Behind the Screens
Nursing, Somology, and the Problem of the Body

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When I first began this research for a PhD in sociology in 1985 few people were publicly interested in the issues which are explored here and I became aware very early in the project that I was researching areas on the fringe of respectability. My original supervisor, Terry Leahy, helped me to believe that it was possible to study taboo topics such as excreta, genitalia, and dirty work, and furthermore, that it was important to do so. He provided the intellectual climate which allowed my ideas to take shape according to what my experience as a nurse and the literature told me. Without his assistance I may not have persisted with this area of research. I am pleased I did because I am finding it increasingly fascinating and increasingly topical in nursing and sociology.

I had originally started this project with a vague idea about studying why it is that nurses are so often ignored and taken for granted. As a feminist I had an enduring interest in nursing as women’s work but the more I looked for answers the less I was satisfied with the notion of women’s work as the only possible explanation for nurses’ invisibility. I looked also for some guidance in the literature on dirty work but this did not add a great deal, though it was interesting and useful. In my search for a way of explaining the relative invisibility of nursing care, I kept returning to the notion that some of what nurses did as work was regarded as highly private and it tended, in general conversation, to make people socially uncomfortable. The central notion in all this, when I eventually saw it, was both the presence of the body and the relative absence of any discourse on the body. I therefore came to study the body in nursing more by accident than design. That I stumbled across it, so to speak, is indicative of how taken-for-granted the body is in our everyday lives.

When I eventually turned my attention to the body as my primary focus and the more I read and reflected, the more it seemed to me that the body was the pivotal construct which had the capacity to
explain lots of things about nursing as an occupation. More than that, however, I came to realise that nursing practice is essentially and fundamentally about people’s experiences of embodied existence, particularly at those times when the body fails to function normally.

This research has left me with a very profound and new respect for nurses. I have become deeply impressed with the extent of their sensitivity to the experiences of their patients and I have become even more sceptical about what traditional logico-positivist science offers an occupation such as nursing. The issues which are discussed in this book cannot be reduced to categories of care or levels of illness – they are too rich in both socially constructed meaning and the situations which locate individual experiences in time and space. To that end, I am even more convinced that what separates the (proper) nurse from those who are technically competent to perform nursing care is not what is done, but rather, how it is done – that is, nursing is more a social entity than anything else. I am also more convinced than ever that the debate over whether nursing is (or can be) a science, or an art, or some mixture is really no argument at all. Nursing is none of these, though people are trying to make it look scientific. I think we should get on with the business of articulating what a rich and interesting discipline it is, and just call it nursing.
ACKNOWLEDGEMENTS

I owe a great deal to the nurses who helped in this study, in particular Marianne Murphy, Rosemary McIndoe and Barbara Chapman who all generously organised some of the interviews for this study. Without their assistance my task would have been much more difficult.

The people who agreed to be interviewed require special mention. They not only gave their time freely, they also talked openly about many things which one does not often discuss except with trusted colleagues. I thank them for trust and the information they provided. My only regret is that they cannot be identified and they will not therefore receive the recognition I think they deserve for their skills, their sensitivity, and their ability.

Lois Bryson, who took over my supervision in 1987, was exceptionally supportive, constructive, and encouraging while I wrote the many drafts which a thesis requires.

My thanks also to Judy Waters who had a vision of what my study would look like as a book.
KEY TO TRANSCRIPTS

[ ] added to make the context and/or meaning clear

… words, phrases or sentences of the interview deleted

R. means the researcher

I. means the interviewee

*Italics* are used for interview material
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INTRODUCTION

This book describes a study about the body and social life, how the body is managed by nurses in their work in our culture, and about what I have called ‘the problem of the body’. To the extent that the body and some of its functions have been constructed as private matters, it is a subject which is not readily researchable. Almost by definition, if a subject is taboo it is difficult if not impossible to research. I chose to use nurses’ experiences as a ‘window’ to the body so that we might better understand how the body is constructed in social life and to find out more about the highly private and invisible parts of nurses’ work.

In our society, the body has a fragmented, silent, and ambiguous presence despite an obvious and prominent fact about human beings: they have bodies and they are bodies. More lucidly, human beings are embodied, just as they are enselved. Our everyday life is dominated by the details of our corporeal existence, involving us in a constant labour of eating, washing, grooming, dressing and sleeping (Turner 1984:1).

As a registered nurse, I know that nurses’ work brings them into sustained and intimate contact with people who need help with what Turner (1984:1) calls ‘the details of ... corporeal existence’, and that most patients require some assistance with the body. In requiring and providing that assistance, patients and nurses must socially negotiate the various norms, values, taboos, beliefs and learned ways of behaving with respect to the body, but which need re-definition in the context of reduced individual independence. And they must socially accommodate the body as a physical and biological entity. In order to manage these aspects of life and nursing practice, nurses must first know about taken-for-granted rules which govern the body in social life and about the ways in which their role as nurses is assigned a particular place in the social ordering of the body.
‘The problem of the body’ is a function of two things – the organization of knowledges and a way of life which has rendered the body private and silent. The emphasis on empiricism, abstract knowledge and increasing specialisation in the sciences (and academia generally) have resulted in a theoretical and epistemological fragmentation of our corporeal and embodied existence. ‘The problem of the body’ means, therefore, that, although a social and human body is integral to our existence, no discipline has yet overtly, explicitly and theoretically accommodated it, except in pieces. The body has been subjected to reduction and so too has our knowledge and experience of the body in social life. Our understanding of the body has been constructed in terms of the separate body and mind and not one entity of body and mind.

The physical body is the subject matter of a number of disciplines, for example, biochemistry, physiology, pathology, and medicine. More recently, the body has become the focus of attention for new disciplines, such as ergonomics, kinesiology, and chiropractic, each of which takes a particular, specialised and usually scientific, view of the body. Although these disciplines, to a greater or lesser extent, take account of social factors, they share a common framework which is fundamentally mechanistic, reductive and empiricist and they view the body as an objective reality. Such a viewpoint leaves little space for other aspects of lived existence, such as feelings and emotions, except to the extent that these things can be understood as biologically determined processes – albeit processes which can be influenced by social life.

As the physical body has been increasingly fragmented by the organisation of knowledges, so too has the mind and non-material aspects of being. Several disciplines, for example, psychology, education, neurology, sociology and psychiatry now concern one or other aspect of how we think or behave. Although these disciplines acknowledge physical being, they are nevertheless fundamentally concerned with social organisation, individual behaviour and group processes which leave little space for the body.

The organisation of knowledges, as we currently know it, pivots on differences and on methodologies which institutionalise those differences. One consequence of this process is that territorial boundaries are established and maintained between disciplines. Works which attempt to cross these boundaries do not cause a shift
in the organisation of knowledges because such works are conceptualised as ‘interdisciplinary’ or ‘multidisciplinary’. Questions which do not reflect the existing organisation of knowledges or dominant paradigms and methodologies are variously labelled ‘non-scientific’, ‘applied’, or ‘practical’, among other things – locating them beyond the margins of legitimate and mainstream scholarship.

Becoming an accredited knower of the world – an academic, a scientist, a scholar, a nurse – requires one to learn ways of seeing, ways of knowing and ways of sharing that knowledge. That means operating within disciplinary boundaries and procedures established over the last two centuries in Europe and North America by upper-middle and upper class white men (Hubbard 1988:6).

More recently, however, feminism and the works of Foucault (1974a, 1974b) are beginning to challenge thinking about the construction of knowledges. Feminists have been particularly and generally critical of established disciplines and their boundaries, especially where they are sexist if not misogynist (see, for example, Oakley 1974, especially Ch. 1, Ashley 1980, Spender 1981, Strathern 1985, Harding 1986, Longino 1988, Haraway 1988, Keller 1988, Genova 1988, Caine et al 1988). These critiques raise questions about why certain boundaries exist between disciplines, what processes maintain them, what is admitted or excluded as legitimate knowledge and why; and they focus attention on the consequences of our construction of knowledges.

The study reported in this book is an attempt to illustrate that the existing disciplinary framework and reduction of knowledges will not accommodate the body in social life and that ‘the problem of the body’ is in part a consequence of a configuration of knowledges which excludes it. I will argue, however, that nursing can, and does, necessarily and inevitably accommodate the body and corporeal existence, but that, for various reasons, the body’s presence in nursing literature has been implicit, subsumed and privatised. In nursing practice, though, the body is very explicit and known in a way which is integrative of mind and body and which emphasises embodied existence in everyday life. ‘The problem of the body’, however, is such that nurses’ work presents them with some very real social difficulties both in practice and in social life and it presents theoretical difficulties for the discipline and its relationship to other disciplines.
This research is about those difficulties and about the ways that nurses deal with them and it is an attempt to explicate the body by drawing on the experiences of nurses whose work involves helping others with the ‘constant labour of eating, washing, grooming, dressing and sleeping’ (Turner 1984:1). Nurses call this ‘basic body care’ but in the context of a patriarchal society, it is work typical of the domain of women and it is classical women’s work (see Finch & Groves 1983). What is reported here is, therefore, about nursing practice and work associated with the caring roles of women. It is also about aspects of corporeal and embodied existence which have been privatised and designated as dirty work in social life and which have therefore also been largely ignored in academia.

Existing explanatory frameworks and methodologies do not adequately accommodate the body within the social sciences and neither has nursing yet accommodated it theoretically or methodologically, although there have been some attempts (Benner 1984, 1988, Parker 1988, Gadow 1980, 1982, Colliere 1986, Wolf 1986a, 1986b). Such attempts have not made the body their central and primary concern as I have done here, but they have contributed to a process which will, if it continues, acknowledge the body as a pivotal concern for the practice of nursing. However, nursing has been ambivalent about the body both with respect to ideologies and practice and in putting ideologies into practice.

Nursing’s discomfort with the body not only reflects prevailing attitudes but it also reflects a construction of knowledges and an emphasis on empiricism which do not make a space for the body. This study is an attempt to make such a space by moving beyond the macro level sociological analyses of nursing, such as those which take women’s work and dirty work as organising theoretical frameworks. While an understanding of nursing as women’s work is useful at a macro (structural) level it does not provide us with a mechanism to tap the everyday experiences of working nurses or what they take for granted about the ways in which it is possible to have privileged access to other people’s bodies. The dirty work framework is also useful for understanding nursing because it too can provide a macro level perspective, but the dirty work construct does not really establish why some jobs are considered dirty and others not, given that dirtiness does not necessarily inhere in tasks designated as dirty.
Through the ‘window’ of nurses’ work experiences of the body we can better understand the body in society, not only in the sense of how women’s traditional roles have involved caring for others (which is central in nursing) but also how that is done when the work in question is designated as ‘dirty’ and when it is taboo and hidden from public view. This study, therefore, attempts to analyse things which feminists have identified as typically sex-typed female tasks and roles which have been limited by an inadequate space in which to articulate them – in the sense that they are of low status, unrecognised, undervalued, privatised, invisible, and unproductive (in an economic Marxist sense). As well, it is a study of highly sophisticated and subtle social skills which nurses (mostly women) have developed to deal with what they know is potentially or actually embarrassing, threatening, frightening, and unfamiliar for patients. In essence it is a study of the privatised and professional everyday working lives of nurses and hence it is about things which are not available to public scrutiny or to the average sociological researcher.

METHODOLOGICAL ISSUES

Macro level analyses provide us with abstractions of everyday life but the knowledge nurses accumulate through the experiences of dealing interactively and intimately with people is not abstract knowledge – though it is possible to draw abstractions from it. When nurses deal with the bodies of other people they operate from a knowledge base which is interpretive, contextual, and integrative of object and subject – it is what I have called a somological approach. It is the sort of knowledge which comes from practical professional experience. I wanted to tap that professional knowledge in order to build an understanding of the body in society. This study was conducted, therefore, with five major methodological challenges:

(1) It was about taboo and hitherto largely invisible and unresearched topics;

(2) It was about the details of professional nursing practice which concern the intimate aspects of other people’s bodies and lived experience during illness, recovery and dying, in which case it is a sensitive topic;
(3) It was a study conducted about a subject which has inherent epistemological and theoretical difficulties and for which there is no one single adequate methodological framework;

(4) The subject matter is familiar to me in the sense that I know about these things in a way which had not yet been translated into language, that is, it is about the things I had learned to take for granted as a nurse and which I now wanted to be made explicit; and

(5) I was researching the knowledge of nurses who were predominantly expert practitioners and who cannot always easily describe what they know.

Each of these five factors had direct implications for the theoretical and methodological approach which the topic demanded. However, my background as a nurse allowed me access to the knowledge which nurses have and in that sense one of these constraints could also be advantageous if I could use it in conjunction with established and appropriate methods of research.

Because nursing practice is heavily influenced by experience, the researcher must share the same professional experience in order to decide what questions to ask nurses, if indeed the researcher wishes to get at the very essence of nursing practice. This is a study which must be grounded in more than abstractions and observable reality because nurses may not deliberately think about their practice until someone like me asks them to explain why they do certain things – that is, to explain what they take for granted. Additionally, because I was researching silent, taboo and hidden aspects of social life the methodology would need to allow for that. One persistent feature of research involving nurses’ work is the extent to which researchers have asked the ‘wrong’ questions (see Lublin 1984). There is also a general trend in research in the health care area which results in nurses being ignored, undervalued or invisible. Oakley (1984:24) noted this when she ‘confessed’ (her term) that during a ‘... 15 year career as a sociologist studying medical services’ she had ‘been particularly blind to the contribution made by nurses to health care’.

My research was designed to explore very deliberately what nurses know and take for granted. As a consequence of my own professional background, my research questions were derived not only from the literature but also from my experience as a nurse and a researcher. I was interested in the generalised social methods which
nurses use to manage the body. Some of these methods help to structure situations so that they become manageable for the patient and for the nurse at times when high levels of intimacy and trust are required. They are also designed to manage embarrassment. Without these methods nurses’ work would be impossible.

Research questions

The research questions centred around one pivotal theme – what made nursing care socially possible, what were the major obstacles in transgressing normal social rules and what normal social rules are suspended or alternatively, which context specific rules apply in nursing? In effect, I wanted to know how nurses construct a view of the body which allows them to function as practitioners whose role involves transgressing taken-for-granted rules governing normal social relations and the body in ‘civilised’ society. I wanted to explore the specific problems created by this rule-breaking (if indeed it was rule-breaking) and the practices which are employed to counter or manage such situations when rule-breaking concerns the body.

Specifically I wanted to know:

(1) How, in becoming nurses, they overcome what they have been socialised to believe about the body, body exposure and body accessibility in our culture;

(2) What they remember of the first time they performed body care for another;

(3) What occupationally-specific methods they learn which facilitate doing their work, especially those aspects of it which are invasive of the body, and which therefore give rise to potential and actual embarrassment;

(4) How the context of care is constructed so that it is socially permissible to touch the body to provide nursing care;

(5) How nurses negotiate the social territory of doing for patients what they would normally do for themselves in private;

(6) How they manage when they must touch those parts of body which are proscribed and how they construct these encounters with patients so that this level of intimacy is possible;

(7) How they manage sexuality and sexual behaviour during body care and what they do when the situation becomes problematic;
(8) How they manage the body care of dying patients and the dead body;

(9) How they care for others when the tasks to be performed are potentially or actually nauseating or truly awful;

(10) How they help people cope with a dysfunctional, disfigured, deformed, or damaged body in illness experience;

(11) How they recognise embarrassment and manage it;

(12) How they purposefully and deliberately help patients with situations that would generally be considered embarrassing;

(13) How patients make the nurse’s job easier or more difficult during body care and what particular patient behaviours facilitate or hamper the nurse’s activities;

(14) How they manage an occupation which concerns aspects of life normally kept from public view and not discussed openly and which may be considered dirty or sexual;

(15) How they manage nursing care of the body when the patient has a high public profile or high status.

The questions I had posed would be difficult to answer, not only because they concerned delicate and sensitive subject matter, but they also concerned the very basis of nursing practice – that is, the things which nurses seem to do routinely in the course of their everyday practice. The questions, therefore, appeared to be both very complex and simultaneously very simple, but they raised very difficult methodological problems. How is it possible, for example, to research things which are by nature hidden and around which there is considerable silence? How is it possible to make explicit those things which nurses take for granted? How is it possible to start research in an area where what is known is not written down or explicitly articulated?

THEORETICAL CONSIDERATIONS

The specific theoretical backgrounds which informed the research approach to this study are drawn from grounded theory, ethnomethodology and Garfinkel’s (1967) notion of disrupted social order – a specific technique within the ethnomethodological framework. The particular research techniques employed to collect the data were chosen to take account of the methodological problems
outlined above. I combined observation (of different types) and in-depth interviews and the interviews were adapted to take account of the sensitivities of the topic.

The application of this particular combination of theoretical and research approaches takes account of the inadequacy of studying nursing only in a logico-positivist way and of the need to document what has been unexplored. As a first measure it was necessary to study nurses in their ‘natural’ surroundings and to plot the major concepts and parameters of their daily work, and later, to ask them to explain (in so far as this is possible) what they do and why. In this sense, however, I had the added difficulty of the lack of theoretical space for the body – I could not study the body within any particular theoretical stance because the space for such work did not exist.

Grounded theory, therefore, offered great potential for my topic because it provides the framework for starting almost from a blank slate, so to speak. It allows the researcher to inductively build a theory about the social world by allowing the field to inform the course and theoretical outcome(s) of the research. It does not necessarily impose on the researcher any preconceived ideas about the eventual nature of any theory which might emerge from the work, though, I am sceptical about the notion that the researcher goes into the field without any preconceived ideas at all. Field and Morse (1985: Ch. 1) see great advantages in grounded theory for nursing. This is particularly so for those

who are attempting to identify unknown or unclear phenomenon [because] the current state of underlying theory development in relation to research questions of relevance to nurses require that more attention be paid to the development of concepts and the reality of the context in which they occur (Field & Morse 1985:6–7).

Grounded theory provided the scope to theorise areas of social life which have not so far been well studied and where I had little to lead me, other than literature which told me the topics I wanted to explore were dealt with largely by silence and invisibility. One of the fundamental principles of grounded theory, as Glaser and Strauss (1967) described it, is that it allows theory to arise from data. It is a way of generating theory which is grounded in data taken from real and naturalistic settings. It is, in this way, a very pure kind of theory because it does not presuppose any particular perspective or way of
looking at a problem. It was ideal for my purposes because I wanted to study nurses going about the ordinary everyday business of nursing care. While it was possible to follow the fundamental processes of grounded theory which Glaser and Strauss (1967) outlined (that is, by using theoretical sampling and comparisons from different sources, memo writing, generating theory and verifying it), grounded theory alone would not allow me to focus my attention on how, exactly, nurses manage their work. Ethnomethodology, though, provides an approach which is not only philosophically compatible with grounded theory, but which also allows the researcher to concentrate on the ways in which people actively make their social lives manageable and meaningful. Not only that, it emphasises the particular social (interpersonal and intrapersonal) strategies (methods) which contribute to a meaningful construction of social life, and I was particularly interested in the strategies which nurses use.

The combination of ethnomethodology and grounded theory provides a solution to the difficulty of working on subject matter where little is known but where there is a simultaneously need to know how nurses manage the demands of body care in ‘civilised’ society. Grounded theory provides the framework for generating theory while ethnomethodology contributes the perspective whereby the researcher focuses on how people make sense of the world and what rules they assume underlie the taken-for-granted. In the context of nursing, normal social rules are somehow suspended in relation to body exposure, physical intimacy and touch. This is where Garfinkel’s notion of disrupted social order is applicable. Sharrock and Anderson (1986:29–33) describe how Garfinkel became famous for devising ‘experiments’ where he and his students deliberately disrupted social order by breaking taken-for-granted rules, such as behaving inappropriately in familiar contexts. These experiments were designed to make social rules explicit as organising elements of social life in which one assumes a high level of mutual understanding about what it ‘normal’. It is not considered ‘normal’, for example, for people to subject themselves to the sorts of practices which nurses engage in with patients – rather, nursing takes place in a specific context and it is constructed as such. Although it is common sense knowledge that nurses do certain intimate things, the particular details of their work is highly privatised and not necessarily widely known unless people have had personal experience of hospitalisation.
Nurses are allowed privileged access to other people’s bodies, but how is it possible for nurses and patients to relate to each other if there is a disruption of the normal social rules which apply in society generally? This was a fundamental question, which, if answered, had the potential to illustrate how the body is constructed and managed in social life. Even allowing for the occupationally specific latitude given to nurses in their professional role an analysis of their work had the potential to yield valuable information about the body in ‘civilised’ society because nursing is practised in particular cultural context; it is not a de-culturised activity.

**Research design**

The study was conducted in two major stages and it took place over a four year period. The first stage involved two kinds of observational data collection to identify and code the major concepts in the form of a working theory. This particular approach was adopted because, firstly, little was known about the subject matter of the study, and secondly, there was a need to observe the natural setting of nursing practice in order to start identifying fundamental practices and concepts. Field and Morse (1985:75) argue that in circumstances such as this, observation allows access to events which may not be explored in interviews because the interviewees may not think to tell the researcher – that is, they take them for granted.

This working theory and its component concepts formed the basis of the second stage, that is, in-depth interviews with 34 nurses. From these interviews I refined the working theory into a grounded theory of the management of the body in nursing – what I came to call *somology*. The interviews were constructed on the basis of the theoretical sampling (Glaser & Strauss 1967:Ch. 3) from the observational work. These interviews allowed me to talk with the people whose work I had been observing and to ask them to explain, in as much detail as they could, how their work with other people’s bodies was managed as a social and professional process.

A qualitative approach, using both observation and interviews, and taking ethnomethodology and grounded theory as my philosophical and theoretical context, allowed me to make taken-for-granted aspects of nurses’ work explicit and, in the case of the body where so much silence exists, to establish a dialogue between the researcher and the researched which is essential. Such a dialogical approach is necessary
because ample evidence exists (see Lublin 1984 for example) to illustrate that interactive methodologies are required for researching some aspects of nursing practice.

The combination of research methods I selected provided a way of maximising the validity and reliability of my theory. My observations and the concepts I derived from them were validated and refined repeatedly as the interviews proceeded and I asked experienced nurses to tell me how and why they did things – the interviewees were a test of validity and reliability because I had to present to them for verification the things which I had observed and which I theorised were taken for granted in their everyday working lives. In doing this, I had to cause them to think through and put into words what they knew – a process which requires a high level of reciprocity (Schutz 1962).

The observational data, therefore, served to establish the baseline concepts which were explored in detail and refined, particularly in respect of the rules which operate in nursing care of the body. They also formed part of a triad design consisting of observational data in which I was firstly a visitor and secondly a patient, and of interview data. There was, therefore, a triangulation of methods – a process which enhances the validity and reliability of the study and which contributes to the ability to generalise from it.

THE OBSERVATIONAL DATA

As a ‘native’ (Schwartz & Jacobs 1979:48–49) of hospitals it is easy for me to gain access to the field and to become part of the local environment. As a known nurse and academic my presence in (some) hospitals is not unusual, although the purpose for my being in a particular place at a particular time usually requires explanation. In order, therefore, for me to do a block of field work for this study I needed a good cover because I did not want people to know I was ‘making observations’ or ‘doing research’. I did not want anything unusual to appear to be happening while I focused my attention on this aspect of the study. The known observer can, by his or her presence, disturb the natural environment which causes a change in normal behaviour (Field & Morse 1985:79) and consequently the researcher can record unreliable data.
There was, however, an ethical issue to be considered if I was to do unobtrusive (covert or secretive) observational work. Some authors (for example, Field & Morse 1985:76) believe such measures are never defensible, however, others disagree. Lofland and Lofland (1984:21-24) argue that one needs to consider what they call ‘open’ and ‘closed’ settings as well as whether or not the researcher is engaged in covert activities. They define ‘open’ settings as places where ‘in law and tradition’ any person ‘has a right to be’, such as airports and bus stops, whereas ‘closed’ settings are defined as those where not just ‘anybody’ can go and where the researcher needs to negotiate access (Lofland & Lofland 1984:21–22). In my case, my setting fell somewhere between the two – I was concerned with a relatively open place (a hospital) but where not everyone has a ‘right’ to be. That is, one is expected to have some specific purpose to be in a hospital, but in the Australian context, they are relatively public places.

The question of secrecy was clarified well by Roth when he observed that

All research is secret in some ways and to some degree – we never tell the subjects "everything". We can escape the secrecy more or less completely only by making the subjects participants in the research effort, and this process, if carried far enough, means there will be no more "subjects". So long as there exists a separation of the role between the researchers and those researched upon, the gathering of information will inevitably have some hidden aspects even if one is an openly declared observer (1970:278).

Roth (1970:279) also highlights that we are, as social scientists, always engaged in the process of observation.

Most of us, in fact, never cease observing the social sphere about us and are continually interpreting the behaviour of people about us. Some of these observations are systematically organized into a ‘research project’, but most of the observations and interpretations are casual and are never recorded. But there are obviously all levels of observation and interpretation between these extremes and the appropriate place for a boundary line remains a moot point (Roth 1970:279).

I had been doing small pieces of observational field work as I went about my normal work-related activities (such as doing some hospital-based work in relation to my normal teaching responsibilities), but I also needed some time to be an observer without the distractions which come from being a participant-as-observer (see Field & Morse
The ideal opportunity to do some sustained field work arose when a close friend required relatively major surgery and she was admitted to a small private hospital. Both of us were known to many of the staff so my extended visits over a five day period were not seen by them as unusual. I spent the time not only doing the things one does when visiting friends in hospital, but also making field notes and marking assignments. My cover remained intact, although some staff wanted to know how I could have a job which allowed me, seemingly, never to work. To these people I replied that I had brought a batch of assignments and that I could mark them anywhere.

While I was well aware of the ethical considerations inherent in using this situation for collecting data, I was also legitimately in the field as a visitor and it was inevitable that I would find this time rich in ideas and data and that it would contribute to my thinking on the ways in which nurses manage other people’s bodies. I took advantage, opportunistically, of a naturally occurring event. Lofland and Lofland (1984:23) take the view that there are very serious, perhaps damning, ethical problems in all covert research if the presumed immorality of deception is the overriding concern. Deception is no less present in public and open setting research than in preplanned, ‘deep cover’ research in closed settings. On the other hand, if other concerns are also important (for example, lack of harm to those researched, or the theoretical importance of a setting which can never be studied openly), then we can find no more justification for abolishing all deep cover research, preplanned or not, than for abolishing secret research in public settings.

Because the opportunity to do some valuable field work had presented itself I was particularly observant and made notes on things which I needed to explore more thoroughly. My primary role, however, remained that of visitor and friend to the person I was visiting and my status as researcher was secondary. In this situation I could be both a friend and visitor and simultaneously I could be a researcher because my reflections on the way people behaved toward me (as a visitor) was the very stuff of my research project. It was naturalistic research in real and uncontrived circumstances. Before I progressed to any further data collection, however, I talked with the Director of Nursing of the hospital and told her about my note taking. This did not surprise her because I was known as an avid people watcher anyway, and I was simply being my ‘normal’ self.
As a visitor, I was able to observe the daily activity from the viewpoint of a researcher and ethnographer. During this time I was able to identify and develop many of the ideas which formed my working theory and which I later explored in the interviews. For example, I knew that nurses preferred to do much of their work without relatives and visitors present and that they usually asked them to leave the room when they tended to the patient. This practice also extended to me, a known nurse, but also a visitor and, to the staff, my status as visitor was dominant in this context. On several occasions I was asked to leave while various care procedures were conducted. There were some exceptions to this when I was very well known to the attending nurse and had an established relationship extending over many years, but even then some staff were not comfortable about my presence and I waited outside the room during various nursing activities. I was able to explore this more fully in the interviews which followed.

This period also enabled me to identify what appeared to be a taken-for-granted trajectory toward recovery and I identified the signals which nurses took to mean that a patient was, or was not, progressing at the perceived ‘normal’ rate. This trajectory was accompanied by a re-negotiation of how dependent the patient was on the nurse for assistance with body care. As the patient regained independence, nurses invaded less and less of the patient’s body space, inquired less about a range of body functions and the level of surveillance was progressively reduced. During this time I also noted that both language and the manner of discourse about body products and body functions were problematic. Not only was there a need to talk to patients about things which patients would not normally discuss, such as bowel movements, but this was also an ever-present difficulty for all parties and it required particular management. As a nurse I am familiar with the problem because of my own experiences, but I was interested to locate the problems of language and discourse in a more interpretive and integrative social framework. I was able to observe that ‘civilised’ body functions required a style of discourse which ensured at least partial privacy and later I explored this more fully in the interviews. These five days of observation, which covered the period of admission to discharge of the person I was visiting, contributed to the scope and content of the interviews which followed. Several months later I had another opportunistic occasion.
for some field work when I was admitted to hospital for elective surgery. Although this event was unrelated to my research project, it was inevitable that my experience would contribute to my research as had been the case of other sociological researchers who found themselves admitted to hospital and the temptation for recording their experiences was irresistible (see Fairhurst 1977, Hyndman 1985). I took the opportunity to reflect purposefully on my own experiences (as a patient this time rather than a nurse or visitor/friend), to make field notes and, when the opportunity arose, to talk informally to some of the staff about aspects of nursing practice. Strauss (1987:11) says that such experiential data ‘not only give added theoretical sensitivity but provide a wealth of provisional suggestions for making comparisons, finding variations, and sampling widely on theoretical grounds’. They contribute also to the formulation of ‘conceptually dense and carefully ordered theory’ (Strauss 1987:11).

However, in contrast to others who have studied the experience of patienthood through their own experience (Fairhurst 1977, Hyndman 1985), I am, as a (sometimes) practising nurse, very familiar with routines in hospital life. I was able to concentrate more on the social aspects of these routines and on my own reactions and feelings.

I was hospitalised for ten days during which time I required little assistance with anything after the first two days so I had plenty of time for observation and reflection on my own experiences. During this time it became apparent to me that the nature of the nurse-patient relationship and ‘the manner’ of the nurse were central to the management of the body and its various functions, embarrassment, and the patient’s sense of vulnerability. I was also able to further develop the concept of the recovery trajectory. I later explored each of these observations in the interviews.

THE INTERVIEWS

A semi-structured interview schedule (developed from the observations data and from the literature) was trialed with two colleagues (both academic nurses), one male and one female, both of whom are familiar with the methodology I was using. No major changes seemed necessary so I proceeded to interview an additional 32 nurses. I was later to discover, however, that because of what was being revealed in the interviews, my schedule had not addressed the issues of sexuality and its relationship to nursing as explicitly as some
of the interviewees indicated it should have. These constant comparisons (Glaser & Strauss 1967) contributed substantially to the refinement of my theory of somology and produced minor modifications to the interview so that sexuality became more centrally tied to the notion of embodied existence and body management in nursing. I was aware when interviewing, of the difficulties Oakley (1981) encountered when she studied the experience of childbirth because, in her case, the textbooks had provided little guidance for the immediate and practical difficulties she faced when her interviewees looked to her for support and information during labour. I expected that many of my interviewees might not be comfortable with the subject matter I wanted to discuss, particularly issues related to sexuality and sexual expression, which was one topic area which caused me to deviate from textbook models of interviewing.

At the time of commencing this work I was not aware of any literature other than Oakley’s (1981) work that helped the researcher interview people on sensitive and taboo topics. I sometimes found myself in situations where I knew I was talking about things which are highly sensitive and often regarded as very private matters. At these times I was delving into subject matter akin to incest and rape because I was asking about things which make women feel vulnerable, exploited and sometimes guilty. As a researcher one does not go into such matters without considering the potentially traumatising (or therapeutic) effects of discussing such issues. I had to be very careful how I asked certain questions. For example, if I asked ‘have you ever been sexually harassed by a patient?’ the answer was usually ‘no’. But if I asked if they had experienced situations where patients had made sexually explicit and uninvited advances toward them, or touched them in intimate ways, the answer was often ‘yes’ and they related instances about particular patients. I was later to discover that Cowles (1988) had experienced similar difficulties; she had called these ‘sensitive topics’ and they required the researcher to take a much more empathic and supportive role than is usually suggested as appropriate.

Language selection was also difficult at times and while the texts often stress the need to use language familiar to the interviewee and they emphasise the importance of phrasing the questions to fit the interviewee’s frame of reference, there is little to help the researcher to talk about some of the things that were relevant to my study. I
occasionally found myself relying more on my training and experience as a nurse than on my training and experience as a social researcher, though the two share many common elements.

In deviating from the (recommended) detached stance of the researcher, I became involved in discussions about topics which carry a sometimes heavy emotional burden and which are issues for us as nurses. It is not possible in such circumstances to retain the role of the researcher all the time, rather, it follows that in such encounters people talk as fellow members of the same professional group. In my study, that was a necessary component of the research process and it is not possible to talk only in the roles of researcher and ‘researchee’.

Later, when it came time to report my data analysis, I also took notice of Cowles’ (1988) comments on the methodological difficulties of studying sensitive topics, in her case the surviving friends and relatives of murder victims. She described how the textbook does not always help researchers who are dealing with emotionally charged and sensitive issues. Though Cowles’ (1988) work was not published until after I had collected my data, it confirmed my experience that what has been written in textbooks on interviewing techniques has, in the main, excluded the sorts of situations and issues in which I was interested. That is, they have avoided discussing the emotions which often accompany research of this kind and they have generally not been helpful for the researcher who is exploring topics which people normally do not discuss. In some interviews, therefore, I sometimes had to lead and probe and look for non-verbal signs, rather than rely only on verbal interaction. The discomfort that was sometimes apparent when I asked about some topics supported my view that the body is a problem in our culture and that researching its management in nursing is a sometimes delicate matter.

I was also later to read Cannon’s (1989) report of the ‘emotional pain’ of interviewing people about stressful and sensitive topics. In her case, she was concerned with women undergoing treatment for breast cancer – a process she described as requiring compromise and negotiation because the textbook models of qualitative methodology did not allow for what she encountered. She explains how she quite specifically made an emotional input into her encounters with the women she interviewed in order to establish the trust she needed to find out what it felt like to have cancer of the breast. While my study did not involve the level of emotionality one would suppose Cannon
(1989) experienced, I was, nevertheless, asking about highly sensitive and emotional matters – the sort of things people often do not want to tell anyone.

To adapt the interviews specifically to suit my subject matter, I asked questions about areas of practice where I suspected the interface between professional culture and ‘normal’ social culture would be in conflict. For example, if nurses had to care for people they knew socially, would this represent a disruption of social order as Garfinkel’s experiments had (Sharrock & Anderson 1986:Ch. 3)? When they first started their professional careers it would be reasonable to expect that they would transgress what they had learned about the underlying rules about the body in society. I wanted to problematise these times in order to identify the social rules – a process which Garfinkel had used successfully.

Another adaptation I used was to tell the interviewees about what I had observed in my field work and ask them if they could tell me about the reasons for various practices, such as sending the relatives and visitors away. I also outlined a small scenario (which I later came to call *minijisms*) to explore one very specific way in which nurses make the body manageable. Having outlined the scenario I asked the interviewees if they could tell me why nurses did such things and what functions they had. Their responses (and the scenario) are discussed in detail in Chapter 7.

**The interviewees**

The sample of 34 interviewees consisted of 27 registered nurses (2 of whom were retired), 2 students in their third (and final) year of a pre-registration diploma program, and 5 enrolled nurses. There were 4 males and 30 females, making the male/female proportions approximate to those in the Australian nursing workforce generally. They ranged in age from 19 years to over 60 years (the precise age was not revealed), with the largest number (N=13) being in their 30s, and about equal numbers in their 20s (N=8) and 40s (N=7). They were all either engaged in, or had previously been engaged in clinical roles.

The interviewees have a wide range of experience which covers all areas of specialisation in nursing, but because I was predominantly interested in the adult body, the sample does not include many with
extensive experience in children’s nursing, although there are several who have worked in this field. The sample was chosen so that all areas of specialisation were covered, and in favour of those with at least 5 years experience of clinical practice. The 2 participants who had less than 5 years experience were students. They were included in order that all current groups in nursing could be sampled. (The mean number of years of experience = 14.33, s.d. = 8.41 years).

The reasons for sampling from more experienced nurses were: firstly, I believed that they would be more comfortable with the socially sensitive areas of their work; and secondly, I wanted to sample as many expert practitioners as possible (see Benner 1982a, 1984, Benner & Tanner 1987, Benner & Wrubel 1988) because they would be more likely to articulate the more subtle aspects of practice and I was interested in what they had learned from experience. It is a reasonable cross section of the nursing workforce, although skewed in favour of more experienced nurses.

As a group, they were a well qualified sample of nurses, with thirteen of them having tertiary education. With respect to the nursing qualifications of the registered nurses all were registered to practise general nursing, 12 were also registered midwives, 5 held qualifications in the acute care/intensive care/coronary care area, and 2 were registered to practise psychiatric nursing. In addition, 3 held certificates in mothercraft, 1 in ophthalmic nursing and 1 in orthopaedics.

They revealed a strong bias toward British ancestry with English being the most common in this sample. The ethnic backgrounds of those I interviewed had some influence on their early experiences as nurses because of the way they were socialised at home (discussed in Chapter 5).

THE DATA: HOW DO NURSES MANAGE THE BODY?

In keeping with the grounded theory process I had adopted for this project, data analysis began very early in the study with memo writing and preliminary and provisional theory building during the periods of field observations (Strauss 1987:Ch.5, Glaser & Strauss 1967) and it continued. In grounded theory, data analysis is an ongoing process – it is inductive and therefore the theory is never completed, rather, one
gets closer to an accurate theory the more data are analysed and verified.

When it came to analysing the data I became aware that they did not fit models of knowledge that I had been taught to see as a social scientist. Nonetheless, the data ‘felt’ familiar to me as a nurse. I became aware that what I had researched was not knowledge which nurses had ‘received’ as some ‘objective’ reality, but knowledge derived from and accumulated through personal experience and practice. It was not immediately easy to describe in discrete thematic ways.

It became apparent from the data that sexuality was a major problem, particularly male sexuality, and that this was intimately connected to the way maleness and masculinity are constructed. I had made several memos early in the project about the need for sexual matters to have a prime place in my theory, and throughout the collection and analysis of the interviews sexuality increasingly emerged as a difficult area for nurses. Consequently, it has been incorporated here as a central consideration for a theory of the body in nursing.

Each of the other major themes in the data has been taken as the organisational basis for the chapters which form Part II of this book and they illustrate how the body is fundamentally and essentially a genderised and sexualised construct around which many aspects of social life are organised. So important is sexuality/body in our culture and so central is it to nurses’ work that it recurs as a theme throughout the following chapters.

The theory of somology which is described here is an attempt to draw some more general conclusions about the body, in particular, how it features within a theoretical construct about the work of nurses. In this way, the theory can transcend the data.

The book is in two parts. Part I is a critique of the nursing and social science literature on the body. Chapter 1 examines the literature on the body in nursing theory and practice. Chapter 2 examines the ways in which the body has been conceptualised and theorised, particularly in philosophy, history and sociology. Chapter 3 discusses aspects of social life in which the body has been explicitly studied in relation to what Norbert Elias’ (1978) called the ‘civilising process’, and in anthropology and psychology. Chapter 4 analyses the intimate relationship between the body and sexuality. These four chapters are
crucial to understanding the research data because they not only provide the essential background for understanding the nature of what was studied, but they also establish an awareness of the complexities of the body in social life and the sensitive nature of the issues that are explored in the chapters which form Part II. These early chapters, therefore, formally state the context in which the data are to be understood and they provide a rationale which attempts to illustrate why empiricism and reduction will not lead to an adequate understanding of the body in social life. Chapters 5 to 10 analyse the empirical work for this study. Chapter 5 is a general introduction to what nurses learn about the social management of the bodies of others, how that learning compares with their socialised patterns of relating to others, especially as it concerns emotional control and language. Chapter 6 details specific methods which nurses learn as part of their occupational socialisation and professional practice and which make their work socially acceptable in the context of hospitalisation and it deals with the structural and organisational aspects of that sociology of body. Chapter 7 analyses the more interpersonal and existential aspects of the practices which Chapter 6 describes. It also illustrates, in more detail, the somological approach to the body which nurses use. Chapter 8 deals specifically with the temporal dimensions of who controls the body during its ‘handing over’ from patient to nurse in illness and dying, and its ‘handing back’ from nurse to patient in recovery. Chapter 9 is concerned with sexuality in nursing and the problem of the sexualised body. Although sexuality is a feature of discussions in other sections of this study, Chapter 9 examines this issue in its own right as a central problematic of the body for nurses. Chapter 10 shifts the emphasis from ‘the problem of the body’ within nurses’ work, to the wider social and public consequences of that work because of the underlying ‘problem of the body’. As is the practice with material of this kind, the data are reported verbatim from transcripts of the interviews. I resisted the temptation to sanitise or launder some of the language and I expect some people may find parts of it offensive in this ‘civilised’ society of ours. I decided there was no point in continuing to hide the body and its management from public view, especially in a study where I am attempting to make that aspect of social life more explicit. Furthermore, the language which the interviewees use is often so graphic that any attempt on my part to ‘clean it up’ would detract from its impact.
From my own viewpoint, I had to overcome a sense of (learned) inhibition in order to report some of the material. In particular the data which deal with very basic aspects of human existence, such as excreta, are not regarded as appropriate topics of conversation in most social settings. Throughout the course of this research, when I have been asked what I am studying, I have become acutely aware of the need to choose my words carefully when I describe what I am doing. For instance, if I said I was researching a sociology of the body, people did not know what that meant. If I said that I was interested in how nurses managed other people’s bodies and body products I often perceived that some people (non-nurses) were reluctant to pursue the conversation any further. Some, however, were intrigued by what I was doing and expressed great interest in the project. I am aware, though, that I have been researching a taboo topic and that there are possible negative consequences of that for me (see Faberow 1963). For example, there have been instances over the last five years when people have indicated to me that the things I was researching were best ignored and kept private.

The following chapters attempt to explain these reactions in relation to ‘the problem of the body’. Nurses, whose work involves them so intimately with the body, are also members of society and they are not immune from the beliefs and norms which influence social behaviour.

**Postscript to the study**

There are several interesting events which occurred in the aftermath of this research. Some of these events were deliberately constructed by me in order to test reaction to my analyses and some events were spontaneous. I modified some of my concepts and terminology in response to comments made by two of the interviewees who read an advanced draft of the data analysis. I have talked to others, both formally and informally about what I was researching. What is reported here is, in part, a reflection of their reactions as well as my analysis of what the data mean to me.

In response to people’s reactions I revised the chapters which concerned the notion of somological practice because while the two interviewees knew well what was intended in this concept and they liked the term, they argued that the way I had described it then, was perhaps too subtle for anyone other than a nurse to understand and that this was because of the very reason I was arguing – that it is not
received and objective knowledge. I also used the word ‘privatised’ in place of Elias’ (1978) term, ‘civilised’, to more accurately reflect the way in which the body is dealt with in social life. The notion of ‘civilisation’ is not as descriptive as ‘privatisation’ and the latter is more applicable in nursing contexts.

The issue of sexuality (and its relation to sensuality) is by far the most interesting and intriguing aspect of this research and I have but scraped the surface. I recognise now, with the benefit of hindsight and experience, that the sample does not adequately represent the views of men in nursing and that this is a function of the extent to which the male body is fundamental to notions of maleness and masculine power and to patriarchy. It would therefore be useful for a similar study to be conducted by a male researcher with male nurses. There is also an unexplained atmosphere of fear about the sexualised body and there are some ways in which we view the body which can only be described as mysterious and superstitious. This is true not only of women in their dealings with men, but it is also probably true for men (according to one person – a male) because men react to the power of women’s reproduction, the mysterious and hidden organs of reproduction – and most of all, the hormones!

There is a mystery about the body and the power of sexuality which this study has hinted at and which is worthy of further investigation. It is similar in many ways to the mystery and fear which surrounds death – an attitude which would seem to have some of the characteristics that might be expected in a non-industrialised and non-scientised culture. My analysis of this material has left me with the firm impression that, with respect to the body, we are culturally very superstitious and fearful or, at the very least, discomforted by the body in social life. I do not know why that is so, nor do my data give any indication of likely reasons beyond the possibility that our dominant world view promotes science as the most powerful way of knowing, yet science is deficient when it comes to knowing about death. And while science has illuminated some aspects of embodied sexuality, it has almost entirely focused on objective reality and not existential reality (personal meaning, physical experience, sensuality and the like).

There are a number of recurrent themes in this research. First, there is the extent to which men have power over women, how this is often expressed bodily, and how male and female bodies are conceptualised
differently. As one person remarked, ‘male bodies are seen in terms of power, the female body in terms of its problems. The only good thing about the female body [in the perceptions of men] is if its worth looking at or fucking’. Another recurrent theme is the extent to which nursing knowledge and nursing practice do not fit comfortably into positivist scientific frameworks and will not do so until there is a paradigm shift. Such a shift may come with changing societal attitudes to such things as the value of work that women and nurses do. A third theme is the invisibility of nurses’ work and the relationship of this to women’s work in general and to the privatised body in particular. Again it is recognised that such invisibility is likely to continue until such time as there is a shift in our cultural definitions of acceptable public behaviour with respect to the body.

A fourth theme which recurs is the problem of language, not only in reference to privatised bodily functions, but also with the inability to articulate what nurses do when they practise. The analyses of the term, ‘doing nothing’ is seen as a particularly vivid illustration of this problem.

A fifth theme, and one which is potentially controversial in nursing, is the notion that somological practice is not necessarily holistic. For me to argue that nurses, especially experienced and expert practitioners like those interviewed for this study, do not practise holistically is to attack an ideological cornerstone in nursing. These data, as I analyse and interpret them, do not support the idea that nurses practise holistically (meaning that they consider all aspects of a person – social, biological, medical, pathological, spiritual, psychological, and so on). The data, however, do support the idea that expert nurses acknowledge the embodied existence of their patients, that they take account of the person as well as the body, and that they integrate various aspects of patients’ and nurses’ experiences of giving care into a composite and integrative view. They consider what is relevant and they make judgements about what is relevant based on the context of the particular circumstances (patients and situations) with which they are concerned. To me, this is something quite different from caring for ‘the whole person’ (whatever that means) in a way which encourages surveillance and a comprehensive survey of the patient’s nursing (read social and life) history.

In addition to the follow-up interviews, I have talked to groups of students in pre-registration and post-registration nursing programs at
the university where I work. I have outlined my data about embarrassment, the management of nakedness and intimate body care, dying and recovery and its relationship to the ways the body is managed and I have talked about sexuality in nursing practice. Without exception such sessions have been followed by requests from students that we concentrate more on these topics. The students want to learn more about the social management of the body. Clearly there are educational implications of this work for nurses.

During some of these teaching sessions I have been told by some of the young male students that sexual harassment is not just a problem for their female colleagues, that female patients sometimes ‘accidentally’ touch the nurse’s genitalia during body care, that this is not uncommon, but men tend to laugh about it. It is not taken seriously by the men although they may be surprised by it when it happens. It seems that female advances where body contact is initiated by women provokes an altogether different reaction from men than is the case when men touch women. This is a topic for further research and one which is beyond the scope of my data.

I have also had many opportunities to talk informally to non-nurses about what I have been researching and almost without exception people have wanted to talk about their experiences of hospitalisation. This has been a rich and fascinating experience for me because men have talked (and seemed to have a ‘need’ to talk) of their sensual and sexual confusion during body care episodes which felt nice and comforting but which they also found pleasantly arousing – an arousal which they felt to be social inappropriate. They talked of not knowing how to behave toward a nurse, particularly one who was young and warm and attractive and who did such sensual things to a man’s body, as wash and massage his back.

Like any research, this study has raised many questions and it has identified many areas for further work. One of the most obvious is the need to talk with patients about similar things which I discussed with nurses and I have started to explore this area; there is a need to talk more about these things with nurses who are male; there is an obvious area for further research in the areas of sexuality and its relationship to embodiment; and there is a need to more thoroughly explore so called ‘basic’ nursing care, that is, body care. For example, how does it feel, existentially, to be dependent on and to be handled by, others?
One of the most neglected and potentially valuable areas for further work is in the area of how nurses view their own bodies, their illnesses, their experiences as patients themselves and their need to sometimes be dependent on others. My own experience as a patient, which is reported in Chapter 7, caused me to comment not on how my medical care would be managed but how I would be nursed and how I would respond to that care. Though I have not reported it here, some of my interview material contains comment on nurses as patients – they represent one of the most problematic groups to nurse. A number of intriguing questions could be explored. Why, for example, do nurses generally make either the very best or the very worst patients? Do they, as I did, recognise the vulnerability associated with being a patient? Why do they sometimes neglect their own bodies and delay, often dangerously, seeking attention when they are ill? Why are they sometimes so stoic as patients and why are they sometimes the opposite? Why do they worry about whether or not they will be ‘good’ patients? What worries them about their own experiences of patienthood and why and do their own experiences influence the way they practice?

Notes

i Empiricism is taken to mean an approach to the development of knowledge which: (1) relies fundamentally on human experience; (2) is able to be communicated in language – a necessary condition for the dissemination of ideas; (3) is usually, but not always derived from some form of deliberative research which is typically experimental in design; and (4) has come to share a relationship with positivism such that empiricism is assumed, in dominant ideologies of scientific knowledge, to require positivism. As a consequence, empiricism tends to produce knowledge which is reductive but which can be readily shared because it concerns those things for which there is some objective reality. Empirical research, as I define it and use the term here, is taken to mean the range of ways and methods by which it is possible to know and construct ‘reality’ (however it is defined by individuals) because all forms of experience contribute to perceiving and constructing reality. Although certain physiological capabilities are a necessary condition for empirically knowing the world, what one comes to regard as knowledge is a function of interaction between the biological and social.

ii The 1986 Australian census shows that of those qualified in nursing 0.46% also hold an award at the level of bachelor, and 1.89% at the level of diploma.
It is important when dealing with samples of registered nurses to take account of the area in which they practise. In Australia there have been several categories in which it was possible to register as a nurse (general, psychiatric, mental retardation, midwifery, geriatrics, mothercraft) and additional specialty areas, such as intensive care, where it is possible to hold additional qualifications. While there is variation in emphases in what (precisely) is practised among and within specialisations, there is also considerable commonality among areas of practice.