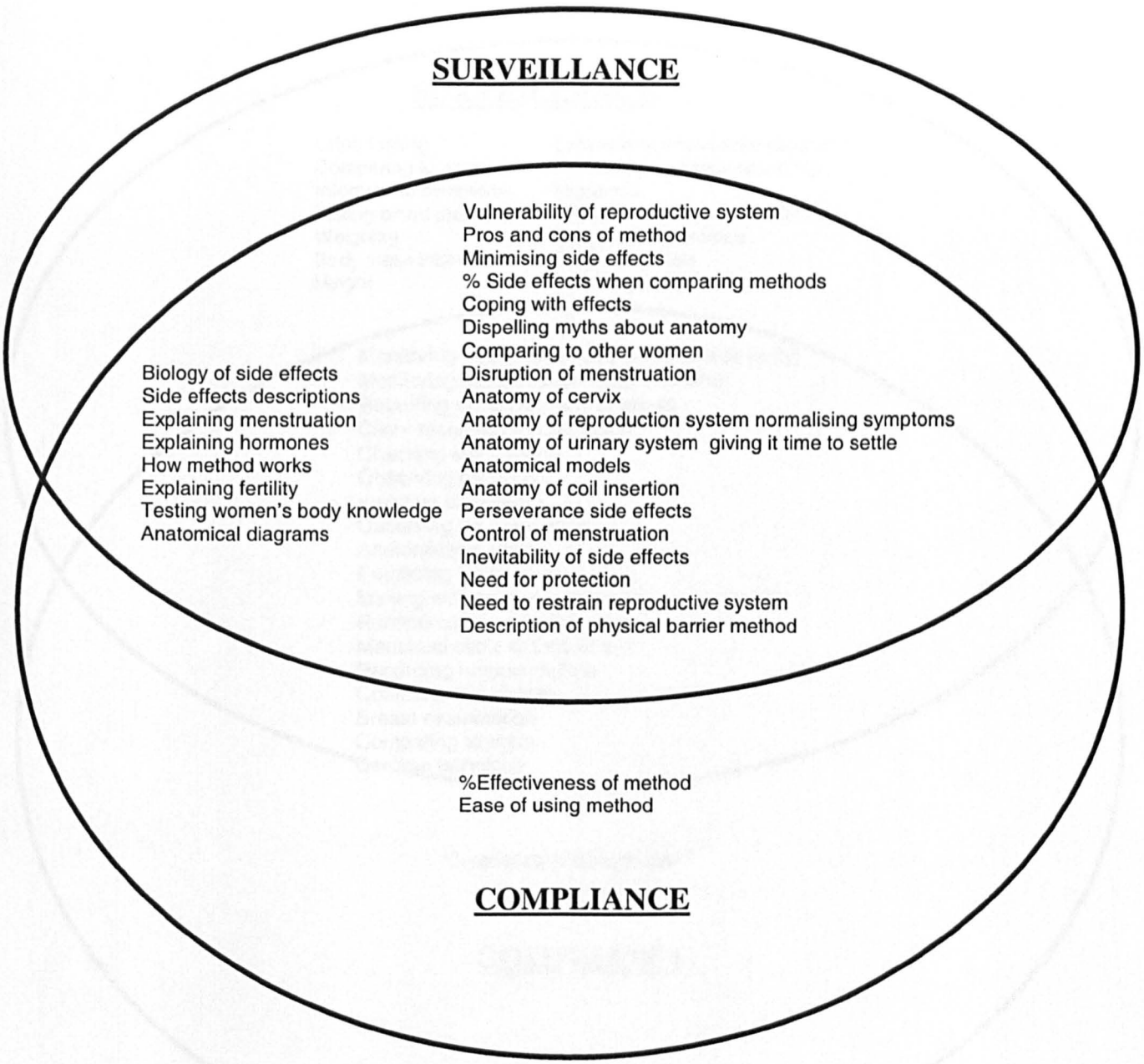


Figure 9: 'Body Surveillance' codes within 'Surveillance' and 'Compliance'

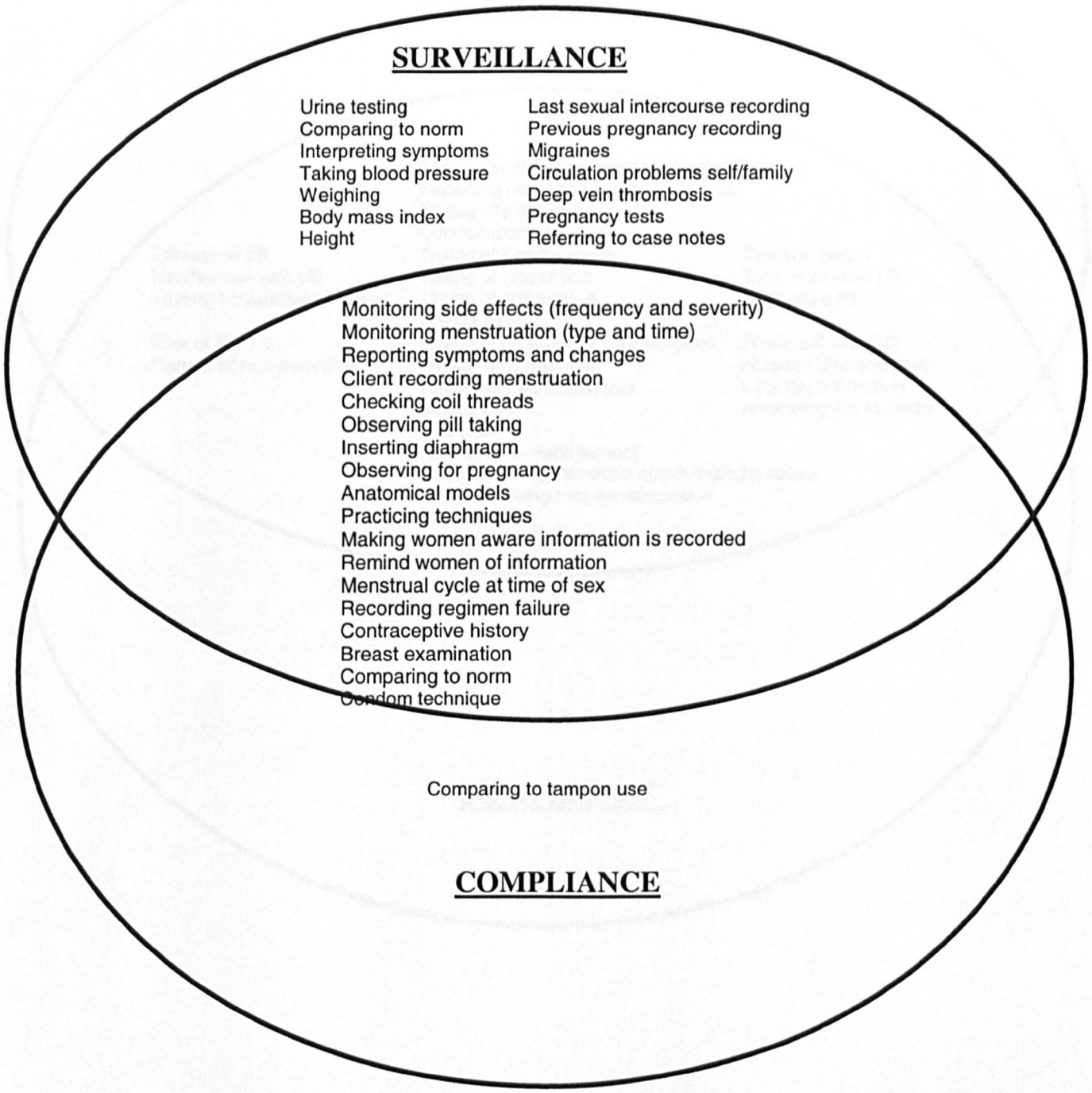
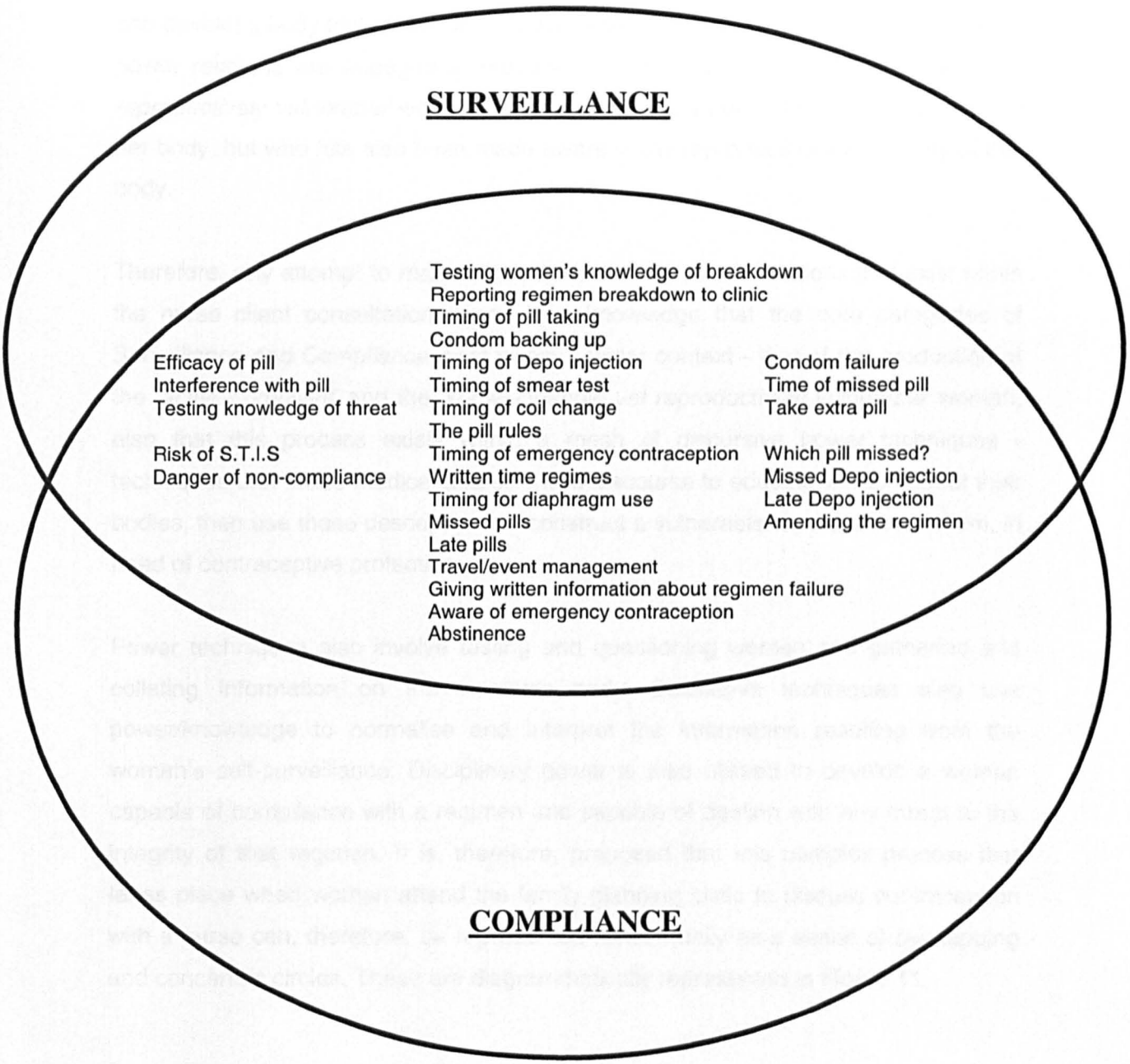


Figure 10: 'Regimen' codes within 'Surveillance' and 'Compliance'

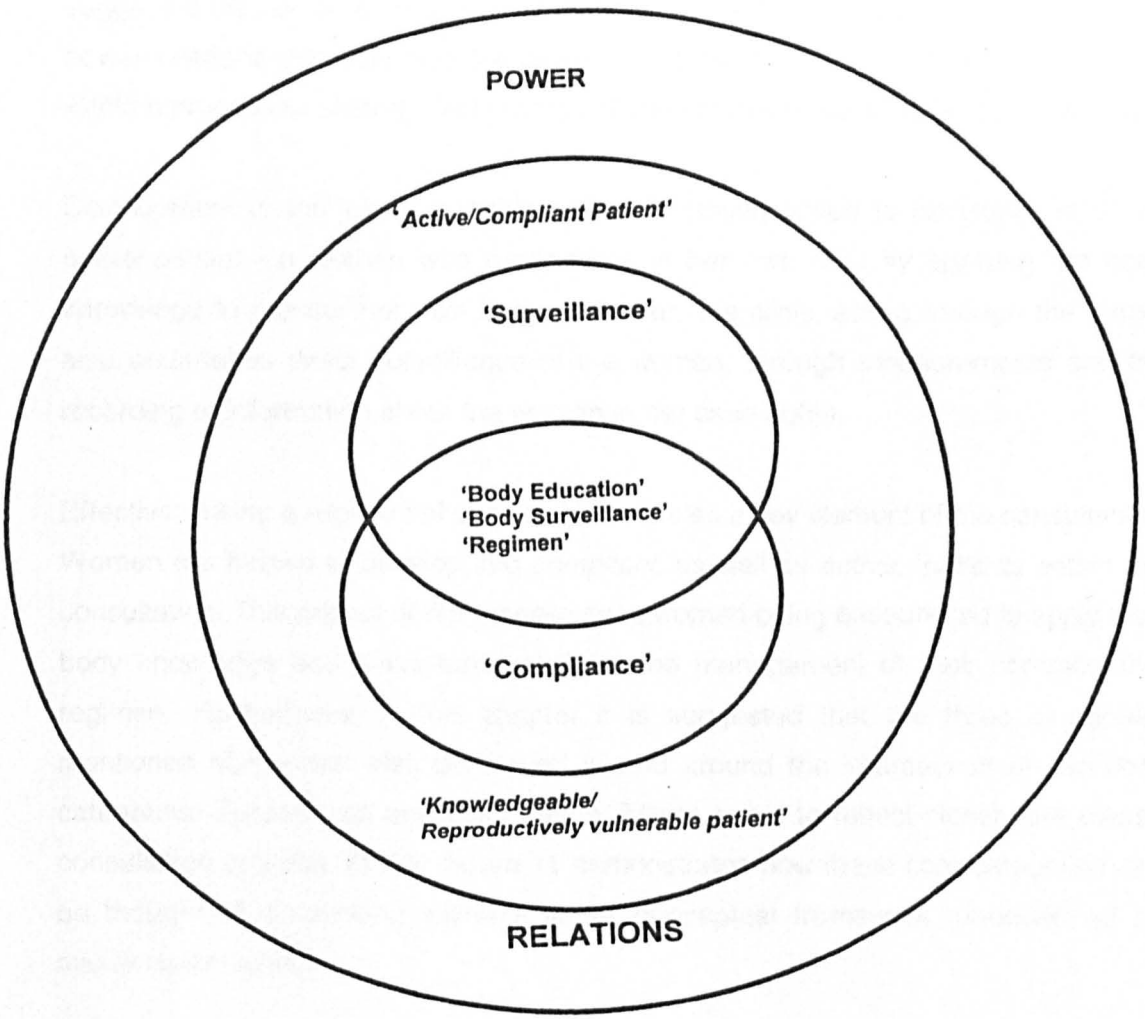


Furthermore, the core categories also exist within a wider system of power relations that are involved in the development of the simultaneously *'active yet compliant'* woman - a woman who participates in the surveillance and monitoring of her body and develops body techniques and practices as part of this surveillance. Additionally, power relations are engaged in producing the simultaneously *'knowledgeable but reproductively vulnerable'* woman - a woman who has been given information about her body, but who has also been made aware of the reproductive vulnerability of that body.

Therefore, any attempt to map out the nature of the power relations that exist within the nurse client consultation needs to acknowledge that the core categories of Surveillance and Compliance exist within a wider context - that of the production of the *'active/compliant'* and the *'knowledgeable yet reproductively vulnerable'* woman, also that this process exists within a mesh of discursive power techniques - techniques that utilise medical and scientific discourse to educate woman about their bodies, then use these descriptions to construct a vulnerable reproductive system, in need of contraceptive protection.

Power techniques also involve testing and questioning women and gathering and collating information on the woman's body. Discursive techniques also use power/knowledge to normalise and interpret the information resulting from the woman's self-surveillance. Disciplinary power is also utilised to develop a woman capable of compliance with a regimen and capable of dealing with any threat to the integrity of that regimen. It is, therefore, proposed that this complex process that takes place when women attend the family planning clinic to discuss contraception with a nurse can, therefore, be represented conceptually as a series of overlapping and concentric circles. These are diagrammatically represented in Figure 11.

Figure 11: Conceptual framework of the contraceptive consultation



5.23 Summary of consultation findings

This chapter presents a framework developed from the analysis of the 49 contraceptive consultations. It demonstrates how women are developed into effective users of contraception by nurses who draw upon discursive techniques, centred upon the three categories of: *Body education, Body Surveillance* and *Regimen.* It is suggested that, when women enter the consultation in clinic they become engaged in power relations that construct the reproductive system as *vulnerable* to pregnancy, within a process of utilising medical/scientific discourse to develop body knowledge.

Development of the knowledgeable patient is closely linked to development of the active patient - a woman who participates in her own care by applying her body knowledge to monitor her own body. However, the clinic, acting through the nurse, also undertakes direct surveillance of the woman, through measurements and the recording of information about the woman in her case notes.

Effectively using a regimen of contraception is also a key element of the consultation. Women are helped to develop into *compliant*, as well as *active*, *'patients'* within the consultation. This aspect of the process sees women being encouraged to apply their body knowledge and surveillance skills to the management of their contraceptive regimen. Furthermore, in this chapter it is suggested that the three categories mentioned above can also be placed in and around the intersection of two core categories: Surveillance and Compliance. These seem to reflect closely the overall consultation process. Finally, figure 11 demonstrates how these core categories can be thought of as existing within a larger conceptual framework, underpinned by micro- power relations.

The next chapter will discuss how these findings relate to the theoretical and empirical literature introduced briefly in Chapter 1 and discussed in more detail within Chapter 2. It will also utilise additional literature to explore the issues generated by the data. It will discuss the way in which these findings can be related to, contrasted with - and make a significant contribution to - the literature on the body and power, particularly utilising the work of Foucault (1981a, 1984, 1986) and Frank (1991, 1995). This discussion, in keeping with a constructivist grounded theory, will be enriched by incorporating data from the interviews conducted with family planning nurses in Clinics A and B.