‘Healthy Eating’: Lay and Professional Perspectives in Scotland

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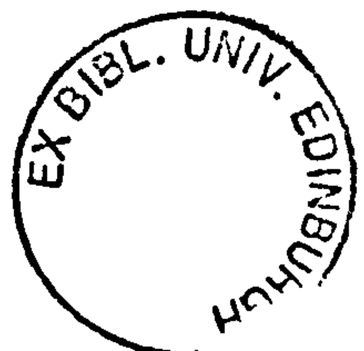

Abstract

By exploring both lay and professional perspectives on 'healthy eating', this thesis aims to identify the socio-cultural processes which are relevant to understanding the potential for general practice as a setting for providing 'healthy eating advice'. Lay views of 'healthy eating' were explored in relation to their everyday lives, so that their views on advice provided in the general practice setting could be understood within this broader context. For the general practitioners, the focus was upon their professional views of 'healthy eating' work, how this related to their 'personal' views on food and eating, and how this may influence any advice they do provide. The study used qualitative methods based on semi-structured interviews with 30 lay respondents. These were all married couples with primary school aged children, who did not suffer from any chronic disease or illness and were in social classes 3, 4 and 5. 15 general practitioners were also interviewed (8 female, 7 male) and recruited to represent a range of different ages.

The interviewing and analysis of the data were based upon a social constructionist methodology, which draws upon the traditions of ethnomethodology and phenomenology. To unpack the taken-for-granted status of social processes and these respondents' understandings, the data were analysed inductively to generate theory that was grounded in the data.

Analysis of the lay interviews revealed that lay concepts of 'healthy eating' are deeply embedded within everyday understandings of health and subsequently 'health' is only one priority that explains why people eat what they do on a day to day basis. The lay respondents also distanced themselves from different types of 'healthy eating advice', by evaluating it in relation to 'common-sense' understandings of the relationship between food and health. Although a distancing process was also applied to evaluating the general practitioner's role in this area, they questioned the legitimacy of 'healthy eating' as a discussion topic because they felt that a GP's role was to treat illness.

The analysis of the interviews with general practitioners revealed they also drew upon certain 'models' of general practice to evaluate the potential of the setting for providing 'healthy eating advice'. Their accounts revealed contrasting enthusiasm towards preventive work more generally. It was apparent that these 'models' appeared to influence how these general practitioners talked about what preventive work their profession should be undertaking. However, these 'models' also appeared to influence how they talked about their own experiences of the 'healthy eating advice' they did provide.

The thesis makes both practical and theoretical contributions to understanding the potential of general practice as a setting for providing 'healthy eating advice'. It argues that the implications for health promotion theory and the practical success of programmes to improve dietary inequalities, are centred around a need to understand the views of all the parties involved.

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Declaration

In accordance with University regulations, I declare that this thesis is my own work and has not been submitted for any other degree or professional qualification:

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Acknowledgements

According to Paul Theroux, the Chinese say that "Investigation may be likened to the long months of pregnancy, and solving a problem to the day of birth". I started writing this thesis in January and so it seems rather apt to suggest, that some nine months later, this thesis has been submitted. However, this thesis is the result of three years work and would not have been possible without the support and assistance of many people.

At its conception, my PhD was funded by the Chief Scientist's Office of the Scottish Executive Department of Health department and the award was obtained by my supervisors. I would like to thank Kathryn Backett-Milburn and Jane Hopton for their committed support over the three years and meeting my demands to submit this thesis on time. It was a demanding journey for all of us, but I thank them especially for their thoroughness and attention to detail.

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I must also thank all those who provided support on the sidelines. I'm sure my family will be delighted to see me return from my "Ivory Tower". Many friends also provided much needed support. My flatmate Gareth had to put up with my constant mess around the flat, although thanks to him and the friends and family who made sure I never became a mess myself! Finally, thanks to Alex for the proof reading.

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1 Introduction

1.1 General Introduction

A quick glance at any British newspaper reveals that information about food and health is a contemporary issue. Yet in general, both Keane (1997) and Murcott (1999) agree that national campaigns appear to have been unsuccessful in their aims to reduce diet related disease and obesity. In reviews of healthy eating policy in the UK, these authors suggest that throughout the 20th century and up to the present, British governments have conceptualised dietary change as a consumer issue, rather than a state or industry responsibility. Concerns, however, have shifted significantly - from a focus on malnutrition in the 1900s - to the development of nutritional theories in the 1950s. While the earlier focus may have been on achieving and maintaining 'strength', since the 1970s attention has shifted to 'diseases of affluence'; such as heart disease, cancer and diabetes. This has subsequently resulted in a focus upon diets which are high in fat, sugar and salt, and low in fibre. Keane (1997:175) also importantly argues that "The perceived necessity to limit the costs of state health care has formed an increasingly significant element of government rhetoric during the 1980s and 1990s". A key feature of which she argues is an overall emphasis upon 'personal responsibility', and 'informed choices'.

Health targets for the population in terms of reducing fat and sugar content have also been a key feature of government policy and successive British governments have frequently stressed the need for healthy alliances between the government, the NHS, voluntary groups and employers to achieve these. This more general summary also aptly describes the Scottish context, where the *Scottish Diet Action Plan* launched in 1996 (Scottish Office 1996b:7) has been described as the backbone for a health promotion strategy to tackle Scotland's poor diet related health record (Lean and Anderson 2000). The plan recognises the needs for all members of the community to be involved, specifies dietary targets and also makes a number of recommendations aiming to make the country's "men, women and children healthier, through a better diet". This it claims, is because "The conditions to which poor diet and obesity give rise are, in health terms, burdensome to treat, poor in outcome, and more common in Scotland than almost anywhere else."

A recent 'White Paper' on health (Scottish Office 1999:21) also stated that: "The Scottish diet is notoriously high in fat, salt and sugar and low in fruit and vegetables. Next to smoking, our diet is the single most significant cause of our poor health". Scotland has the

highest mortality rate from CHD in the European Union and the second highest for women. Women in Scotland also have the highest rates from cancer, while men have the second highest rate (Scottish Office 1988). Although a recent report said that life expectancy in Scotland continues to improve slowly (Scottish Executive Department of Health 2000a), it also stated that Scotland is still lagging behind the majority of comparable Western counties by some two to three years.

During the 1990s, policy makers therefore emphasised the need for health education initiatives to address the relationship between Scotland's diet and the country's poor health record (Scottish Office 1993; 1996a; 1996b; 1997; 1999). Although it has been recognised that many different approaches are needed to tackle the 'Scottish diet' problem (Scottish Office 1996b), doctors have been identified as a key resource, because

> *"The medical profession has a crucial leadership role in most areas of health care and health promotion. For this reason, it is particularly important that Scottish doctors should appreciate the extent to which dietary inadequacies contribute to Scotland's dismal health record and the potential role of dietary changes in improving the health both of individual patients and of the population as a whole (1996:96).*

Another report referred to how a "GP can tackle healthy living issues in the context of a routine consultation" (Scottish Office 1998:53).Therefore echoing claims made some twenty years previously, general practice was again being described as a 'natural setting' (Calnan and Johnson 1983) with 'exceptional potential' for preventive work (Stott and Davis 1979). There has certainly been increasing support for GPs and colleagues to have a greater degree of involvement in preventive activities, an emphasis strongly supported by professional bodies such as the Royal College of General Practitioners (RCGP 1981) and in UK government policy, particularly the *Health of the Nation* (Department of Health 1992).

Although recognition of the role of general practice in health promotion appeared to have arisen prior to the health service reforms of the 1990s (Beattie 1990), the 1990 changes, were nevertheless according to Hopton (1996), a significant development. The 1990 changes to the *General Practitioner Contract* linked health promotion to financial incentives, however in 1993 the system was substantially reformed, narrowing the scope of health promotion with an emphasis based primarily upon coronary heart disease prevention. Payments were targeted specifically on the basis of risk factor interventions, leaving this policy open to the accusation that it was based upon a narrow model of health promotion, neglecting broader social and environmental factors (Hopton 1996).

These concerns have led to further changes in the contract which were made in 1996, aiming to allow practices to develop their own plans for health promotion and payment of a

quarterly fee upon approval of a 'health promotion committee'. Even taking on board more recent changes in the late 1990s, it appears that current provision of healthy eating advice is a decision left to individual GPs and practices. In terms of the criticisms of healthy eating advice policy in the UK outlined by Keane (1997:176) above, this appears to reflect what she calls a "laissez-fair attitude". UK policy therefore has instead left healthy eating decisions to the market place, where information appears to be provided in the context of personal responsibility.

1.2 Exploring lay and professional perspectives

While there appear to be many reasons which make general practice an appropriate setting to change dietary habits, this thesis adopts a more critical and reflexive position. International evidence for example, indicates that preventive health interventions are more likely to be successful if they are based on detailed understanding of local customs and social structures (Fieldhouse 1986). Indeed, this new 'preventive ideal' in general practice has also been critically labelled as another form of 'creeping medicalisation' – that is, another attempt by the medical profession to enhance its professional status (Armstrong 1979). Furthermore, despite the emergence of this 'preventive ideal', Williams and Calnan (1994:373) for example, argue that there may be "a considerable discrepancy between the rhetoric of prevention, as espoused by the Governenment...and professional bodies...and the reality of prevention and health promotion at grass-roots level within general practice."

Therefore, it has been suggested that not only do general practitioners (GPs) need to more adequately understand the perspective of their patients (Backett *et al* 1994), but there is a further need to complement lay understandings with the views of those who have to provide this advice (Williams and Boulton 1988). Hence this thesis will argue that, if programmes to improve dietary inequalities are to be successful, then there is a need to understand the views of *all* the parties involved.

As such, this thesis contributes to one specific area, within a much wider need to adequately review the practice of health promotion in the light of social theory (Beattie 1991). Recognising the complex relationship between the categories 'lay' and 'professional' (Freidson 1970; Blaxter 1990), this present study concentrates upon the social context of lay health concepts and the disparity between everyday 'lay' and 'professional' understandings of preventive advice. For Backett (1996), this is not simply a matter of whether one account is 'true' and the other is 'false', but that they are related to two different *levels* of accounting practices and should be recognised as such. Thus by exploring both 'lay' and 'professional'

perspectives on 'healthy eating', this thesis aims to identify the socio-cultural processes which are relevant to understanding the potential for general practice as a setting for providing 'healthy eating advice'.

The purpose of the remainder of this chapter is to introduce the main body of this thesis, by briefly reviewing the thinking behind the approach taken and then putting the findings into a broader research context. I will begin by focussing on the theoretical ideas which underlie the methodology of this study.

1.2.1 Contextualising 'lay' and 'professional' knowledge

This research is primarily focused upon the context outside the general practice setting. This I will argue, is because the approach taken recognises that the processes relevant to understanding lay views of 'healthy eating' are embedded within their everyday lives. Supporting this theoretical position, a multi-layered research design was developed to explore the contexts in which both perspectives were constructed.

The methodological approach taken consisted of three different layers of exploration, which structured the way I conducted each research stage. The first two of these layers apply to the lay context and the third to the GP's perspective. The first layer therefore explores lay understandings of 'healthy eating' within the context of everyday life. This then provides the background to the second layer, which explores the lay perspective on 'professional' concepts of 'healthy eating advice' (including how these relate to the general practice setting). Finally, in the third layer, the lay views are complemented by exploring the perspectives of GPs. However, the idea that GPs are enculturated within a wider social domain (Williams and Boulton 1988) seemed to be particularly relevant to a focus on food and eating advice. Hence it was decided to explore both their 'personal' and 'professional' understandings of 'healthy eating'.

1.2.2 Everyday understandings of health relevant to 'healthy eating'

For Backett *et al* (1994), health promotion policy and practice needs to be theoretically informed by the social processes which influence lay understandings of health. These ideas are very much at the heart of the approach taken to this thesis, but their origins are rooted in a sociological tradition that has placed a sustained emphasis on the 'everyday' and taken-for granted nature of human knowledge (Schutz 1970; Garfinkel 1967).

It has been argued, that a family context is an important setting in which lay views on health are located (Backett 1992b). Moreover, by approaching their accounts of 'healthy eating' as being related and relevant to their understandings of health, this thesis therefore considers

how 'health' may be only one priority (Calnan and Williams 1991) which is relevant to understanding why people eat what they do on a day to day basis. Using these theories to interpret the data, both *Chapters 6* and *7* reveal the gendered context in which family meals are provided. They explore how in the majority of households in this study, the role of 'feeding the family' was assumed by the female respondents, and where a tacit understanding of 'health' appeared to be construed as a form of 'caring for'. It was apparent that women had to face a number of conflicting requirements brought about by providing these meals. However, 'healthy eating' was an issue that appeared to be absent from these women's accounts, where the priority was instead given to managing a number of 'inconveniences' by relying heavily upon pre-prepared foods.

Chapter 8 explores how lay respondents constructed 'healthy eating' within the context of their everyday lives. While the chapter argues that 'professional' concepts do play a role within lay accounting practices, respondents' understandings of the relationship between food and health were deeply embedded within a broader conceptualisation of a 'balanced diet'. The chapter therefore explores how these ideas about 'healthy eating', which were constructed around the theme of a 'balance', can be viewed as a further example of how respondents' understandings of 'health' were rooted in their everyday lives. These constructions appeared to help these respondents to make sense of, and routinely manage 'healthy eating' on a day to day basis.

1.2.3 'Healthy eating advice'

Chapter 9 moves towards exploring lay views of the general practice setting, by exploring views on 'healthy eating advice' more generally. The chapter describes the process by which lay respondents distanced themselves from a number of different types of 'healthy eating advice', by evaluating it in relation to 'lay' or 'common-sense' understandings of the relationship between food and health. They emphasised a priority upon their own understandings of food and health, which then formed the basis for how they criticised 'healthy eating advice'.

The last section of this chapter focuses on exploring the idea that GPs should be providing advice about food and health in general practice; the findings suggest that lay respondents also apply their general criticisms of 'healthy eating advice' to this setting. However, it was also apparent that their views were strongly influenced by a particular 'conventional model' of general practice, where they argued that the GPs' role was to treat disease, rather than prevent it.

1.2.4 Professional views

In *Chapters 10* and *11*, I turn to the data from the interviews with GPs, but the central theme of both chapters begins where the analysis of the lay data ended. Like the lay respondents, it was apparent that particular 'models' of general practice dominated these GPs' accounts of 'healthy eating' work and subsequently their views on the provision of 'healthy eating advice'. Drawing upon the ideas of Williams and Boulton (1988), it was apparent that they were orientated towards two different 'representational models' of general practice. While a clinical representation of general practice in the accounts of older and male GPs reflected the views of the lay respondents, the younger and female GPs displayed far greater enthusiasm towards prevention.

Both chapters explore how these different 'representational models' of general practice also appear to shape how GPs talked about the 'healthy eating advice' that they were providing. In *Chapter 11*, I focus more specifically on how this was apparent in the contrasting ways that GPs were evaluating dietary work as professional undertaking. While the chapter explores several different consequences of this process, it highlights the different ways that GPs appeared to use 'personal' experiences of food and eating within their professional work.

1.3 Summary of conclusions

Analysis of both the lay and professional interviews revealed that a number of socio-cultural processes appeared to influence how 'healthy eating' and 'healthy eating advice' were being evaluated. Thus although 'lay' understandings of 'healthy eating' may be influenced by 'professional' concepts and vice versa, the way in which the relationship between food and health was evaluated should be recognised as different types of accounting practices. From the lay perspective, concepts of 'healthy eating' appeared to be deeply embedded within their everyday lives. Consequently, a claim to healthiness was only one priority that explains why people eat what they do on a day to day basis. From both perspectives however, different 'models' of medicine appeared to influence lay and professional views on the legitimacy of 'healthy eating' as a topic to discuss in general practice. Therefore the implications for health promotion theory and the practical success of programmes to improve dietary inequalities focus on a need to understand the views of all the parties involved.

2 Reviewing lay perspectives

To read without reflecting is like eating without digesting
(Edmund Burke, 1729-1797).

2.1 Introduction

This and the following chapter provide the theoretical and empirical background to both the approach taken in this thesis and the findings presented in *Chapters 6* to *11*. In this chapter, I will concentrate on exploring theoretical ideas about the way that lay people understand food and health within their everyday lives. Following on from the position I outlined in the introduction to this thesis, I will therefore be taking an approach which puts an emphasis upon the social context and construction of 'healthy eating'.

To support the structure of the research design outlined in the previous chapter, I begin by exploring a number of theoretical and empirical perspectives on food and health in the context of everyday life. I will then explore the relationship between lay and professional knowledge of food and health. However, the lay perspective on general practice will be left until the following chapter, because I believe it can be more appropriately considered within a wider debate about medical power and 'professionalism'.

Notes on the preparation of the literature chapters: The literature presented here has been compiled through a combination of breaking down the research questions into stages and critiquing each study found in relation to a sociological and social constructionist position on 'health'. Where possible, an online database system *(Web of Science)* was used to search for relevant literature and identify cases where certain studies had been cited elsewhere. A more manual system had to be relied upon to search for book references. The literature cited draws upon a broad range of different disciplinary approaches, but I will critique them in relation to the sociological position on 'everyday life' outlined in the following section.

2.2 Food and health in everyday life: an introduction

In the introduction to this thesis, I argued that international evidence indicates that preventive health interventions are more likely to be successful if they are based on detailed understanding of local customs and social structures (Fieldhouse 1986). Such comments seem to be particularly relevant to the Scottish perspective, because a recent government

report on Scotland's poor diet commented that, "We are not short of advice, and surveys show that most people know what makes a healthy diet and what does not" (Scottish Office 1996b:7). Therefore, sociologists have argued that their discipline can play a key role in informing health promotion policy and practice, because it can help to identify the processes which influence lay understandings of health (Backett *et al* 1994).

Yet if these processes are so important to understanding the effects of health advice, why in relation to the aims of this thesis, have sociologists tended to ignore lay understandings of 'healthy eating'? One explanation may be that this is only part of a wider situation, where an examination of health in the context of everyday life is inadequate (Calnan and Williams 1991). Nevertheless, it has been argued that food, more specifically, may have been neglected, because trying to find answers to explain why people eat what they do is methodologically complex. Warde (1997:180) for example argues that food is a "complex case", because its consumption is universal and most of us eat several times a day without even reflecting on it. Indeed, in support of this observation, it has also been argued that the very taken for granted nature of food may have made this field "invisible to sociologists" (Beardsworth and Keil 1997:2).

Despite these methodological difficulties, the value and priority that people place on health in relation to other aspects of their daily lives, has been theorised as being of central importance to the study of lay health concepts (Illsley 1980). It is for this reason that Backett (1992b:267) argues that lay understandings of 'health' cannot be divorced from the context in which they are constructed, because they are only "one aspect of prioritising and decision making about time allocation in daily life". Although it has also been argued that 'health' may be a major consideration in why people eat what they do (Blaxter 1990), researching the priority given to 'healthy eating' is problematic, because the links which join them together appear to be both subtle and complex ones (Beardsworth and Keil 1997).

2.2.1 Food and health in sociology and the influence of social anthropology

In order to understand the social context of 'healthy eating', the first half of this chapter explores how sociologists have attempted to explain the processes which shape lay understandings of the meaning of food and health in everyday life. This task is not a straightforward one, especially because it has been argued that the sociology of food and health is a developing area and lacks the disciplinary depth and maturity of some other areas of the social sciences (Beardsworth and Keil 1997). Commenting upon this, Mennell *et al* (1992:44) say that medical sociology in particular has tended to "marginalise the

ethnonutritional", which is somewhat remarkable considering how much work there has been on lay health 'beliefs'.

Perhaps the lack of a well-developed sociological tradition of studying food and health, may explain why some sociologists have turned to social anthropology for inspiration. In a recent collection entitled *'Food, Health and Identity"*, its editor (Caplan 1997:3) argues that "food is never 'just food' and its significance can never be purely nutritional", because it is intimately linked with social relations and the meaning of 'health'. Unlike sociology, theories on food and health can be found in the very foundations of social anthropology. Mary Douglas and Levi-Strauss for example have both had a particular influence on sociological thought in this area, by suggesting that the relationship between food and health can be viewed as a language.

Studies conducted within the discipline of social anthropology have suggested that certain rules operate and underlie the food classification schemes of most cultures. For Jeliffe (1967), these include taboos, avoidance and prohibitions, while for Fischler (1986:961), a humoral 'model' of food classification is linked with the concept of dietary balance. Sociologists have developed this work in a number of ways, but have instead placed the emphasis upon how these cultural structures are interpreted in Western countries. Several sociological studies have therefore argued that lay meanings of the relationship between food and health are full of paradoxes based upon these anthropological classification systems. Hence Lupton and Chapman (1995) suggest for example that 'healthy eating' is often conceptualised in terms of dichotomous beliefs around conflicting notions of 'good'/'bad' or 'healthy/unhealthy'.

While such perspectives seem to be close to the position which I have outlined already, Kemmer (2000) warns that the sociology of food must be careful not to lose its sociological perspective. For example, she argues that there is a tendency to underplay the effects of social class and gender in these studies. In this section, I will therefore be attempting to reconcile a number of different debates whilst focusing upon the meaning of food and health in everyday life. Sociological concepts such as class and gender will be considered, along with how these divisions have been reconsidered in the more recent postmodern turn. Therefore in line with the social constructionist position adopted in this thesis, I will concentrate upon discussing the social construction of food 'choice' and how 'choice' has been theorised in terms of structure and agency. This tenet of sociological theory (Bruce 1999) therefore provides a sense of continuity as I firstly discuss a shift in theoretical emphasis from social class to consumerism and secondly the sociology of the family.

2.2.2 *From social class to consumption*

Featherstone (1991) comments that frequently in sociological theory, social class is taken to be the source of important social divisions or cleavages. However, he also observes that increasingly these divisions have been accounted for by differences in patterns of consumption – that is, more complex reasons and explanations for why and what people buy. In this section, I want to critique this observation in relation to the sociology of food and health and consider the extent to which there is support for consumption theory - but also how these different perspectives have been reconciled.

Social class, food and health

Warde (1997) says that it is often widely accepted that class used to be the dominant social division to investigate what people ate and cites consumption behaviour based on income in Hosbawm's (1978) description of British proletarian culture in the pre WWII period, Cronin's (1984) account of a homogenous working-class culture in inter-war Britain and Martin's (1981) depiction of traditional working class life in northern cities in the 1950s. The consequences of such diets often included deficiency diseases such as rickets, high rates of infant mortality and poor levels of physical development (Beardsworth and Keil 1997). Thus for Crotty (1999:135), the inequitable distribution on the basis of some form of social stratification "is perhaps as old as human organisation".

Higher socio-economic groups are generally reported to consume a greater range and variety of foodstuffs, which may be more in line with current nutritional thinking than those lower down the social scale (Mennell *et al* 1992). Calnan and Williams (1991) for example provide some more contemporary insights into the process of dietary change and have shown that this process may be more complex in working class households. Mennell *et al* (1992) reveal that in lower social groups, fruit is consumed less, along with higher fat diets and less healthy cooking methods, while they also suggest that middle-class infants are more likely to be breast fed or vegetarian. Complementing some of the investigations into family life that I will discuss later in this chapter, a few studies have also explored the intersection of social class and gender. Calnan and Cant (1990) for example found women were responsible for 'healthy eating' more generally, whatever their social class.

Consumer culture

The notion 'consumer-society' however, embodies the claim that modern societies are distinctive in that they are increasingly organised around consumption, related to rising affluence, the aestheticisation of everyday life, and increasing commodification – to name but a few (Abercrombie *et al* 1984). Warde (1997) argues that although there has long been a

link with consumption theory and social class, particularly that of Marx and Weber, the idea consumption can be envisaged as a corollary of class position is being challenged by more contemporary social theory. Developing the ideas of postmodernists such as Baudrillard and Jameson, social constructionist theorists for example have argued for a reorientation of the personal motivations which underpin culture, combined with an empirical and anti-foundational question concerning the very concept of social class (e.g. Gergen 1971; 1999).

Crotty (1999) for example points out that we cannot assume a simple relationship between diet and income, and there is growing evidence to suggest that economic inequalities no longer generate nutritional inequalities in such extreme forms as they may have done in the past. Beardsworth and Keil (1997:87) therefore suggest that:

"Of greater relevance for the contemporary sociologist are the cultural, economic and ideological differences between social class groupings in relation to food, and the ways in which these differences produce characteristic patterns of food preference and facilitate or constrain food choice."

One such approach on food and health which can be associated with the post-modern turn towards consumption, is the concept of 'lifestyle'. Giddens (1991) for example has argued that people have considerable consumer freedom in how they live their lives and that individuals choose lifestyles from a range of different sources. While they may include some decisions about food and health, it is also in relation to a broader range of their relative benefits and advantages. A good example of the relationship between food and the idea of 'lifestyle', is demonstrated by Kandel and Pelto (1980)'s study of what they refer to as the 'health food movement' in the Boston area of the USA. The authors reveal how the respondents in their study adopted a particular lifestyle in order to lead a more satisfying life, and one which to their respondents could provide an 'alternative health maintenance system' to mainstream food culture.

Another consumerist theme which can also be associated with the postmodern-turn is an increasing emphasis upon the sociology of the 'body'. Drawing upon Foucault, Turner (1991) relates this concept to a growth in consumer culture and argues that the body is subjected to an increasing array of disciplines and rules. Elias for example wrote of how in contemporary western societies, food tastes and habits are highly related to understandings of the 'civilised self' (Elias 1978). For Turner, lay concepts of the body also reveal how individuals talk about *how* their bodies work. So by drawing upon a Cartesian concept of the body, Turner argues that the body represents a 'machine' whose functioning inputs and outputs can all be subjected to precise measurements and quantification (Turner 1982).

Feminist researchers as I will discuss in more detail later in this chapter however, have developed these ideas to argue that many women feel dissatisfaction and guilt about their

bodies (*see* Lupton 1996). Yet the additional pressures on them to provide meals, has led Charles and Kerr (1988:143) to suggest that this provides a further reason why they may see food as "the enemy". As these authors also stress, although eating is not a pleasure for everyone, it is a pleasure that many women have great difficulty in allowing for themselves. They argue that a woman's own individual relationship to food presents a range of contradictory choices. Not only does she have to set aside her own requirements in preference to her family's needs and tastes, but she is also acutely conscious of herself as a female and the pressure to main an attractive body image. However, reflecting an upsurge in men's health in gender studies, Watson (2000) argues for a focus upon on the lay male perspective. In contrast to studies which have focused upon female views, his empirical work identified that many male respondents in his study appeared to present their accounts as a form of resistance to developing 'healthy bodies' (Crawford 1984).

Reconciling class and consumerism

Yet whilst Warde (1997) accepts that food choice may be increasingly shaped by consumerism, he is not prepared to accept the demise of social class and attempts to reconcile structure and agency more satisfactorily. Similarly, whilst patterns of consumption may influence why people choose what they buy, Feathersone (1991) also views the theoretical rise of consumerism with caution and considers the extent to which it can be prioritised as a determinant of everyday life.

In attempting to reconcile these debates, Warde draws heavily upon the work of French sociologist, Bourdieu (1979), who has influentially argued that taste is deeply embedded in class structures. 'Taste' is therefore highly regulated through taken for granted practices which are evident in an individual's sense of appropriateness and validity. While Bourdieu explores how social class influences food and eating patterns, he stresses the ways in which conceptions of taste and actual consumption practices are used to establish and maintain hierarchical social class distinctions. Hence through the concept of 'distinction', he argues that the tastes in food of high-status individuals like professionals and senior-executives tend to be towards "the light, the refined and the delicate" (p185). This he argues serves to set them apart from popular working class tastes for the "heavy, fat and the coarse" (ibid).

Indeed, it is certainly possible to review a number of findings in light of Bourdieu's concept of cultural distinction. Calnan and Cant (1990) for example found that working class families seem closer to traditional meals and ideas, while a similar type of view was also reflected in a study of elderly Aberdonians by Williams (1983). Referring back to the work I discussed previously, Calnan however (1987) found a less clear-cut social class difference than other studies on health in families, and argued that working class women more

frequently drew upon a unidimensonal definition of food and health. By this, he meant that they talked about being able to "get through the day" or that they were "never ill" and "rarely went to the doctor" (Calnan 1987:34). Similar findings can also be found in more recent work by Keane (1997), who interviewed a range of different people from different ages and class backgrounds about their views on 'healthy eating'. Keane also found that working class respondents talked about how not being ill was 'proof' that they were eating well and that a healthy diet will strengthen the body's resources.

Such an approach also brings Abel *et al* (2000) to argue, that Bourdieu's position helps to reconcile debates concerning structure and agency – that is the extent and processes by which people come to choose what they eat. While food can play a role in maintaining class distinctions, these authors believe that Bourdieu raises the possibility that people are choosing foods on the basis that they have particular properties. Thus by consuming certain foods, the eater is incorporated into a culinary system and into the group which practices it. However, Warde is concerned that in the world described by Bourdieu, there can be only a minimal role for choice and also draws upon Bauman (1988), who argues that most people are less restricted in the field of consumption and have a remarkable responsibility for choice.

This facilitates a theoretical marriage with other consumption theories - such as Gidden's (1991) concept of lifestyle that I referred to earlier, but also his idea of structuration (Bryant and Jary 1991) which provides a framework for understanding 'structured choices'. Akin to Giddens, the idea of 'choice' does not always present a source of anxiety, because Warde theorises food choice as being much more structured. Instead, Warde believes that contemporary consumption is best viewed as a process of continual constrained selection among a range of accessible choices. Returning to the earlier sections of this chapter, this concept is clearly influenced by sociological anthropological concepts of food and health, because Warde argues that a number of antinomies structure food choice such as novelty and tradition; health and indulgence; or economy and extravagance.

Summary

The claim that consumer culture lies at the heart of why people eat what they do is a debate which tries to move consumption theory beyond conceptualisations of social class based upon income and instead to view 'choice' in more complex ways. Post-modern ideas such as the 'body' and 'lifestyle' are criticised because their concept of structure is theoretically weak. For this reason I have therefore drawn upon further ideas which attempt to reconcile structure and agency debates. By revealing how 'choice' may be to some extent a consumerist freedom, the meaning attached to certain foods needs to be viewed as a

structured process of selection. While the origins of such ideas can be associated with social anthropology, this chapter has explored how sociological theory can help to further develop cultural perspectives on food and health.

2.2.3 *Food and the family*

"Recommendations concerning diet as an element of healthy lifestyles are likely to be seen both formally and informally, to be the responsibility of those most closely concerning with caring, that is, wives and mothers." *(Gregory 2000:40)*

I have so far considered that while social class is generally believed to have declined as an influence on food choice, cultural structures are considered by many theorists to have an important influence on what we eat. In this section, I want to continue developing these debates by examining the sociology of food and health in terms of the sociology of the family.

It would be misleading to suggest that a focus upon family life has only been a development in the sociology of food or health, because it reflects a sociological growth in this area more generally. By focussing on the family context as one which structures why people eat what they do, this body of research has however highlighted the role of 'the family' in shaping food 'choice' - particularly at certain life stages. Indeed, such a focus appears to be justified, because there is now considerable evidence that the process of producing meals which the family consume together is where many understandings of food and health are located (Murcott 1983a; 1983b; 1983c; DeVault 1991, Charles and Kerr 1988).

Functionalism

By concentrating upon the cultural processes which underlie lay health concepts, early studies put forward a simple functionalist view of the family. Incorporating a Parsonian element into a Marxist-feminist position, some anthropological studies suggested that women's role of 'feeding their families' is the "skill that produces group life" (DeVault 1991:228), because women maintain the family's health in order that they can fulfil their family responsibilities or help the family economy (Calnan 1987). Thus Calnan (1987) for example, compared the accounts of middle and working class mothers in the UK, and by developing the work of Herzlich (1973) in France, he explored the different ways that women were defining 'health'. Similarly to Herzlich, Calnan found that health can be defined negatively (as the absence of illness) or positively (as the ability to cope with everyday activities), but also in terms of fitness and well-being. Indeed, other studies have all

found rather similar distinctions (Pill and Stott 1982; Blaxter and Paterson 1982; Williams 1983).

Criticism has however increasingly been at a narrow Parsonian inheritance which characterises a narrow functionalist perspective of the family. This as Gregory (2000) argues is because 'the family' has often been conceptualised as a North American, white, heterosexual married couple with children. Even a more realistic definition Gregory argues is still problematic, as the functionalist view of the family proposed by Parsons and his contemporaries was aimed to draw together form and function in one theory. While this view of the family pervades many approaches to the family, attention has begun to shift to the process, and an emphasis upon *how*, and the meaning by which family members negotiate different roles. In this respect, the same trend towards a more reflexive sociological approach I outlined previously can also be seen here.

Power relations

Feminist writers in particular, began to stress the problematic assignment of domestic roles to gender (Oakley 1974), which then made it possible to draw attention to the power relations which took place within the home, how these created inequalities and the processes by which everyday activities were apparently constituting these power relations (Connell 1987). In her study of Welsh mothers, Murcott appears to be the first in the UK to draw attention to the significance of food and eating more specifically within family life (1983a; 1983b; 1983c). Murcott's approach has been repeated in similar studies conducted in the UK and abroad, although irrespective of their setting, they have all tended to reach similar conclusions (Pill 1983; Charles and Kerr 1988; DeVault 1991).

The above studies were seminal because they revealed the inherent inequalities associated with these gendered roles, by consistently identifying how women assume this position and continue to bear the responsibility for the preparation of family meals. Further examination of these studies in terms of 'power' however, revealed that these women exercised relatively little control over the underlying patterns of provisioning and food selection; while men had a tacit patriarchal authority over what women were providing. From the accounts put forward by women in the 1980s studies, male roles were said to be peripheral and were confined to cooking for special occasions and rarely for routine mealtimes.

Yet criticism has been directed not at the 1980s studies' findings, but at the methodological approaches they took. Beardsworth and Keil (1997) for example, argue that the other half of the equation was neglected because these studies did not interview these women's partners. Some notable exceptions to these asymmetrical methodologies have considered the male

perspective. Nevertheless, Horrell's (1994) work continues to suggest that if men undertake some of the tasks associated with providing meals, women still play a more demanding role in the home more generally. Several studies have therefore argued that although men may choose to cook, they are selecting this particular domestic task because it is seen as having a higher social status (Sullivan 1997; Gregson and Lowe 1993).

Care

It is possible to note several more recent themes of the family which have adopted a constructionist and reflexive position on structure and agency. One key theme, often associated with the work of Finch (1983) adopts the idea of 'kin' to introduce notions of duty and obligation. Finch (1989) and later in conjunction with Mason (Finch and Mason 1993) began to explore how obligation and responsibility were translated into action by women and the way that their everyday activities can constitute relationships over time. Yet rather than caring being a consequence of these relationships, they argued that the very act of providing care, especially if repeated routinely over time, could actually create that relationship.

Although recognising that 'care' is a complex term (Thomas 1995; Bowlby *et al* 1997), Murcotts's work (1983c) which focussed more specifically on food and health broadly reflected the types of processes outlined in the following decade by Finch and Mason (1993). To Murcott, the provision of a 'proper meal' is a powerful symbol of gender roles and symbolises that a wife has been spending her time in an activity 'appropriate' to her status and gender by sustaining her family. However, because meals are provided in the context of a 'caring' role, this was conceptualised as being more than merely a function of family life, because she also argued that women gain some pleasure and satisfaction in providing them.

For Kemmer (2000:10) however, changes in working patterns since the now outdated studies of the early 1980s, mean that for many women, cooking is now a 'far cry' from what Murcott suggested. Addressing similar concerns , Warde (1997) again develops the idea of constrained selection and the concept of 'care', by considering how feeding families can be a fruitless task. Hence he argues that this 'caring' role produces a source of tension for many women. Because increasing pressures on time require a trade-off between a need for 'convenience' and for 'care', this can lead to feelings of guilt, where women may believe that they are not feeding their families in the 'proper' way.

Strategy and negotiation

Terms such as 'strategy' and 'negotiation' have however increasingly been used as sociological tools to examine the interplay between agency and structure in a family context (Morgan 1996). Indeed, Morgan's concept of 'family practice' attracts a sense of the active and everyday, yet at the same time emphasises how family life is an on-going process where negotiation may take place, albeit at times with very little freedom. Nevertheless as Gregory (2000:31) warns, the term negotiation "cannot be seen to imply equality and or agreement, and requires a recognition of power relations." Thus as I referred to previously, "the interplay between social identities attached to family and gender and everyday family activities and interaction might even be seen to constitute power relations." A provocative but perhaps extreme example in Charles and Kerr's (1988) work of these processes was demonstrated by their finding that food preferences had to often be 'negotiated' under conditions of domestic violence. Under these circumstances, they argue, it is perhaps no wonder that a wife would want to cook according to her partner's tastes because of the negative effects of their authority.

Kemmer (2000), also argues that since many of the studies of food and family life were conducted nearly 20 years ago, they may now therefore be out of date. Thus McIntosh and Zey (1989) for example have argued that women can yield considerable influence in determining what is eaten. Warde (1997) has more recently considered the role that convenience foods may play in helping women to negotiate their responsibilities. Some evidence he suggests however, reveals that women may be providing a greater range of meals than they did in the past and that this has been accelerated by the now greater availability of pre-prepared foods. Reflecting Charles and Kerr's (1988) observation that women tailor their menus to suit their husband and children's needs, he also argues that any 'liberating' potential of convenience foods should be viewed sceptically. On a similar theme, Bose (1979) also considers how it is questionable whether food technology has given women more power, and argues instead that various inventions may possibly allow them to take on new burdens. Evidence on all these issues does seem to be inconclusive and as Warde (1997) also observes, it is far from being clear if the greater availability of pre-prepared foods and kitchen technology has reduced the amount of domestic labour required for cooking. For example, some evidence does suggest that pre-prepared foods may only save time in the cooking stage and not with other elements such as the shopping (Cowan 1983).

Summary

The family has been theorised in sociology in a number of different ways and more recent notions of 'the family' have placed an emphasis, in Goffmanesque terms, on the way that family life is being acted out. For Bernardes (1997:54), 'the family' is a justifiable context to focus upon, because some sense of 'normality' comes from our own understandings of "normal family life". Unpacking the taken-for-granted and everyday meanings of the family therefore, reveals not just how societal structures may be constituted through actions, but also how women (in particular) may negotiate and overcome the difficulties associated with their responsibilities on a daily basis.

2.2.4 Summary

Reflecting the different ways that sociologists have explored the relationship between food and health in everyday life, in this section I have drawn upon a number of different sociological themes. While it might be argued that food can be consumed in many different settings, this section has concentrated upon the everyday context of daily life, because of the amount of evidence which suggests that this is where lay understandings of food and health are located and produced.

However, I have also argued for a focus on the social context of these understandings and adopted a position where food 'choice' needs to be located within a deeper set of social structures and cultural processes. By relating the concepts identified here to the relationship between lay and professional understandings of food and health, the following section will explore how they appear to be directly relevant to health promotion theory and practice.

2.3 Lay perspectives at the interface

Following on from the previous discussion, I now therefore want to explore how lay understandings of food and health are of direct relevance to the theory and practice of health promotion. Amounting evidence suggests that the lay perspective is crucial to the success of health promotion, because of the way that health advice appears to be understood and prioritised within the context of everyday life. After firstly outlining the need for lay theorising in this area (Backett 1996), I will then explore the different ways that 'professional' knowledge about food and health have been explored from the lay perspective.

2.3.1 Health promotion: a need for lay theorising

Although in *Section 2.2* I briefly argued that the lay perspective is directly relevant to health promotion, I now want to consider this idea in more detail. This discussion will begin by introducing the medicalisation critique which appears to underpin sociological concepts of lay theorising. In the following chapter I will consider this critique in more detail, however for now it is only necessary to explore how medical power may oppress lay perspectives.

Medical power

It has been argued that at the heart of Medical Sociology lies the medicalisation critique (Strong 1979a). This seeks to question the dominance of medicine by arguing that medical practitioners are trained to think in certain ways and which are continuously reproduced through medical institutions. Tuckett *et al* (1985) argue for example that by cultivating an aura of superior 'expertise', doctors throughout the ages have sought to establish and guard their status. Deborah Lupton (1997b) discusses how many medical sociologists took up this critique to challenge and subvert the power of the medical profession. She argues that the discipline has critiqued the way that medical power devalues lay knowledge and 'expertise' and how it maintains a hierarchical relationship between doctor and patient as if it were a norm. A serious consequence of this process for many medical sociologists however, is that medicine actually undermines lay people's autonomy in managing their own health, because it is a system which claims to 'know' (Illich 1975).

Critiques of health promotion

This critique has also been applied to health promotion, because it has been suggested that like in other areas of medicine, processes which structure 'lay' and 'professional' relationships both reflect and reinforce wider social relations and structural inequalities (Burrows *et al* 1995). However, while there are many different forms of health promotion which have formed the focus for sociological review, in this chapter I will be concentrating more specifically upon the area of preventive lifestyle advice, because this is more relevant to the focus of this thesis.

To question whether health professionals have the right to intervene in how people chose to life their lives at all, at the most critical end of the spectrum medical sociologists have developed a Foucauldian perspective. O'Brien (1995) for example views lifestyle advice as an increased form of medical surveillance in some settings and suggests that health promotion is significantly more intrusive in people's lives than medicine has ever been. Reflecting the concept of 'lifestyle', and 'choice' I referred to previously, other critiques however have debated the extent to which people choose their lifestyles and argue that

health promotion should instead target 'up stream' factors such as poverty and refocus on structural inequalities (Abel *et al* 2000).

The lay context

Although it has been argued that health professionals should not intervene in how people may 'choose' to live their lives, a more practical approach has been to apply a medicalisation critique to clarify and review health promotion practice (Beattie 1991). Social science therefore can assist in understanding lay concepts of health, and in ways which are directly relevant to health promotion (Kelly and Charlton 1992). Backett *et al* (1994) argue that these insights are necessitated by the far from successful nature of many health promotion campaigns and policies. Therefore more needs to be known about how the public understands and evaluates preventive messages and the disparity between everyday 'lay' and 'professional' understandings of health promotion advice (Backett 1996).

In the following chapter I will consider that while these approaches talk about a disparity between 'lay' and 'professional' perspectives, some critiques have questioned whether or not it is theoretically possible to divorce the two in the first place. Thus for Blaxter (1990), there is often a crude and false distinction made between a biomedical 'model' (which characterises medicine more generally) and a more holistic one which she says is often associated with the 'lay' perspective. Intermixing is therefore inevitable because lay people have been taught to some degree to think in biomedical terms. Burrows *et al* (1995) take a similar line on this, but argue that the blurring of 'expert' and 'lay' knowledge is bound to be inevitable with a shift from producer to consumer driven economy.

I will now be taking the idea of intermixing on board when I review how sociologists have sought to explain the contrasts between lay and professional understandings of health. However, reflecting the apparent divergence between them, I will instead be concentrating upon how these two types of knowledge represent different *levels* of accounting practices. It is not until the following chapter therefore that I will attempt to extend this point, and discuss the complex relationship between 'lay' and 'professional' knowledge more reflexively.

2.3.2 *Risk, anxiety and confusion*

The different sociological shifts identified earlier in this chapter, are also reflected in the ways that sociologists have theorised lay understandings of a range of professionals' concepts of food and health. While I will begin by exploring this relationship from a post-modern perspective, I will argue and explain that because they appear to bypass social

processes and contexts, these approaches are inherently problematic. Therefore, when exploring the way that 'healthy eating advice' is understood, I will again be focusing upon how 'choice' is best viewed as a form of constrained selection (Warde 1997) and an emphasis upon the social construction of food choice.

'Healthy eating advice' and uncertainty

Much attention has been devoted within the sociology of food and health to concerns about the safety of food. Mennell (1985) suggests that the public are facing an ever increasing number of food choices, while at the same time they are becoming increasingly anxious as "one never knows what one is eating" (Mennell *et al* 1992:73). These approaches often seem to be placed under the heading of 'risk'. Therefore for Beck (1992), who is one of the key proponents of this approach, society has become pre-occupied with the problems unleashed by its own development and is turning inward on itself. Food scares appear to be one particular focus for these analyses, as it has been argued that as a result of advice by 'experts', people are constantly in a state of flux about the health implications of what they eat (Levenstein 1988). More recent work undertaken by Reidar (1999) also suggests that food scandals are a central feature in understanding lay experiences of a risk society, where issues such as mad cow disease raise serious questions about who we can trust.

The media's role

Karpf (1988) takes these themes a stage further and argues that the media play a key role in creating moral panics. There have been a number of studies which have therefore attempted to explain the media's role in translating scientific information and subsequently how it is then understood by the public. Reilly and Miller (1997) for example, suggest that lay understandings of food scares are not simply a result of people passively absorbing everything that is beamed from their television sets. Findings from their study found that many respondents blamed the media for sensationalism surrounding food scares, and felt that the media played a key role in creating an aura of confusion. For Lupton and Chapman (1995), who explored discourses on diet, cholesterol control and heart disease, these examples reveal how the media's presentation of scientific information appears to be limited by journalistic conventions. However, at the same time, they argue that this picture is complicated by a continuing emphasis upon them to mediate.

Health promotion and the media

Lupton and Chapman's study suggests that similar negative comments about the credibility of 'healthy eating advice' are applied to a range of different sources. Lay criticisms included advice from both medical practitioners and health promotion authorities, and this was

demonstrated by how professional advice was subjected to criticism based on the confusing messages evident in media accounts. A similar study by Keane (1997) in the UK, also found that respondents found it difficult to differentiate what they were seeing and hearing and it was also apparent that the media played some role in creating this confusion. By referring to those who were providing this information in terms of an anonymous and generalised 'they', Keane found that most respondents were therefore talking collectively about 'healthy eating advice' being confusing. However, Keane's work suggests that the degree to which the media's role was being questioned depended upon the respondent's social class. While working class respondents viewed 'healthy eating advice' as a homogeneous mass, the middle class respondents said that there are bound to be contradictions in advice because the relationship between food and health is so complicated.

2.3.3 The relevance of lay health concepts

Keane's study found that as a result of concerns about the reliability and trustworthiness of 'expert' and official sources of information, respondents often identified their own personal experience and knowledge about food and health as being the most credible. Lupton and Chapman (1995:492) however, warn that we should not believe that the public are dismissing 'expert' advice completely and argue instead that most people are placed in a "somewhat invidious and ambivalent position". By exploring how lay health concepts may draw upon professional ones, this section explores how lay people's own ideas often take greater priority.

It is the work of Davison and his colleagues (See Davison *et al* 1989; 1991; 1992) which has probably been the most influential in developing the relevance of what they call 'common-sense' ideas to preventive measures. Davison *et al* (1989) believe that given the amount of confusion about food and health, then it is no wonder that many people in Britain today are sceptical eaters and see little point in changing their diets. Commenting on Davison's ideas, Beardworth and Keil (1997:142-3) argue that because of the apparent difficulties in translating nutritional guidelines into practice, then it is "hardly surprising" that 'common-sense' concepts continue to shape lay understandings about food and health. I now want to explore two key examples of these 'common-sense' ideas in more detail:

Lay epidemiology

Lupton (1993) argues that there is a need to move beyond the apparent confusion brought about by 'expert' opinion, by arguing that 'risk' is not a neutral term and is socially constructed. Davison and colleagues attempted to do just this, by identifying how the public understood the risks of inheriting heart disease from health promotion advice. Reflecting

the problematic nature of the lifestyle debate I referred to earlier, they argue that presenting risks as choices which the public can therefore 'rationally' decide upon, is inherently problematic. To capture the contrast between lay and professional understandings of scientific risks, they coined the term 'lay epidemiology' to describe the process by which knowledge based on personal experience was the most highly valued (Davison *et al* 1991). Although this mechanism helped people to assess personal risks, it appeared to also have a practical purpose, because it provided reassurance in the face of uncertainty. So developing similar findings by Pill (1983), Davison *et al* (1992) suggest that there was a variation in the degree of control which people felt they had over their health. Respondents either felt that their lifestyle did not affect their health or that their mortality and morbidity were determined more by fate alone.

Backett *et al* (1994) refer to the autonomous management of health, to capture how the prioritisation of 'common-sense' knowledge reveals how the public are distancing themselves from 'professional' advice. So while 'professional' advice appeared to play a role within lay understandings of health, this highlighted how 'health' and 'lifestyle' were often viewed as a matter for the individual. By comparing the findings from three different studies, they also suggested that respondents were 'weighing up' the desirability of changing their lifestyle within a broader risk balancing framework (see Davison *et al* 1991; Backett 1992a; Mullen 1992). Yet as I discussed earlier, what makes these findings so relevant for health promotion, was that being 'healthy' was only seen as one priority and they were practising a process of trading off 'healthy' behaviours with 'unhealthy' ones.

Balance

I have already touched on the idea of 'balance' earlier in this chapter, but for Beardsworth and Keil (1997), when faced with dilemmas about what to eat, or contradictory advice, British people often invoke ideas about a 'balanced diet'. A number of empirical studies have therefore argued that lay ideas of 'balance' are a further demonstration of how competing priorities may be managed in everyday life. Lupton and Chapman (1995) for example explored the role that nutritional information may play in lay ideas about 'balanced diets'. By drawing upon the adage 'everything in moderation', their respondents felt that it was possible to balance nutrition with other requirements. This they argue, revealed how such ideas appeared to be viewed as strategy for coping with the confusions which surround dietary advice.

Developing Backett *et al's* (1994) idea that lay people 'trade-off' different aspects of their health-related behaviour, Keane's (1997) study in the UK identified the difference between the idealism of a balance and a much more practical form. Keane argues that while

respondents talked about their diets as an overall pattern of harmonious consumption, further exploration revealed that they were trading off what they saw as 'good' and 'bad' foods. The social anthropologist Fischler (1986) raises a similar idea and argues that some form of 'balance' is inevitable because there may be forces that re-stablish an equilibrium in the face of contradictory understandings about food. Fischler's ideas echoe Herzlich's (1973) view that a 'balanced' diet might be linked to the concept of health as an equilibrium and this can help to restore a balance or a sense of order (cf. Calnan 1987). Thus:

> *...for the greater number of respondents, a true dietetic balance seemed to result from equilibria of another nature, i.e., as it were, of a moral order. Balance, in more than one way, could indeed be viewed as an almost ethical requirement. What must be balanced, the interviewees believed, was pleasure and health gratification and duty, appetite and reason (Fischler 1986:961).*

Commenting upon how dietary equilibrium appears to be a feature of many different societies, Sellerberg (1991) raises the question of whether any culture is likely in the longer run to permit a set of anxiety-provoking dilemmas to continue. Ideas of 'balance' therefore appear to play a key role in making sense of, and managing dilemmas about food and health on a day to day basis.

2.3.4 Summary

Despite there being a range of different sources of 'healthy eating advice', several studies have suggested that it is criticised en masse, because it is collectively seen as being both confusing and contradictory. Qualifying this suggestion, I have also explored the idea that the media are relied heavily upon to mediate scientific knowledge and appear to play a key role in influencing lay ideas about 'expert' opinion. Contrary to a post-modern position on 'risk', a crucial set of structural processes appear to play a key role in the day to day management of the confusion which surrounds 'healthy eating'. However while the priority given to these ideas may possibly be 'inevitable', this should not at the same time prevent a sustained emphasis on the relevance of lay knowledge to health promotion theory and practice.

2.4 Chapter summary

In this chapter, I have argued that even before the potential for general practice as a setting for providing 'healthy eating advice' can be considered, it is has been necessary to firstly focus on how 'healthy eating' is understood in lay people's everyday lives. I began by putting an emphasis upon how food 'choice' is structured in exploring the social construction of food and health in everyday life. I then shifted the focus to consider a failure to understand

the lay perspective, and the constrained nature of 'healthy eating' in a way that is directly relevant for health promotion. However, by recognising that there is a complex interplay between lay and professional ideas, I have identified the relevance of the lay perspective to health promotion. In the following chapter I will consider how particular ideas about the purpose of general practice setting are also shaping lay views and discuss the necessity of adopting a more critical position on medical power.

3 'Lay' and 'professional' perspectives in general practice

3.1 Introduction

I will continue to argue in this chapter that an understanding of the lay perspective is directly relevant to providing preventive advice in general practice. However, this chapter combines this argument with a review of the theoretical and empirical literature on the GP as a health 'professional', whilst also considering how a sociological understanding of the relationship between the doctor and the patient is necessary to explore the potential of the general practice setting for providing 'healthy eating advice'.

Only a very few studies have used a qualitative approach to explore either the patient's or the GP's views of providing preventive advice. Therefore, this chapter is based mainly around the findings of Calnan (1987) and Stott and Pill (1990) for the lay perspective and Williams and Boulton (1988) and Williams and Calnan (1994) for the professional's. Before focussing upon these studies, this chapter will begin with a sociological discussion on 'professionalism' by exploring the relationship between the health 'professional' and their patient.

3.2 The patient and the 'professional' in medical sociology

In *Chapter 2* I discussed the idea of 'lay expertise' and its importance in everyday decisions about food and health. Indeed, it could be argued from the evidence presented so far that health professionals are presented as the 'bad guy'! This brings Blaxter (1990) to question the very idea of theoretically separating the terms 'lay' and 'professional' knowledge. If this is combined with Strong's (1979) concerns about sociological imperialism and the creation of biomedical caricatures, it is easy to forget how lay ideals have also permeated into medical thinking (Davies 1984), or the interplay between lay and professional ideas (Davison 1991). Indeed, one may also overlook how just as lay people's perceptions of prevention do not wholly conform to one 'model' and often show active dissent from them, so too do those of health professionals. This is because it has also been argued that practitioners "draw upon a range of knowledge, personal and professional values and clinical experience to interpret their preventive responsibility" (Williams and Boulton, 1988:234). One of the key priorities of this chapter therefore is to explore the complexities in the relationship between doctors and their patients, but also within the medical profession itself.

Nevertheless, whilst it is theoretically problematic to talk about 'lay' or 'professional' knowledge, this section of the chapter takes a critical look at the concept of professionalism, not just to assess how the lay perspective may have been devalued in medical encounters, but also to understand in a more reflexive manner, the changing nature of the doctor-patient relationship. In the second and third part of this chapter, I will be looking at several empirical studies which investigated the provision of preventive advice in general practice from both the doctor's and the patient's perspective. Before it is possible to make sense of these findings, however, it is firstly necessary to consider how medical sociology has contributed theoretically to the concept of the health 'professional' and the relationship between doctor and patient.

3.2.1 Medical sociology and the profession of medicine

Gabe *et al* (1991) argue that there are three phases which document the development of medical sociology in post 1945 Britain. It was not until the early 1960s that the discipline really began to develop a distinctive disciplinary base and by the late 1960s and 1970s it was turning into a new phase that was becoming increasingly critical of government health policy. In particular, a critical perspective towards medical power was developed by considering the theoretical position of the profession of medicine. Gabe *et al* (1991) argue that this was a crucial stage in the discipline's development, because it stopped seeing medical professionals claim to power as a legitimate form of social control and argued that the medical profession's dominance needed to be curtailed or to be made more accountable.

Freidson (1970) for example produced a wide ranging critique of medicine's monopoly over the definition and treatment of illness, considering how it also subordinated other occupations in the health division of labour. He argued that in sociological terms, medicine (like law) was the "paradigmatic profession, a publicly mandated and state-backed monopolistic supplier of a valued service, exercising autonomy in the workplace and control over recruitment, training and the regulation of members' conduct" (*c.f.* Elston 1991:58). Johnson (1972) on the other hand, took a different position and argued that the key to understanding professional power was to look at the provider-consumer relationship. Thus the type of occupational control was related to the social and economic resources available to these two parties, and perhaps more crucially to the distance created by any differential in knowledge.

It seems however that throughout the discipline's consensus on the existence of medical power, there has been considerable disagreement among social scientists to its basis. On the one hand, did it stem from organisational characteristics of the profession, from its control

of valued expertise, from societal trust of the profession or indeed, its success in reproducing capitalism's labour force (Klein 1974, Freidson 1970; Larson 1977; Navarro 1976)? More critically however, Williams (2001:135) argues that Medical Sociology and its 'ally', public health, have a "vested interest" in the diminution of the medical empire as it is currently constituted. As de Swaan has pointed out (1990), one key problem with the medicalisation critique, is that the power medicine has to establish authority in the first place is to some extent a matter of collusion between the medical profession and patients. Therefore the Parsonian (Parsons 1939) principle which underpins this argument, states that society comprises of different actors who perform a range of social roles and whom facilitate the functioning of society (Nettleton 1995). 'Functionalist' perspectives argue that doctors have a privileged position in society, because they provide services which are socially valued (Turner 1995). Therefore the doctor's 'expertise' is valued because the doctor can approach the patient's health with some degree of authority (Tuckett *et al* 1985).

3.2.2 A more reflexive account of medical power

Through the 1980s and into the present, accounts of medical power have been redeveloped and there has been a renewed interest in illness and its definitions influenced by the writings of Michael Foucault (see Petersen and Bunton 1997). In particular, this has led to a more reflexive consideration of the relationship between doctor and patient, particularly because of changes brought about through societal trends such as consumerism (Burrows *et al* 1995) and various structural changes to the way general practice operates (Calnan and Williams 1995). In this section I want to review a number of different theoretical approaches that highlight the complexity of medical power and the concept of 'professionalism' in the general practice context. Therefore as Popay and Williams (1996) argue, there is a key need to develop a much more reflexive understanding of the ways in which 'expertise' - whether this is 'professional' or 'lay' – is structured.

The decline of medical power and the professional?

Providing a unique review of general practice, Calnan and Gabe (1991) explain how general practice has developed in relation to hospital medicine, a history which they argue is essential to understanding its current status. In the past the professional development of general practice was hindered by the power of hospital doctors who had more influence, and GPs lack of involvement with the state necessitated an enhancement of their working conditions. However, in the 1970s and 1980s they argued that these relationships changed as general practice carved out a distinct identity for itself. GPs and their representatives were able to secure better pay and conditions, thus contributing to the greater professionalisation of their profession. Before considering the empirical research into

prevention in general practice which has re-examined this status, it is firstly necessary to consider how neither the functionalist or medicalisation critiques appear to provide an adequate explanation of the changes that have taken place over the last few decades. There are several issues which therefore need to be considered, and concern whether we are on the threshold of a 'decline in medical power'.

Two main theses have been put forward to explain and predict the 'decline of medical power'. The first, the 'deprofessionalisation' thesis often associated with Haug (1975), concerns how the knowledge gap between doctor and patient is said to be decreasing. This also links into my earlier discussion in *Chapter 2,* concerning how personal concepts of health may often be the most valued. Hence, the deprofessionalisation thesis centres around the idea that the public are becoming increasingly sceptical about medical knowledge. Consequently however, this problematises both the functionalist and medicalisation debates, because it questions the idea that doctors are more powerful than their patients, or that patients regard them as having an authority on health matters (Lupton 1997b).

A second thesis concerns the process of 'proletarianisation' and is a Marxist analysis often associated with Oppenheimer (1973) and McKinlay (McKinlay and Arches 1985). This thesis refers to the process of transformation of a profession gradually losing its autonomy and skill base. Thus the logic of capitalist development is such that medicine is now undergoing a transformation of its labour process, whereby doctors have to focus on managerial requirements, largely brought about by changes to their contracts referred to in *Section 1.1* (Calnan and Williams 1995). Physicians according to Elston (1991) are identified as having less control over training, terms and content of work, objects of labour, equipment and amount or rate of remuneration.

Yet the challenges to their profession through various contractual changes and the charge of the diminishing knowledge gap is to Calnan and Williams (1995) an area which has received little empirical research. While a review of other studies appears to have shown little evidence of either deprofessionalisation or proletarianisation (Calnan and Gabe 1991), an empirical study (Calnan and Williams 1995) suggested that the social, economic, and clinical freedoms of GPs remain intact. However, external influences were apparently affecting their style of clinical practice and was a source of concern and dissatisfaction to some, but not all GPs.

Reprofessionalisation and the doctor as a 'resource'

But for other GPs, as Calnan and Williams (1995) also found in their empirical study, structural changes to their profession were not regarded as a threat, neither were the

pressures of changing their practice styles to meet a more demanding type of patient. For Lupton, (1997a) there is growing evidence that although doctors are changing to meet their patients' needs and the needs of the health service, that they are not necessarily being 'deprofessionalised', but are 'reprofessionalising'. Lupton (1997b:104) argues that this indicates how there is a continual negotiation of power that is 'contingent' upon the context in which the patient interacts with the doctor or other health professionals. This seems to provide a more adequate explanation of the contradictions which Calnan and Williams (1995) reveal, by requires transcending the notion that doctors possess more or less power as a social group, to an understanding of power:

> *... as shared, negotiated, relational, situational and a resource for action' and furthermore that is, the notion of 'power to' as well as 'power over' (Law 1991, cf. Lupton 1997a).*

This more complex Foucauldian definition of power therefore moves beyond the idea that health professionals can simply act as the final authority on health matters, or that lay people are prepared to passively accept their advice. Firstly, this is because, as Strong (1980) reminds us, doctors never claim to have 'expertise' in everything and that they are granted 'expertise' as a profession. As such, "lay people are not simply passive or active, dependent or independent, believers or sceptics, rather they are a complex mixture of all these things (and much more besides)" (Williams and Calnan 1996:1619). Secondly, an issue which further necessitates this more complex definition of medical power, is the suggestion that the criteria which lay people use for assessing the performance of a medical practitioner, are often not linked to those which they used to assess the value of medicine more generally (Calnan 1988; Lupton and Maclean 1998). For example, Lupton and Maclean (1998) found that while the medical profession may be collectively criticised, individual doctors or certain professions within medicine were viewed more positively.

3.2.3 Summary

These different positions on medical power raise questions which are fundamentally important to the NHS in the UK. This is because in terms of providing any particular form of health service (in the case of this thesis: 'healthy eating advice'), the relationship between doctor and patient and the way in which medical power operates throughout this relationship, ultimately structures the way it is provided, received and implemented. Fundamentally I argued in this section that the concept of medical power needs to be discussed in order to understand the context of the lay-professional relationship. Whilst it has been argued that the asymmetrical division of power between doctors and their patients may be changing, I have focussed specifically upon a more reflexive account of this relationship, to illuminate the following sections on prevention in general practice.

3.3 Providing lifestyle advice in general practice: the lay perspective

While I argued throughout the last chapter that there is a need to understand the lay perspective and here to view medical power more reflexively, the majority of attention given to providing 'healthy eating advice' in general practice has not taken this approach. Stott and Pill (1990:125) say that views of patients towards preventive advice in general practice was scanty until the surveys of Wallace and Haines in 1984 and 1987. Although there has been very little work in this area, most of what has been undertaken has used quantitative methodologies. Because there is so little knowledge of lay views of 'healthy eating advice' in general practice, it is necessary to briefly summarise these quantitative approaches. Despite their lack of depth, they do reveal some interesting findings which have been expanded by the qualitative studies to be explored later in this chapter.

Survey based approaches

It appears that the key theme identified in these survey based approaches to prevention, concerns the finding that the public view GPs as credible source of health information and would welcome more (Wallace *et al* 1987). Taking this point further, Silagy *et al* (1992) have also suggested that demand for advice about health is widespread and not just confined to middle class 'health freaks', while Butriss (1997) in the UK for example observed that 53% of patients said that a conversation with their GP on dietary advice was a source of advice they trusted. While this casts doubt on the idea that the public do not trust their doctors, the complexities of what patients expect from them were suggested by Eggleston *et al's* (1995) findings. They found that it was the ability of health professions to respond to patients' health concerns, rather than the type of health professional running the clinic that was important for patients. This supports other research which has also shown that the nature and presentation of lifestyle advice is crucial (Fullard *et al* 1984).

Having shown that dietary advice in general practice may be viewed positively by the public, but with some qualifications, these studies have not explored the socio-cultural processes that influence these views and which are therefore in need of further exploration. The remainder of this chapter will consider two key studies which have approached health promotion in this way. However, they both explored prevention more generally, and therefore it can only be assumed that they are directly relevant to this study on 'healthy eating advice'.

3.3.1 *Lay perspectives on lifestyle advice*

In addressing the lack of indepth research in this field, Stott and Pill (1990) argue that a better understanding of the lay perspective can help health professionals to intervene more sensitively (Stott and Pill 1990). This reflects the ethos of this thesis, because they argue that a broader conceptualisation of prevention in general practice can reveal concerns about the application of this knowledge to the practical world of everyday life. Surprisingly, this remains the only study which has specifically focussed upon lay understandings of preventive advice in general practice. Calnan's work (1987) on lay health concepts however does direct some attention towards the general practice setting, and his approach very much reflects the structure of this thesis. Calnan argues that while it is necessary to explore lay views on doctor's role in this area, this is also dependent on exploring how they appear to relate to lay health 'beliefs' more generally. Both these studies therefore fit within the direction which has been taken in this thesis so far, and I now want to consider what they add to the ideas I have already discussed on lay perspectives of 'professional' health advice explored in *Chapter 2.*

Stott and Pill (1990) used a mixed method approach and interviewed 130 mothers of lower social class groups, to study their views on the desirability of a GP discussing their lifestyles. The authors challenge the idea that health advice is not wanted by the public, because their study should be interpreted as revealing a 'gap' between expressed and satisfied need. Revealingly, the vast majority of respondents thought that this was an acceptable extension of the GP's role. It was only a minority who said that they did not want such advice and that the GP should only treat those who were ill. Like Stott and Pill (1990), Calnan (1987) also found that the women he interviewed thought that the GP's involvement in providing preventive advice was generally a good thing and he also showed that they thought this was more meaningful than general and impersonal advice provided elsewhere. Again a gap between expressed and satisfied need was established. However, of those who said their GP does have a role to play in health maintenance, just over a third said that their doctor should, but did not carry it out.

Constructing the purpose of general practice

Both of these studies therefore revealed that the majority of patients showed some flexibility in how they felt the GP's role could be extended, however findings from both of these studies suggest that this degree of flexibility was associated with respondents' social class. Calnan found for example that, although some women from both social classes felt that their GP should be encouraged to have a role in maintaining their health, he also identified a working class minority who said that GPs did not or should not have a

responsibility in this area. So while lay respondents in all studies may have been drawing upon certain ideas about the purpose of general practice, the working class patients were drawing upon a more 'conventional model', because they talked about how the GP's role was primarily to treat illness. Nevertheless, it was also interesting that while middle class respondents also talked about there being a lack of time to provide preventive advice, there was notably more sympathy for the doctor's workload in the working class group. Tod *et al* (2001) found similar findings in a more recent survey, which therefore supports Stott and Pill's concept of 'collusion', because both GPs and some patients were constructing general practice as a site for treating illness. Contrasting sympathy for the GP's workload between the different social classes, may then be a further example of how lay respondents were drawing upon different medical 'models' to evaluate their GP's role in this area.

Evaluating preventive advice

While these findings suggest particular processes were shaping lay understandings of general practice, this was also subtly apparent in the various qualifications and reservations identified in Stott and Pill's study. They argue that this reflects the delicate nature of the doctor-patient relationship, which relates back to some of the ideas that I have already explored in this chapter. So despite some expressed enthusiasm towards prevention, their study found that the majority of women were in favour of counselling on 'specific' topics by the GP and that most respondents expected the issues to be relevant to the problem they would be presenting. This qualification was also complemented by the finding that respondents also often said that their own lifestyle was a matter for the individual.

These findings appear to support many of the ideas I discussed previously. On the one hand while these lay respondents may have had positive views of their GP's role and possible extension of it, they were again drawing upon the idea that health was a personal matter. Furthermore, the idea that many respondents welcomed an extension of the GP's role, suggests that Lupton's (1997a) idea of the 'resource' may be particularly applicable here. This was because respondents appeared to be enthusiastic about the idea of general practice as a source of preventive advice, but that they were ultimately responsible for choosing if they accepted it, or deciding when it was necessary. However a further issue was that particular ideas about the purpose of general practice were still shaping the ways that they appeared to evaluate preventive advice. This was most apparent in the idea that preventive advice had to be relevant to what they were presenting, and this could possibly be an example of how they were applying different criteria to different types of medical advice (Calnan 1988).

While these studies provide valuable insights into how preventive advice may be understood and evaluated in general practice, the findings provide little information about dietary advice more specifically. One notable exception which did explore lay understandings of food and health, sheds some interesting light on these more general studies. Cohn (1997) explored diabetic patients' understandings of dietary advice and he discussed how respondents felt that the promotion of 'healthy' diets falls outside the remit of medical 'expertise'. This was because they felt that food should remain within a personal and social domain, not a medical one. This does again support the idea that views on preventive advice may be shaped by particular 'models' about the purpose of general practice. However, Cohn's study of the management of diabetes in this setting, does need to be viewed with some degree of caution, because it was focusing upon people with a specific illness. Interestingly Stott and Pill (1990) do conclude by saying that the acceptability of preventive advice will depend upon the individual patient's perception of the doctor's role and the context and manner in which such advice is offered. Cohn's work does therefore add an interesting perspective to the ideas raised in their study and Calnan's (1987), because it appeared from Cohn's (1997:198) study that talking about food and eating may be a topic which lay respondents felt was more legitimately "open for review".

These qualitative studies therefore have raised interesting questions about lay understandings of health promotion in general practice and expanded on the earlier survey based approaches. However, despite a contrast in the views expressed towards this type of advice, there also appears to be a notable common theme, where it was found in both studies that particular ideas or 'models' about the purpose of general practice were shaping lay understandings. Moreover, bearing in mind the discussions on medical and professionalism that I begun this chapter with, it is also possible to see how in the context of health promotion, GPs may be viewed as a 'resource'. A simple definition of medical power therefore does not suffice when applied to these studies, yet primarily there remains a strong need to understand how lay understandings of 'healthy eating', as a form of preventive lifestyle advice are relevant to the general practice setting.

3.4 The GPs perspective on 'healthy eating advice' in general practice

There have only been a few indepth studies of GPs' views on preventive work. Nevertheless, it should be noted that the lack of qualitative research in this area appears to be part of a wider picture where few studies have used qualitative methods in a general practice setting (Hoddinott and Pill 1997). Despite this, there is a large body of quantitative work which has considered the provision of many diet-related issues in this setting, but has

not necessarily focused on prevention and instead includes many specific diet-related illnesses. Although these studies do not take a sociological perspective, I believe that their findings still have relevance for this thesis. Indeed, because the key studies which will I refer to later explore prevention in general practice more generally, they do highlight some specific issues concerning 'healthy eating advice' which are not identified in qualitative studies.

Talking about diet

Many of these studies appear to be conducted within the field of international *Clinical Nutrition*. On a positive note, several have shown that there is little evidence to suggest that GPs and other Primary Care Professionals are dismissing the value of nutrition in maintaining and promoting good health. Morris *et al's* (1999) study of obesity management among Scottish GPs for example, revealed that 89.6% agreed that nutrition has an important role to play in the management of disease. This reflects similar figures from other European countries (Wiesemann, 1997; Van Binsbergen, 1997). However, when it comes to considering how GPs view the task of actually providing dietary advice, it has been suggested that they do not see it as being a priority (Fleming and Lawrence 1981) and commonly refer to a lack of time to undertake such work (Mant 1997). Indeed, rates of nutrition advice appear to vary greatly and there is some conflict with regard to the level of nutritional advice that takes place within primary health care. Glanz (1997) reviewed nine studies and found that rates of nutrition counselling ranged from 17% to 70%. However, a higher figure was identified by Cade & O'Connell (1991), who indicated that 98% of GPs believed that it was part of their role to counsel patients with a weight problem.

Identifying 'barriers'

In addition to exploring the nutritional advice which is being provided in general practice, a number of studies have tried to identify the reasons why GPs are not providing more. However because they do not explore the social processes which underlie their explanations, these studies unreflexively refer to a number of 'barriers'. So some research has suggested for example, that many GPs do not feel competent in educating patients about nutritional information (Morris *et al* 1999). Buttriss (1997) argues that confidence seems to vary between different areas of nutritional advice, while Drenthen (1997) argues that this is perhaps because GPs feel that they do not have sufficient 'proof' that their advice will be effective.

Other research has argued that the variation may be explained by the lack of nutritional knowledge in the primary care team itself (Moore *et al*, 2000) and a number of studies have

suggested that GPs need more nutrition counselling skills (Levine *et al* 1993; Young *et al* 1983). Although it has also been shown that some GPs are aware that they have a lack of knowledge and nutrition counselling abilities (Drenthen 1997), some evidence suggests, that where training has been provided, it is not necessarily satisfactory (Buttriss 1997). Interestingly, in a Scottish study, Murray *et al* (1993) make a similar point and argue that overall the primary care workers had a broad understanding of recommendations for 'healthy eating', but there was some confusion over specific aspects of these recommendations.

Turning to the theme of ethics, it has also been argued that many GPs doubt that they are entitled to interfere with patients' lifestyles unless asked (Drenthen 1997). Even when they do consider they should provide advice, the patient themselves may be perceived as a 'barrier' to achieving nutritional improvement (Kottke, Foels, *et al.* 1984). A more recent study has therefore found that health professionals believe that the public are unwilling to make dietary changes (Moore *et al* 2000), particularly because a lack of motivation on the part of the patient is perceived to be a key barrier (Buttriss 1997).

Quantitative approaches have identified that GPs regard diet as having an important influence on health. However, they have focused upon exploring the gap between this view and actual practice, by identifying 'barriers' which are offered as explanations for why nutrition provision varies so widely. Although these approaches do not expand on the social processes which may be responsible for their findings, they do nevertheless highlight a number of key themes. Thus they identify that GPs' training in nutrition varies quite substantially; that GPs perceive a lack of evidence about the effectiveness of dietary advice; and they question the patient's motivation to change their dietary patterns.

3.4.1 Sociological approaches to prevention in general practice

No indepth studies have therefore attempted to explore professional perspectives on providing 'healthy eating advice', however, several key studies which have focused on prevention more generally, do identify and expand on what the Clinical Nutritionists call 'barriers'. Although these indepth studies do not discuss diet in any detail, they do offer insights into the processes which appear to play a role in the construction of these 'barriers'.

Both of these studies reflect the findings of the Clinical Nutrition studies I have just discussed and were based upon the idea that, in terms of enthusiasm towards health promotion in general practice, there is a considerable gap between the policy makers and the GPs themselves. Addressing the broader context of this problem, Beattie (1991:162)

observes, that sociology can play a key role in helping to understand "what health promotion is" and why it may be the "subject of fierce and incessant disputes among professional practitioners and policy makers."

The first of these key studies, was an investigation by Williams and Boulton (1988). This study aimed to promote discussion of the relationship between the 'rhetoric' of prevention and the 'cultural construction of clinical realities' (Kleinman 1980) among individual GPs. The second was a later study by Williams and Calnan (1994), who interviewed GPs to explore the construction, value and priority that 'rank and file' GPs place on prevention as a professional undertaking. Bearing in mind the theoretical discussion at the beginning of this chapter, it is possible to identify contrasting accounts of 'professionalism' in both these studies.

3.4.2 Enthusiasm towards preventive work

Having considered the theoretical background to these key studies in the first part of this chapter, I will now begin to explore their findings in more detail.

Williams and Boulton

In the findings presented in their 1988 publication, Williams and Boulton identified four different orientations towards prevention, based on a study of GPs who were also advisers and course organisers; which was also associated with other work involving GP trainees (Boulton and Williams 1983; Tuckett *et al* 1985; Boulton and Williams 1986). In the trainer study, which I will concentrate upon here, they interviewed 34 experienced GPs in the Oxford and SE Thames Regions in England. The study classified the professionals' views into four categories, which reflected a considerable variation amongst GPs in their enthusiasm and approach towards preventive work. Having few qualms about this type of work, the first group saw it as a new technical service to build into routines. The second, while appearing more concerned about being responsive to the patient's problems, were more reserved about different forms of health promotion, because lifestyle issues were seen as intrusive and moralising. A third group appeared to take a more 'integrationist approach', whilst the final group saw this work as being 'bio-medically disruptive'. From their study of trainees however, it was found that while in general they knew about health education topics, these were largely disease-oriented and they took a relatively narrow view of health education (Boulton and Williams 1986).

Williams and Calnan

Williams and Calnan's (1994) paper was based on data drawn from a national UK study and like Williams and Boulton's, included face to face interviews with 40 GPs. Instead they were sampled from selected geographical areas, and the GPs represented a range of different ages, practice sizes and types of practice (ie. single handed or partnership). The authors do not publish a classification system *per se*, but instead identified a number of key themes which reflect issues raised in these earlier studies. This particular study was undertaken to examine how changes in GPs' contracts may have influenced their views of prevention. However similarly to Williams and Boulton's research, this study also explored how this type of work was seen as being 'biomedically disruptive', because GPs explained that they had little time to undertake it and felt it was a distraction from curative medicine. This study therefore revealed that GPs found preventive work both tedious and boring and were subsequently delegating it to lower status colleagues such as practice nurses. Likewise they also identified the uncertainties of and showed much ambivalence towards the effectiveness of behavioural change and the problem of patient motivation. Finally, there was also a similar concern that it represented a moral intrusion into patients' lives and may also increase anxiety levels unnecessarily. Williams and Calnan do note however, that their study showed a greater degree of polarisation than Williams and Boulton's and they suggest that this may be because their own study had a greater age range. To make a comparison between these studies more straightforward, I will in this chapter concentrate only upon these polarised orientations.

3.4.3 Representational accounts

These findings show some similarities with the quantitative research referred to in *Section 3.4*. However, taking these findings at face value, fails to recognise the complex processes which underlie GPs' views towards preventive work and their accounts of professionalism. Based upon a theoretical insight from Caws (1974), Williams and Boulton (1988) argue that the GPs in their study were drawing upon contrasting 'representational models' of general practice. These they argue were abstractions of their clinical experiences and were shown in an earlier study to be reproduced more widely in the local sub-cultures of general practice (Health and Prevention Project 1987). Similarly, for Williams and Calnan (1994), these accounts should not be taken on a literal basis, because it is more productive to see them as an inherent feature of a more general discourse about different professional approaches to general practice.

Practice

Williams and Boulton argue that these accounts do not only represent a particular image of general practice, but they also argue that these ideas were influencing how these GPs may actually practice. Williams and Calnan make a related point and argue that such ideas serve the respective interests of GPs because they "legitimate their limited involvement and professional preferences" (p.388). Hopton (1996) however has also considered the relevance of these different 'models' to general practice and suggests that a range of structural factors are defining the context and shaping the division and nature of work in primary health care. She argues that as a consequence, these 'models' influence the roles of individual primary care professionals, their relationships with each other and their client groups or populations. Therefore it is possible to view the type of constraints identified in quantitative studies as social constructions, which reflect different characteristics of these contrasting positions. For example, the differing views about time in both key studies reveals the interest and priority GPs attach to their preventive roles (see Horobin and McIntosh 1983).

3.4.4 Orientations towards prevention

Having raised the idea of 'representational models', I will now explore the two contrasting orientations in more detail:

Influence of a biomedical/ clinical 'model'

Williams and Boulton's (1988:236) study showed that those GPs who presented a more "Traditional" and "Clinical" orientation viewed preventive work as an addition to their main role of treating disease. Yet both studies also found that these GPs tended to be reluctant to get involved personally with this type of work. Williams and Calnan argue that their study raises questions about the extent to which GPs' concerns about professional competency and their patients' best interests are shaped by biomedical 'models'. Hence one example they provide is that GPs raised a concern that such work would lead to lower quality consultations, because of the time they would have to devote to health promotion.

In particular, both key studies showed that GPs found the evidence of risk factors associated with preventive advice as being 'uncertain'. Williams and Boulton (1988) suggest that this provides an example of how biomedicine confines doctors by legitimating a negative view of prevention. They go on to argue that these negative views may also come from patients who become more aware of the uncertainties which characterise medical knowledge (Williams and Calnan 1994) and which may the make doctors feel anxious about this type of relationship (Tuckett *et al* 1995). Yet both studies also argue that this is an

example of how GPs are legitimating their own involvement, by perceiving patients as holding them back from making changes. Such views may be based on stereotypes or discursive ways of talking about patient behaviour (Tuckett *et al* 1985). This was typified by how both studies identified that some GPs blamed patients for their unhealthy lifestyles and demonstrates the effects of medical power to define illness that I referred to earlier in this chapter.

Preventive 'model'

Williams and Calnan's paper says very little about the GPs who were more enthusiastic about health promotion work. Williams and Boulton however do talk in more detail about the other GPs' views, and those that had a clear idea of health promotions aims, and their own role in promoting change and encouraging greater self care. In contrast to the more 'conventional' group which they identified, they argued that these GPs viewed health promotion work as practice policy, and that their enthusiasm was based upon a personal commitment. The idea that they were drawing upon a different 'model' was apparent through a number of findings and appeared to lead to an opposing view of this type of work and their relationship with patients. Hence Williams and Boulton argue that it was apparent that they had taken on board the rhetoric of health promotion and emphasised that general practice was well placed to educate patients. In contrast to the less enthusiastic GPs, they were wary of the dangers of blaming patients for being 'victims', and instead emphasised that unhealthy behaviour was caused by cultural factors. Their role therefore was said to be about encouraging greater responsibility for healthy behaviour.

Although it was suggested that these GPs were viewing their patients more positively, such approaches are not without their problems, because these alternative 'models' may still lead to an authoritative claim 'to know'. Hence it is also possible to identify how they enforce a particular way of thinking on the social causes of poor health, and subsequently the GP's right to intervene. While these GPs did appear to be sensitive to 'victim blaming', Williams and Boulton argue that there remained an assumption that good communication alone will solve patients' problems (see Calnan *et al* 1986). Reflecting the rhetoric of health promotion which I mentioned in the previous chapter, they also draw upon the idea that unhealthy lifestyles are 'baggage' which can be removed.

3.4.5 The implications for practice

I argued earlier that Williams and Boulton drew upon the ideas of Caws (1974:3) to argue that there was a need to distinguish between 'representational' and 'operational models' of general practice. That is a distinction between the "the way the individual thinks things are" and 'operational models' which correspond "to the way he practically responds or acts".The

main practical issue for Williams and Calnan, was that GPs appeared to be delegating preventive work to practice nurses. However, as I already mentioned, both studies also found that GPs had a tendency to blame victims for their behaviour.

These issues for Stott and Pill (1990) are extremely important, because they say that the variation in how general practice is represented must also affect the way doctors practice. Thus they argue that the degree of respect that GPs give to lay views or the understanding they give to their concerns will vary tremendously depending upon the approach taken. For Calnan *et al* (1986) these issues are also vitally important, because an understanding of the lay perspective is necessary for GPs' ability to deal with health promotion and dealing with patients more generally.

While both studies revealed that some GPs felt that they had the right to counsel their patients about their lifestyles, Williams and Calnan (1994) say that their findings cast doubt on the idea that GPs are simply attempting to increase their power and professional status. They suggest that the limited nature of 'creeping medicalisation' in their study shows that this is more a case of how GPs were arguing for a limited role. So they say that GPs felt preventive work requires a greater degree of involvement in patients' lives, and this may be viewed as an unnecessary moral intrusion, or further still, beyond the GPs' remit. Hence they argue that this provides some evidence that this requires a more mutually-participative form of relationship, which doctors may be reluctant to participate in (Calnan *et al* 1986). This is supported by similar findings from a more recent qualitative study of GPs providing smoking advice. Thus Butler *et al* (1998) have suggested that GPs felt talking about this topic could potentially damage their relationship with patients. Additionally in another recent study, Lawlor *et al* (2000) also revealed that GPs were reluctant to provide lifestyle advice, because they felt that environmental factors were more important and that they had very little influence over them.

It has been suggested that the UK medical profession remains ambivalent about the role of nutrition in disease prevention (Pract Nurs 1994). Furthermore, it has also been argued that despite endorsements by the Royal College of General Practitioners, there has been a large body of academic and professional medical opinion that recommends no action or teaching on the subject of nutrition (Tunstall-Pedoe 1992). While these indepth studies do not discuss specific types of preventive advice in any detail, some of the issues which they raise may shed some light on the 'barriers' identified in the Clinical Nutrition studies (*see Section 3.4*), and may be an example of how some of the rank and file GPs remain divorced from their professional bodies' priorities (Freidson 1988). It is not possible to expand on why nutrition rates vary so greatly. However the idea that some GPs perceive that there is a lack of evidence about the effectiveness of dietary advice, and the idea that they question the

patient's motivation to change their dietary patterns, both echo the findings of these indepth studies more generally.

3.5 Chapter summary

While for Beattie (1991:162) debates about "What health promotion is" may be the subject of much debate in the health services, the studies explored in this chapter do not adequately explain either lay or professional perspectives on providing 'healthy eating advice'. However, debates on medical power and the concept of 'professionalism'; the 'lay' studies of Calnan (1987) and Stott and Pill (1990) and the 'professional' studies of Williams and Boulton (1988) and Williams and Calnan (1994), do provide a strong basis for exploring this topic further. Nevertheless, it is only possible to make some tentative comparisons with quantitative findings. Therefore Beattie's words appear particularly relevant here – that there is still a strong need for a systematic clarification and fundamental review of different forms of contemporary health promotion.

4 Methodology: Constructing plausible stories

4.1 Introduction

The previous two chapters have outlined an analytical focus upon the social processes that create and sustain both individual and shared meaning. In this brief chapter, I want to explore the philosophical justification for this approach and consider its practical application in social settings. To establish how the methodological justification for a study should be treated as a separate entity from the research design itself (Melia 1997), the next chapter will describe the actual methods used in this study.

It has been argued that a methodological discussion is necessary, because it facilitates an awareness of the potential implications particular decisions may have during the course of a project (Seale 1999:ix). Mason (1996) argues that, on the whole, such concerns should be pragmatic and that all of the research process needs to be informed by philosophical debates. This helps to maintain a logical consistency; justifies why decisions were taken; and provides structure and guidance where they are needed.

4.2 Debating 'reality'

Methodological debates centre on concerns about the status of the knowledge, or the 'reality' that research produces; and debates about social reality are often presented as the twin problems of epistemology and ontology. The former concerns different ways of 'knowing' and the latter refers to the nature of 'reality', or what is 'out there' (Gergen 1999). However, the two are linked together in a way that is directly relevant for social research.

For Mason (1996), an understanding of this relationship is essential because there has to be some logic between what you think you can know about the world and what you can actually ask people about it. However, there is considerable debate within the social sciences about these issues, often stereotypically associated with either quantitative or qualitative approaches. Thus, quantitative methodologies are generally positivistic - that is there tends to be an assumption that 'facts' and 'truths' can be produced objectively, while qualitative methods are often more open-ended and challenge positivism's essentialist claim to *know*.

Qualitative researchers challenge the positivists claim that they can be 'objective'. This is because they argue that the world is an inherently more complex place than is assumed by positivism. Instead, they suggest, we should be concerned with subjectivity, that is with understanding the individual's shared and personal views of 'reality'. Philosophically, positivism argues that the 'real' world (i.e. the ontological) can be directly observed by the researcher. However at the other extreme, a post-modern turn has led to the conflation of epistemology and ontology, suggesting rather controversially, that there is no such thing as 'reality' at all. For post-modernists, any 'real' foundation to knowledge is called into question and they maintain that all knowledge is constructed and contextually relative.

Silverman (1997:14) argues that there are no principled grounds to be either qualitative or quantitative in approach and that it depends upon what you are trying to do. This point is fundamental to this thesis, because the research aims outlined in the next chapter do necessitate an indepth approach (especially because survey methods appear to have overlooked a vital set of social processes). On first appearance, these different positions may seem to be completely irreconcilable. Seale (1999) however, argues for a more pragmatic approach, which is necessitated by the somewhat nihilistic tendency of debating what is 'reality'. He argues that there is very little point in trying to resolve these debates and suggests instead that they should be used as 'resources'.

In the remainder of this chapter, I want to consider how these debates can be used to help establish a position that is relevant for this thesis and which is consistent with its aims. I will therefore be exploring how the post-modern principles of subjectivity and also positivism's objectivity, can be combined in a way that enriches social research. However the constructionist position taken sits much closer to the post-modern position, but with a greater emphasis upon shared meaning and the ways that people make sense of, and manage their day to day lives.

4.3 Unpacking 'normality'

Practically speaking, the primary purpose of this present research is to try to understand the cultural meaning of respondents' views on food and health within the context or 'realities' of their everyday lives. Before considering the philosophy behind the 'interview' as a research method, I want to outline a more practical position on social 'reality', which transcends the dilemmas raised by many philosophical debates. So how can we can step out of this philosophical continuum, yet take seriously the goals and ideas of researchers at both

of its poles (Miller and Glassner 1997)? For my own thinking, Gergen's (1999*): 'An Invitation to Social Construction'* was particularly inspiring.

For Gergen (1999:50) and other social constructionists, at the very core of this approach is the need for reflexivity. That is:

> *the attempt to place one's premises into question, to suspend the 'obvious', to listen to alternative framings of reality, and to grapple with the comparative outcomes of multiple standpoints. For the constructionist this means an unrelenting concern with the blinding potential of the 'taken-for-granted'.*

In the previous chapters, I argued for a need to unpack either 'lay' or 'professional' understandings of food and health. However, although it was established that these were located within two very different social settings, the constructionist position is applicable to both. This is because it attempts to explore the very processes where knowledge and views are unproblematically assumed to be 'normal'.

At the heart of social constructionism lie a number of core ideas. Schutz's (1970) *phenomenological* position for example is based on the view that our experience of the world is governed by our 'natural attitude'. By this, Schutz means that our sense of normality is a by-product, not of the world as it is, but of what we take for granted. It also echoes Garfinkel's (1967) *ethnomethodological* position, where he argued that linguistic expressions are used to achieve what we take to be normal and taken for granted. Like Schutz's notion of the *homunculus*, we treat words as if they match the objects to which they refer and therefore 'make do'. Subsequently, social constructionists are therefore not concerned with whether knowledge is 'real' or not. Instead they aim to unpack or deconstruct the very fabric and shared cultural meanings that hold the social world and our everyday lives together.

4.4 Interviewing

It has been argued that interviewing is often chosen as a research method because it is synonymous with qualitative research (Mason 1996). In my defence, I chose interviewing above participant observation or other qualitative methods because it was the most suitable method available. Primarily I needed a method which would provide a high degree of interaction, but also be flexible enough to accommodate issues I had not anticipated. This seemed particularly pertinent to this present research, especially considering how very little appears to be known about lay and professional views on 'healthy eating advice'.

Interviewing therefore offers the potential for more interaction than observation can, and allows ideas to be developed or for order to be deliberately put under stress (Dingwall 1997). Furthermore, interviewing was also better suited to this research, because of the pragmatics of gaining long term access to either GPs or their patients. I identified that this would have been difficult to obtain, therefore interviews offer the further benefit of requiring less commitment and can be treated as a 'one off'.

4.4.1 Methodology of interviewing

I have now argued for a constructionist position on cultural 'reality' and that the indepth interview was the most suitable method available. However, I will now consider that although interviewing may produce certain limitations on the generation of data, the strengths I outlined above are logically consistent with this study's aims and requirements. So how does the interview method logically fit with the need for exploring our 'natural attitude'?

Post-modern debates raise the possibility that the interview's relationship to any 'real' experience is not merely unknown, but in some sense is 'unknowable' (Dingwall (1997:56). Indeed, at the core of Denzin's (1989) *interpretive interactionism* are not just questions relating to the relational and biographical processes of social interaction, but also concerns about the construction of 'reality'. Goffman (1959) for example argued that our primary task in social life is to create a sense of public identity and that we must understand language as a form of social interaction. Schutz and Garfinkel however, do not take such a provocative approach as Goffman. For many therefore, his ideas are deeply unsettling because he argues that we all perform for each other whilst knowing at the same time that what we seem is scarcely who we are (Gergen 1999).

The proposition that our interviews are meaningless beyond the context in which they occur is a daunting one. Like Miller and Glassner (1997:99), I am not prepared "to discount entirely the possibility of learning about the social world beyond the interview in our analyses of interview data." They face up to the issues raised by Goffman and others, yet take a practical position which transcends their concerns. Hence for Miller and Glassner (1997:100), the interview "...provides us with a means for exploring the points of view of our research subjects, while granting these points of view the culturally honoured status of reality."

Such an approach requires treating the interview itself as a social construction (Dingwall 1997). Although there are inherent problems in assuming that such methods are a way of

getting 'closer' to respondents (Silverman 1993), it is the constructionist concept of reflexivity which helps to transcend these dilemmas. The interviewer therefore attempts to understand the world from the subject's points of view and helps to unfold the meaning of individual and group experiences (Kvale 1996). However, at the same time, we have to recognise that interviews are sites where data are generated between an interviewer and interviewee, rather than occurring in any form of 'natural setting' (Dingwall 1997; Mauthner *et al* 1998). Thus for (Gergen 1999:50) "we must be prepared to doubt everything we have accepted as real, true, right, necessary or essential". This therefore raises the possibility that we can be 'objective' in spirit and simulate induction. As Charmaz (1995:54) declares - this is in the sense that:

> *We start with the experiencing person and try to share his or her subjective view. Our task is objective in the sense that we try to describe it with depth and detail. In doing so, we try to represent the person's view fairly and to portray it as consistent with his or her meanings.*

While the interview may not provide a 'natural setting' as sought by ethnographers, the constructed nature of the interaction between myself and respondents is a key consideration reflected in the following chapter. Interviewing allows exploration of areas within individual awareness and the extrapolation of personal and shared meaning (see Lofland and Lofland 1995). Fundamentally, this puts the emphasis on the respondent's point of view and subsequent probing by the interviewer may help to minimise misunderstandings and elucidate issues in more depth (Kvale 1996). Crucially, the interactive element of interviews adds an additional depth to the research because it allows an exploration of how people articulate and work out their responses (Mason 1996). This is why I believe that more invasive methods such as videotaping would not have provided the level of interaction required and focus groups would have been more likely to generate socially-accepted or presentable accounts (Bloor 1997).

4.5 Quality in research

So far I have distanced myself from the positivist idea of truth and objectivity, but I have also challenged the idea that all meaning is relative, and that interview data are meaningless beyond their site of construction. I want to now consider how the constructionist position which transcends these debates, can be coupled with further ideas which may help in producing qualitative research of the highest standard.

Returning to the post-modern concept of relativism, Silverman (1997:19) argues that, by challenging the positivistic idea of 'truth', we must consider the messages that are sent to research-funding agencies by being negative about the nature of social reality. This is namely

that they should not fund qualitative research because even its proponents have given up any claims to validity. Yet what constructionism can sell to the research community and beyond, is the value of its critical perspective and above all how it aims to question what is often taken for granted. There is therefore a meaningful difference between being sceptical about the bases of our claims and recognising that 'validity' is a problematic concept for qualitative research, while carefully examining the grounds upon which these claims are founded (Sanders 1995).

For Seale (1999), a modified form of realism which has a reflexive attitude is essential to putting out a positive message about social research. This fits well with the principles of social constructionism, because it is a pragmatic methodology which treats knowledge as being 'real', at least in the sense that it means something to us and influences what we say and do. Explaining this position further, Seale draws upon Hammersley's (1992) concept of *subtle realism* to argue that we should define knowledge as 'beliefs' about whose 'validity' we are reasonably confident. This, Hammersley argues, is because if we say that our 'beliefs' are always known without certainty, we could always be wrong.

Hammersley argues that as researchers, we make 'truth' claims but these do not change the relative aspects of reality. Therefore, the aim of social research should be to represent 'reality' in some way but not to reproduce it – and which appears to be akin to Schutz's (1967) postulate of 'adequacy'. As researchers, Hammersley also argues that we are producing an abstraction of 'reality', rather than a facsimile. In practice therefore, such an approach can actually heighten the sensitivity so needed in qualitative research. Thus as Schutz (1967) said so eloquently, our purpose as researchers is to be objective in exploring human subjectivity.

Researchers can therefore have a *spirit* of objectivity if they are reflexive about the decisions they make. As Hammersley (1992) says, only if we do maintain this sense of objectivity, can we retain the values of an ethnographic approach. That is, seeking to understand and explain people's behaviour and 'beliefs' independently of their supposed 'truth', while not lapsing into relativism. It is somewhat naïve to assume that the unstructured interview is not a form of social control in itself (Hammersley and Atkinson 1983). However by adopting a reflexive position which considers the researcher's own role and the decisions made, these factors can contribute to the research process (Bloor 1997) and the analysis of these effects on the interview (Dingwall 1997).

4.6 Grounded theory

According to Charmaz (2000), Glaser and Strauss's *The Discovery of Grounded Theory* (1967) which was acclaimed for providing systematic inductive guidelines for data collection and analysis, was written at critical point in social science history. For Glaser and Strauss, there was at the time a strong need to counter the undermining of ethnographic methods, as assumptions of truth and objectivity in quantitative theory furthered the quest for precise measurement. Their methodology offered analytical procedures which were acclaimed because they offered the potential of taking the researcher beyond the interview data to a more conceptual level. Using a coding process, theory therefore emerges from and is grounded in data. Charmaz says that Glaser and Strauss's work was revolutionary because it challenged the arbitrary divisions between theory and research; the claims that qualitative research was a precursor to quantitative study; beliefs that qualitative methods are unsystematic and also the separation of collection and analysis.

However, since the 1960s, Glaser and Strauss appear to have fallen out over the future direction and philosophy of grounded theory (see Glaser 1992). Strauss and Corbin's (1990) method has been labelled as 'forcing' by Glaser (1992), and he prefers to see his own method as a less restrictive process of 'emergence'. Strauss and Corbin (1998) on the other hand believe that more rigorous procedures are necessary to create analytical codes, and avoid the more descriptive style of analysis emphasised by what Geertz calls 'thick description'. Nevertheless, external criticism from postmodernists and poststructuralists have posed further challenges to either version (e.g. Denzin 1994), attacking the method's positivistic premises and claiming that grounded theory assumes an objective reality which can then be verified by the researcher through the use of analytical codes – in other words - hypothesis testing.

When considering these criticisms, the fundamental dilemma for the researcher therefore, concerns the methodological problem of induction and deduction which I have already discussed earlier in this chapter. By adopting grounded theory therefore, the potential danger can be envisaged as an unsatisfactory scenario where theory may force the data or even suppress reflexivity because of the systematic and formulaic nature of the method. Yet, it should not be forgotten that the attraction of grounded theory was rooted in idea that theory emerges from, and should be grounded in the data. The emphasis on the relationship between data and theory was placed upon *plausibility*, whereby theory helped to enrich descriptive data by guiding researchers to produce conceptually dense theory (Strauss and Corbin 1998). As this present study is an empirical research project which draws upon sociological theory to illuminate health promotion policy and practice, how then can

grounded theory's aims still be maintained whilst accepting the criticisms that it is positivistic?

Charmaz (2000:523) believes that postmodern theory can be used to inform empirical study, rather than serve as a justification for abandoning it. In doing so, she draws upon a philosophical argument akin with the discussions above, that we should change our conception of social life "from a real world to be discovered, tracked, and categorised to a world made real in the minds and through the actions of its members." In terms of collecting and analysing data, Charmaz calls for a *constructionist grounded theory* that means collecting data which is analysed with the primary aim of seeking meanings. "Posing new questions to the data" she says, "results in new analytic points".

The aim with empirical research such as this present study therefore is not to verify theories, instead we must go further than surface meanings or presumed meanings, continuously going to and fro between empirical data and theoretical concepts. According to Melia (1997), in their 1967 book, Glaser and Strauss stressed the point that researchers should feel free to develop the grounded theory method to achieve these goals. Charmaz provides one possible redevelopment, and Denzin's (1989) development of Garfinkel and Goffman's ideas, further opens up the possibility of a more creative and flexible methodology. This means therefore that a grounded theory can according to Melia (1997) include the principles of interpretive interactionism that I referred to previously, drawing upon biography, history and emotion - yet still with methodological rigour.

Finally, it is worth considering Bechhofer's (1974) argument, that in many senses, Glaser and Strauss's grounded theory offered nothing new and merely represented a labelling of a process which had long been accepted as good practice in sociology for many years. Accepting the principles rather than all the details, I have in this chapter attempted to develop a consistent philosophical argument concerning the construction of interview data. By adopting a constructionist grounded theory, which draws upon some of the original aims of grounded theory, the meanings and actions of respondents can take priority over the goals and interests of the researcher. The reflexive use of theory therefore can help inform, rather than dictate data collection and analysis.

4.7 Conclusion

In the following chapter I will outline the research methods in more detail, but the aim of this chapter was to avoid the scenario where the methodological tail is wagging the dog

(Melia 1997). Adopting the advice of Mauthner *et al* (1998), I have tried to steer clear of what they call a 'naïve realism'. So, while we should reject the idea of getting nearer to the 'truth' (Bloor 1997), a subtle realist approach does mean we potentially have the opportunity to convince because we have not given up on the idea that our research has no meaning beyond the interview context. Qualitative methods are however inherently complex and as Strong states (1979b:250), perhaps under these circumstances "the best we can hope for... is a plausible story." Considering the problems I have identified in this chapter, the reflexive attitude which a constructionist grounded theory offers (Charmaz 2000), therefore appears be a practical way forward.

5 Research methods

5.1 Introduction

We do not claim that attending to the relevance of [methods] in a study makes the study more truthful, but only that the truth claims of the researcher can be more systematically assessed by readers who share a concern with the relationship between what was observed and how it was accomplished (Altheide and Johnson 1994:494).

In the spirit of Altheide and Johnson's words above, the primary aim of this chapter is to explain the various methods which have formed the basis for the findings presented in this thesis. A secondary aim is also to illustrate how these methods were logically consistent with a social constructionist view on the status of interview data. Therefore this chapter discusses the methods used in this research, by building on the methodological foundations outlined in the previous chapter.

Because the qualitative research process is a creative one, this chapter will explain how strict methodological rules could not always be applied (Seale 1999:49). As I argued previously, it is an imperative of qualitative research that it is approached with an open mind, hence this chapter aims to demonstrate that the research was rigorous and strategic, while remaining sensitive and flexible to changing needs and circumstances.

This chapter takes a chronological structure and presents each stage of the research mainly in the order it was conducted. These stages are an examination of the research process prior to interviewing, the fieldwork stage itself and finally the post-interview phase (based largely around coding and analysis). To reflect on the decisions made, I will be relying heavily upon two books. This is because they offered many pragmatic insights into qualitative research, without over-saturating their approaches with theoretical concepts. While there are many books that describe the theory behind qualitative methods, Lofland and Lofland (1995) and Mason (1996) therefore proved invaluable.

5.2 Research aims

In consideration of the theoretical and empirical issues explored in the previous chapters, the research aims of this thesis are as follows:

Main aim:

To investigate socio-economic and cultural influences on the provision, receipt and implementation of 'healthy eating advice' in general practice.

Specific aims:

To explore in depth the professional and personal understandings of 'healthy eating' issues among GPs, their accounts of existing practice, and the potential of general practice as a setting for such discussion and advice.

To investigate social and cultural influences on lay understandings of food, nutrition and eating, in a sample of general practice clients.

To explore GPs' and clients' perspectives on consultations and interactions involving 'healthy eating advice' and information, and to study the influence (or potential influence) of socio-economic circumstances on these processes.

5.3 Before fieldwork

5.3.1 Redevelopment and sensitising

Although this thesis has been my own responsibility, the original aims were derived from a research grant proposal developed originally by my supervisors: *Kathryn Backett-Milburn, Jane Hopton* and colleagues. However, the same proposal then formed the basis for a *Chief Scientist Office* (Scottish Executive Department of Health) PhD Studentship, which I was awarded in October 1998. The original proposal had envisaged that a number of different Primary Care Professionals would be interviewed, along with clients who GPs would have selected to participate on the basis that they had received 'healthy eating advice'.

The original research proposal would have required a greater number of interviews and it therefore became necessary to adapt the research design to suit a PhD. In particular, I was able to decide in advance of further decisions about sampling that I would not have the resources to interview other members of the primary care team as envisaged in the original

research proposal. Instead, I decided to focus on GPs as gatekeepers, although there were a number of other changes that were made as a result of a sensitising phase.

Sensitising

After familiarisation with the relevant background literature, a pre-fieldwork sensitising phase was undertaken to help familiarise me with the research area. While this helped me appreciate what the research aims were about, this was invaluable in assisting with thematising and design of appropriate research methods (Kvale 1996:88).

Initially, I decided to interview GPs about their views on 'healthy eating advice' to expose me to the general practice setting. After conducting the interviews, these were transcribed and coded. For convenience, the GPs were recruited from a university general practice department and a topic guide was developed for the interviews with three male and two female GPs. One of the key changes that I made was to question the feasibility of relying upon GPs to conduct an audit of their patients. The original idea had been to ask GPs to identify patients who had received 'healthy eating advice'; then these patients would be invited to participate in the study. It soon became clear however, that if I had asked them to provide me with patients to whom they had provided 'healthy eating advice', then the list that I received would be based on their assumptions about what constituted 'healthy eating advice'. Increasingly, I became more aware of how the term had no common meaning. Therefore an 'audit' would not have been a suitable recruitment method and patients would have to be sampled by different means. Nevertheless this sensitising phase, as Britten *et al* (1995) argue, did also highlight the appropriateness of qualitative methods when researching a previously unexplored topic.

After interviewing GPs, the sensitising phase with professionals was complemented with five lay interviews. Again, an appropriate topic guide was developed. Four men and three women were recruited and this time I relied upon personal contacts from a range of different social classes. Reflecting the findings from the literature reviews presented previously, there appeared to be meaningful differences between the way that male and female respondents talked about food and health. Likewise, there were notable differences between the classes, and taking this into account alongside the increased policy emphasis on such groups (Dobson *et al* 1994), I decided that the lay sample should focus on people from 'working', rather than 'middle'-class groups.

A further benefit of conducting the sensitising phase was that it enabled development of the food inventory, which is a research tool I developed to facilitate discussion in lay interviews. Parry *et al* (1999) discuss a life-grid tool which they used to help explore smokers' attitudes

indepth. They argue that this helped to stimulate discussion and build rapport by giving their respondents something that they can work with. Such a method would not have been appropriate here, but a tool was required to facilitate discussion. I first learned of the idea through a quantitative study by Patterson *et al* (1997) in the US. The authors discuss how they conducted a telephone interview to request if people had certain key foods in their 'pantry' and argue that it is a reliable way of examining dietary intake. While I was not aiming to verify what foods people were eating, such an approach, when adapted for the indepth interview, appeared to have a number of benefits. In comparison to other food assessment techniques (such as 24-hour recalls and food diaries, see Anderson 1995) it offers the potential of providing an insight into what respondents were eating without influencing their diet through the process of recording it. Additionally, views about how the inventory may not reflect what respondents were eating could also be explored.

5.3.2 Topic-guide preparation

Insights from the sensitising phase were used to help develop topic-guides for the main interviews. A full copy of both lay and professional topic guides are provided on Pages 1-2 and 5-6 of the *Appendix*.

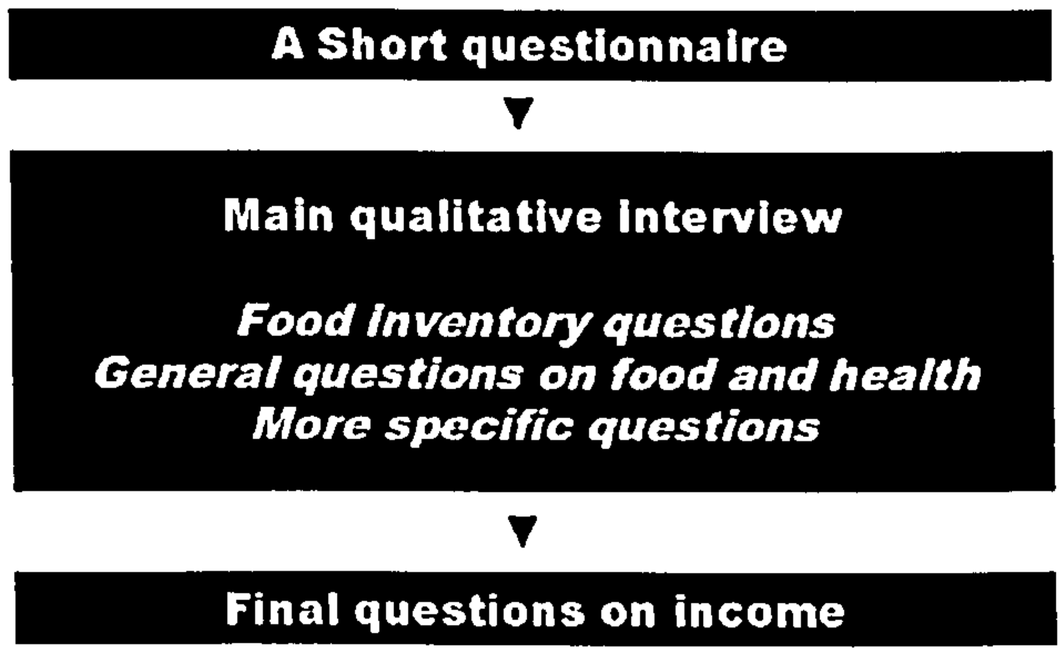
Expected time pressures necessitated that the format of the interviews be semi-structured, while still allowing for variation in question order. However, there were substantially fewer questions in the professional interview topic-guide, because the interview length was set at 45 minutes. This was because it became apparent that GPs would not spare more than this time. Questions were designed not to lead respondents and were prefixed with "some people might say..." to suggest that no views were necessarily fixed and non-negotiable. To increase the potential for spontaneity, consideration was given to question order both within the main topic-guide and the surrounding stages of the lay interview (see Lofland and Lofland 1995).

The questionnaire (*see Appendix Pages 3-4*) was devised to gather background information about lay respondents using the Registrar General social class measurement of job occupations. However, acknowledging the epistemological difficulties of measuring social class (Miller and Glassner 1997), I also aimed to ask respondents about what their parents' jobs had been, and at the end of the interview asked them about their salary. I positioned the questionnaire and food inventory discussion near the beginning of the main interview to help build rapport and provide a comfortable start to the interview process. Difficult questions were kept to the end of the schedule along with the question on salary, because it was expected that better rapport would have been established by then. To overcome any

sensitivity concerning their level of income, I used an income band table so that they did not have to provide a precise answer. For Lofland and Lofland (1995), this is necessary if some topics are of a sensitive character or potentially embarrassing to respondents or interviewer.

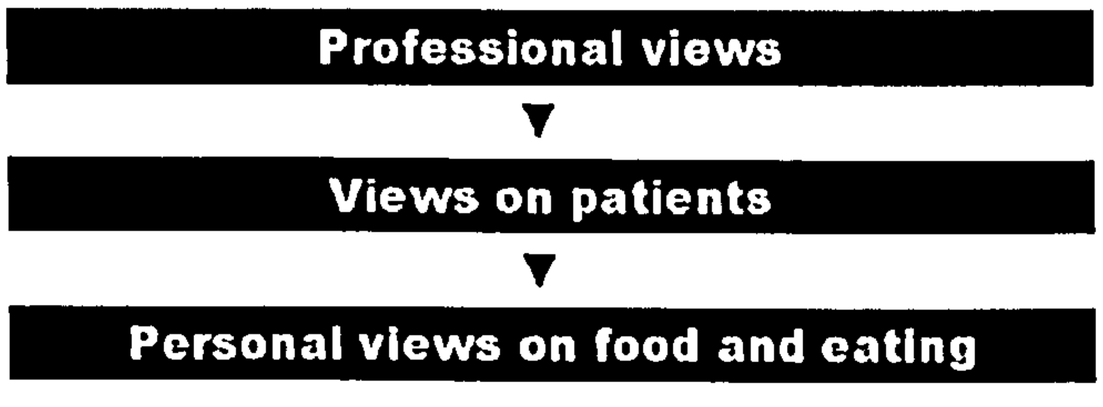
Reflecting how the study aimed to explore questions about 'healthy eating advice' within the wider context of food and eating, the questions were ordered in a way that gave respondents the opportunity firstly to talk freely about food and then about health more generally (*see Diagram 5.1 below*). Once these issues had been discussed, further and more specific questions were included about general practice and the 'Scottish diet'. A number of probes were also added throughout the schedule and were designed to ensure that areas I had identified were covered if respondents did not spontaneously discuss them.

Diagram 5.1: Lay interview format



Similar logic was used in the professional schedule but the interviews were divided into three discrete sections (*see Diagram 5.2 below*). No pre-interview questionnaire was considered necessary with professional respondents, but I aimed to ask at the start of the interview; when they graduated from medical school and how long they had been practising as a GP. This was deemed necessary as previous studies (Williams and Boulton 1988; Williams and Calnan 1994) have shown that generational factors may influence GPs' views on prevention. By enquiring about when they had trained, this avoided asking direct questions about their age and also gathered more meaningful data about the dates of their medical school training. Additionally, personal views on food and eating questions were placed later on in the topic-guide so that GPs could discuss 'professional' areas before potentially more sensitive 'personal' issues.

Diagram 5.2: Professional interview format



In both interview guides, essential information was provided to respondents before the interview began (See Lofland and Lofland 1995). A brief account of the research was provided at the start - aiming to provide enough information to satisfy curiosity without causing undue influence. Respondents were reminded about the guarantee of confidentiality and anonymity and that they could withdraw at any stage. They were also reassured that "some questions may sound 'silly' or 'obvious' but that people often had different views about simple things and that was why I was asking them". Even though they had agreed to participate, I also ensured that they were happy to be taped. At the end of the interviews, respondents were asked if they had any views about being interviewed and if they had any questions they wanted to ask me. I offered to answer any questions they may have when the interview was over to prevent interruption and help me to subtly stay in control.

5.3.3 Sampling

Mason (1996:83) says that "discussions of sampling are often absent from qualitative methods texts, and we should also dispel any notion that just because the studies are often small-scale, systematic sampling strategies are unnecessary". The strategy here is mainly purposive rather than representative, meaning that the sampling approach explicitly recognises its links with generating data and theory (Mason 1996). Because of practical factors, indepth interviewing requires a small sample and therefore respondents were being recruited with a specific purpose in mind.

As I have already mentioned, previous research and confirmation from the sensitising phase indicated that gender and lower social class should influence the sampling strategy for the lay respondents. Although there has been little research into gender differences within GPs' views on preventive work, Brooks (1998) suggests that female GPs tend to approach their work very differently. Therefore I decided that the GPs would be sampled by gender, and by age to represent a spread of time in practice. To capture 'working class' views, lay respondents were recruited within the class groups ideally between the Registrar General

classifications of III (manual) to V. The key reasons for focusing on this middle group between the most affluent and most deprived groups were that it would hopefully avoid a separate research area of food poverty (which did appear to be the case – *see Section 12.4.2*) and that higher status social groups appear more likely to follow nutritional guidelines (Mennell *et al* 1992).

Logically, GPs were to be selected from areas where the majority of patients were in this social class grouping. Because lay respondents were to be selected by GPs *(see recruitment Section 5.4 below)*, I aimed to sample them from three different practices to provide alternative perspectives on geographical locations and different practice types. Reflecting the focus of earlier studies on food and families (see Charles and Kerr 1988; Murcott 1983a), lay respondents were required to have primary school-aged children. To satisfy the gender and family component of the strategy, lay respondents would also need to be couples with children, because this would provide the opportunity to explore different perspectives from the same family. Additionally, lay respondents were also to be selected on the basis that they did not suffer from chronic diseases such as diabetes or coronary heart disease (CHD). I felt that such groups were more likely to have discussed food and eating within general practice and would therefore not be representative of the general population.

Translating these requirements into numbers, I decided to interview both partners in 15 couples and 15 GPs (which gave a total of 45 interviews). Following Kvale's (1996) suggestion, this number is an effective compromise between obtaining a representative sample and the resources available. However in making this compromise, I was reminded of Britten *et al's* (1995:108) warning that one of the most common mistakes made by qualitative researchers is "to collect far more data than they can hope to analyse properly". Nevertheless, one inevitable drawback was that sampling GPs by 'age' and 'sex' would split the variables into even smaller groups. Additionally, the need to interview both GPs and lay respondents also restricted me to one interview with each, making repeat interviews unfeasible. Nevertheless, these decisions are a compromise and reflect the exploratory nature of this work. As there have been no previous studies that have attempted to explore both lay and professional views on 'healthy eating' in general practice, these appeared to be appropriate sampling decisions.

5.4 Recruitment

It is one thing to decide for yourself about interest, appropriateness, accessibility and ethics; it is quite another gaining the acceptance of the people being studied (Lofland and Lofland 1995:31).

The sampling and recruitment stages of this research are not discrete stages. Although the broad sampling strategy was defined before recruitment commenced, the approach realistically had to be flexible enough to reflect the reality of gaining access. Lofland and Lofland's (1995:37) comments above were particularly valid, but I also heeded their advice that the researcher is more likely to be successful in their quest for access if negotiations are entered with "connections, accounts, knowledge and courtesy".

All of these were required in abundance, although it is interesting to note that the recruitment process was not difficult and those approached were nearly always keen to participate. It is possible that this may be due to the topic itself, although it may also be related to my personal approach. I have previously worked in marketing and sales and hence I felt that tenacity and confidence can be particularly useful skills when persuading people to give up their time to talk to you.

5.4.1 Ethical approval and other ethical considerations

Lofland and Lofland (1995) quote the psychologist Bronfenbrenner (1981) who said that the only safe way to avoid violating principles of ethics is to refrain from doing research altogether. So rather than take this drastic measure, a number of key ethical considerations were made. It was identified that recruiting lay respondents via GPs' lists would require official ethical approval. A successful submission was made to the *Lothian Primary Care Research Ethics Committee.* The application consisted of detailed information about the research including topic guides and correspondence to be used to recruit GPs and lay respondents (details of which are provided in the *Appendix*).

A number of ethical considerations were addressed at different stages of the research (see Mason 1996), although they were considered extensively before entering the field. In particular, severe negative consequences for the respondents were seen as unlikely because of the nature of the research topic. I also ensured that there were adequate procedures to ensure confidentiality and anonymity which would protect respondents from exposure. It was also believed that sensitive areas would probably not be covered which should minimise any issues of helplessness to myself or emotional distress to the respondents. Moreover, the implications for those participating were unlikely to be significant. Indeed, the exploratory

nature of this research and the focus and presentation on respondents' views should only serve to represent their interests. In terms of representation, however, it is an ethical requirement of any researcher to assume a position where the respondents' perspectives are faithfully represented (see Mason 1996).

5.4.2 Recruitment of key practices

Recruitment comprised of three phases: Key practices were needed to recruit lay respondents (See Bowler 1997); once these had been found, the lay respondents could be recruited. Finally, more GPs were needed when they could not be recruited from the key practices themselves.

To recruit the key practices, letters were drafted and focussed on the 'selling point' of "how during the sensitising phase doctors who had thought that they would have nothing to contribute actually found that they had a lot say." An initial approach to a practice which was believed to possibly be interested was unsuccessful. Practices were recruited over several months and meetings were arranged to discuss the research and work involved. Practice one ('Edingstone') was recommended by a university colleague, Practice two ('Walden') via a recommendation of the local health board's primary care health promotion department, and Practice three ('Burnside') via a contact made during a lay sensitising interview. An example of one these letters is provided on Page 7 of the *Appendix*.

Decisions to participate were made easier by Practices one and two being single-handed practices. In Practice three, I had to attend a practice meeting and gain agreement of a number of GPs, although this had the by-product of helping to gain respondents for the professional sample. Despite initial agreement by this practice they did express some concern about the ethics of recommending patients, but were later reassured by the project being ethically approved by the Health Board. Interestingly, and as is apparent in the findings, out of the nine GPs who worked at the practice only six female GPs attended (and none of the three male doctors).

Suitable practices were screened to determine the likely social class mix of their area, and verified using a ranked list provided by the Information and Statistics Division Scotland, of 104 practices in the Lothian Health Board area. All three practices (*see Table 5.1 below*) had a DEPCAT score of 4 or above but varied by the more detailed Carstairs index (Carstairs 1991) which quantifies relative deprivation and affluence using a combination of four variables. Out of a total of 104 practices in the Edinburgh area, Practice one was in the bottom quartile and Practice two and Practice three in the bottom middle. This meant that

the three practices were all mid-way between the most affluent and most deprived areas and met the sampling criteria. Note also that the practices represented a range of different city centre and semi-rural geographical areas, and their list sizes ranged quite considerably.

Table 5.1: Participating key practices

No.	Practice name (fictional name)	Practice size	Depcat[12]	Carstairs[13]	Rank	GPs
1	Central Edinburgh 'Edingstone'	Small - medium	5	2.30	95/104	1 male (although 2 females joined shortly after I approached the practice)
2	Central Edinburgh 'Walden'	Very small	4	0.35	69/104	1 female
3	Midlothian 'Burnside'	Very large	4	-0.29	56/104	6 female, 3 male

1 - Data: ISD Scotland 1997
2 - Depcat: A more generalised form of Carstairs
3 - Carstairs: The index is based on scores of the following four person-level variables from UK Census Local Base Statistics: male unemployment, households with no car, overcrowding (over 1 person per room), and head of household's social class categories IV and V. See Carstairs (1991)

5.4.3 Recruiting GPs

8 of the 15 GPs required were recruited through the key practices. The remainder were recruited using recommendations from GP4 (Michelle) in Practice three, or by selecting from the list provided by the Information and Statistics Division of 504 GPs in the Lothian Health Board area. I excluded GPs from more affluent DEPCAT 1 and 2 areas, and focussed on 4 and 5 where possible. Phone calls were made to a total of 21 GPs. 6 declined to participate; 5 on the basis that they were interested but could not spare 45 minutes and 1 due to another GP in the practice already participating. Phone calls stressed the guarantee of confidentiality and anonymity and the interviews were aimed at a 45 minutes maximum to persuade GPs to participate. GPs were told that "the research was into food and eating issues in general practice because very little was known about this area and we needed to learn more information." Very few asked any further questions, and despite insights from sensitising interviews, I tended to underplay the personal element of the interviews because I felt it might dissuade them from participating. So while recruitment was on the whole unproblematic, I may only have approached GPs who generally had strong views on this research area – revealing how the recruited sample is self-selected, rather than being truly representative. However, I did have particular difficulties contacting a GP from key practice 3 and decided after several attempts to include the GP pilot interview (GPP1 Janet) in my final sample of 15 GPs (*see Table 5.2 below*).

Table 5.2: GP sample characteristics

GP Name[1]	Gdr	Key Practice	DEPCAT[2]	Carstairs[2]	Practice	Graduation
Janet	Female		5	1.43	1974	1972
Gillian	Female	1	5	2.3	1999	1989
Edward	Male		5	1.43	1971	1965
Pauline	Female	3	4	-0.29	1984	1981
Michelle	Female	3	4	-0.29	1993	1986
Laura	Female	2	4	0.35	1996	1978
Barbara	Female	3	4	-0.29	1975	1970
Graham	Male		4	-0.17	1968	1963
Liz	Female	3	4	-0.29	1987	1974
Leonard	Male		3	-2.1	1982	1974
Martin	Male		4	0.94	1979	1972
David	Male	1	5	2.3	1989	1982
Karen	Female	3	4	-0.29	1995	1989
Robin	Male		5	2.3	1982	1978
Gareth	Male		5	1.23	1995	1988

1 - Pseudonyms **2 - Data:** ISD Scotland 1997

5.4.4 Recruiting lay respondents

Recruiting lay respondents required substantially more effort and flexibility than the GP sample had. The ethical approval necessitated devising a systematic and ethical approach to recruitment, although exact requirements varied according to each practice's circumstances. Practical reasons necessitated different approaches: In the single key Practices (one and two), GPs were able to provide me each with a list of 10 patients that met the sampling criteria from checking their lists manually. In Practice three the list size was more extensive and so the practice computer was used to find respondents by focussing on a postcode known to contain respondents in the required social class groups. Although class was determined differently by each practice, the respondent *Table 5.4* shows the successful uniformity of the sample determined from the pre interview questionnaire. While there were substantially more respondents from the III non-manual group than I had requested, none of the respondents fell into groups I or II. Furthermore while their incomes did vary substantially, they were all evenly spread around the mean household income for Scotland; and all of the respondents' parents had been in jobs which fell into the 'working class' category.

The main benefit of recruiting through GPs was that it provided quick access to people by using a 'gatekeeper' (see Argyris 1969) who could persuade people to participate and could screen for chronic disease. There were possibly some disadvantages of recruiting via the GP (such as that acceptance may have been related to their relationship) however this only rarely appeared to influence the interviews. Using the names provided to me by the practices, lay respondents were sent a letter on practice notepaper which was signed by their GP (*See Appendix Page 8*). This was accompanied by a patient information sheet (*see Appendix Page 9*) explaining the research in a simple non-technical account (Lofland and Lofland 1995). This explained that the research was about food and eating in Scotland and GPs had been asked to help find people I could interview.

The above contact letter did not mention that the research was examining the "potential of primary care as a setting for the provision of healthy eating advice" as it was believed that this would prevent respondents from being able to discuss food and eating issues in an unbiased manner. Roth (1970) says on this somewhat controversial point, and challenged by feminist methodologies (Olesen 2000), that the researcher does not want the subject's behaviour influenced by his knowledge of what the observer is interested in. Following Roth's (1970) suggestion, I decided that because respondents will not necessarily understand the precise details in the same way I did, it made little sense telling them everything about the research. I therefore also used paper without my department's name on it (*Research Unit in Health and Behaviour Change*) to prevent the title from influencing accounts. Confidentiality and anonymity were again promised and all names were removed from the transcripts (the list below uses pseudonyms). The letter stated that I would call at their house and specified a time and a date. A postage paid envelope was enclosed to enable them to either accept, reject a visit, or specify another time to call. This initial call would enable me to establish rapport and in all the households who agreed for me to call, no one then withdrew from the research.

Some lay respondents had to be followed up by a phone call or a house visit after 14 days (a condition of ethical approval) if they had not replied to my letter. At the follow-up visit, some then agreed to take part, and mentioned that they had "just forgotten to reply" This helps suggest that this was a productive sampling method, and following up those who have not originally replied can yield a higher response rate. In total, 33 household details were given to me by the three practices (*see Table 5.3 below*). 17 of these declined to participate or could not be contacted, although in one household the male only declined, which meant I had to decline the offer from his partner. 16 couples agreed to take part, although one completed interview was later withdrawn from the sample because her partner had left her. After contacting all the lay respondents on the lists, the quota of 15 couples had not been

met and a different doctor in key Practice three provided a further list. This GP kindly contacted lay respondents herself to recruit them saving me a preliminary visit, however this may have had an small effect on these interviews as one participant in this group was unsure of the purpose of my research as I had not been able to explain more fully beforehand. Notably different response rates were yielded by each practice with the smallest practice (Practice two) being the most successful. Interviews later revealed that this GP was highly regarded by her patients, which may explain this higher rate.

Table 5.3: Response rates by practice

Practice	Number of households provided	Acceptances	Interviews
1	10	3	6
2	6	4	7 (1 rejected)
3	17	9	18
TOTAL	33	16	31 (1 rejected)

I was consciously aware of an element of self-selection when recruiting lay respondents, and it is hard to comment on why they may have declined to participate. However on appearance, they often looked more stressed in comparison to those who agreed to participate and I had a gut feeling that they may have been less relaxed about food and eating issues. Perhaps therefore those who did take part were on the whole more happy and relaxed about these issues.

Finally, I also found that women were acting as gatekeepers to recruitment. They were more likely to be in when I phoned or called and were often responsible for persuading their partners to take part. This appears to reflect the roles that I explore in *Chapter 6*, but it did present a practical problem because I made a point of trying to interview their husbands first in case valuable time was spent interviewing one partner and not getting the other.

Table 5.4: Lay respondent characteristics

Female[1]	SES[2]	Number	Male[1]	SES[2]	Number	Household income average GBP [3 4]	Recruiting Practice
Deborah	-	L06	Colin	IV	L09	9360	Practice 2
Tracey	IV	L27	Keith	IV	L28	11440	Practice 3
Mary	IIIn	L13	Noel	IIIn	L21	11440	Practice 3
Rachel	-	L30	Jim	IV	L26	11440	Practice 3
Annabel	V	L11	Gary	IIIm	L25	13520	Practice 1
Sue	-	L05	Richard	V	L07	13520	Practice 2
Amanda	IIIn	L18	John	IIIm	L23	13520	Practice 3
Nicola	IIIn	L15	Peter	IIIn	L16	17680	Practice 3
Catherine	-	L29	James	IV	L31	19760	Practice 3
Alison	-	L02	Mike	IIIm	L12	19760	Practice 2
Phillipa	IIIn	L04	Scott	IIIn	L08	19760	Practice 1
Caroline	IIIn	L24	Ted	IIIn	L22	19760	Practice 3
Jennifer	IIIn	L01	Robbie	IIIm	L03	23400	Practice 1
Lynne	IIIn	L17	Stuart	IV	L20	24000	Practice 3
Jo	IIIn	L14	Simon	IIIm	L19	28600	Practice 3

1 - Pseudonyms
2 - Registrar General Social class grouping: I Professional; II Managerial/technical; IIIn Non-manual skilled; IIIm Manual skilled; IV Partly skilled; V Unskilled; Blank (-) "housewife"
3 - Household Income: Shown in £ (GBP sterling), and represents total earnings of both respondents after tax. One total figure calculated by taking the middle value in each respondent's income group which was then combined with their partners.
4 - Mean Income: The black line shows those who are over and under the mean annual joint income for Scotland (£17322 after tax) Source: Scottish Executive (2000).

5.5 Fieldwork

A decision was made to conduct the lay and professional interviews concurrently. This would allow issues raised from one group to be fed into the other. GPs were the first to be interviewed because they were recruited before lay respondents. The research was conducted in three phases determined by when names became available and other practical factors. The phases were November to December 1999, January to March 2000, and April to May 2000, and a maximum of three interviews were conducted per week to prevent fatigue and maintain alertness. Christmas was consciously avoided because of the likely effect of the festive season on food and eating discussions.

5.5.1 Piloting

Before beginning the main series of interviews, pilot interviews were conducted with one GP and with a lay couple (two separate interviews). The piloting was deliberately a small phase because of the extensive sensitising. I was able to test out the changes made from the sensitising phase and gain familiarity with the new topic guides and procedures. Based on feedback from GPP1 (Janet) the key change needed was to make GPs more explicitly aware of the personal content of the professional topic guide. This was because she had commented that the transition from 'professional' to 'private' had made her feel uncomfortable.

5.5.2 Managing interviews

The joy, anxiety and practicalities of interviewing have been well-documented by authors such as Lofland and Lofland (1995). The interviewer is posed with many tasks: They have to manage their time, quickly establish rapport, gain indepth knowledge, maintain a position, follow a script, think ahead, sensitively consider the respondents' needs and views, and above all - listen. Or as Mason (1996) puts this, it means considering what you ask, how you ask it, and how much you let them tell you. This section discusses some of these points and aims to explore what was very much a personal process.

Mutually convenient times were made with respondents for interviews. Reflecting my aims, GP interviews were fixed at 45 minutes for access purposes, but lay interviews normally lasted between an hour and an hour and half. GP interviews were conducted in the GP's practice, although one GP invited me to her house (GP4) as she worked part-time. All lay interviews were conducted in respondents' homes and interviews with each partner were arranged separately (although L27 and L28 were interviewed back to back for practical

reasons). A brief summary of the research, guidelines about the interview, the confidentiality and anonymity guarantee and consent to record were made before starting the interview. Before each interview the respondents were set at ease by making neutral 'small talk' (such as topical items or the weather). Lay interviews began with the questionnaire, followed by the main interview and were concluded with further questionnaire items as outlined earlier.

Bowler (1997) suggests that some individuals make better interviewers than others, but there are a number of guidelines which can help to guide the interviewer, regardless of personal skills. Kvale, below (1996:144) therefore, cites a number of criteria which can help the interviewer produce and manage the 'richest possible data' (see Lofland and Lofland 1995).

> The extent of spontaneous, rich, specific and relevant answers from the interviewee.
> The shorter the interviewer's questions and the longer the subject's answers, the better.
> The degree to which the interviewer follows up and clarifies the meanings of the relevant aspects of the answers.
> The interview attempts to verify his or her interpretations of the subject's answers in the course of the interview.
> The interview is 'self-communicating' – it is a story contained in itself that hardly requires much extra descriptions and explanations.
>
> From Kvale 1996:114

Secker *et al* (1995) offer some further pointers which I followed and which helped to practically apply the methodology I outlined in the previous chapter: For example, in framing questions I strived to set aside my own assumptions. Where accounts appeared to be taken for granted, they were still explored and where possible I explored respondents' views indepth to delve deeper into their understandings. Furthermore, I explored inconsistencies where they seemed apparent and I also heavily utilised a technique of sometimes repeating their last few words to stimulate responses.

Time was carefully managed, and in the GP interviews this meant that I had to skim over some questions because of the strict 45-minute time limit I had set. In the lay interviews, this was less of an issue, although I did find that respondents seemed to lose interest if the interview went on for too long. Fresh copies of the topic guide (see Lofland and Lofland 1995) were used in each interview and notes were made either on the topic guide or notepad to maintain track of questions that had been asked in the wrong order. This helped to inform further questioning and proved invaluable in the analysis phase. I felt that a flexible approach to question ordering had to be taken to what are essentially "guided conversations" (Lofland and Lofland 1995:85).

Reflecting how I had designed them, my interviews leant more towards a semi-structured format rather than being completely free-flowing. However, in some cases I made a note of a respondent's comments, if I thought that their issues would be worth exploring subsequently. All of the interviews were recorded for future transcription so I took very few notes during the interview. Lofland and Lofland (1995) say that the people being interviewed usually expect interviewers to be taking notes, but I found to the contrary that it seemed to disturb the positive atmosphere I had established. Only one interviewee (*L4* Phillipa) seemed consciously aware of the tape recorder and discussion became more spontaneous once it was switched off at the end. Post-interview notes when relevant were made after each interview, either on tape or in a notebook.

After the questionnaire, lay respondents were 'warmed up' (Mason 1996) with the food inventory that I had asked them to complete before I arrived. Some respondents had not completed it and so I asked them to "think about what was in their cupboards and jot down a list while we were talking about what they had". The inventory method proved to be a very productive way of facilitating discussion and although it may have engaged the respondents in the research before I arrived, I did not feel that this had a negative effect on the interviews. I had asked respondents to make comments next to the list, but no participant did, saying only that it was what they usually bought. As is apparent from the findings presented in *Chapter 7*, this seemed to be indicative of how their food choices were presented as a routine which was not normally questioned. I also aimed to keep partners out of the interview if they were in the house at the same time and tried to arrange interviews when the other partner was out. If they did sit in, I found that after a few minutes of the interview they left probably out of boredom from not being asked anything. Therefore no lay interview was conducted in front of a partner, minimising any 'leakage' between interviewees and allowing each interviewee to speak freely (see Bowler 1997).

GP interviews were more structured than lay interviews. The shorter time-scale necessitated a greater degree of control on my part and they appeared resentful on the occasions when the interview did run over. To avoid covering the grounds of previous survey-based work in this area (and to try and avoid the interview being treated like a test) I explained that I "just wanted to listen to their views. Furthermore, because GPs were more used to talking about their views, I found as Bowler (1997) has suggested that some people or groups made better interviewees than others. Indeed while GPs are probably more used to talking about their attitudes than most lay respondents, some said much less when it came to talking about their own personal views. The relevance of this will become apparent later, when I discuss how the way GPs talked about personal issues reflects their different orientations towards preventive work.

Finally, during the interview process, interview topic guides were rarely altered. I did not make dramatic changes to the guides because I wanted to maintain some consistency across the sample. Particularly in the lay interviews, questions that did not seem to work were skipped over or only briefly considered. Those which seemed to stimulate more of a response were covered in more detail and in some cases feedback from other interviews (both lay and professional) were fed back to play a subtle devil's advocate or explore their opinions further.

5.5.3 Positioning and getting along

The explicit recognition in qualitative research that the researcher is not a neutral observer necessitates some consideration of the researcher's role in the research process (Mason 1996). The interactive and interpretative nature of the interview meant that I was an integral part of generating data and it is essential to explain my position within the interview process. As Altheide and Johnson (1994:494) state, "the more a reader (audience member) can engage in a symbolic dialogue with the author about a host of routinely encountered problems that compromise ethnographic work, the more our confidence increases." Reflecting the methodological issues discussed in the previous chapter, Seale (1999) says however, that researchers should avoid turning their reflexive commitment into a confessional that devalues their contribution. Thus for Lofland and Lofland (1995:24): "Just because you are not 'identical' to the persons you wish to study, you should not automatically conclude that such research is impossible or even unusually difficult."

In attempting to produce the richest possible data, the crux of the problem lies in deciding where the researcher should position him/herself in relation to the respondents, and to sensitively understand what exactly that position is. The stance taken was informed methodologically from the position of subtle realism outlined in *Chapter 4*. I took the view that it was my role to maintain a sense of detachment when exploring respondents' subjective understandings. While it was important to build rapport, my position was of a researcher, not a friend, a counsellor or anything else for that matter (Schutz 1967). I adopted both a 'learner role', that I should be open to ideas, but competent where necessary so that I did not patronise respondents (see Lofland and Lofland 1995). This even extended to dress code, so I dressed appropriately for both groups. However the researcher must also decide if the stance taken is to trust or suspect respondents' accounts (Silverman 1993). I had no reason to believe that people would lie to me, so an element of trust was essential. Yet, I had to explore accounts fully with respondents to ensure that they were being honest to themselves (Lofland and Lofland 1995) but interviewing both partners did help provide a

form of 'verification'. While acknowledging the problems in gathering couple or household accounts, in *Section 9.4.1* I do discuss briefly the benefit of having a second view on the same family setting

Rapport had to be established and methods were used which helped to reduce the potential distance between researcher and respondent. My position as a young (25 year-old), white, southern, English-sounding, educated male had its advantages and disadvantages. In lay interviews, I was aware of how this gap was accentuated by class, age and gender. In GP interviews the class issue was less of a concern. In fact, this turned the balance of power around as they potentially had a higher status than myself. I expected that my position as an English researcher who was coming to talk about food and eating in Scotland would be potentially problematic. However, only in one interview did someone explicitly refer to my nationality being English and I did not feel that this presented any meaningful problems. Furthermore, the benefit of being a student has some advantages. Particularly with GPs, I felt that they were more willing to explain their views, because they assumed that I was there 'to learn'. Switching between the two different types of respondents was sometimes a challenge, but it did help to continuously explore the similarities and differences in the way that they talked about food and health and heighten my awareness of my own role in the construction of these data.

'Getting along' with respondents can hardly be called an exact science. My techniques for building rapport are based on my personality (Clarke 1975) and I am confident that this was established across the fieldwork and is expressed in the quality of the data. Although I was genuine in my rapport, I did feel that at times with lay respondents I had to 'act' by appearing interested in things which did not really interest me (e.g. football). This felt slightly uncomfortable but I was sure that it was a necessary part of the position that I aimed to achieve. In contrast to the GP interviews, I felt they may have seen me more as professional than as a student. Moreover, I may have appeared as a detached stranger whom they could share their feelings with. This could have been connected to my perceived 'association' with the key practices. While I had anticipated that there was a downside to recruiting through practices, the data presented in this thesis show most people had a positive view of their GP, perhaps revealing again why they were willing to participate.

The content of the interviews was rarely personal, but on occasions when I did encounter difficult issues, such as bereavement, I glossed over them because I had not recruited respondents to specifically talk about such issues. I also felt that because I was only visiting once it was unethical to explore deep feelings, especially given the topics we had agreed to discuss. Both female and male lay respondents did seem happy to talk quite openly to me

about their weight (which could have been a sensitive area) and a range of more personal health problems were sometimes covered. On several occasions, lay respondents expected me to answer specific dietary questions and I had to explain my role more clearly to them, therefore making my position more overt than it already was. This was compounded in the final interviews because they had been recruited directly by the GP and I had not been able to meet them beforehand to explain who I was. As is apparent in the data and transcripts, my position was established to the degree that I was rarely asked questions, therefore indicating an asymmetry of power. Thus as Kvale (1996:126) aptly describes this stance, "The interviewer defines the situation, introduces the topics of the conversation, and through further questions steers the course of the interview."

5.5.4 Personal issues

There were also a number of personal issues faced during the research process. Mason says that good qualitative interviewing is hard and creative work and can also be a much more complex and exhausting task than conducting survey-based research (Mason 1996). Indeed, the combination of the interview process and the antisocial hours made the fieldwork a tough and exhausting process. This was relieved somewhat by rarely exploring personal issues with respondents. However the downside was that I did find myself identifying with Davis's (1961) view that this can result in a sense of guilt and a sense of disreputability about one's position. Only one participant (L10) seemed to view me as more than a researcher. On several occasions I had to make contact to arrange an interview with her husband and she discussed a number of personal issues with me. In the end, I could not make contact with her husband because he had "left her". I decided to exclude them both from the research because I did not want to be drawn in more deeply. On such occasions, as Hubbard *et al* (2001) have recently discussed, chatting to other researchers can provide a welcome form of therapy.

After the interviews, a number of respondents said that it had made them think differently about food and eating. I had not given them any advice and it would appear that the very process of talking may have made them think differently about their diets. If I had covered a more sensitive area, I would have followed up my interviews with phone calls but decided a simple thank you letter would suffice. There may have been some benefits to lay and professional respondents as it may have made them think more carefully about their views on food and eating. In addition, I did promise to feed back the findings of the research to GPs.

Finally, Lofland and Lofland say that (1995:51) "...persons doing intensive interviewing may find themselves feeling that it would be far more comfortable to stop the interview and just have an informal and unrecorded conversation." This temptation was almost excruciating on occasions, especially when I felt that people wanted me to engage more in the interview and give an opinion. I normally avoided this by smiling and nodding which seemed to provide reassurance that what they were saying was valid, especially when I wanted them to go into more detail. This did contribute to the often painful sense of separation between the observer and the observed, (Lofland and Lofland 1995), however it did mean that I was able to aim for a type of research which I outlined in the methodology chapter.

On reflection, I became very aware of the process by which the respondents and I were constructing data. Where appropriate, comments have been made within the analysis to highlight how I became sensitised to the limitations of the interview method and the consequences this appeared to have on the accounts that were produced.

5.6 Analysis

5.6.1 Preparing the data

Analysis was split into several stages, whichwere not entirely separated, due to the dynamic nature of the collection and constant analysis of the interviews. After each interview, the tapes were reviewed and comments made in a field notebook which were recorded for future use or to provide assistance with further interviews. The majority of the transcription was undertaken by myself, which had the additional benefit of immersing me further into the data (Lofland and Lofland 1995). During transcription I also made extra notes using *Microsoft Word's* comments feature within the transcription itself. Some interviews were transcribed by different professional transcribers who were briefed to transcribe the interviews in verbatim. There was some difference in transcription style, because my transcription tended to be less colloquial and I found it easier to try and transcribe into a more standardised format. Once all the tapes had been transcribed, the interviews were anonymised and a list of pseudonyms were used to hide respondent's names (*see Tables 5.2* and *5.4*)

5.6.2 Coding and categorising

The dominant kind of qualitative study appears to be one in which the investigator carries out a bunch of semi-structured interviews which are taped and transcribed. The results are thrown into a qualitative data management package and a few themes dragged out in ways that seem rather like what we used to call 'data dredging' (Dingwall 1997:52).

I was very aware of these criticisms of poor analysis of qualitative data. My original plan for analysing the data had been to use *QSR's Nvivo* software to manage the large volume of field data, which in total comprised of 340,000 words of typed material (90,000 words of GP data and 250,000 words from the lay interviews). I had attended a workshop run by the creators of this software package and was impressed by its potential for avoiding 'data dredging', or as it has been called elsewhere – 'code and retrieve logic' (Mason 1996). Durkin (1997) says that, used properly, Qualitative Data Analysis programs can help increase reliability and validity by reminding us of data and their contexts at all stages of research. However, although they might help to ensure that all the data have been considered, I found myself drowning in a sea of codes, rather than being productively immersed in the generation of relevant themes.

It would be unfair to criticise these programs based on one experience and I think that this problem was caused by the difficulty of the analytical process more generally. The analytical phase of the research was by far the most demanding and frustrating task I had been required to undertake. However in time it became a rewarding process and it was only really when I started to think more reflexively that I could see the wood from the trees. So, rather than working with a software package, I decided to work on a more direct, manual level with the data. Because I had been responsible for designing the interviews, conducting them, discussing them regularly with my supervisors and even transcribing them, I was already fully immersed within the data. Consequently I had a very good idea about what respondents had been saying and some preliminary ideas about key themes. With both data sets, I began the analytical process again by re-reading the transcripts many times and making notes. I then wrote summaries of each interview and began the longer task of putting my notes together and building categories around key themes.

One of my biggest concerns was that I was also finding it difficult to produce themes which were analytically developed. I was very much aware of Glaser and Strauss's concept of 'grounded theory' and indeed, their 'fall-out' over what it actually meant (Melia 1997). I firmly accepted the essence of their original work, that analytical categories should be derived from and grounded in the data. However, it was their argument over where more general theories need to be brought in that I was unsure about. I decided to lean more

towards Glaser's approach of the *Constant Comparative Method* as I felt this was better suited to non-computer aided analysis. For Glaser (1992:43) this "gets the analyst to the desired conceptual power, quickly, with ease and joy" as analytical codes are produced until they become saturated. In the end, I resorted to a tried and tested method of printing out interview quotations and sorting them into piles by hand. I then was able to produce hierarchical diagrams as a basis for my analysis chapters.

Now that this process has been completed, I think that the computer software might have helped speed up the later identification and retrieval stages of the analysis. However it was apparent that this was such a complex task that it was more important to learn the basics first. I also felt that working with the data had been difficult because of some of the features I had incorporated into the research design. The key problem that I faced was that I sometimes had very little data on some of the more interesting and relevant themes. Therefore on occasions, the research had been too broad and would have benefited from being more focussed on particular areas. Similarly, by only interviewing a small number of respondents, I sometimes had very few specific examples to work with. Finally, because I tended to stick to my interview schedule, I did not always explore themes as much as might have been desirable. Nevertheless, these weaknesses are symptoms of the research's strengths, because I wanted to concentrate on exploring certain issues which have previously received very little attention.

The following six chapters present the findings from this research, although a summary can be found on *Page 201* of the discussion.

6 Providing family meals

6.1 General Introduction

This and the following analysis chapter, provide the context for and constraint upon the adoption of healthier eating practices examined in *Chapters 8*, and *9*. Reflecting previous work on food and the family, this chapter explores lay respondents' accounts of the day to day provision of family meals and establishes how it was the women who assumed the responsibility for providing them (Murcott 1983a; 1983b; 1983c; Charles and Kerr 1988; DeVault 1991). The second half of this chapter, however, will explore the few households where men did appear to be more involved and the contrasting ways they constructed food provisioning.

6.2 Feeding the Family

This first section explores how and why in the majority of households, both male and female respondents explained that it was the woman's responsibility to provide a cooked family meal. The first key point that I will raise, was that female respondents constructed this arrangement as an obligatory role and rarely challenged the assumptions that it appeared to be based upon. The second part of this section, considers how these women spoke about prioritising other family members' needs by providing a 'proper' meal, but it will also explore how they appeared to incorporate their own dietary preferences into this equation.

It should be noted that all of the data referred to in this section have been taken from interviews with respondents where the female was responsible for providing family meals on a routine basis. It will not be until later in this chapter that I will look more closely at the few accounts where respondents talked about how they shared this role, or where men appeared to undertake this role exclusively.

6.2.1 "Women's work"

In two thirds of the fifteen households sampled, both respondents said that it was the female respondent who provided family meals on a routine basis. Because I had deliberately focused upon food in the family setting, respondents explained that it was the female's role and responsibility to plan, buy, prepare and cook nearly all of the main meals that were eaten in the home.

It will become apparent, that there were two fundamental issues which arose from talking around food and eating in families. The first of these concerns how this gendered role was rarely *questioned.* Hence neither respondent in each household questioned the underlying theme that it 'should' be women who do the cooking, and which also appeared to be related to an assumption that women were more suited to cooking in the first place. Secondly, because female respondents constructed their responsibilities as an *obligatory* role, they appeared to both expect, and to be expected by their husbands, to cook for their family.

Many women explained that they were responsible for the vast majority of the tasks associated with providing family meals. While it was also typical that they did not question these roles, they were more likely to talk about the implications of being the adult who had the responsibility of feeding the family. Yet it is difficult to convey how 'normal' they appeared to think that their roles were, because they seemed to be playing down any negative issues associated with this responsibility. When I asked the female respondents how they felt about having to take responsibility for providing their family's meals, some said that this role really did not bother them or that it was "not something that they thought about very often" (Alison). On other occasions, a sense of normality was constructed around the idea that this was "something that they had always done" (Rachel), or that they did not "mind doing" (Tracey).

However to convey this sense of normality more accurately, this following account typified the limited extent to which female respondents were willing to talk about the reluctance they felt towards this role. It was apparent therefore, that even on the occasions when Amanda could not provide a meal, she still had to get everything ready. Rather than questioning the role itself, she laughed it off and also talked about how she could be "difficult". This appeared to be a rhetorical construction, because she implied that she was confined to only complaining about this role:

TF: You talked about planning, could you say a bit more about the whole process of where you get to the stage where you actually eat the food, so who's responsible for all the different parts, the planning and the buying and the preparing and things.

AMANDA: Me. Hahahaha, very much so. Erm, the times I am not doing the preparing it's a case of A, B, and C's there, this is when it's got to go on. Or if I'm being particularly difficult, you can read the packet and see we're having and such and such, it'll tell you on all the packets when you are to do anything, which he does, but he tends not to.

Most female respondents talked about working either full-time or part time in addition to their role within the home. As the example above also suggested, many women also said

they had to provide a meal on the occasions when they were not in the house or when the meal was being eaten. Thus some women explained that if they were on a late shift they would have to cook a meal for their husband and children in the morning, and that they or their husband would heat it up when they needed to eat it. Even in households where working patterns had been changed (because children had to be looked after at home), female respondents said this has not made any difference because they had always been the one who had to cook the evening meal:

RACHEL: It's something I've always done. Even when I worked full time, I still made dinners at night. It meant you had to wait a bit longer, but it was still me, it was me that cooked.

When I asked this particular respondent if she "felt this was fair", she acknowledged that it was not, and said that "you've just got to do it or it won't get done". This was a very untypical response, because as I explained earlier, any negative feelings about always being the one who had to cook were usually implied, rather than explicitly stated. Also unlike the majority of female respondents, she then added to this view and said that there was very little point in challenging this "unfair" obligation, because it made things "worse". Notably, this comment only reflected the account of one other female respondent, who made a related but more general point, about how it was "unfair that women were expected to do this work" (Nicola).

RACHEL: It's unfair, yes it is unfair, but you've just got to do it or it won't get done.

TF: So that's the bottom line is it?

RACHEL: That's how sometimes I think, well no I'm not doing it, why should I have to do it all the time, but it never works, it makes it worse.

To address how these women did not appear to question their roles, I asked a range of probing questions with the aim of exploring their views further. In fact, from the way they talked, rather than addressing the assumptions behind the roles themselves, they appeared to be constructing the difficulties as 'symptoms', which arose from always having to provide meals. The most common example expressed by the majority of female respondents, was how the actual task of cooking was constructed as something they did not enjoy. Some female respondents said that they would probably only ever enjoy cooking if they could "find the time" (Annabel) or that they "didn't regard preparing evening meals as cooking" (Jo). Such accounts seemed to imply (on one level at least) that cooking was constructed as a chore, because of its mundane status. However, perhaps the most meaningful illustration of this theme, was that several women talked about how if they were ever on their own, then they would probably not cook at all. Hence in addition to implying that they did not

enjoy cooking, this also suggested that cooking was a role that they were routinely obliged to undertake:

CATHERINE: Em, well if I was just myself I probably wouldn't cook very often, to be honest with you.

Similarly:

CAROLINE: If it's just for me, if I'm in on my own I would probably be awful if I lived on my own.

A further way that some female respondents constructed cooking as a mundane responsibility, was to suggest that it was often difficult to enjoy eating a meal that you had cooked yourself. Sometimes, female respondents talked about how they were always rushing to provide meals, which was because somebody in their family had to have it at a time which suited their needs; alternatively one of their family had to be somewhere else when the meal was usually being served. So here for example, this female respondent talked about how if you had taken a long time to prepare a meal, then you did not really "fancy" eating it.

TRACEY: I think especially if it's taking long to prepare and cook by the time you do sit down and eat it, you think you can't eat that now, because you've probably spent that long cooking it, preparing it and all the rest of it and you are dishing it up, making it nice for everybody else, and you think I don't fancy it.

Men's involvement and views

The male respondents in this study were asked the same basic questions, although it was inevitable that they would be probed differently according to how they responded. As will become apparent, male respondents never disagreed with the roles that their wives described. While this supports the accounts of female respondents, the fundamental issue raised from these accounts, was that they also never questioned why their wives had assumed this role.

Male respondents therefore explained that buying, planning, preparing and cooking meals was not their responsibility. Moreover, it was also apparent that before I probed them further about their views, their answers to these questions were often very concise, and they talked about how "mostly my wife does all the cooking" (Gary) or that "My wife does it all" (Ted). Thus like the female accounts, this appeared to tacitly reflect how 'normal' they felt these roles were. As I also identified earlier, when talking about who provided meals, male respondents were usually referring to evening meals. Hence this male respondent explained that he was out during the day, and that he made his own breakfast:

SIMON: Well that's all the wife's. I make the breakfast, and I'll eat it on the way to work. I make my own lunch, made the night before.

Furthermore, when asked to talk more about their wife's role, these male respondents implied that they expected meals to be provided for them, yet they never questioned why they had adopted this particular division of labour. As with the female respondents, they talked about the difficulties associated with this role, rather than the assumptions behind the role itself. The male respondents tended to praise their wives, or other women, for any difficulties that they were overcoming to provide meals. Therefore, several male respondents talked about how they thought providing meals must be a hard job, and that they felt that their wives were making a good job of it. Yet while on the one hand these accounts supported the work that they said their wives or other women were doing, they were also reproducing this role. Because of the admirable way their wives dealt with these difficulties, it appeared that these men were implying that it made more sense for them to undertake this type of work. This particular example below, therefore typified how male respondents talked positively about "what [women] do" and challenged the possibility that being a 'housewife' was in any way easy.

JAMES: A woman's job in the house is the same all the time and I know people would say it's easy sitting in the house but they are kept going all the time. I admire them for what they do. I would say that there is quite a bit of pressure on them.

The idea that it made sense for the female respondent to be the person responsible for providing meals, was a pervasive theme throughout this part of the interview. When I did ask respondents why it was the female who cooked all the evening meals, both tended to agree that their current arrangement was a matter of 'common-sense'. One frequent explanation offered by many female respondents, was that *they* were providing the meals, because they were working fewer hours than their husbands. Interestingly, while it was implied that the division of labour in this way was an arrangement, there were no accounts where respondents explained that these roles had been negotiated. This therefore represented another way that this role often remained unquestioned, but also how it was being reproduced through the idea that it was a sensible way to apportion domestic tasks.

TF: How do you feel about doing all the cooking?

CATHERINE: I don't mind, because he is working most of the time…. Whereas if I'm in the house all day so it's easier for me to have it ready for him coming on, or you know have it on for him coming in half an hour later or whatever.

Likewise, the male respondents put forward a similar explanation, because they also talked about this apportioning of labour making sense. Thus, some men said that "she is in the house more" (James), or that "she's usually in before me so it makes sense that we do it this

way" (Simon). Moreover, in this particular example, Gary did not mention why he was the one going out to work in the first place, as he said "it's just our situation".

GARY: Well it's just our situation. I'm out working and she's in the house eh. I'm just coming in at teatime.

Another set of reasons that respondents gave for how their respective roles made sense to them, were in discussions about the limited involvement that male respondents had in the various tasks associated with providing meals. Interestingly, when it came to talking about the involvement that their husbands actually had, many female respondents felt that their peripheral or occasional involvement was a good thing. Some explained that they sometimes brought their husband along with them when they went shopping, but that typically their involvement was limited to making suggestions about what they should eat. Notably, this lack of involvement was often viewed positively and female respondents said that their husband would contribute by saying what they would like to eat, or alternatively they would say that they were not fussy:

ALISON: Well I'll do, well I'll say to Mike maybe the day before, what do you fancy for your tea tomorrow, and he'll just say anything. So as I say, so I'm going to make him spicy pepper soup and that, and we'll have that.

It was also interesting that female respondents never constructed this lack of input into planning menus as being a problem. Hence from some of the data presented later in this chapter, it will then become apparent that this lack of input may have been constructed without criticism for several reasons. One possible explanation was that this may have been something which they had routinely come to expect and so they therefore did not construct it as being a problem. As I will argue later, there was also no indication that male respondents rejected what was being provided, as they appeared to eat their meals without challenging what was in front of them. Moreover, as the themes in this chapter progress, it will become apparent that many female respondents spoke about managing the provision of meals autonomously and which demonstrated how they appeared to feel in-control of food provisioning.

Therefore, one of the other ways that female respondents also talked about their husband's limited involvement making sense was by constructing their own role as a skilled one. However, the idea that their husband found cooking difficult, appeared to reproduce the idea that women are more suited to cooking. These accounts also suggest that female respondents wanted to construct their own role as being a positive one, because they claimed to take some pride in what they were achieving. Some explained therefore, that sometimes occasions arose when they had not been able to provide a meal, and this was perhaps because they had been working, ill, on holiday, or even pregnant. Female

respondents talked about how they often prepared for these occasions in advance and left meals which they felt their husband "could manage" (Nicola) to cook. All their husband then had to do, was to "get something out of the freezer" and then "put them in the oven... or microwave" (Catherine).

CAROLINE: Ted might even make salad tomorrow and maybe put a quiche in [the oven] or something when I'm working.

Another similar theme constructed around this idea of 'cooking skills', was how their husband did not have any, or had made a bad job of the cooking on the rare occasions when he had tried. Typically, female respondents talked about how "He wouldn't know where to find anything" (Tracey), or like this respondent, it appeared to be accepted that this was something her husband was not interested in.

CATHERINE: No he doesn't cook. He wouldn't know what to do I don't think. He never, he has never tried cooking at all. He has cooked me a breakfast I think once or something, that's about it. It's just that he has never been interested, he has just never been interested in cooking at all.

It appeared from the previous examples that, to some extent at least, it was acceptable to these male respondents to not cook, because by implication, cooking was constructed as 'women's work'. Such comments about cooking skills were particularly interesting, because of the assumption that it was women who had to learn how to cook. When asked if things had changed when they got married, some female respondents explained that *they had* to learn. This was because up until then, this role had been their mother's responsibility. Nevertheless, there was no discussion of why men were not expected to learn instead:

TF: Okay. Do you think things changed when you got married, when it came to food and eating.

JO: Yeah, I had to learn to cook! Yeah. I think they changed because you have to learn to cook, and you know the two of you are coming from houses where your mother's been doing it for years, his mother was a housewife, my mother was a housewife. And all of a sudden you have to learn to.

It was also particularly interesting that a few male respondents also used the idea of 'cooking skills' to support the idea that women were more suited to cooking. Some male respondents talked about how they were "not built" (James) for domestic work, and implied that an ability to cook was something you 'naturally' possessed. This contrasted with the views of many female respondents who spoke about learning to cook. Other examples of this theme constructed by male respondents, included ideas about how cooking was not something they were accustomed to doing. Or as was typified in the following account, cooking was viewed as being a "nightmare", because something went wrong when he did do it:

KEITH: I mean I done it for two weeks, she went away for two weeks, on holiday. A working holiday actually and that was a nightmare. It was a nightmare… Probably because I don't cook. Things are burnt, eh.

Fundamentally however, some male respondents also said that they were good cooks, because they enjoyed cooking on the occasions when they did get to do it. Interestingly, such accounts were normally centred around big family occasions or special events such as Christmas dinners or Sunday roasts. Although these accounts contrasted with the male accounts above, they also appeared to support the idea that it was their wives who should cook the rest of the time. This was because they implied that it was particular circumstances which were preventing them, rather than their own 'will'. Furthermore, while they talked about occasionally "cooking", the type of meals that they referred to in the processes of legitimating this point were very different from the routine family meals which female respondents felt they were obliged to provide. So although they talked enthusiastically about cooking more generally, they appeared to be distancing themselves from any idea that they might provide meals on a routine basis.

SIMON: Oh I like cooking yeah, I love cooking. When we were in Holland we used to have er sort of dinner parties they were a big thing. If we invited friends over for dinner, then I would make the food.

Similarly:

TF: So do you see yourself as a cook?

PETER: Yeah if I want to be. Yeah, I don't have any problem with being a cook, and yeah I can cook reasonably well. I can bake, or make all the basic dinners, I can roast a joint, chickens, turkeys, ham, cooked duck. I can make Italian dishes, erm, I can even make pizzas. Erm, and in general I am probably better. Not the word I am looking for, probably more experienced in a vast line of cooking than most females. I'm not saying all, I'll just say most.

6.2.2 Summary

In this section, I have explored how both male and female respondents assumed that cooking was a woman's responsibility. Although both partners commented about the difficulties that arise from this role, the assumptions which were underpinning them were not challenged. Moreover, in many cases it was apparent that male and female respondents appeared to collude with the idea that routine cooking is women's work. However, because of the way they constructed their own 'circumstances', they also reproduced these assumptions by talking about how it made sense to divide this labour in this way.

Nevertheless, because of the demands that were placed upon them and unlike some males, the female respondents rarely talked about how cooking was itself pleasurable. So while in general both sexes may have assumed that it made sense and was 'normal' for women to cook in this way, it was the women who had to undertake this role on day to day basis. Although the female respondents appeared to be under an obligation to provide family meals, their husbands appeared to praise them for what they were producing. In the following theme, while recognising the structural confinements explored here, I will also reveal some further examples of how female respondents presented themselves as being autonomously in-control of their assumed responsibilities.

6.2.3 Managing family meals

I have already explored how female respondents appeared to assume the role of routinely providing family meals, yet I only made a passing reference to what respondents appeared to mean when they talked about a 'meal'. This section however, attempts to explore why female respondents felt obliged to provide a cooked dinner: The first sub-theme aims to unpack the meaning of what they called a 'proper' meal and how this need appeared to be managed on a day to day basis. The second explores how, although these meals were constructed as being an integral part of a 'mother' and a 'wife's' role, female respondents also talked about accommodating their own dietary needs into this equation.

'Proper' meals

As I argued in the previous theme, respondents' accounts of the provision of family meals were normally centred on the provision of a cooked evening meal. However, it appeared that this did not necessarily mean that both parents were present when meals were actually being eaten. This section will therefore attempt to examine how and why it was apparent that many female respondents felt obliged to provide such meals, even though they also sometimes talked about not enjoying the process of cooking them.

I will explore how these accounts were centred on the need for what both male and female respondents called a 'proper' meal. It should be noted that the accounts included in this section were taken from a stage of the interview where I had asked respondents to describe what they thought a 'meal' *should* be. This is an important point to clarify, because it will become apparent in the following chapter, that there was a sense of idealism in the accounts that follow. Thus both male and female respondents felt that it was important to have what was either called a 'proper', 'good' or a 'decent' meal in the evening. Not all respondents used the actual term - 'proper', so I will assume that they meant the same thing and use this as the focus for this theme.

In defining a 'meal', respondents typically distinguished between meals that they had at lunch-time, which were regarded as a 'snack' and a 'proper' meal which was eaten in the evening.

TF: What you think a meal is?

STUART: Well I think er, the chicken curry, that was a meal. Erm, this morning I suppose was a meal, my breakfast sort of thing you know, I'd still call it a snack, hahaha. I know what you are saying, I only have er, one proper meal a day as such.

TF: A proper meal?

STUART: What I call a proper meal, like you sit down and have a big plate of food, not just picking up a roll sort of thing you know.

Furthermore, in explaining what a 'proper' meal should ideally consist of, both male and female respondents talked about how it usually consisted of meat with vegetables. Some respondents were more specific and talked about how a 'proper' meal should be a "roast dinner" (Peter); some also felt that less 'traditional' foods such as "pasta" (James) were also acceptable. Overall, the definition appeared to flexible, and a meal was considered to be a 'proper' one as long as it was cooked and included meat:

TF: Can you say a little bit about food you would regard as a meal?

JOHN: I don't regard sandwiches and things like that as meal. I'm thinking of meat and two veg, anything else would be a snack.

Both male and female respondents also explained that a meal had to be something 'filling', but there was a noticeable difference in how they explained why such a meal was required. Some male accounts for example, focussed upon the need to satisfy their appetite by "making them feel full inside" (Richard). On several occasions, some men also constructed a functional need for their food. Thus a 'proper' filling meal gave them more energy, especially if you had a manual job – this was because "you need something to keep you going" (James). As a further example, the following male respondent explained that "if you work hard", and "it's cold", then you need to have a 'proper' meal to stop you feeling "hungry" and make you feel "comfortable again".

JIM: I think a lot of people eat because they enjoy eating. I find diets don't work with me. Hunger is one of the worst things I feel. If you work hard, it's cold, it's not been a great day at your work. The last thing you want to be is hungry as well. You're no want to be hungry because you're no comfortable if you're hungry. Once you have a good meal you're comfortable again.

Although female respondents also talked about how a 'proper meal' had to be something that "fills you up" (Annabel), this need was viewed as being one of their husband's requirements which *they* had to provide for. One female respondent for example said that it was important that her husband "has a decent meal in him at night" (Catherine), or as this next example revealed, there was an obligation to provide a substantial meal because her husband had a large appetite:

TRACEY: Yes, he eats just sort of constantly, although luckily he's not put any weight on. It's been quite good that way, it's just he eats like a horse.

However, it was particularly meaningful that the way in which female respondents constructed the 'proper' meal appeared to be reflecting their role as the person who was responsible for cooking it. As I argued earlier, although cooking was presented as a task which they did not enjoy, on a different level, it was revealing that they also constructed this role more positively. It became apparent that this was a result of a wider theme, whereby cooking was also being evaluated as part of an obligation to care for their family. On the one hand, it appeared that the need to provide a substantial meal was centred upon the way that they viewed their role as a 'wife'. Yet on the other, talking about how they "saw themselves as a cook?", revealed how this obligation was also being evaluated in terms of their role as a 'mother'. Interestingly, they often replied modestly that they were just doing their job or as is discussed next, "I just see myself as a mummy". So whilst they may have played down the idea that they were a 'cook', at the same time they were also implying that cooking had a more extensive meaning.

ALISON: Not really. Not really. No. Not now, I just see myself as a mummy. You know

Similarly:

DEBORAH: No, just a mother cookin' for her family, aye, I don't see myself as a cook, nuh, nuh.

While there was an inherent modesty in these accounts, it was apparent that the provision of meals had a different meaning from the idea of a 'cook', and instead was being viewed in terms of their roles as both a 'mother' and 'wife'. This meaning was also revealed when female respondents talked about the importance of 'sitting down to a meal'. This particular requirement was explained as being an important way that everybody could 'catch-up' on what had happened during the day. Yet typically, as this following example revealed, female respondents described sitting down to eat a meal as a "family thing". Thus the notion that "it's a big bit of family life", suggests again that female respondents regarded the provision of a 'proper' meal as an integral part of being a mother and wife.

JO:...I feel that erm, it's a family thing. I was brought up when my father was alive, that there was six children and two adults, and we sat round a table and we discussed what we had done that day. And I feel that it's a big bit of family life. We always do it.

Additionally as the above example illustrated, 'proper' meals were often expressed as being a meaningful regular event and appeared to be a practice which female respondents felt was worth holding on to. However, female respondents put forward several different explanations of why this was so. One typical example that several mentioned, was how they fed their children earlier than they did their partner, because it made things easier for them. Sitting down to a meal at the weekends, however, was seen an important way of ensuring that they could all still "sit down together":

CAROLINE: You just get used to it and at the same time they tend to eat a bit earlier than us anyway but come Sunday I will find something that we all eat and we will sit down together and it's quite good but during the week it doesn't happen very often I must admit.

Another example of how sitting down to a proper meal appeared to be meaningful, was the idea that it could act as a counter measure to jobs which were preventing the family from eating a meal at other times. This female respondent spoke about how that on the nights they were in together, they do like to sit down to eat a meal.

MARY: I just feel it's quite important that we all sit together and share the meal. It's just a little time to have a talk, and that [the TV] is on quite a bit, and we enjoy a bit of time together you know.

An examination of the male accounts, further highlights the meanings expressed by their wives and it helps to appreciate the relevance of why male respondents also talked about sitting down to eat a 'proper' meal. It was apparent that some of them were also speaking about this concept, yet there were much fewer examples than in the female interviews. Nevertheless, as this example revealed, some male respondents also constructed the 'proper' meal as a way of bringing the family together. Because they had been working during the day, the dinner table was a time and place where they could catch up with what their children had been doing.

TF: So is that something you do, sit at the table?

SIMON: Yeah

TF: Do you sit at the table too?

SIMON: Yeah, I think so as well. If you have been working, and he's been at school. What did you do at school today, and how was your day.

TF: And that's something you like to do is it?

SIMON: Yeah.

Although male respondents did talk about the positive role that sitting down to eat a meal could play, it was apparent that this reflected their role and contribution towards providing meals more generally. Moreover, to male respondents, wanting a 'proper' meal appeared to be a way that they defined being 'looked after'. For example, they would talk about how they "just sit down and get it handed to me on a plate," (Keith), or as the account below revealed, this was often associated with their definition of a 'proper meal', even when I probed them about the term "sit down":

TF: You sit down?

JOHN: Not necessarily. Although I eat sandwiches at work, I don't consider that to be a meal, that's just a snack. So it would have to be a set meal, meat and two veg or whatever, bacon or eggs. Something that's cooked.

This section has explored how the idea of 'sitting down to a proper meal', was constructed by both male and female respondents as meaningful. This also helps to explain why the role of providing meals, appeared to be centred on an obligation to provide a meal which was associated with a number of associated meanings. In particular, providing a 'proper meal' for the family appeared to be strongly associated with how female respondents constructed their role as a 'mother' and a 'wife'. Thus it also appears from the data presented here, that these women were placing a different meaning and emphasis on how the 'proper meal' is at the very heart of family life.

Dieting and Control

Female respondents also talked about managing their own dietary requirements alongside their day to day obligations to produce family meals. The theme of 'Dieting and control' that I will explore here, also reinforces the idea raised previously, that women provide 'proper' meals to satisfy their family's dietary requirements and not necessarily their own. While many female respondents said that they were concerned with their weight and were dieting, their accounts suggest that they incorporate and manage their own needs into family meal times. As will become apparent, what seems to make these accounts meaningful, is that they provide further evidence of the autonomous way that female respondents provide family meals and also present themselves as being in-control.

In the previous theme I discussed how many female respondents felt obliged to provide a meal for their husbands which had to satisfy their appetites. In this theme, I will concentrate upon how their dietary requirements often differed from their husband's. However, it

should be noted that the relationship with their children's diets will be explored in the following chapter.

Female respondents often explained that they were eating or would ideally like to eat different meals from those eaten by their husband or children. Although they did not always explain why they wanted something different, the implication was that they would prefer to eat less filling and lighter foods: Hence instead, they would "be quite happy to chop up a few bits of [salad] with salad dressing or whatever" (Nicola).

TF: You say you made this lamb thing last night. Did you have that?

CAROLINE: No I made it for them. We had salad. I could eat it but I don't want it so I don't eat it but I could for easiness. I was working anyway and I just left the potatoes and everything. All Ted had to do was heat it up so no we didn't have it.

Some female respondents did talk about why they preferred to eat "lighter" meals, and said that their husband's preferences contrasted with what they wanted. Sometimes they implied that the 'proper' meal was a heavier meal, for example that "he is a big eater so he wants to have like his meat or he likes pasta and things like that as well" (Catherine). Or, as the following example revealed, this female respondent said that she ate "smaller" and "lighter" meals, whereas her husband would prefer food that was "bigger" and "heavier":

LYNNE: For me it's different cos I eat smaller portions and I eat lighter meals. Whereas Stuart eats bigger, he's a bigger man. He eats bigger portions. He eats bigger meals and heavier things as well. But then I have a sister that could probably eat Stuart under the table. So er.

Although female respondents talked about preferring to eat lighter or smaller meals, some also revealed that they needed particular foods because they were dieting. In a few cases, these respondents said that they had been on diets for years and that they kept going on and off them from time to time - whereas on other occasions, they said that they had started a new diet fairly recently. The reasons female respondents gave for dieting were normally centred upon a concern about "weight" and physical appearance. Moreover, the type of diet that they said they were on, was usually 'low-fat' and that they were trying to cut down on fat, or eat low-fat foods. The following example typified how several of these women said they felt particularly concerned about their appearance, especially because they felt that their body was changing as they were getting older.

ANNABEL: I started to get cellulite and everything honestly. And I thought oh god, I better start to watch what I eat. I just noticed it and I thought I'm going to like drink loads more water and eat low fat foods and everything. So basically it's just to try and

have like less fat in my diet. And not to get fat. Just because of diet reasons really.

When I probed this particular female respondent about the reasons behind her diet, she talked about how she thought it was probably inevitable that she had been pressurised into trying to lose weight, and to "have a figure like her on the Special K ad". Indeed, most women who said that they were dieting agreed with the suggestion that "there are more pressures on women in regard to how they look" (Mary), and "to eat the right thing" (Alison).

ANNABEL: Well probably because of these magazines and everything eh? There's me just saying I look at everything in the magazine, and I read all these things and I think I should be doing this and I should be doing that. They must have an influence over us really. There must be some kind of influence there. All these adverts on the tele, to eat low fat, and have a figure like her on the Special K ad. You know there is pressure on you to do that. If you eat low fat, you're supposed to be able to look like that you know.

In comparison to the men that I interviewed, most female respondents also felt that women in general worry more about how other people perceive them. A commonly offered example, was that female colleagues were always on and off diets. It therefore appeared to be accepted that this was one of the things that women like to talk about:

MARY: Well the majority that I work with and my family we are all sort of well, grumble about our weight. I think, I suppose men can feel like that to. But certainly in our workplace, they'll be about half a dozen on Weight Watchers and I don't think that there are many that can turn round and say that they're happy with their weight cos it's one of the most talked about things in the workplace?

However, there were several female respondents who said that they felt that they would probably like to lose weight, but they explained that they were not on diets because losing weight was not one of their priorities. One respondent said she "hadn't got the will power, or that she had tried diets "and it hadn't lasted" (Amanda). The female respondent below, however, had explained in an earlier stage of the interview, that she was "fat". Nevertheless, the idea that "fat people are more outgoing" appeared to be another way of justifying why she was not dieting:

DEBORAH: This is what's happenin' nowadays, people are all thinkin' "Well she's fat an' she's thick" they all think fat people are thick. I think fat people are more outgoin' an' happy than skinny people. I've got lots 'y people who're quite, er, but they're nice.

While many of the women I interviewed did appear to be on a diet, dieting itself was not always viewed negatively. Although some female respondents said they were putting weight on as they got older, this appeared to be presented as something, which they felt they had control over. One female respondent explained for example, that she had been "educating [her]self to eat", so that she did not "feel sluggish" (Alison). Alternatively, this female respondent seemed to feel that looking after the way she looked was a matter of self-pride. Thus she talked about how she did not want to be "old and fat". Whereas she felt that she could do nothing about her age, her weight was constructed as a problem that she could take control of:

JO: I'm on a diet, so everything I have has got to be skimmed, low fat… I have this thing and it's just me, and it's purely me. I have this thing, I don't want people saying to my son when he's at school, your mother's old and she's fat. You know, the old I can't do anything about, but the fat I can. Do you now what I mean?

Developing this theme about control further, I argued previously that female respondents often talked about how their own dietary requirements contrasted with their husband's. However, without the need for conflict and compromise on their own part, it was particularly interesting that they often spoke about incorporating their own requirements into mealtimes. In some cases, female respondents talked about how they had made their husband eat what they were having, as a way of avoiding cooking separate meals. Revealingly, this was not presented as being a struggle, or a situation they had reached by a process of negotiation. One woman I interviewed (Jo) explained that because she was on a diet, everything had to be low fat, but because she was trying to get her husband to lose weight as well, he had to put up with what he was given. In this particular example below, the same idea was made possible. This, Catherine explained, was because she could give her husband low fat alternatives and "he doesn't notice the difference anyway".

CATHERINE: … But I've just got to really watch what I'm putting in it as well. If I'm making something, I'm watching what I'm putting in it, it's not fattening things, like, I basically cook with like, if I'm cooking pasta, it will be half fat and things like that, that I'm watching what I'm putting in. And he doesn't mind that, he doesn't notice the difference anyway when it comes to things like that. He doesn't even know what I'm doing, but he doesn't complain about it anyway.

Most male respondents said that dieting was a woman's problem. This was rarely a spontaneous view and I usually had to prompt them to speak about this issue in more detail. Male respondents often appeared to be distancing themselves from the concept of dieting by acknowledging that there "probably were more pressures on women to look good" (Simon), and that "women are under more pressure that men" (James). However, although male respondents often distanced themselves by constructing dieting as a female pressure,

they were generally ambivalent about their wife's dieting. On some other occasions, these men also talked positively about how sometimes women supported each other:

MIKE: I don't know, the majority of women are bothered about getting fat. Right now we've got her auntie on Weight Watchers, her mum's on a Weight Watchers, and her sister's on a Weight Watchers. That's probably one of them on the phone. "What are you having tonight, how many points is that?" We've had the auntie today already.

Nevertheless, there appeared to be a fundamental contrast between the way that male and female respondents talked about their bodies and their weight. Whereas for many women I interviewed, being 'fat', or having 'cellulite' appeared to be a source of concern, for male respondents it was constructed as being more of a problem that they *should* be thinking about. In many cases, there was less of an immediate concern. So while some commented, for example, that "my waistline is starting to show" (John), they did not suggest that this made them worry about what they were eating or that they had changed their diet in anyway:

KEITH: I mean I would like to start exercising and that because I feel at times I'm just sitting about. I mean look at my belly, em but no I would like to take some sort of exercise up.

It was generally agreed that women were under more pressure than men to lose weight and look after their appearance. This sub-theme has also demonstrated how this was meaningfully demonstrated by the number of female respondents who said that their appearance was a cause for concern, and that they were on or had been on a diet to lose weight. However, it was particularly interesting that these female respondents often constructed dieting as a way of taking control of their bodies, and that they carry this through, by saying that they make their husband eat what they want to. In this way at least, it appeared that these women had some degree of autonomy over what they provided and wanted to eat. Yet considering the other evidence presented in this chapter so far, this sense of power appeared to be centred around their obligation to provide family meals and how they were left to get on with the role of feeding their family.

6.2.4 Summary

The themes presented so far, have established that in two thirds of the households who participated in this study, it was the female of the household who assumed the role of providing what were ideally seen as 'proper' meals. However, these women had mixed views about their obligations to provide these meals. On the one hand they talked about cooking being a chore, yet on the other, their obligation to provide family meals was constructed as being a mother and a wife's essential contribution to family life. Within the taken for

granted confinements of providing meals, the female respondents did appear to possess a degree of power over what they provided. Nevertheless, any sense that they do possess power, must be viewed reflexively, because of the assumed nature of these roles.

6.3 Cooking for pleasure

The data explored in this chapter so far, have been taken from interviews with couples where it was explained that the female respondent was responsible for providing the majority of the family meals. In this final part of the chapter however, I want to consider the five families (one third of the total lay sample) whose views have not yet been accounted for. In contrast to the accounts discussed previously, these respondents explained that the cooking was shared equally, or that the male respondent was completely responsible for this task.

In the light of the themes discussed in the first part of this chapter, the primary purpose of this section is to explore the relevance of the contrasts and similarities that were raised by these accounts. However, one of the key issues that I will raise, seems to be that these male respondents cooked because it was generally felt by themselves and their wives that they enjoyed cooking more. Because there were fewer households that could be associated with this theme, generalisations are more difficult to make than in the earlier parts of this chapter

6.3.1 Men at work

Five male respondents explained that they shared the tasks associated with providing meals, but they generally felt that it was hard to quantify how much they actually did contribute. While three male respondents said that their wife was responsible for cooking more meals than they did, they also emphasised that they played a key role in other tasks, such as planning or buying what they were going to be eating. Overall, they felt it was case of "helping each other depending upon what we are having" (Colin), or that it varied from time to time, but was probably a "fifty/fifty split" (Richard).

> SCOTT: Shop wise it's a shared responsibility. It's got to be severe circumstances where we say, can you bring this in for our tea tonight. It's mostly done at the weekends, or maybe earlier in the week. We do a weekly shop and plan out what we need. At the moment I would say, twice a week I am responsible for cooking the evening meal, the rest of the time, Phillipa would be doing it.

Importantly and in support of these accounts, male respondents' wives never completely disagreed with the way their husband described how these tasks were apportioned. There

was however, sometimes a small variation in the way that respondents emphasised who was ultimately responsible. Again, female respondents spoke about sharing these tasks, or it was apparent that this apportioning would change from time to time:

PHILLIPA: Well the cooking we share, because I go out at tea-times occasionally, em, we share that. Em, mainly, I am responsible, jointly for the buyin' 'y it I would say, we'll occasionally go shoppin' or a lot 'y the time go shoppin' together, eh?

Two male respondents did explain that although they shared the tasks associated with providing meals, they did all of the cooking. Considering the fundamental contrast with the majority of male respondents, it was interesting that this male respondent below responded very differently to the question: "Well some people think things are harder for women".

TF: Well some people think things are harder for women?

STUART: Erm, hahaha. I'm not too sure about that. As I say, we try and share the responsibilities with the cooking. I do all the cooking, she'll do all the washing.

Furthermore, the comment that this respondent did "all the cooking" while his wife did "all the washing", suggests that there was a fundamental contrast in the way that these male respondents viewed cooking along with other domestic tasks. Subsequently in the rest of this chapter, I want to explore these contrasting accounts in more detail.

Similarly to a theme that I identified earlier, both male and female respondents felt that the roles which they were undertaking made sense, either because of their work patterns or other responsibilities. One male respondent for example, spoke about how his wife had a "more demanding job" and that this was why he did a "wee bit more cooking and tried to help around the house." (Stuart). Interestingly, in contrast to the majority of accounts explored previously, this respondent's wife explained that she did not feel obliged to cook because she did "other things" which made their roles in the home "equal". However, although these accounts contrasted with those explored in *Section 6.2.1*, there was no suggestion that their roles or 'arrangements' had been negotiated. They again appeared to be assumed and likewise the emphasis was placed upon how this was the most sensible way to do things, especially because they both worked shifts:

LYNNE: I do other things. I do all the washing and the ironing and see to Jane and deal with other bits and pieces, so er it's equal. We work shifts, it's what you do.

Nevertheless in several cases, male respondents also talked about how their input was a moral issue and that it should not be up to one member of the household to do all of the cooking and housework. Thus further to the idea that their arrangement made sense, this

male respondent constructed this as being about "your attitude" and that "you can't expect your wife to do everything":

ROBBIE: I don't know it just depends upon your attitude or whatever you are thinking.

TF: What do you think your attitude is?

ROBBIE: Er. You can't expect your wife to do everything basically eh? Try and split things up pretty well. But she probably still does more than me. Can't expect her to do it all.

While it appeared that these male respondents constructed these moral accounts in relation to the idea that men often do not help in the house, only on one occasion did a female respondent compare her husband with someone else's. In this particular example, she talked about how she felt she was "quite lucky":

DEBORAH: So I thought well, and I. I can sometimes I thought "Oh God, I'm sittin' here an' other people are moanin' cause their husband willny even lift a fork" I mean that, I suppose I'm quite lucky in that way.

Fundamentally, when I probed both male and female respondents about the differences between their household and the others that I had interviewed, the differences were usually accounted for around the themes of 'cooking skills' and the pleasure gained from cooking. Several female respondents for example said that they were quite happy to let their husband get on with the cooking because they were good cooks, or they were better cooks than themselves.

JENNIFER: I'm terrible he says, so I think it's got a lot ti do wi' what he would rather cook. So he likes cookin' better than me, he'll experiment a bit more than I will.

As this particular account revealed, these female respondents appeared to be happy to let their husbands cook because they did not enjoy cooking. In this example, Phillipa implied that her husband was more happier to spend time in the kitchen than she was:

PHILLIPA: I mean I can knock up a meal but I wouldny consider myself a cook. I see it as a chore. In fact Scott's quite good at that, because his second career choice would have been a chef, as opposed to what he's doin'. So he likes ti dabble in the kitchen.

Notably though, the view that these female respondents constructed cooking as something that they did not enjoy, was reminiscent of the same theme that I identified in *Section 6.2.1*. I explored there, that although those female respondents felt that they did not enjoy cooking, they were still obliged to undertake this role. Nevertheless, the similarity identified in these accounts was interesting, because of the contrast in how domestic labour appeared to be apportioned in these households. So in contrast, these female respondents implied that they

had some say in choosing not to cook, or they were able to divide the housework because their husband wanted to cook.

It is difficult to expand on why the women I interviewed (regardless of whether they did all the cooking or not) still constructed cooking as something that they did not enjoy. Although one clue was contained in the previous account. Hence the idea that this female respondent (Phillipa) saw cooking as a "chore", but her husband "would have been a chef", is worthy of further exploration.

What these following accounts suggest, is that these male respondents cooked because they constructed this task as pleasurable. I have already argued that these men spoke about certain circumstances necessitating their input in the kitchen. However, the idea that cooking was something that could be enjoyed on a routine basis, revealed a meaningful contrast with the majority of accounts presented in this chapter. Thus as this example typified (while also verifying the accounts of the female respondents), these male respondents felt they enjoyed cooking more than their wives:

STUART: It's just always been that way I think. Erm, basically because I think I enjoy it more than Lynne does.

Yet apparent in these accounts was the idea that cooking itself could be a pleasurable task. Thus several male respondents felt that they liked to experiment in the kitchen and found it therapeutic. Some also mentioned that this made an interesting change when they had been at work all day. Additionally, they also talked about how they liked to experiment and try and cook new things. This particular example represents the views of several male respondents, who said that they liked to watch cookery programmes or try out new recipes:

SCOTT:...Yeah. I like experimenting. I watch all the cookery programmes, obviously the recipes in the women's magazines, yeah. I would say there again, you go back to the advertising thing. Yeah, I like to potter about in the kitchen, I find it quite therapeutic. I hate the washing up, but I like the preparation.

One other element of the idea that cooking could be for pleasure, was that several male respondents spoke of how they would have liked to become a chef. Hence, it was implied that cooking all the time was not necessarily a bad thing.

COLIN: Er yeah, I wouldn't mind, erm maybe if I had got into it when I was younger I would have done it at college, and hoped to have maybe carried it on from there.

However, as this particular example suggests, part of the idea that cooking could be pleasurable appeared to be based around the idea of 'role models'. Although such accounts were not followed up in detail, the idea of 'cooking like a chef' constructs cooking more positively than I identified in *Section 6.2.1.*

RICHARD: This was something that I started doing, producing meals, getting cookery books out of the library, watching Graham Kerr on the tele. A quick slurp. Do you know him?

Unlike many female respondents therefore, the men who were responsible for some or all of the cooking were evaluating this task very differently. On the one hand, cooking was presented as something which they liked to do. However at the same time, they were not evaluating this role within the broader notion of care that I identified in the majority of female accounts. There was some evidence to suggest that these contrasts arose because these men were choosing to cook, and as a result did not construct cooking as a chore. However, although their involvement appeared to be far greater than the majority of male respondents in this study, cooking as something which men do appeared to be presented as a higher status role than when undertaken by women.

6.4 Chapter summary

The contrasting gendered accounts presented in this chapter appear to speak volumes about the social construction of food provision within the home and the day to day routine of having to manage a number of different priorities. This was symbolically revealed by how women rarely questioned their obligation to provide a 'proper' meal and the further need of incorporating their own dietary concerns into this equation. It was apparent therefore, that they were not constructing the management of this role as one that presents conflict. However, the difficulties that were identified appeared to be tacitly resolved by an attitude where they were obliged to take control and 'get on with it'. Although for many women cooking itself was not a task they appeared to enjoy, the way it was constructed, seemed to be attributed to a wider meaning of feeding their family.

7 Dealing with inconvenience in family meals

7.1 Introduction

In the previous chapter, it was apparent that female respondents had to face and manage a number of contrasting and competing requirements when providing 'proper' meals for their family. Yet they appeared not to be presented as conflicts, because meals were provided which accommodated different preferences, or alternatively separate meals were being made altogether. By focussing upon their reliance of *pre-prepared foods*, it is the aim of this chapter to explore further the ways that female respondents spoke about the day to day management of these competing requirements. It was apparent therefore, that these pre-prepared foods had a practical meaning, because they helped to manage a number of different inconveniences on a day to day basis.

7.2 Having and needing to have a routine

I have already argued that the concept of 'sitting down to a proper meal' appeared to be constructed as an integral part of family life. Moreover, it appeared to be imbued with a meaning which suggested that providing such meals was integral to how female respondents evaluated their role as a 'mother' and a 'wife'. This theme however, explores how these women talked about the everyday reality of providing such meals necessitating a compromise, and how this was accomplished by a reliance upon pre-prepared foods. Therefore, it will be argued that as a result of this compromise, while these foods appeared to help make feeding the family more manageable, female respondents also felt 'guilty' about relying upon them. It will be suggested that these accounts are a manifestation of ideas about what a woman *should* provide for her family, and what these female respondents thought that they could realistically achieve.

7.2.1 A matter of routine

Before the interview, I had asked respondents to complete a food inventory *(see Section 5.3.1)*. Not surprisingly in light of the evidence I have presented so far, it was mainly the female respondents who had taken the responsibility for compiling a list of the food they had in the house. When they were asked about this list further, they claimed that what they were buying and preparing was very much a routine, and they went on to explain that it was necessary to keep it this way. The key point I will be making in this sub-theme, was that pre-

prepared foods appear to be associated with maintaining the provision of meals on a routine level.

For example, female respondents often emphasised how they frequently bought the same things. Many also said that it was just like making a shopping list, because they always had the same things, or that writing the inventory had made them realise "The pattern does not really change much" (Alison) because "we are buying the same sort of shopping every week" (Caroline):

ANNABEL: Nine times out of ten you're buying the same things all the time, er we buy, we probably buy these items all the time and use them every week.

Some of the female respondents also explained that writing down a list had been a fairly straightforward task. This was because they said that the foods which they usually bought had become such a routine, that they did not have to give shopping much thought. As this example below suggests, female respondents appeared to value the meaning of these routines, because they said it felt as if no effort was being made. In particular, their accounts suggest that this helped to reduce the amount of planning that had to be undertaken:

JO: They are so routine, that I don't have to think about it. I know exactly what I am doing and so I just throw it all in the pan, so I'm not really making an effort.

Moreover, many female respondents explained that it was important to have a routine because they led busy lives, and the need was greater on occasions when "everybody was rushing everywhere" (Tracey). This was perhaps reflective of the life-course stage characterising these respondents' lives, since they often explained meal times were often prioritised around their children's activities. So as a result of this scenario, this female respondent talked about how "an evening meal" had to be something that can be "prepared within the half hour" and could fit around a busy lifestyle.

AMANDA: As I said before the evening meal is something that can get prepared within the half hour, which is coming in and getting the homework done and the routine done, and he comes in at half five and we like to eat, and other things start at six. Youth Club at six, Brownies at six.

As I identified in the previous chapter, many women also said that cooking was not something they really enjoyed, especially because they had to do it all of the time. Perhaps as a result of this, they stressed that meals had to be easy to prepare. This appeared to be because they did not always want to spend lots of time cooking, or also that it was something that they did not feel they were very good at.

Although this shows an interesting contrast with how some female respondents constructed cooking skills *(see Section 6.2.1)*, in comparison to other women that they knew, they sometimes spoke about how they were personally not very adventurous in the kitchen. Therefore this next example typified how some of the women said that they were unable to cook from scratch or make up their own recipes. The implication of this seemed to be that they were often eating the same things:

CATHERINE: Em, well yes and no. I mean sometimes I would like to try to cook different things, I mean I have friends that have, we have people for dinner and things like that and they are more adventurous than me and you know they are not scared to make up their own recipes.

Female respondents appeared to maintain meal times on a routine level, by relying on pre-prepared foods. Commonly, these consisted of cooking sauces which respondents explained were useful, because you could buy one of these (in a jar or can) and then you just added the meat. The reasons for using these foods were normally justified in terms of the issues that I raised above. Hence respondents often talked about the time factor, and that they had the benefit of saving time. In other cases, they said these foods were easier to prepare and you always got the right quantity:

CAROLINE: I suppose it would be the time factor again. It does I suppose. If I was in here all day every day then maybe you would be spending more time with the cook book out and what have you and I'm not saying we eat convenience food all the time either but yeah I suppose it does. How much time you have will affect how much time you spend in the kitchen.

On other occasions it was apparent that what respondents meant by "convenience foods", were a range of pre-prepared *frozen* foods. Many talked about how they relied heavily upon their freezers, and that it meant that what they were eating was a last minute decision and they could eat whatever was in their house at the time. Again, it was implied that this was another way of not thinking about what had to be provided. The following quotation was typical:

TRACEY: It's very seldom that I go out in the morning and buy mince and then have it, it's usually in the freezer. So maybe take it out, em, and I would think right well everybody eats this and if they do fine.

Finally, in only a few cases did female respondents talk about routines and systems which did not necessitate pre-prepared foods. Hence in two interviews, it was explained that they would prepare food in the morning, so that it was just a case of switching it on when they or their husband got home from work:

NICOLA:…during the week, you come in at half past five and it's a rush to get whatever it is, whether it be macaroni, or sometimes you will peel potatoes and carrots and things, even if its just a question of switching it on. Or as I say, if there's soup made, then you don't even have to boil it, you can put it in a boil and put it in the microwave and two minutes later he's got a plate of soup and bread.

It was apparent that pre-prepared foods were associated with the need to maintain the provision of meals on a routine level. Furthermore, female respondents explained that this was necessitated by their busy lifestyles, or that they did not feel they could cook from scratch. Nevertheless, it appeared that pre-prepared foods are meaningful to the themes discussed in the previous chapter, because they save time and they help to reduce the inconvenience of always being the person who has to provide meals. However, within a context where these tasks still have to be undertaken on a day to day basis, it appears that these foods help to make cooking *feel* like it is a matter of routine.

7.2.2 Compromising

Although in many cases certain types of pre-prepared foods appeared to be relied upon heavily, these female respondents also spoke reluctantly about using them. The point that I will be stressing in this sub-theme, is that they were being evaluated in relation to the 'proper' meal. Cooking in this way was constructed as a compromise and it was acceptable for a cooked meal to not be home-made or cooked from scratch.

In contrast to the way that female respondents talked about what a 'proper' meal should be, it was apparent on several occasions that their accounts were based on idealistic sentiments. When I asked about how their concept of a 'proper' meal reflected what they had actually eaten, female respondents often explained that the day to day reality could be very different. Here for example, a previous comment about what a meal *should* consist of, was contradicted by what she had eaten and cooked over the last few days.

TF: Erm, so how would that fit into what you've had to eat over the last few days?

ANNABEL: Oh, completely. It contradicts everything I've just said, what with being up the town on Saturday. I wasn't in to cook or anything, so that was convenience fast food. I was out on Saturday night so I didn't even make a meal, my husband gave the boys something eh. But I just like got myself a burger, I mean, everything I don't want to eat, I ate, sort of thing. It's just convenience then, or just whatever you can get at the time. And then Sunday I was working all day, and last night I just fried the bit of meat, I just had that. I mean I even fried that. But normally I wouldn't eat like that, it was just because I was out all weekend, and then working. You do a lot of things for convenience actually.

Further suggestions that there was a difference between the ideal 'proper meal' and what was being bought and provided were also apparent in a number of accounts where respondents talked about how times had changed. Such accounts appeared to construct a reliance upon pre-prepared foods as being 'normal'. While respondents appeared to talk with some reluctance about how pre-prepared foods were a product of the way that we now live, they were also simultaneously normalising their use. In this following example, it was felt that in the past people "went out and bought fresh stuff every day" and that they did not have "freezers". Having to rely on the freezer instead, meant having less fresh foods which were "not the same":

TRACEY: I think now, like when we were young, your mum and your gran and that probably went out and bought fresh stuff every day, nothing was like, they didn't have freezers and things like that, so nothing was as convenient, it was always fresh fruit, fresh veg, fresh meat, whereas now we maybe buy frozen stuff and it's all put in the freezer. I mean I daresay it does, but I think to a certain extent it probably does, it is not the same is it, whereas like fresh ready made, and now it's like you open the freezer and think oh I'll have that for tea and em, so and I think that's probably why there isn't so much, there are more of everything now.

This next quotation also typified how several female respondents justified why pre-prepared foods were now more acceptable and had become more necessary. This links into the point I raised in *Section 6.2.1*, about how respondents constructed their work patterns as their 'circumstances'. Thus the idea that you can make a meal from "scratch" was regarded as being less relevant, because this respondent was not "in the house" and did not have the time that her mother may once have had.

NICOLA: Well my mother's always going on about how you should have a cooked meal, and it should be prepared the night before, and er she always did that you see, but she tended to be in the house until we were all at the high school, my mother was in the afternoons. She had plenty of time, and she thinks you should make a dinner every night and you should start from scratch.

In other cases, several women also said they felt pre-prepared foods were very useful, but they implied that they felt guilty about using them because they would "prefer to cook from scratch if they had the time". In this next example, there was a sense that such foods are not quite the same. Hence because of the "way" that this female respondent said she was "brought up", she would prefer not to rely on a "cooking sauce" and keep it for the emergency of "just in case":

TF: Some people would maybe use a cooking sauce, wouldn't they?

RACHEL: Oh, I've always got one there handy just in case, but em, it's usually I would make it myself.

TF: Why do you prefer to make it yourself?

RACHEL: I think it's just the way I was brought up, it's the way I've been brought up.

Several other female respondents also spoke of how relying upon pre-prepared foods was a lazy way of cooking and that despite their value, it really came down to the issue that sometimes they "just wanted something hot and quick and out" (Alison). This kind of statement also typified how respondents appeared to be evaluating these foods in terms of the meanings imbued in the concept of the 'proper' meal. She also talked about how frozen foods "made" her "lazier", because she was "getting into the habit that" she "wasn't cooking". Similarly another female respondent talked about a time when she had relied more heavily on pre-prepared foods:

CATHERINE: I mean it made me lazier I suppose, you know what I mean, it did make me lazy because I was getting into the habit that I wasn't cooking.

Thus although pre-prepared foods may have conflicted with what the 'proper' meal appeared to represent, they also seemed to satisfy some of these women's requirements. This was apparent in the way that female respondents also talked about the 'health' issues associated with pre-prepared foods. On the whole, they appeared to play down any 'health' issues associated with them, especially in favour of the need for foods that were quick or easy to prepare. Moreover, such views were normally only revealed after I had introduced this topic and only on a very few occasions did respondents talk about the health implications of 'additives' and 'E numbers'.

In the few cases where food additives were raised as an issue, they were always played down as being a potential health problem, because some respondents put forward reasons which they felt meant they did not have to take any potential side effects too seriously. This was because they constructed any health issues related to food additives as a problem that did not affect their own children. Interestingly this relates to the short-term theme of health that I will explore in *Chapter 9*.

TRACEY: I mean when we were young, classrooms were fine, they were quiet and everything, and in Gill's class alone, there are about three or four of them that have actually had to be taken out because of their behaviour and it could all be down to their diet, it could be down to the sweeties that they eat.

So far, I have raised the issue of how pre-prepared foods appeared to be constructed as a compromise. This was between the apparently idealistic requirement that a 'proper' meal

should be cooked from scratch, and a day to day necessity to ensure that the provision of family meals needed to be maintained on a routine level. However in the previous chapter, I also argued that the 'proper' meal appeared to play an important role in family life, because it provided an occasion when the family could sit down together. I now want to explore the idea of compromise further, by focusing upon how many women felt that pre-prepared foods still allowed these meaningful occasions to take place.

7.3 'Fussy eaters' and pre-prepared food

A further theme of how pre-prepared foods were often viewed as a compromise, was revealed in lay accounts of 'fussy eating'. Revealingly, there appeared to be a marked contrast between those families where respondents said their children ate the adults' 'proper' meal, and those where pre-prepared frozen foods were relied upon as a way of managing 'fussy eating'. Although I shall argue that each perspective appeared to have different consequences in terms of what children appeared to be eating, the main contrast was in the way they constructed the 'rights' that their children had to choose what they wanted to eat.

7.3.1 Getting them to "eat something"

Notably, it was usually the same families where female respondents were responsible for all of the routine cooking of evening meals, and where both respondents referred to their children as 'fussy eaters'. As a consequence of 'fussy eating', both respondents talked about how separate meals were provided which their children would eat, and which normally consisted of a range of frozen processed meat and fish, referred to as "Turkey Drummers", or "Chicken Nuggets" (these foods are often marketed as children's foods).

Female respondents, in particular, said that meal-times involving children could be a nightmare or alternatively, they said they found them frustrating. They explained that after spending time cooking more elaborate meals, their children might say "I'm not trying that" (Amanda) or it was also felt that "it takes the heart out of it a bit when you have prepared a meal, and they say oh we don't like this" (Mary). As a result, many female respondents talked about a need to cook separate meals for their children. So although the adults still ate a 'proper' meal such as a Sunday dinner, the children would have chicken nuggets or fish fingers instead.

TRACEY: Yes, and a Sunday dinner is a nightmare, because I seem to make it for me and Keith just, because the girls like you say we'll be having pork or something and they are like oh I don't

like that…. It's like sometimes at teatime it's like a café in here because Gill doesn't like things like sausages and bacon or anything like that, but she loves fish, fish fingers, fish cakes and things like that, whereas Linda would rather have the chicken things.

Perhaps because both parents reported that they often ate their meal together with their children, male and female respondents talked about how they hoped that their children would improve as they got older and said that "we're just biding our time" (Amanda), or "hopefully they will start to try more things" (Catherine). In many cases, respondents talked about how this was a "gradual process", or that there would be a time when everybody was going to be able to sit down and eat the same things. It was also fairly typical (as this next respondent states by his point: "like any kids") that this was constructed as a 'normal' process and that they will improve. So for the meantime, "it's just a matter of taking things slowly":

TED: And hopefully as they get older, they will begin to enjoy other foods. They can sit down together and have the same things, but they're still at the stage of having fish fingers, or chicken dippers and they like going to McDonalds - like any kids. But it's just a matter of taking things slowly.

Another way that respondents talked about how it was 'normal' for children to be 'fussy eaters', was to talk about their own childhood. They said for example that parents always made them eat things and then they ended up hating them. Alternatively they also said that they used to be forced to eat something and now they liked it:

AMANDA: I'm thinking, how are you going to learn about anything if you don't try, but I've still got vivid memories of being forced to eat my fish on a Wednesday, we're relaxed about it.

However, as this idea of "being relaxed about it" also suggests, some respondents also constructed forced-feeding as a moral issue. Thus several talked about how they did not think that it was fair to force things into kids mouths which they did not want to eat. As the following quotation suggests, this was because Ted thought that children were "independent people", and should have the 'right' to eat what they wanted. This was constructed on the premise that he would not "like to go somewhere and eat something that" he did not like, "So why should they?":

TED: Well I don't think that's fair. I don't think I would like to go somewhere and eat something that I didn't like. So why should they? There's nothing better to put you off food than to have to eat something that you don't like. Because they are independent people, and they tell you what they do and they don't like. Do you know what I mean. Sometimes it's what they used to be happy with, and today they decide they don't like it or what have you.

Some respondents elaborated further on why they thought forced-feeding was not a good idea. In many cases, this were presented as being a matter of 'common-sense', and to do otherwise would not be sensible. As this next example illustrated, one view was that no matter how hard you forced them, if their children did not like what they were being given, then they would not eat it:

CATHERINE: Yes, you can't force them. He just wouldn't eat it at all, so you've just got to give him what he wants, what he likes and that's it.

There were noticeable differences in the reasons which male and female respondents gave for why they did not like to force their children to eat certain foods. Female respondents' accounts appeared to reflect their role as a mother more generally, whereas the male respondents only appeared to face 'fussy eating' at the meal table. Therefore one issue that this female respondent below raised, was that if you give children something they do not like to eat, then they will go looking elsewhere for food and which may not be satisfactory.

TRACEY: Because then you will find that they won't eat it, and then ten minutes later they are down and they are raking for junk, and they are filling themselves up with biscuits or crisps or sandwiches or whatever...

This again raises the idea that pre-prepared foods were being constructed as a compromise by many women. However, it was especially noticeable here that these foods were being viewed hierarchically. This idea of a compromise appeared to be centred upon a view that it was better if children were eating these pre-prepared foods than something which was a snack. Thus as the example above revealed, while this female respondent appeared to not be particularly enthusiastic about "chicken nuggets", the implication was that they were regarded as being more of a meal than "biscuits". Furthermore, in the following account, the point about "I wanted them to sit down and have a proper meal", suggests again that this respondent viewed pre-prepared foods as a compromise between eating something at all and the type of meal which she would prefer to provide.

TF: Just to make them eat something?

RACHEL: Yes, because they would just maybe say well we'll have a tin of soup or em, they would just maybe have a burger or something like that. Do you know, something easy. And I wanted them to sit down and have a proper meal.

Another important point to mention, was that several female respondents had said that providing separate meals for their children was not a problem. This links into the point that I raised earlier, about how they constructed the provision of meals as being a matter of routine. Generally, the need to provide different meals was presented as something that had

to be done. Or, it had developed into such a routine that it was carried out "subconsciously" (Caroline).

However on several occasions, it was explained that sometimes all of the family ate these pre-prepared foods (which were marketed as children's meals), and that this was because it was easier to do it this way than to cook separate meals. Hence one female respondent said that this was sometimes necessitated, because "there are times when you think it'll be easier to have what they are eating" (Rachel). Again, there was some reluctance expressed in everybody eating pre-prepared foods, because as identified previously, they were sometimes viewed negatively and called "junk". Despite this criticism, these meals were again being constructed as a compromise. Therefore in this next example, it was implied that the benefits were outweighing any potential harm:

AMANDA: [We] balance our needs very poorly, but their needs are probably catered for better than ours. Erm, I sometimes I feel I deprive him of things, he gets all the kiddies junk, he doesn't get a very varied diet.

Finally, in contrast to their wives, male respondents usually had a totally different perspective on 'fussy eating'. Although their accounts agreed with the female respondents' view that it could be frustrating, it was often felt that they did not really have to deal with it directly because they were not responsible for the cooking:

TF: I mean how do you feel about them having different things, people say it can be a nuisance?

KEITH: Well it can be I suppose, for the person who is cooking it all.

This different perspective certainly also appeared to be reflected in how male respondents talked about the effects of 'fussy eating' being felt only at the meal table, rather than in the buying and preparation of meals. This male respondent for example, said that he wanted a "quiet life" and so did not want to get into any conflict with his children.

JOHN: Well yeah, aye. With them anyway, I suppose I want a quiet life. It's my weekend off, I don't want to spend the time arguing with the children.

Similarly in this example, this male respondent made a point about 'conflict' and felt that he did not want "to be a sergeant major and ram it down their throats". Again however, there was a recurring moral theme that it was wrong to force children to "do something they don't want to do":

GARY: I'm no going to be a sergeant major and ram it down their throats ken.

TF: Some people also tell me that's the sort of attitude they take. How do you feel about that?

GARY: No danger eh. You're no going to stand and shout at somebody to eat something, to do something they don't want to do ken. You just tend to give them what they like to eat sort of thing eh.

Although it was apparent that both male and female respondents felt you had to accept that children were 'fussy eaters' and it was unfair to force them, there was a noticeable difference in how they talked about the consequences of providing separate meals. Male respondents talked about wanting to avoid conflict with their children when they were eating, yet for female respondents they felt it was necessary to cook separate meals to make their children 'eat something'. Perhaps like their view of pre-prepared foods more generally, they did not talk about conflict, because this reflected how female respondents were managing the day to day realities of feeding their families by 'getting on' with the provision of meals. Thus once again, although female respondents appeared willing to provide separate meals, this was unproblematically presented as being part of the obligations that come with being a 'mother' and a 'wife'.

7.3.2 Eating 'properly'

It was identified in the previous theme that most respondents felt that it was normal for children to be 'fussy eaters' and that it was necessary to provide separate meals that they *would* eat. However, not all respondents appeared to be willing to accept a compromise. There were two households where respondents said that their children did eat 'adult' meals, and these men and women appeared to have a different outlook on pre-prepared foods more generally (Deborah and Colin; Scott and Phillipa). It must be stressed again, that there appeared to be a relationship between the way that pre-prepared foods were constructed and how the division of labour associated with providing meals was said to be apportioned. In these families therefore, the cooking was apparently being shared.

In both families, one of the respondents talked about how they had 'educated' their children to eat the sorts of foods that they wanted to eat. Although they did not always have the same meals, it was felt that they had had to work at their children's tastes to make life "simpler" (Scott). Noticeably, and unlike the respondents who constructed 'fussy eating' as being 'normal', there was no suggestion in these accounts that it would be tolerated. However, this female respondent for example, spoke of how she had to hide vegetables in her son's food:

DEBORAH: Well if the kids get more a wee bit fed up wi' things than, or Will, I think he was livin' on pizza an' I went "No, you canny keep eatin' that every night" but he'll no' eat vegetables

for some reason, that's why, when I make soup I try an' hide it in the soup.

Fundamentally, unlike the respondents who felt that pre-prepared foods were a compromise, respondents from these families talked more negatively about them and said that they usually cooked their meals from scratch. This male respondent for example had mentioned that he did not think pre-prepared foods were very 'healthy' in comparison to a meal he had cooked himself. When I probed him "Why", he talked about how they were full of additives and that anybody living off such foods was not really doing themselves a "hell of a lot of good":

TF: Why would they not be as healthy?

SCOTT: If you read the backs of the pack, I mean there's a lot banded about the E numbers, but you've got modified starches, and glutomin. It's alright, it may taste like what it's supposed to taste, but how they got it to taste like that is another story. Enhancers, I don't think anybody living off these things is doing themselves a hell of a lot of good, to be quite honest.

The key point raised here was that these accounts contrasted with the view of the majority of respondents, because it was felt that children should not be allowed to be 'fussy eaters'. From the small amount of evidence presented here, it is only really possible to speculate on why they constructed different accounts. It may be possible to suggest that they were more willing to confront the issue of 'fussy eating' because they did not want to compromise and provide pre-prepared foods. Furthermore, it may be the case that because these respondents shared the cooking more equally, they found pre-prepared foods less necessary and had less of a need to accept their benefits.

7.4 Chapter summary

Female respondents constructed pre-prepared foods as having practical benefits, because they help to reduce some of the inconveniences that result from providing meals, and because they help to make cooking feel like it is a 'matter of routine'. However on reflection, they were constructed as being a compromise solution - because female respondents also constructed a gap between what they felt they should provide, and what they felt was realistically achievable. Therefore feelings of 'guilt', issues about food additives, or a view that such foods are 'junk', were not presented as being barriers which were preventing pre-prepared foods from being used on a day to day basis.

For these reasons, it is possible to suggest that any conflict was managed within the everyday reality of providing these meals, because the need for cooking to be a routine was

constructed as the foremost priority. However, it is not necessarily the case that any conflict goes away and is resolved, but the data presented here suggests that pre-prepared foods were being valued because they still resembled 'proper' meals. This was perhaps typified by how respondents said that they still all sat down to eat a meal together, even if they were eating different foods. For many female respondents therefore, they were considered to be an acceptable way of feeding their family, which still fulfilled the way that they constructed their obligations as a 'mother' and a 'wife'.

8 Getting the 'right' balance

8.1 General introduction

The two major themes presented in this chapter explore how lay understandings of 'healthy eating' were pervaded by the idea of a 'balance'. Building on the themes discussed in *Chapters 6* and *7*, this chapter develops the theme of *"Getting the 'right' balance"* to reveal how 'healthy eating' was embedded within respondents' everyday understandings of food and eating. The idea that there was a *right* and *wrong* way to approach food and health however, demonstrated how respondents felt that 'healthy eating' had to be balanced against a range of other needs and requirements in their day to day lives.

8.2 Part I: Balancing the 'healthy' and the 'unhealthy'

In this section, I wish to look at some of the ways in which lay accounts of 'healthy eating' were centred upon the terms 'variety', 'balance' and 'moderation'. While I attempt to unpack and separate the different meanings associated with these terms, it will become apparent that although these terms were used in different ways, they also appeared to be connected by the idea of a 'balanced diet'. Lay respondents drew upon these terms to talk about how it was important to be *"Getting the 'right' balance"* of food that was 'good' for your 'health' and food that was 'bad' (but enjoyable) or was necessitated by other factors.

8.2.1 Avoiding the extreme

Although it will become apparent that respondents felt eating a 'healthy' diet was important to their health, they often said that it was necessary to avoid the extreme of worrying *too* much about what you ate. *Part II* of this chapter will explore how they also constructed a need to avoid the extreme of not caring enough. This theme is included here nevertheless, because it demonstrates how respondents said they felt 'health' was only one priority which affected what they were eating on a day to day basis.

Respondents often said that while food and health issues were important to them, you should not be "too conscious about what you eat" (Jim) and that you should not "worry too much about it" (Mary). Thus in the following example, although Amanda felt food had an important relationship to her health, this had to be balanced with being "relaxed and happy with what you are doing", because it was not "healthy if you get too fanatical" about your

diet. Such accounts also revealed how 'healthy eating' was constructed multi-dimensionally because their accounts drew upon a range of physical, moral and psychological discourses.

AMANDA: Well it's very important. You need food to survive. Too much of the wrong food's going to lead to all sorts of health problems. Erm, but you have also got to be relaxed and happy about what you are doing, I don't think it's healthy if you get too fanatical about how much of how many bits and pieces are in every bit of food. Erm, you've got to get a happy balance.

On other occasions, respondents would talk about food and health in terms of how other priorities were more important (such as those discussed in the previous two chapters) and that we should only be concerned about them to "a certain extent" (Rachel). However, they often presented these concerns as being at the "back of their minds":

TED: Health does not come top of the priorities when I think about what I am going to be eating even though it is in the back of my mind I suppose because if it wasn't I do suppose we would be eating a lot more fatty foods not so much salads, even though we enjoy the salads and the vegetables and the fruit. I suppose even though I am saying that health does not come top of the priorities in a way it must, you know if we do eat these things.

One particular issue that two women identified, was the fear that worrying too much about food could lead to eating disorders such as anorexia. It was therefore considered to be very important that their children took a sensible approach towards food. In this example below, it was apparent that this female respondent was balancing being teased about her own weight with the extreme of "skinny pop stars":

TF: Well, it's been said that there are more pressures on women?

AMANDA: Erm, well I suppose, er yes. The self-image thing. And eating healthily, and keeping a nice figure and all the rest. Can be an effect and I must admit that I am quite, not strong in the fact that, I don't erm, discuss things that are fat, and they tease me about being fat, and it's all a big joke. Erm, but I would hopefully instil in the kids that it's not a big issue. It's how you feel, but you get all the skinny pop stars and all the rest, role models for children. It's worrying.

Interestingly, on several occasions, the term "moderation" was used to imply a balance between the extremes of caring 'too much' about being 'healthy' or not caring enough. One respondent (Sue) mentioned a relative who had lived to an old age and that this person must have eaten all sorts of things. She implied that by eating 'everything in moderation', health would still be looked after, while at the same time she did not have to take it too seriously. Similarly, another respondent who also talked about 'moderation' said:

DEBORAH:...But I think when you get older an' you read about things an' you hear about heart disease an' you think, well if it's gonny

make your life that wee bit longer, you will try an' cut it back a bit, won't you, I mean like in moderation really.

This brief theme has explored how to legitimate not taking 'healthy eating' to an extreme, respondents put forward a range of different discourses about health. As will become apparent in the following section, this was also meaningful because it related to their idea that 'health' is and should only be one priority in everyday life.

8.2.2 Weighing up the 'good' and the 'bad'

Developing the idea that 'health' was only one priority in everyday life, this section begins by exploring how lay understandings of 'healthy eating' were constructed around the need to balance 'good'/'healthy' foods with 'bad'/unhealthy ones. The second sub-theme within this section however, explores how this dichotomy appeared to provide a mechanism for talking about, and making sense of, maintaining a 'balance' between different priorities on a day to day basis.

The varied balance

Lay understandings of a 'balanced diet' laid claim to a basic knowledge of nutrition. While respondents talked about how 'healthy' foods were 'good' for you, the implication was that 'unhealthy' foods were primarily for enjoyment or had to be eaten for other purposes. However, within this meaning of a 'balance', there also appeared to be a view that the two could coexist, because they were 'balancing each other out'.

Lay understandings of nutrition appeared to influence how they constructed 'healthy eating'. However, it was noticeable that respondents rarely referred to food groups by scientific names and it was more common that they would talk about varying different food groups such as fruit and vegetables. On other occasions for example, carbohydrates were sometimes referred to by food types, such as chips or potatoes.

Nevertheless, respondents implied that a varied diet can be a 'balanced diet', because different food groups were being balanced. Typically, respondents said that they would "try and eat a reasonably varied diet which included vegetables and fruit, and only have chips every now and again." (Nicola), while in this following example, a male respondent said that he tried to give his daughter as "varied [a] diet as possible". Note that *Part II* will focus upon how 'chips' also appeared to have a symbolic value in representing 'unhealthy' foods, but it was often apparent that respondents saw them as being part of a 'balanced diet', along with 'healthy' foods such as vegetables and salads.

TF: How do you balance their needs with yours?

STUART: Erm, well as I say, just trying to make her eat as varied as possible really. Erm, we don't have the same thing every night, sometimes chips or something like that. We try and alter it. She's not into eating a lot of vegetables, but she likes salad and that sort of thing, so, we try and give her salad.

This following example however, was again typical of how respondents constructed a 'balanced diet' in terms of different food groups based around the idea of 'healthy' and 'unhealthy' foods. Yet here, this female respondent talked about refined sugars being "unhealthy", but that this was okay, "as long as you do not eat them all the time". Once again, this was typical of how lay concepts of 'balance' were often related and linked to an understanding of variety and moderation:

AMANDA: Erm. Yeah it fits in, to a certain extent. But again, it's a mix and a variety like you could say that [pause] refined sugars in your cakes are unhealthy if that's all you are eating, but it's not unhealthy to have a cake. I feel there's a reasonable mix of foods.

I have argued so far that what respondents appeared to mean by a 'varied diet', was often based upon an understanding of 'healthy eating' presented as a need to balance out 'healthy' foods with ones which were regarded as being 'unhealthy'. Therefore, some understanding of nutrition appeared to be constructed as a need to have a balanced variety of different types of food groups. However, in all of the themes that follow on from this one, it will become apparent that the dichotomous classification of food as being either 'healthy' or 'unhealthy' pervasively underpins the concept of *"Getting the 'right' balance"*.

Evaluating a 'healthy' balance

This theme makes a subtle distinction from the previous one, because it explores how respondents appeared to be evaluating and subsequently constructing the 'healthy' and 'unhealthy' parts of their diet as a 'balance'. Therefore, through a process of 'weighing up', respondents appeared to use the concept of a 'balance' to talk about how they were *"Getting the 'right' balance"*.

Importantly, when they were asked to talk about how their diets were 'healthy', respondents appeared to 'weigh up' the different parts of their diet and talk about a 'variety'. Importantly though, such accounts were often in response to a question I asked concerning "How do you think healthy comes into what you've got on your list". Here for example, this female respondent used the notion of a 'balance' to evaluate that her diet "isnae too bad", because it was "quite varied":

ALISON: It just made me question my diet. Whether or not I was eating healthily. It actually made me stop and think, it isn't too bad you know [okay]. I thought it was quite varied actually, I didnae realise that I had so much stuff, cos I'm always moaning that I havenae got any food in, but actually we have got tonnes of stuff. We look in the fridge and you think there's nothing for eating, but erm I thought it isnae too bad, there is, well we havenae really got a fatty diet or anything like that so im quite conscious, I thought my fridge was needing cleaned! That's what I thought as well.

Respondents often talked about the variety of their diet being a mixture of the 'good' and the 'bad'. In the following example, this respondent again talked about a 'variety' as a way of 'weighing up' and subsequently constructing that he had a 'balanced diet'. Carrying on from *Chapter 6*, the idea here of the 'good' and 'proper meal' that contained vegetables was balanced with chips and burgers which were seen as being 'bad'. Therefore by implication, these are less 'healthy' and serve a different purpose of keeping the peace. Such examples revealed how the idea of a 'balanced diet' appeared to be an integral mechanism for making sense of a range of different priorities in everyday life. 'Healthy' foods therefore were often just one of these priorities.

RICHARD: But no, if your fridge is large enough it can be varied, and as Sue has probably said, we go for at least every other day, proper food with vegetables, fresh vegetables. We wouldn't have fast food two days in a row, chips and burgers, just to get some vitamins in for the children. They do eat their vegetables, they don't get pudding if they don't eat their vegetables, so they have the incentive.

Moreover, sometimes respondents talked more about the 'good' things that they were eating. Although they still implied that they had a 'balanced diet', this also appeared to represent how the balance of their diet was weighted towards the 'good and healthy' rather than the 'bad and unhealthy' side of a balance. However, unlike the following quotation, it was unusual for respondents to talk about 'healthy' foods in this way unless I specifically asked them if "healthy came into what they had" on their list:

DEBORAH: Em, well, as I said, it's no' too bad, em, I suppose it depends on: I mean it's quite a varied list, I mean there's quite a lot 'y good things like cheeses and bread and pastas and lot's 'y fruit. I mean I've always got lot's 'y fruit and vegetables and there's cereals and beans and things, so it's a varied sort 'y list, em, I mean we try 'y cut down an' go on diets but they dinny work, so I give up.

Such an example revealed again how the term 'weighing up' is appropriate here and how the idea of a 'balance' appeared to form the basis for presenting an image of a 'healthy' diet where the scales were weighted in favour of the 'good' side. Another example of this was when respondents were evaluating if their family (as a unit) was eating a 'balanced' diet. This

revealed how on a few occasions, the idea of a 'balanced diet' incorporated all of the family's likes and dislikes and that just because one person was not eating a certain 'healthy' food, this could be compensated by someone else liking it.

LYNNE: Erm, cos people take pieces. Stuart eats a lot of fruit, I'm not a big fruit eater. Neil doesn't eat a lot of fruit. Grapes. An occasional kiwi fruit, erm. Very seldom an apple or an orange. I don't know why I buy it sometimes, but I think it's my conscience tells me I have to. Andy doesn't eat fruit. But we do eat a lot of veg. A lot of fresh veg, broccoli and cauli and all that, we all like that..... you think I really need to have fruit, but then you think, why am I buying it because nobody eats it, but then as I say, Stuart does eat a lot of fruit. He eats, at least two or three pieces a day. I'm just not into fruit, and I probably should. And Andy never eats fruit.

As is again demonstrated here, even if someone did not like a certain food (such as vegetables), respondents felt that their family were getting a 'balanced diet' because children were still eating plenty of fruit for example. Therefore one factor was "compensate[d]" for by another:

TF: How do you feel about them not being good with vegetables?

CAROLINE: It does worry me sometimes. I have to admit yes sometimes it does worry me. Even this meat thing well I think that's another different thing apart from fish fingers, chicken dippers the pizzas they eat, what I call junk but they'll eat it so at least if they're eating. I make sure they have yoghurts and milk and they do get two pieces of fruit away to school. They have fruit for their supper. If they came in now and asked for something I would say you can have an apple or a banana or grapes and if you don't want them then you're not really hungry. I probably compensate with the fruit for the lack of vegetables.

Finally, several respondents talked about how having a 'balanced diet' was something that was at their 'back of their minds'. This appeared to provide a practical mechanism for helping them 'weigh up' if what they eating was nutritionally balanced, because it was "at the back of your mind" and helps you decide "what you do buy" (Caroline).

NOEL: Well a balance of minerals, vitamins. Fibre. I don't go round the supermarket thinking that's nutritional. Hey excellent. I just have enough of an idea to balance up what I am eating and what they are eating, and what Mary's eating through the week. Yeah, pretty balanced diet.

In this section, I have explored how the idea of a 'balanced diet' was based upon a basic and dichotomous understanding of different food groups. However, the way respondents constructed this concept in relation to their everyday lives revealed the complexities of achieving such a 'balance'. It was apparent therefore, that they took a broad perspective when talking about a 'balanced diet'. So while they constructed 'healthy eating' as a need to

balance 'good' and 'bad' foods, this was not just based on their own and other family members' diets, but also within the wider context of providing food and managing other family imperatives.

8.2.3 The holistic 'balance'

The previous section explored how the lay concept of a 'balanced diet' appeared to be based on a dichotomous view of 'healthy eating. This section however, explores how these ideas were also related to a view that 'health' and pleasure should coexist together and in such a way that the sum of their parts was greater than the whole. Similarly to the previous section, to make sense of the need to eat food which is both 'good' and 'bad' for you, I will also discuss how respondents related this concept to their everyday lives.

Wellbeing: Balancing body and soul

As I mentioned in *Section 8.2.1*, it was apparent that on some occasions respondents were constructing 'health' as being more than just a physical concept. The notion that 'health' was also a mental state was implied in how they also talked about: "health in the sense of well-being" (Amanda). However, while some respondents used this particular term without expanding on what they meant, other respondents constructed more detailed accounts by implying that health has both a physical and mental 'side'. This male respondent below for example, implied that health and wellbeing are related, but the separation of the terms also implied that they had separate meanings. Furthermore in the second quotation from his interview, this respondent expanded on what he meant by "wellbeing" and talked about balancing the "facts" of eating with what he "feels" he needs. The implication here, was that while the "facts" of eating might contribute to his physical 'health', that 'health' as "wellbeing" also involved a mental state. Such an example suggests that the balance based on different food groups which I discussed earlier, was also connected to *this* idea of the holistic 'balance':

SCOTT: Yeah, I think as far as I'm concerned, I know what I like, and I know to a certain extent what I should be eating. The diet that I have seems to suit me, and I don't have any ill effects with what I am eating. So obviously to a certain extent, whatever I am doing, I am doing reasonably correctly. Er, I'm not a great believer in the quick fix thing. If someone says this is gong to improve your health, or your wellbeing, by so many percent, I tend to be a bit sceptical.

TF: You said you know what you should be doing?

SCOTT: From a dietary point of view, you see the facts that are published by the various health boards. Your intake of fruit and vegetables, bread, milk - it should be so many units a day. Yeah

the evidence is there to prove it. In that respect, I know what I should be doing. As to doing it, I don't say I will follow it to the letter of the law. But I try somewhere in between to get as much as what they say I should, as I feel I need, I think without going overboard on it.

Another example of how respondents appeared to be constructing an understanding of 'wellbeing', was to talk about their 'lifestyles', although typically of most accounts constructed around this theme, the actual term 'wellbeing' was not used. Like the previous example, the role of different food groups in lay understandings of 'healthy eating' was sometimes explained as the "facts about eating". In this particular example, the notion of 'wellbeing' was constructed around the idea that having a 'balanced diet' should incorporate a range of different foods and was about maintaining the "health of your lifestyle" and "a good standard of life".

MARY: Well it's very important really to a point, because what you eat keeps you going really, doesn't it? And you know the facts about eating, and sort of keeping healthy and eating healthy, and we're very aware of it, but we don't always stick to it you know what I mean, everybody varies and what have you. It is important. It does play a big part if you have a balance.

TF: You said about the facts of eating?

MARY: The things that you are supposed to eat that you know they are good for you and the health of your lifestyle. Keeping you healthy to maintain a good standard of life.

The notion of 'wellbeing' appeared to conceive a holistic notion of balancing that brought together both 'mind' and 'body'. Although respondents did not always make an explicit distinction between them, the idea that food can maintain your standard of living again invoked a sense of 'wellbeing'. However, several respondents did distinguish between the two. Here for example, this female respondent talked about how a good meal was a "balanced meal" which helps you to "feel better mentally as well". Thus it was implied that the idea of a "balanced meal" provided a degree of comfort on the occasions when she was not "avoiding certain foods".

TF: Do you still feel that you need to go on specific times when you are avoiding certain foods?

ALISON: Probably, aye but it doesnae always go like that. I always feel that as long as we eat one good meal a day, it helps you feel better mentally as well, cos you think, oh I've had one good balanced meal today so you know.

In this similar example below, a biological necessity to eat food was explained as "keeping you going", but this female respondent also talked about how a "physical" need was additional to "healthy living". Again, a physical definition of "needing to eat food to

survive" was complemented by a more extensive definition of a 'balanced diet'. Hence the notion of "healthy living" implied that having a 'balanced lifestyle', where you are "watching what you are eating", provided a sense of wellbeing.

TF: How important is eating to our health?

LYNNE: Well you cannot have health without eating, cos your body needs food. It needs it to keep you going, so I suppose for health wise, you really do have to watch what you are eating… It's quite difficult to get your head round it, but you do have to have a balance, but you do need it for healthy living, and you need it physically.

Respondents appeared to construct balancing the requirements of both 'health' and pleasure as having a harmonious relationship which maintains the 'total-self'. Thus the holistic notion of 'wellbeing' drew upon the idea that it was important to feed both the 'mind' and the 'body', because food should be about more than just physical health. Fundamentally, although respondents did not always talk about balancing in this holistic way, the following sub-themes will reveal that a tacit notion of 'well-being' was implied in how respondents talked practically about balancing 'health' and pleasure.

A little bit of what you like does you good

As I explored above, the concept of 'well-being' implied a need to balance 'health' and pleasure holistically. Yet in most cases, what respondents appeared to mean by a 'balance' actually appeared to consist of a *trade-off* between these different requirements. It would probably therefore be more accurate to describe how the process by which they appeared to manage and maintain a 'balanced diet' was more like a 'balancing act'. This was because respondents talked extensively about how they had to *try* and *hope* that they were balancing 'health' and pleasure together. However, it was also apparent that although these two requirements were not in perfect harmony, there appeared to be a view that a sense of 'equilibrium' could be maintained or restored by approaching 'healthy eating' in this way.

It could be argued that this notion of a 'balance' was actually a moderator between lay understandings of 'health' and pleasure. However, only on one occasion did a respondent talk about this notion of a 'balance' in terms of the adage 'everything in moderation'. Moreover, as was apparent from many concepts of balancing throughout this chapter, it is possible to suggest that the two were synonymous with each other in this context. Nevertheless, the 'reality' of negotiating dilemmas faced by these different requirements was evident in the precarious nature of how this 'balance' was presented (i.e. as "I think" and followed up here by laughter).

PHILLIPA: Well if you enjoy, like everything else I suppose in moderation it'll no' do you any harm, I think. (Laughter)

Another adage that was often more implied than actually stated was the idea that 'a little bit of what you like does you good'. Again, such accounts were often centred upon balancing nutrition with pleasure, but fundamentally respondents talked about how it was important to not give up on the things that you liked at the same time. As this particular example revealed, the emphasis here is upon "trying" to eat a more "balanced diet". The idea that 'a little of bit what you like does you good' therefore, ran throughout all the accounts in this theme:

JENNIFER: Just trying 'y well you try 'y eat a more balanced diet, I know we never get properly there, eh, I mean we don't eat as much vegetables an' things like that that we should, but eh, I think you try to eat as healthy as you can, without givin' up too much o' what you do like as well at the same time.

Sometimes respondents would talk about 'healthy eating' in terms of knowing that "they should not eat certain foods" (Rachel) or that they "should eat" certain foods such as "grilled food instead of fried food" (Annabel). Thus they often implied that while they 'knew' about what they should or should not be doing, the reality *of "Getting the 'right' balance"* was more like walking a tight-rope. Although the need to enjoy food was sometimes presented as being more important, the 'health' requirement was always constructed as a competing factor. Furthermore, in the majority of cases, respondents felt that overall they were attempting to get the 'right' balance.

However, this male respondent was untypical of the majority of respondents because although he felt that he knew what was "good for you", the need to "enjoy my food" was constructed as a competing requirement which he seemed to have difficulties in balancing. Nevertheless, and like many respondents, he did then talk about 'trading off' these requirements because he said that he did not "mind carbohydrates and vegetables". While this appeared to partially resolve this conflict, this account was still an anomaly. This was because most respondents implied that you could still have a 'balanced diet', even if enjoying food was the foremost priority.

TF: You said that you're not food conscious. What do you mean by that?

JIM: Things like I should be taking carbohydrates and should be eating vegetables, should be eating fruit and I know it's all good for you but when you work hard I like to enjoy my food you know. I like chips and I like curries and I like basically I like a lot. I don't mind carbohydrates and vegetables. I can eat them. Fruit I don't know.

TF: Why do you think you do that?

JIM: Probably because of the pleasure. I enjoy a packet a crisps more than I would enjoy a bit of fruit or an apple.

It was more common however, that respondents constructed a need for 'health' and pleasure as a 'trade-off'. Although these requirements may not have been in harmony, they talked about how they tried to balance these different requirements together. Moreover, as I commented in an earlier theme, it was apparent that when constructing this notion of a 'balance', respondents tended to divide 'health' and pleasure into 'good' and 'bad' foods. Therefore, there was often a view that some foods were "junk" (Jennifer), or "rubbish" (Tracey) but that these had to be balanced with 'healthy' foods. However, on other occasions, respondents talked about foods that were specifically for 'health' and foods that were specifically for pleasure. In this typical example below, a female respondent appeared to be 'trading off' these two different requirements and hoped that they could be 'balanced'. The suggestion seemed to be, that having a "goodie cupboard" was okay, because they also had other 'healthy' foods. Hence the 'good' parts of their diet were being 'traded-off' by the 'bad' ones.

LYNNE: As I say, we eat a lot of chicken and things, erm and we tell to grill everything, and erm, we have the fruit and the veg and everything, but then in all honesty if you went to the goodie cupboard, and it's biscuits and sweeties and snacks and crisps and things, and that's hardly healthy is it.

Furthermore, respondents sometimes felt that managing the same dilemmas between 'good' and 'bad' foods was analogous to walking a 'tightrope' because they were walking or taking a middle line. As this female respondent explained, she "tries not to" eat these "bad" foods, and had bits of both categories. While this was constructed as a form of a 'balance', she again appeared to be 'trading-off' these different requirements. Importantly though, the comment that "I'm not going to lose sleep over it" typified again, how respondents appeared to construct a 'balanced diet' as a relaxed and 'common-sense' approach to 'healthy eating'. Therefore the very idea of even trying to have a 'balanced diet' appeared to be reassuring, because it was implied that the 'good' parts were being balanced out by the 'bad' ones.

SUE: But I feel that you er, well, I walk a middle line, I suppose.

TF A middle line?

SUE: I try not to you know, I go well I have, you know, I have bits of everything, I have bits of that's good for me, and bits that are bad for me and, you know, it's, I don't know, you know, it's, I'm not going to lose sleep over it.

Although on a few occasions respondents constructed a need for both 'health' and 'pleasure' as being like a 'balancing act', a 'balanced diet' was often presented as one which made it acceptable to have 'treats'. Again, any notion that this was a state of equilibrium was an illusion, because respondents always talked about how they "tried" to balance these different requirements. So they talked about how they had to 'trade-off' the 'good' with the 'bad', by managing these 'realities' on a day to day basis. Here for example, "convenience foods" were constructed as being acceptable as a treat, but only on the condition that none had been eaten during the week:

SCOTT: There'll be no convenience foods, it'll be properly home cooked, so you try and balance that out. If there has been no convenience food during the week, then you might say, oh as a treat, you know, a ready-made meal. So we do try and keep it in a balance, a balanced approach to it as best as we can

Similarly, respondents would often talk about a period of 'control' versus one of 'release'; some explained that the weekends were a time when it was acceptable to have treats such as cooked breakfasts. Yet again, these were presented as being a 'balancing act', because they talked about trying to 'trade-off' the periods of control when they were being 'healthy' (and eating what they normally ate) with the occasions when they were being 'unhealthy':

RACHEL: Unless it's the weekend, we have a cooked breakfast.

TF: Okay, every weekend?

RACHEL: Not every weekend, but most weekends. We try to have it Saturday or Sunday. Sunday is usually the day that we do have a big breakfast.

In the previous theme, it was apparent that the notion of a 'balanced diet' was based around the concept of a holistic 'balance'. As I explained, this was where respondents constructed 'health' and pleasure as being balanced together, in a way where the sum of their parts was greater than their whole. However in this theme, I have suggested that this idea of a 'balance' contrasted with the 'reality' that respondents were describing. Fundamentally, what this appeared to suggest was that the idea of 'health' and pleasure coexisting in harmony was in part ideological. Nevertheless, respondents appeared to try and maintain a 'sense' of what this represents by 'trading' off the nutritionally 'good' and pleasurably 'bad' parts of their diet. This therefore implied that their meaning of a 'balance' in some way resembled and restored an equilibrium.

8.2.4 Summary of Part I

Perhaps the key reason why the terms 'balance', 'variety', and also to a lesser extent, 'moderation' were so pervasive, was because of the way that they were connected around

the idea of a 'balanced diet'. In *Part I*, I have attempted to draw out the different meanings which they attributed to this concept, and present them in a way which has helped to explain the more general theme of this chapter. I began with a discussion on how respondents talked about avoiding the extreme of worrying too much about 'healthy eating'. However, the rest of the chapter developed this theme by exploring how, alongside a range of other requirements, 'health' was just one priority which respondents felt had to be balanced in their everyday lives.

At the very centre of the way respondents constructed 'healthy eating' appeared to be the dichotomous classification of food into 'healthy' or 'unhealthy' categories. As the basis on which their understandings of a 'balanced diet' were constructed, this then provided a mechanism for talking about, and managing 'healthy eating' in their everyday lives. While there may have been a view that a 'balance' was in some way an equilibrium, any difference between the ideology of a 'balance' and the 'realities' of their own diets, seemed to be rewarded by an understanding that this was a comforting and reassuring way of accommodating any sense of failure.

8.3 Part II: You are what you don't eat

To recap, in *Part I* I explored how lay understandings of 'healthy eating' were based upon a need to get the 'right' balance, between 'good' and 'bad' or 'healthy' and 'unhealthy' foods. In *Part II* however, I want to explore several further ways that respondents talked about 'healthy eating' and a need to be *"Getting the 'right' balance"*. In this theme, entitled *"You are what you don't eat"*, I will discuss why respondents appeared to use certain foods to symbolically represent the 'bad' and 'unhealthy' side of this balance. Indeed, the idea that they used this as a mechanism to talk about a 'right' and 'wrong' way to approach 'healthy eating', suggests that *"Getting the 'right' balance"* was also felt to be a moral issue.

8.3.1 Symbolising a 'healthy' diet

Before exploring lay accounts of the 'Scottish diet' in the following theme, the focus here returns to the concept of 'weighing up' that I explored in *Part I* of this chapter. Although I will again explore how respondents talked about balancing different food groups, this time I will be considering the role of *symbolism* in this process.

The majority of respondents often mentioned *chips* as a classification of food that was 'unhealthy' or 'bad' for you. In this section, I want to explore how chips and fried-foods appeared to be symbolically representative of 'unhealthy eating' and the role that this played in the idea of *"Getting the 'right' balance"*. Methodologically, the frequency with which symbolically 'unhealthy' foods was an interesting finding, because the questions I asked could have had no influence on why chips had such a symbolic presence throughout the lay interviews.

Respondents often talked about "chips" within accounts where they were 'weighing up' if what they were eating was a 'balanced diet'. When asked to "list the types of food that they ate", or to talk about "if their diets were healthy", they would mention "chips" as being something which they rarely ate. They mentioned for example how they might eat a lot of 'healthy' foods such as "broccoli, cauliflower, carrots and potatoes and stuff", but that "We don't eat a lot of chips" (Lynne). Therefore in terms of a 'weighing up' process, this produced the effect of symbolising that the balance of what they were eating was weighted towards the 'healthy' side:

STUART: …If I don't take sandwiches for lunch, then the canteen's there, what I usually have is maybe a baked potato. Erm, with either egg mayonnaise or tuna, something like that. We don't eat many chips actually.

It was apparent therefore that knowledge of food groups was being constructed symbolically to represent different 'healthy' and 'unhealthy' foods. There was evidence of this in the previous quotation, but in other cases respondents talked about why chips had to be eaten in 'moderation'. Some respondents felt that they could be eaten as part of a 'varied' diet, but because they contain a lot of fat, it was important that they were only eaten "now and again" (Alison), or "occasionally" (Deborah). Again in this example below, other 'healthy' foods such as "vegetables and fruit" were included within this idea of a 'balanced diet':

NICOLA: Well, it's not chips every night. It's not, erm, a lot of fat. It's not lard and dripping and things that are well, so-called fat! So I try and eat reasonably varied and include vegetables and fruit, and have chips every now and again.

As I also identified in *Part I*, the precarious nature of a 'balanced diet' was revealed when respondents talked about how they were trying not to eat *too* many chips, or that they were cutting down on how often they did have them. Typically in this next example, respondents often mentioned how it was important that the 'filling' benefit of chips needed to be substituted by something healthier, such as pasta or rice:

JENNIFER: I mean we cut down on a lot 'y like chips an' things like that, an' potatoes, an' maybe eat a bit more pasta an' rice an' things like that... I'm not too keen on eatin' chips like five days a week or six days a week or that, it's just a bit: a bit different than havin' chips with everything, we'll maybe have rice or pasta or just break it down a wee bit.

Additionally, as I also identified earlier, scientific names of food groups were rarely used. Likewise in this example, respondents rarely talked about a need for 'filling foods' in terms of actual food groups such as "carbohydrates":

MIKE: Chips. I wouldn't class that as getting all the nutrients that the body needs. It's just carbohydrate to fill you up. At least with things like pasta you've got a bit of cheese and tomatoes and everything.

Yet respondents' accounts often mentioned how chips were not really a suitable way of satisfying appetites, and which were constructed in response to a question which asked: "Can you say a little bit about the food that you would regard as a meal?". This respondent for example, was typical of several who spoke of how a 'meal' could never really consist of chips. Whilst chips were sometimes felt to be more acceptable for children, they were generally not considered to be suitable for an adult's 'proper' meal (see *Section 6.2.3* for more on 'proper meals'):

PETER: As a meal. Generally the word potato comes into my meals. I am not a chip lover. I am seriously not a fry lover at all.

> Funnily I quite like McDonalds fries, but that's about. The chip shop now, just wouldn't entertain me at all. I don't really like chips. I would regard as a meal, sitting down to something like potatoes, cold meat, salad or vegetables, steak pie and potatoes, erm.

Although respondents sometimes spoke about chips being a "fatty" food, it was also apparent that one of the key reasons why they symbolised 'unhealthy' foods, was because they are often cooked by deep-fat frying. Commonly, respondents would talk about how they never really fried anything and on a number of occasions respondents spoke of the symbolic gesture of throwing out their chip pan. Alternatively, they mentioned how they did not "even have a chip pan" (Annabel):

> LYNNE:…We're not big fryers in here. Erm, we'd rather have a baked potato actually, and mashed, than sit down to a plate of chips. In fact, I think we very seldom have chips. Erm, but we do eat a lot of salads, and stir-fries and things. A fish supper on a girls' night, when it's just Jane and I, but I can honestly say that that's hardly ever eaten. And if we have chips, it's usually micro chips, but we have a deep pan fryer, and I can honestly say that it's been about a year and half since it's been used. Erm, we tend to grill everything, bacon, and everything's grilled.

It appeared that *chips* and *deep-fat frying* were viewed as symbols of 'unhealthy' eating. Furthermore, they played an important part in the 'weighing up' process, where respondents were constructing that they had a 'balanced diet' because they were balancing out the 'healthy' and the 'unhealthy' elements. Respondents therefore often said that they tried to avoid such foods and keep them to a minimum. This appeared to weight their diets towards the 'healthy' and 'good' side of a 'balanced diet', and this weighted 'balance' therefore appeared to have two related effects. Firstly it provided a way of constructing their diets as 'healthy', and secondly it reinforced this process, because it suggested that their diets were weighted in favour of 'healthy' foods.

Reconstructing a 'balance'

Another interesting role that these symbolic foods appeared to play in lay accounts of 'healthy eating', was in how respondents talked about accommodating *chips* and *frying* within the concept of a 'balanced' diet. Moreover, as symbolism also appeared to be an inherent part of the 'weighing up' process, in this sub-theme I will also consider how it related to the idea of 'trading-off' discussed in *Section 8.2.3*. Fundamentally therefore, respondents talked about how chips, or certain types of frozen or oven chips, could be part of a 'balanced diet' only if they were being 'traded-off' by other 'healthy' foods.

Interestingly in the next example, the same points about the chip pan and frying pan were made again. However, this respondent also talked about how they would only have sausages

as an occasional 'treat' and so fried foods were considered to be acceptable - as long as they were only eaten occasionally.

TF: You said you didn't have fried food?

TED: No. Very rarely do we fry food, occasionally if the kids want sausages we'll get them, but that's maybe once a month,...but we don't usually fry things. We wouldn't think of getting the frying pan out, or we don't have a chip pan. Just something we don't do...

Again, in this next example, fried foods were also viewed as being acceptable, but only as long as this was 'traded-off' by grilling (therefore reducing the fat) in other parts of a meal:

TF: You talked about Weight Watchers and that it was about a 'balance', can you say a bit more about that.

ALISON: Not really. It's just like, if you want your bit of meat right well you've got to think well this has got fat in it, sort of thing. Even if you grill it or whatever, it's still going to be, or if you want to have chips say. If you want to have fried chips, have your fried chips but don't have a fried egg, fried bacon, fried sausage with it. Have your baked beans, or a bit of grilled bacon, or something like that. That's all really, balancing out.

One other fascinating way in which chips were felt to be an acceptable part of a 'balanced diet', was if they were of the oven and frozen variety. As this particular example again revealed, it was the association of chips with fat, deep-frying and saturated fat, that respondents often gave as being reasons not to eat them. Again, this appeared to be another example of 'trading-off', because relative to deep-fried chips, the oven variety by implication, were 'better for you':

TF: So you talked a bit about not having rubbish, could you say a bit more about that?

PHILLIPA: I dinny deep fry or anything like that, it's just a dot 'y oil, you know, it's no' saturated fat stuff.

TF Yeah, so what's: oh, OK.

PHILLIPA: Like deep fat fryin' chips or whatever you deep fry.

TF Right, so is that something: do you think that's something you've changed?

PHILLIPA: I don't have a chip pan, but then we have oven chips.

In this final example, although this male respondent talked about how "Frozen chips" (presumably implying oven chips) were "probably healthy", like the previous account there again appeared to be some uncertainty as to whether they were 'healthy' or not.

TF: Looking at the list do you think you're healthy in terms of what you've got there?

GARY: Frozen chips. They're probably healthy eh.

It appeared therefore that oven or frozen chips were viewed as being 'healthier' than deep fat frying. Although notably these two accounts also implied that there was some ambiguity in how they fitted into the dichotomous classification of 'healthy' or 'unhealthy foods'. However, the previous examples suggest otherwise, because some respondents felt that 'unhealthy' fried chips or fried foods were acceptable, if they were balanced by other 'healthy' foods or only eaten as an 'unhealthy' treat. Yet what links these accounts together with the other themes explored in *Part II* so far, was the way that chips and fried foods appeared to represent symbolically 'unhealthy' foods. Oven chips however, do not seem to be attributed to either category. Therefore, this appears to provide a further example of how deep-fried chips and fatty foods more generally, had a meaningful influence on the way that lay respondents talked about 'balanced diets'.

8.3.2 Distancing from the Scottish diet

As I identified in *Chapter 1*, Scotland's poor health record is frequently linked to the 'Scottish diet'. Several questions were therefore included in the interview schedule to explore lay views on what they thought the term meant and how they felt it related to themselves personally. Lay views on the 'Scottish diet' were connected with the ideas I raised in the previous theme, because they felt that by definition, it was symbolic of an 'unhealthy' diet. However, a further consideration in this section, will also be an examination of why this symbolic view of the 'Scottish diet' also formed the basis for how respondents constructed their own diets as 'healthy'.

The 'Scottish diet'

In the following theme I will argue that respondents *distanced* themselves from the concept of the 'Scottish diet'. Before considering the relevance of this within the more general theme of *"Getting the 'right' balance"*, I want to begin this section by exploring how respondents constructed the Scottish diet as 'unhealthy'. While on reflection this was acknowledged to be a stereotyped view of what people ate in Scotland, there was still a common shared view that it was a poor diet.

Only on a few occasions when I asked respondents about their views on the Scottish diet, did they say that they had never heard of the actual term before. Furthermore, only rarely did they also talk about traditional Scottish foods, such as "mince and tatties" (Peter) or "black puddings [and] whiskey" (Sue). However, once I had said that the diet was

sometimes referred to as an 'unhealthy' one, they often responded by talking about how "everybody likes to indulge in something" (Deborah), or "Scotland is often picked on and is probably the same as other countries." (Jim). I did also probe "how Scotland compared to other countries" and it was often felt that there was "not too much of a difference between Scotland and England" (Robbie), or some people spoke about America's bad reputation for obesity, for example. On two occasions, respondents' accounts had a nationalistic tone, as it was felt that an attack on the 'Scottish diet' was a case of the English having a go at the Scots.

Therefore in this particular example, the 'Scottish diet' was not recognised as a term *per se*. However when I probed about it being "quite unhealthy", the idea of a diet that could be attributed generally to any one country was dismissed through a number of different examples:

TF: I want to talk about the Scottish diet, can you tell me what you views are?

JAMES: I have never heard of that, this is the first I have heard of that. So what is the Scottish diet then?

TF: Some people say that it is quite unhealthy?

JAMES: In general, I know a lot of people who eat junk food, drinking, burgers and crisps. There is a guy at my work eats a tin of tuna everyday with brown bread and a slice of ham. The Scottish diet is the same everywhere, England would be the same. When you go to Corfu and places they all eat well from what I have seen and people that I know that stay in places like that. They eat fruit and meats and always look healthy. You can only go by what you see from people at your work, I would bet that 60% of them eat crap especially at their work and I don't know what their habits are back home.

More commonly however, most respondents (even without this probing) interpreted the term by talking about how it was 'unhealthy'. Yet, they also felt that it was not necessarily an accurate description of what everybody ate, and questioned the extent to which this criticism could be generalised. Moreover, it was apparent that the term was synonymous with the symbolic foods I explored previously, as most respondents mentioned chips or fried-foods:

DEBORAH: What is the Scottish diet? (Laughter) Ahhhh what is it, fish an' chips an' a pint 'y beer, is that what it is, I don't know?

On a few occasions, some respondents offered a more detailed analysis of the idea that the 'Scottish diet' was 'unhealthy' and talked about how it was a stereotype, or that there must be some truth in it, otherwise people would not talk about it.

NOEL: The stereotyped Scottish diet? Er, well it's quite horrific, high fat, food that is not good for you. Food that is bad for you as opposed to not even particularly good for you. Just not healthy. Bad.

Despite some reservations about applying this term to everybody, the majority of respondents felt that there probably were more 'fried' and 'fatty' foods available in Scotland than there were in England and they often spoke about the excessive number of chip-shops and takeaways. Fundamentally, although the 'Scottish diet' was seen as a stereotype, many people felt that it probably was the "worst diet... compared to other countries" (Annabel):

TF: Why might there be a lot of talk about the Scottish diet?

TRACEY: I think it's the worst diet going is it not? It probably is, em, because it's the chips. There are too many takeaways, too many chippys, too many places like that, with chips, I mean the Scottish fry up, I mean the fried bread and fried eggs. But then even when you go into like cafes and things I mean you will see it on the telly yourself, they have the chips with the fry up with the beans piled on the top as well.

It was also apparent in the majority of accounts that respondents' views had been influenced through the media. Hence it was often felt that these messages were never out of the news and that you could never turn the TV on without hearing about how Scotland does have a bad reputation. Typically therefore, this respondent spoke about how everybody knows that Scotland is an unhealthy nation, but again questioned the extent to which this was "probably true":

TF: Okay, so a couple of more questions. There's a lot of talk about the Scottish diet, what are your views?

ANNABEL: It's probably true! Not all of it, but, maybe fifty percent. Well I don't know what that percentage is. But people are nowadays trying to watch what they are eating. There is so much that you see on the tele, and you read in magazines all the time. I think people aren't trying. I mean in general, they do have a bad diet reputation. It's probably true.

TF: What have you seen on the tele?

ANNABEL: Just about all these low fat things, and not frying your food and grilling it. You know, taking more exercise and everything, and all the adverts and all that, that have been on.

TF: Is that in relation to the Scottish diet?

ANNABEL: Yeah, aye. They are saying that we are really unhealthy and we should watch our diets. I think everybody knows that aye, it's always mentioned on the tele and everything. On the news and stuff like that, we are a really unhealthy nation compared to everyone else, you know.

In summary, most respondents associated the term 'Scottish diet' with 'unhealthy' foods such as chips and cooking methods such as deep-fat frying. Whilst respondents shared some reservations about the extent to which the 'Scottish diet' could be generalised as an 'unhealthy' one, in many cases it appeared their ideas had originated via the media.

Distancing

By talking about how they did not eat a 'Scottish diet', this theme explores how respondents appeared to construct their own diets as being 'healthy'. Hence, it will be argued that they appeared to draw upon its symbolically 'unhealthy' image to help them explain what they meant by *"Getting the 'right' balance"*. Complementing the theme I began this chapter with, this theme reveals how respondents talked about the opposite extreme of not taking 'health' seriously enough.

I argued above that many respondents had reservations about the extent to which the idea of the 'unhealthy Scottish diet' could be generalised. However, many respondents still distanced themselves from this concept, because they said that it did not apply to them. This respondent below for example, talked about how he did not associate himself with "pies, fry-ups or curries" or that he did not see himself as "having that sort of diet". The implication here, was that these foods symbolised an 'unhealthy' diet and this formed the basis for how he constructed his own diet as being 'healthy':

TED: Well again, like you say from the media, we are not a very healthy country. I don't really associate myself with what I see about that because we don't eat a lot of pies, or fry-ups or curries or whatever we want - we just don't eat that sort of thing. Well curries, we do make our curries - but again I don't see myself as having that sort of diet.

Moreover, the following example also provides another illustration of how respondents were also able to construct a positive image of their own diets, just by talking about the 'Scottish diet'. Although they saw it as a stereotype, the 'Scottish diet' symbolised an 'unhealthy' 'benchmark' and then formed the basis for how they then constructed their own efforts as being 'healthy'. This male respondent implied that because he would "like to think" his diet was better than, or nowhere near the Scottish diet, he was therefore doing something positive about his health.

TF: How do you think you fit into what you said about the Scottish diet?

ROBBIE: Er, I'd like to think my diet was a lot better than the average diet in Scotland, I'd like to think it was nowhere near it.

TF: Why do you think that's important to you to feel it's better?

ROBBIE: Well the average, if you're basing it on the average Scottish diet, it's not good for you. Hopefully I'm doing a wee bit to improve my health.

Furthermore, the process of using chips to symbolise 'bad' and 'unhealthy' foods was also apparent in these distancing accounts. In this particular example, I did not probe about the 'Scottish diet' and the male respondent talked about how he "stayed away" from eating such a diet. He specifically mentioned that this was for 'health' reasons and so again, this diet played a symbolic role in the process of constructing positive accounts of 'healthy eating':

TF: Okay, there's a lot of talk about the Scottish diet. What are your views?

STUART: Aye. Erm, well I would agree, fish and chips. Chips with everything, erm, yeah. As I say, we try and stay away from that sort of area. We try and make our diet varied. I can see when you read the paper or see the tele, and they do come up with this sort of Scottish diet and sort of heart disease, it is quite frightening. And hopefully we don't have a sort of Scottish diet in this house. I hope I'm right anyway!

This following example also illustrated how respondents distanced themselves from the 'Scottish diet' on the basis that they were not eating certain foods. Like a number of other respondents, the infamous 'deep fried Mars Bar' was another food that appeared to symbolise an 'unhealthy' diet. However, although this male respondent distanced himself from the 'Scottish diet', this example typified that not eating such a diet was also viewed as a moral issue, because anybody who did eat such foods was "crazy":

JOHN: Well aye, you hear a lot about the Scottish diet, but er, I mean I don't eat deep fried Mars Bars. I wouldn't touch them with a barge pole. Anyone who does is crazy as far as I'm concerned.

You are what you eat

Indeed, moral issues pervaded lay respondents' views of the 'unhealthy Scottish diet' and were an important part of the distancing process identified in their accounts of 'healthy eating'. In the remainder of this section, I shall explore some of the other moral accounts that respondents constructed and focus on the ways they criticised those who ate the 'unhealthy' foods associated with the 'Scottish diet'.

Highlighting the complexity with which pre-prepared foods were seen as a compromise by lay respondents, an over-reliance upon them was sometimes viewed as a failure to cook or feed a family 'properly'. Hence it was implied in this particular example, that if you could not "open a jar of tomatoes or something", then there was "something wrong with you". This was an interesting theme, because in *Chapter 6* it was suggested that many female

respondents spoke about a guilty feeling that they were not always able to provide a 'proper' meal. The point made here however, seemed to be based on the idea that this was better than never cooking one at all and was therefore typical of how there appeared to be a hierarchical element to this distancing process:

ALISON: Right, well my basic point of view is people are using their brains. If you cannae open a jar of tomatoes or something like that and add something to it, then there's something wrong with you.

Related to this point about cooking skills, a more common explanation of why people ate an 'unhealthy Scottish diet' concerned 'a lack of education'. Most respondents' accounts often blamed other people for not having a sufficient knowledge of nutrition. The implication was that if you ate a 'Scottish diet' then you were ignorant of nutritional information and there was a subsequent emphasis upon 'having to learn'. Here for example, this was illustrated by the point about how people "never choose or take the opportunity". Jo appeared to be suggesting that people do possess a degree of agency to change and this typified a view that people have a moral responsibility to look after themselves. Hence this female respondent also said that people have to "improve their condition":

JO: I sometimes think education, or lack of education is a very dangerous thing because I see people who are on and you see on the news everyday, you see people who are on a waiting list for an operation for a year, they have coronary artery disease, which is a degenerative disease. And yet in that year, they never choose or take the opportunity to lose any weight. And by losing their weight and changing their diet it would improve their condition

However, the view that a poor diet could be explained in terms of education, was also related to how several respondents also talked about the relationship with 'healthy eating' and physical appearance. In this example therefore, the effects of eating a poor diet were represented by people's "looks" and this male respondent made a moral judgement about "how" people who look 'unhealthy' must be "living":

SCOTT:... I mean, I'm no dietician, but you can look around in the street, and you are what you eat, and sometimes you look at somebody, you've got a rough idea of how they are living.

On a number of other occasions, respondents constructed accounts concerning physical appearance based around the familiar adage of "you are what you eat". Therefore, they felt that if you were going to eat "junk food", or "chips", then it was going to have a negative effect on the way you look or upon your 'health'.

TRACEY: Well it's true what they say, you are what you eat, if you eat a lot of junk you end up unhealthy, bad skin, bad hair, things like that.

Similarly in the following example, I followed up an earlier comment where this female respondent had mentioned that "you are what you eat". Likewise, she again constructed a moral account about how a poor diet made you look like a "slob".

TF: So can you say a little bit more about what you mean by you are what you eat?

ALISON: Well if you eat fries right and sweeties and chocolate and all the wrong things and drink beer all the time, right you are going to be a slob and inside you're going to look hellish, and you know it tells. You cannae do the toilet right or you go the other way don't you, do you know what I mean? You've had too much beer sort of thing.

By talking about how people had to 'look after themselves', this respondent typified how these accounts were constructed as moral issues. Again, this appeared to be reflecting a common theme in the interviews, that 'healthy eating' was something you had to 'work at'. Interestingly, like the accounts which explained that the Scottish diet could be attributed to poor education, the influence of external circumstances beyond people's control was again mentioned. Yet overall, it appeared in many cases that "you are what you eat" because you 'choose' your lifestyle. Like several other examples, these accounts were often phrased apologetically, which appeared to be an attempt to offset the moral judgements that were being made:

SCOTT: Well, to a certain extent, somebody, this might sound quite well. Well somebody, well with an obvious weight problem is going to show that their intake on certain foods is greater than it should be. Er, there again, somebody, I've seen in the hospital environment with poor oral hygiene. They are what they eat, in a lot of cases, they are not getting the right supplements, the right vitamins. People, even their skin condition, their pallor, their energy. You've got to. It's like a boiler, you've got to be stoking it, putting the right things in to get the right effect, and get the best out of it. So I mean, in these respects, probably working within the health environment, it gives you a wee insight into how they are actually looking after themselves. A lot of it is down to food. There are obviously other external circumstances, but a lot of it can be down to a poorly maintained diet.

Furthermore, one of the other ways that respondents distanced themselves from the 'Scottish diet', was to talk about how they *themselves* could afford to eat well - so a 'lack of money' was constructed as a further reason for why other people eating so badly. Again, such accounts suggest that this distancing process was hierarchical. This was because several respondents constructed the 'Scottish diet' as a 'class' issue and associated it with "deprived areas" (Annabel). Alternatively, people who ate such a diet were "working class" (Deborah). Respondents seemed to be implying that they did not see themselves as fitting into this category, which was interesting considering the way I had recruited this sample. This may

however be an indication of how I did not recruit people from the lowest social class groups (*see Section 5.4.4*).

Although respondents talked about how people were forced into eating a poor diet (which conflicted with the idea of 'choice'), their accounts appeared to be based upon the assumption that if you lived on a low income, you would be putting "chips" on the table. This particular example revealed how chips were again used symbolically to represent an 'unhealthy' diet:

SIMON:… probably to do with money wise as well. If you look at the prices of food. Well, we can afford it, we have got a double income, but if you're on a single income and you've got three, four kids, then I can imagine that quite a lot of people would put chips and beans and that on the table.

In this final example however, a 'lack of money' was constructed as a reason for eating a 'Scottish diet', but an assumption was again made about the 'type' of person who was likely to eat in this way. In this case, "single" and "divorced" parents were thought to be more likely to eat a poor diet and to take the 'easy' option of buying cheap frozen food. Interestingly, as I mentioned above, this account was also phrased apologetically (i.e. "it's a shame").

TRACEY: Money does, yes. Em, because you see all these em, like the freezer shop type places and that, I mean some of the stuff that they try and sell, but people buy it because it's all they can afford. I mean there are an awful lot of like single parents, divorced parents or whatever that maybe don't even work so they are living off whatever they get from the government, but they can't afford to go out and buy chicken and fish two or three times a week so it's like convenient things like 99p for four out of Farmfoods and rubbish. But em, they are living off it because it's all they can afford, so and it's a shame.

So through a process of distancing, lay respondents appeared to construct 'healthy eating' as a moral issue and as an imperative which had to be worked at and achieved. Yet the main implication of this view appeared to be that their own diets were in some way healthier, because they did not have a 'Scottish diet'. Nevertheless, although the Scottish diet' was seen as a stereotype, it still appeared to act as 'benchmark' in the hierarchical construction of the 'wrong' dietary balance.

8.3.3 Summary of Part II

In *Part II*, I have presented two different but related themes. What was most interesting and common to these two themes however, was the role that certain foods and cooking methods appeared to play in the process of distinguishing 'healthy' and 'unhealthy' eating. Hence chips and deep-fried foods had a particularly symbolic meaning, in that they seemed

to help respondents construct their own diets as 'healthy'. Yet the construction of accounts based upon these symbolic foods appeared to be a hierarchical process which was associated with a dichotomous construction of 'healthy eating'. Therefore it seems from the evidence presented here, that this symbolism was meaningful for two reasons. Firstly it allowed respondents to talk about being 'healthy' or 'unhealthy' and secondly, these categories were related to a process where respondents distanced themselves from people who they thought were eating 'unhealthy' diets.

8.4 Chapter summary

I argued in *Part I* that there appeared to be a reality gap between the ideology of a 'balanced diet' and how respondents were achieving or accounting for this on a day to day basis. As I revealed in *Part II*, symbolism was also used to support this idea of a 'balanced' diet, through the processes of 'weighing up' and 'trading off'. Thus, respondents were emphasising that the metaphorical weighing scales were weighted towards the 'good' and therefore 'healthy' direction. It seemed though, that the idea that 'you are what you don't eat' also supported the idea of a holistic 'balance', because it emphasised how it was important to get the 'right' balance. So morally, not making the 'right' food choices, or even not being able to, was presented as being 'wrong' and a moral failing.

This was an interesting process, because in *Part I* I argued that respondents felt that being too fanatical about what you were eating was also not a good thing. Yet the idea that *"You are what you don't eat"* appeared to address the other and more 'unhealthy' extreme, while also helping respondents to construct what they meant by the 'right' balance. Although they talked about a need to be relaxed and happy with what they were eating, 'healthy eating' could not be left to itself, as it was constructed instead as something which had to be achieved. Speaking reflexively on this matter, if the interview was perceived as a test on 'healthy eating' and as a way of testing respondents' moral obligation to be 'healthy'; then respondents constructed the 'right' balance as a way of both passing the test and simultaneously accommodating any failings.

9 The Othering of 'healthy eating advice'

9.1 General introduction

By continuing to examine lay understandings of the relationship between food and health, this chapter explores how lay respondents prioritised their own understandings of 'healthy eating' over and above the advice of health professionals. I argue that from the lay perspective, 'healthy eating advice' was stereotyped as a generalised concept and characterised by an Othering process (*see below*). Any uncertainties raised by this distancing process however, appeared to be played down, because respondents felt that the advice of health 'experts' was often neither relevant nor practical. They justified this, because they felt that their current state of good health was evidence of how they were already eating a diet that was supporting and maintaining their health.

Othering

The process by which respondents distanced themselves from 'healthy eating advice' is conceptualised in this chapter as an example of *Othering.* According to Humm (1995:156), this concept was developed by Simone de Beauvoir in *The Second Sex* (1953) "to explain how, in patriarchal cultures, 'woman' is set up as the negative, the inessential, the abnormal to the male". Surprisingly, the concept has received very little attention within the sociology of health and illness. Hall (1997) however, has located the concept within the field of cultural studies and considers the way that 'representations' are produced as stereotypes. 'Difference' he argues, can be represented as the Other; while the process of Othering stereotypes meaning by reducing and simplifying how we then come 'to know'. Thus for Derrida (1972:41), this is also hierarchical, because Othering splits meanings into dichotomous types, where one term governs and has the "upper hand" over the Other. The relevance of this analytical concept will nevertheless become apparent as I explain this distancing process.

9.2 Part I: 'Common sense healthy eating', the body never lies?

This first section explores how lay concepts of 'health' appeared to be deeply embedded within the context of respondents' everyday lives. The purpose of this section is to identify the different ways that respondents appeared to make sense of 'healthy eating', by examining how they talked about 'knowing' their own bodies. However, analysing these

accounts at the beginning of this chapter will help to appreciate the discussion of 'healthy eating advice' in *Part II*.

Respondents' accounts of the relationship between food and health can be justifiably called 'common-sense' accounts, because they were presented as being sensible and familiar. Typically, respondents explained confidently that because they were 'healthy', this was therefore evidence that they must be doing something right and also that their diet was having a positive effect upon their health. In the majority of examples, and despite a sense of autonomy in these accounts, respondents also spoke about how they were *hoping* that this was the case. Very rarely were these views replaced by over-confidence.

9.2.1 Proving 'healthy eating'

It was apparent during the interviews and subsequent analysis that respondents would often talk about how "I feel healthy" (Scott), or that their family kept "fairly healthy" (Caroline). They then talked confidently about how this in itself was a form of *evidence* that what they were eating was supporting and maintaining their 'health'. However, as explained in *Chapter 5 (Methods)*, this was perhaps not surprising considering I had asked GPs to recruit patients who did not suffer from any chronic disease or illness.

Towards the beginning of the interviews, I asked respondents "How important is food and eating to our health?", which was an attempt to explore their views on the relationship between food and health more generally. Although the accounts were often located in a context where eating was also associated with other requirements (such as pleasure in *Chapter 8*), there was a consistent response that it was "very important" (Amanda) and "you can [only] do without food for a while" (Simon). In most cases, respondents elaborated on these more concise answers and spoke about a variety of health reasons to explain why it was an important relationship. This helps to suggest that in general, respondents were aware of the contribution that food can make to health and its value in preventing disease and illness. As the example below illustrated, these typically included "heart" and "stroke" problems, or also issues such as digestion and occasionally cancer.

TF And how important is eating to our health?

PHILLIPA: I know it should be very important an' you should watch what you eat an' things like that for your health, for a variety o' reasons.

TF Mmhmm, right, for example?

PHILLIPA: Heart, stroke, blood pressure, just, I suppose there's loads 'y things health-wise.

Importantly, only in one interview out of thirty did a respondent actually question the importance of eating to health. This particular man said that he thought that other lifestyle issues were more important. However, in another part of the interview he had also mentioned that he thought "too much beer" caused his weight problem and so this particular issue might explain this anomaly in the sample.

TF: What importance do you place on eating a diet relating to health?

JIM: No. Not very important. If you're exercising and watching what you drink. Drugs and smoking is taboo so that's the top two you wouldn't want to get involved in. Then your drinking. You should limit your drinking for your health and then maybe your food, your diet. I'd class it about fourth.

Respondents nearly always talked about their health in the short-term, which was apparent in response to questions which asked them to consider if they had one view which summed up how they felt about 'healthy eating' or 'health' more generally. Hence when asked if they had one view which summed up how they felt about 'health', many respondents would talk only about their current health and said that while they recognised they could probably "do better", they were generally happy.

JOHN: As far as I'm concerned, we do okay. We could probably do better, things we could cut down on, and things we could do better. But generally it's okay.

Or alternatively when I asked them if they had one view which summed up how they felt about 'healthy eating', they would talk about how they were happy with their diets. This reflected a view held more generally, that they did not really need to "change anything" (Phillipa) about their diet or that it was not really something they worried about.

JAMES:...I am quite happy eating what I and Catherine are eating.

Noticeably, when they were asked to talk in more detail about being happy with what they were eating, respondents rarely mentioned 'health' concerns and were more likely to focus upon the compromises they had to make at mealtimes. This also links into the views I explored in *Section 7.2.2* on Compromising.

TF: Are you happy with what you eat?

NICOLA: Generally. I think there's a difference of opinion, I mean Peter would eat boiled potatoes every night. And you know he likes them boiled, and I like them mashed.

However, when discussing these issues in more detail, respondents often presented their current health as evidence that they hoped what they were eating was having a positive

effect. This therefore typified how they were trusting this type of evidence, rather than claiming that it was an established truth. Such constructions were often emphasised by the phrase that: I must be doing "something right" (Scott), or additionally in this case, the phrase "touch wood" also suggested that a certain degree of luck was involved. While such accounts implied that there was a positive relationship between their diet and their health, they also often drew upon the more negative absence of illness to support this idea. So because this female respondent said that "None of us, touch wood, are ever ill" or "never at the doctors'", then she felt that as far as 'healthy eating' was concerned, she "must be doing something right".

TF: Why do you think people eat what they do?

CAROLINE: That's a really hard question. I don't know. Because they like what they eat. You do try to think well is that good for you. None of us, touch wood, are ever ill, never at the doctors' so I think well you must be doing something right

Although such accounts were constructed during the early stages of the interview, they were also more common in discussions about the potential role that GPs could play in providing 'healthy eating advice' (*see section 9.4.2*). Respondents constructed similar accounts about how "they were never ill" or "rarely at the doctors'", again revealing how 'health' tended to be defined dichotomously as the absence of illness. It was also noticeable that women (much more than men) would talk more about "healthy families" rather than just themselves. This may of course reflect the gendered roles I explored in *Chapter 6*.

TF: How often do you see your GP?

ANNABEL: Not very often actually. I was there a couple of weeks ago, that was like the first time this year, so quite a healthy family. Not really at the doctors' very much at all.

The male respondents however, did talk more about their own 'health'. Although they often drew upon the same idea that they were never ill, they also talked more positively about how they could do "the things they wanted to". On a few occasions, some men said that they "were able to keep up with their children when playing sports" or "that they were fit and healthy". Although this next male respondent felt that he had a"pretty negative attitude", he also explained that this was a not a problem, because "at the moment" he "can do everything" he wanted "to do":

JOHN: Unless it was to affect me and I was to have a problem with it, then I would do something. It's probably a pretty negative attitude, but er, at the moment I can do everything I want to do. I've been cycling and I can keep up with her. The boys at camp. It doesn't affect me at the moment.

Interestingly, the phrase "It doesn't affect me at the moment" was often implied and was very rarely explicitly stated. This typified the degree of trust that most respondents placed in their present health, rather than considering or basing their accounts on any future consequences. In some interviews however, respondents said that this was not a topic that that they ever really gave much thought to and the short-term idea that 'you do not think about it until it is too late' was also fairly common. Such accounts appeared to imply that on the whole, respondents felt that health was something that they took for granted. This was illustrated in the following quotation:

CAROLINE: You probably don't honestly think about it that much until you sit there and ask me all these questions! Then you really sit and think about it and I think possibly when you really think about it, it's maybe going to be too late. If you've not done it right and I'm not saying we're doing it right, if you've done it wrong and you end up with something wrong with you, you'll maybe think about it more then. Like if you drink too much, it's probably going to be too late before you give it very much thought. I think eating is the same. You maybe think you're doing ok, hope you're doing ok or you know you're not doing ok but you don't do anything about it until its too late.

When I did ask respondents about what they thought would happen when they got older, a sense of 'vulnerability' was sometimes implied. However, they rarely talked about how what they were currently eating could influence their long-term health. Here, Ted's idea that "as I get older I will have to be more careful", suggested that such matters were being deferred to the future.

TED: Well I have put on weight the last few years, but maybe that's because I'm getting older. I can't do what I used to, and you are going to spread out a bit. On my mother's side of the family, they are not so much heavy but they are not skinny on that side. So I do take after my mum, and the chances are as I get older I will have to be more careful.

So, the majority of respondents talked about their short-term health, and how they currently felt 'healthy' and were happy with what they were eating - future consequences were therefore rarely raised as an issue. In accounting for the relationship between what they were eating and a perceived state of good 'health', different ideas were raised as evidence that their diets were 'healthy'. While this relationship was defined both negatively and positively, such understandings of 'health' were often based upon a dichotomous view that they were 'healthy' because they were not 'ill'. However, although they sometimes said they felt that they were taking this relationship for granted, this was also constructed with a certain amount of trust, especially because they seemed to be hoping that this was why they were 'healthy'.

These ideas of 'never being ill' or alternatively being 'fit and healthy', were in effect, indirect ways of talking about health in terms of the body. However, there was also a much smaller theme where respondents talked about how their bodies worked and which were based upon a 'machine' metaphor of the body. Whereas the more indirect accounts treated the body as a 'black-box', these embodied accounts were drawing upon ideas concerning their own internal workings. Yet because they were asserted as a more conclusive form of evidence, the noticeable consequence of these accounts was that they tended to produce less uncertainty than I identified in the previous theme.

On two occasions, respondents talked about how their body would "tell them what they needed to eat". One male respondent spoke about how he would eat a Mars bar if he felt that his body was telling him that he needed more energy. In this similar example below, Sue talked about a range of different ways that she 'listens to her body'. However, unlike this example, surprisingly very few women talked about a particular relationship with food during pregnancy. She said that she was a "great believer in... that your body'll tell you" and that her body will "object" if and when there is something wrong:

TF: So as knowledge changes, how would you decide which things that you will actually pursue and which you won't?

SUE:...I'm a great believer in, eh, that your body'll tell you, like at the moment I can't: too many processed foods, my body will give me indigestion, you know. Things I would normally eat I can't eat cause my body objects to it, you know. Then there's also the eh, with the pregnancy, the you have to keep up your vegetable intake or you get terrible constipation, you know, so that's your body again saying.

Also in an embodied sense, in two male interviews the analogy of an MOT test was used to explain how they felt that they *knew* how their bodies worked. In both examples, the respondents had been in hospital and had undergone tests. This also suggests that along with lay ideas about health and illness, medical experiences can play a contributory role in how respondents were constructing accounts of their own health.

Doctors had told both respondents that they had very low cholesterol levels and were therefore less likely to suffer from heart problems in later years. Meaningfully therefore, these were one of the very few occasions when respondents did relate their short-term behaviour to long term health concerns. Interestingly, they both appeared to recognise that they were not infallible, but that they could probably get away with more than most people because of the 'types' of bodies they had. Such experiences were again presented as a form of evidence or 'proof' that they could probably do what they wanted. Nevertheless, even

though they had felt very tempted to carry on, they also explained that they had changed their health behaviour. This suggested that despite drawing upon an individualistic idea about how people have different 'types' of bodies, there was still a sense of vulnerability in these accounts about their own health.

RICHARD:...I had a good MOT, it was good to have it. They wouldn't have known from my lungs that I was a smoker, so it was very tempting to carry on, because I know people who live to 90 and are still smoking. Erm, the tar hadn't collected on my lungs, why? I don't know. My lungs were clear apart from the fluid, and my arteries were fine, although I ate an enormous amount of cholesterol, the cholesterol tests were good. I was burning all the cholesterol I ate away...

The final example in this section stood out as being very different from the other lay respondents in this study. Unlike the majority of respondents who appeared to put a certain degree of trust in the evidence that they stated, this male respondent appeared to think that he could eat whatever he liked and it *would not* make a difference to his health. Although Gary's understanding of health seemed to be based around "weight", he appeared to construct a sense of immunity to having to think about these issues. As in the case of a MOT test, this appeared to tell him something about the 'type' of person he was. Yet 'hoping' or 'trusting' did not appear to be the issue here, as he implied that this was 'proof' that he could eat what he liked, because he "couldn't get fat if [he] tried".

GARY: It doesn't bother me. I've never put on a pound in my life. I've always been the same size and shape. I can eat anything or no eat something one day and I lose weight so. I'm just that kind of person.

TF: Some people say that these sort of things don't apply to you.

GARY: That's right.

TF: Is this how you feel?

GARY: As I say, I've never put weight on in my life so. I couldn't get fat if I tried.

TF: What importance do you place on eating in relation to health?

GARY: I wouldn't say a lot of importance. I'm happy with what I eat. It's no affecting my health so I just eat what I've been eating for years.

While accounts about *"How the body works"* were only expressed by a minority of respondents, they do reveal some of the diverse ways in which evidence about the relationship between food and health were presented. Such accounts appeared to be both individualistic and autonomous and were focused upon a sense of knowing that was based on ideas about listening to the body or the 'type' of person that you are. Despite the

confidence and autonomy with which most of this evidence was presented, the emphasis was again more about a sense of trust, rather than absolute truth.

9.2.2 Summary of Part I

Lay accounts of 'healthy eating' appeared to be located within an everyday sense of 'normality', demonstrated by the way that these respondents spoke about their 'health' being something which they took for granted. These views however, were largely based upon respondents' claims that they were never ill or that they had the energy to do the things that they wanted to do. Confidently, with a sense of autonomy, they regarded this as evidence that their diets were supporting and maintaining their health. Yet it is also important to highlight how these were constructed as matter of trust, rather than as a matter of fact.

Although the relationship between food and the body was presented as a matter for personal responsibility, medical concepts of health also appeared to influence these 'common-sense' approaches. Two identifiable examples were a perception of 'health' and illness based on going to see a GP, and ideas about 'types' of people who will be more likely to have certain problems.

It is my suggestion that an understanding of the meanings which form the basis for these views of food and health, are fundamental to understanding how lay respondents talked about and evaluated a range of 'professional' advice on 'healthy eating'. The 'common-sense' ideas explored here were based on respondents' personal experiences and independent ways of knowing. Ultimately they concerned the here and now and appeared to make sense because they could be trusted by everyday validation. So in some sense at least, the 'body never lies'.

Therefore in *Part II*, and *Part III*, I will turn to see how these meanings were applied to the lay respondents' understandings of 'healthy eating advice'.

9.3 Part II: The practicalities and relevance of 'healthy eating advice'

The interview schedule was designed to explore lay views on 'healthy eating advice' as an actual term. Like many of the questions, these were placed strategically after a general discussion on food and health and also before the more specific focus on GPs discussed in *Part III.* Responses were normally unprompted and in general, respondents spontaneously identified the term with a range of different health messages from several 'professional' and commercial sources.

However, this theme explores both how and the extent to which lay respondents stereotyped 'healthy eating advice' as an impractical and irrelevant concept. I will then explore how lay views were based on stereotyped ideas about how it did not make sense or was not necessary to take all this advice "on board" and that certain 'professional' advice was hard to follow because it could not be trusted. Finally, I explore how the effect of these criticisms was demonstrated by the idea that it was more important to 'go your own way'.

9.3.1 Taking advice "on board"

At certain stages, respondents appeared to be treating the interview like a 'test'. This appeared to be constructed here with an imperative that it was important to be seen to be aware of, or to take 'healthy eating advice' on board. However, respondents often gave very few specific examples of advice and any health promotion messages which they spoke about were often mixed with other forms of advice because they said that it was all the same or they had heard it many times before. Respondents therefore talked about the importance of not being ignorant about 'healthy eating', but this was set against their more serious concern of how it did not generally make sense to take 'healthy eating advice' on board. I will suggest that this concept of awareness appeared to be a product of a dilemma that was raised by exploring 'healthy eating advice' in the interview.

To begin with, it was apparent that respondents identified many sources of 'healthy eating advice', which often did not include the advice of health professionals. Sometimes, as this example typified, respondents would mention the actual sources where they had seen or heard advice, rather than identifying where it had originated from:

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TED: Yes, just on television or in the papers - you don't get many
leaflets through the door - but just television papers and radio
just the media.
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However, there were also some gendered differences in their accounts, because when asked about sources of 'healthy eating advice', women were more likely to talk about slimming

clubs such as "Weight Watchers" or "Scottish Slimmers" (which reflects the discussion of dieting in *Section 6.2.3*). As this respondent typified, in addition to slimming advice, some 'healthy eating advice' came from commercial sources, but this was mixed together with other advice on the television and in magazines.

RACHEL: Well I went to Weight Watchers, so I've got some advice from there. Em, you hear it even at the shops, some of the things that the shops say, you know low fats or healthy eating you know on the boxes and different things like that. And you hear it on the television as well, even in magazines.

Nevertheless, any mention of advice which had originated from health service professionals such as doctors or nurses was less common. Few people may have mentioned this as a source of advice because the screening process was designed to ensure they did not suffer from chronic disease or illness. As I will explore in *Part III*, very few respondents actually said that they had received 'healthy eating advice' from GPs (however these accounts will be discussed in a different thematic context *see section 9.4.2*).

JENNIFER: Eh, probably Doctors and em: I know when I was in hospital wi' appendicitis when I was younger, they would obviously talk about balanced diets. Eh, we've seen it on the telly an' maybe older patients an' things like that, when they try an' bring in certain, or specific diets for certain diseases and whatever, high cholesterol.

Nevertheless, although GPs were rarely mentioned as an actual source of information, respondents sometimes said that they had seen leaflets in their surgery:

TF: I mean where might you have seen or heard advice and information from, on healthy eating?

PHILLIPA: I've picked up leaflets at the Doctors.

TF: Oh right so the Doctors, yeah. And what have you seen in there?

PHILLIPA: Well they give you lists 'y what's good for you and tips on cookin' it like as opposed to fryin' the things, grill an' just wee tippets I suppose, as I say, usually magazines.

It was also very common that respondents would talk about how they were 'aware' of a range of advice and information. Alternatively some respondents said that 'healthy eating' was something that they were increasingly becoming aware of over time and on a number of occasions they also said that they should really be giving it more thought than they currently did. This male respondent for example made this point about awareness, by talking about how 'healthy eating advice' "makes you… sit up and think":

KEITH: But I am sort of, you are sort of nowadays you are made more aware of sort of healthy eating and that eh, which does makes you sort of sit up and think I suppose.

Similarly, this female respondent talked about seeing a doctor on the television and it had made her "realise" about the fat and sugar content in food:

TF: What sort of doctor programmes?

CATHERINE: Well you know, like in the mornings they will have that Dr Hilary Jones or whatever, you watch things like that and you are getting a wee bit more information about how much fat is in things and even like juice and things like that. You don't realise the sugar content and things like that.

On the vast majority of occasions, when attempting to explore this notion of 'awareness' further, it was particularly interesting that respondents often gave very few details and rarely distinguished one element of advice from another. I asked what particular or specific advice they could remember and often respondents would actually give none at all. When I probed this male respondent, he said that "nothing really stands out" and that "No campaign" had really been "pushed":

ROBBIE: I don't know. Papers, magazines, something like that. I'm not aware of having read anything really that's grabbed my attention.

TF: Can you think of anything in particular?

ROBBIE: Nothing in particular, no. Dunno. Nothing that really stands out. No campaign that's really being pushed.

However on a few occasions, some respondents did mention a few key health promotion messages or approaches to 'healthy eating', such as "fruit and vegetables" (Stuart) or a need to "reduce cholesterol" (Alison). Both these two examples provide a typical illustration of how a few types of advice were often presented around a statement that they *could not* recall anything specific, but again they made little distinction in explaining what the term 'healthy eating advice' meant to them. The first respondent mentioned "not a great deal actually" and the second again said that "nothing stands out".

NOEL: Not a great deal actually, there's bits of nutrition. Awareness of daily intake, what you should and what you shouldn't be eating.

TED: Nothing in particular, just in general - you know there is nothing that stands out - just a general thing you get the message that eating fruit and veg. is healthier for you

Although rarely stated, some respondents did actually talk about why they provided very view examples. The phrase below that "I think they all tend to say the same thing anyway",

appeared to reveal how specific messages or sources were not being recalled or provided, because all 'healthy eating advice' was viewed and constructed collectively.

NICOLA: The one about vegetables. Having an influence on cancer. The one recently. So you get things off the news. But I never really pick up leaflets or things like that about healthy eating. I think they all tend to say the same thing anyway.

The ideas that respondents were aware of advice, but thought that nothing stood out or that it was "all the same thing", suggested that they were evaluating 'healthy eating advice' as being in some way important, but also a type of information that they were 'switching off' to. One of the more pervasive themes about 'healthy eating advice' helps to supports this possibility and may help to explain why they were often not talking about specific or particular messages. Respondents spoke about how 'healthy eating advice' was ubiquitous and that it was "never out of the news" (Annabel). As this typical example revealed, accounts were often anecdotal, as respondents would sometimes provide extreme examples of what they had heard:

JOHN: I can't think. There's always stuff on the box if you watch any of these health or medical programmes. A guy on 15 pints a night type thing. Just recently George Best, his liver, that's not food it's alcohol. There was a thing in the paper yesterday, a woman who was 35 stone and confined to bed, and it makes you wonder how she got in a situation like that. Things like that.

Similarly, in several other cases, the language of warfare was often invoked, as respondents felt that they were being bombarded by advice or in this particular example, it was "coming at you from every direction".

NOEL:...Erm, I don't know, I suppose messages coming at you from every direction all the time, not something that I consciously take notice of, it's something that er well I am paying attention to it, so I suppose at some stage, somewhere it's gone in.

As this above example suggested, the idea that some information had "gone in" whilst also simultaneously conceived as "not something that I consciously take notice of", revealed a more elaborate notion of 'awareness' than I referred to previously. Such a view suggested that respondents felt that they had enough advice and that the sheer 'volume' and 'intensity' was altogether unnecessary. Although as I have mentioned already, such views were often implied, rather than explicitly stated.

The following three examples provide an illustration of this 'saturation' process in more detail. The first respondent however, was more articulate than most in her explanation of being overwhelmed by the volume of 'healthy eating advice'. While she unusually described more specific and detailed advice than most other respondents, she talked more typically

about how only 'so much' advice can be "taken on board". However, not everything could be and she implied that taking the advice too seriously would be impractical.

CAROLINE: It is useful and there are certain things that do stick in your mind about anything that you read. Your fruit and veg, the five pieces a day. I must admit I have that quite often in my mind. Like today I've probably said to myself even for them I'll have a couple of apples and I've had a couple of apples already and then with the salad I would class that, depending on how much I eat maybe two or three. I think well I'm almost there, maybe not quite today. So things like that that stick in your mind. It's not hard to remember but you do take it in. Even with the semi-skimmed milk they say it's still good. That's useful information but sometimes it can get, I don't watch that much television but it can be a bit. Every time you open the paper in January, there's this diet and that diet they can be a bit.

Reflecting the themes raised in the previous analysis chapters, a number of respondents also talked about the difficulties of following 'healthy eating advice' too seriously, especially because you had to consider people's likes and dislikes. Several respondents talked about how it was not always possible to eat fruit and vegetables all the time, or as I explored in *Chapter 8*, there was also a need to eat foods that you "enjoy" and like the "taste" of. This respondent therefore mentioned that you could not pay attention to everything that was being said:

MARY: Well just if you're reading the magazines or something like that. I'm always interested in reading things like that. And erm, I don't suppose I carry out all the healthy eating advice, but you take on board, what is important, but it does tend to depend on people's likes in the family and everything.

This example below was more negative than most and it revealed a more extreme example of how respondents felt that it was difficult to follow all the advice that they were hearing. This male respondent therefore summed up his response to all this advice, as "going in one ear and out the other". Again, this appeared to be more a matter of 'awareness' than how such 'healthy eating advice' related to everyday behaviour.

KEITH: I mean I've seen the adverts and that, and I've seen the television but really it just goes in one ear and out the other, you know, you don't sort of stop and think about it.

Respondents' accounts appeared to have been based upon a stereotyped understanding of 'healthy eating advice', and health promotion messages themselves were rarely mentioned or distinguished from other advice. These accounts therefore appeared to suggest that they had preconceived ideas about the value of 'healthy eating advice', and a view that this advice was 'all the same'. Such understandings did however appear to present a dilemma. Hence the terms 'aware' and 'on board' were metaphors of the mind, which implied that there was a conflict between an obligation to *know* and how *knowing* was at the same time problematic.

Moreover, the idea that advice will be taken 'on board' implied that 'advice' was a factor that at best may be considered, but that following it to the letter was felt to be impractical.

9.3.2 Trusting advice

One of the main themes respondents constructed in discussing the concept of 'healthy eating advice', was how it was difficult to trust the providers of advice and information because 'they' were constantly changing and contradicting themselves. Indeed, this anonymous and generalised 'they' appeared to be a further indication of how 'healthy eating advice' was stereotypically constructed as being "all the same". Exploring how respondents viewed the professionals who provided such advice will therefore help to explain why 'healthy eating advice' was viewed with such scepticism.

As I demonstrated in the previous theme, I had asked respondents to talk about where they had seen or heard 'healthy eating advice' and information from. Although they identified a range of different sources of information (which were rarely differentiated), their criticisms were normally directed at two different types of advice. Noticeably however, they often made the same criticisms regardless of which one they were talking about.

The first example was a concern about food manufactures and several respondents mentioned the same type of products. Respondents often stated or implied that they were sceptical about what "sort of miracle" (Nicola) a yoghurt or margarine which was meant to lower your cholesterol could actually do. Although price and taste were also mentioned as contributory factors, the key concern appeared to be doubts about placing trust or putting faith in the claims that were being made:

SCOTT: That, in the wee bottles, Yakuu [misquoted, real name Yakult] or something like that. It's meant to be good for your well. Er, I'm just a bit sceptical about that, because it just seemed to appear from nowhere, and maybe it's just the thought of the culture stuff. It doesn't appeal to me seeing the likes of, well I detest yoghurt. It's possibly, well it might be really good for you. If somebody was marketing that and came round to our house like you are surveying here, and said we are bringing this product out, and here's the data on it. Like the products I use at work. You've got to have the data sheet before you can use it. You've got to read that, er and you think well, er that sounds good. It's authentic. I'll give it a go. Just to see something appear, er no. Call me old-fashioned if you like, but maybe I'm just slightly sceptical about these things.

The majority of criticism about 'healthy eating advice', was however, directed towards 'expert' scientific advice which appeared to have originated via the media. Yet, respondents rarely talked specifically about who the 'experts' were. Instead, they spoke about how

science could not be trusted because of the quality and nature of the advice that was being given. Some comments specifically concerned the authoritative basis on which certain scientific truths were grounded and a common view that you cannot trust scientific information anyway. In some cases this view was also extended to the idea that you cannot trust anything that was being said.

RICHARD: Don't believe anything you read anywhere, I honestly believe that. As far as food statistics go.

A similar related point was the idea that the 'experts' could sometimes be wrong. Respondents often made such views very assertively, which implied that they were not just challenging the 'experts', but that in some way they also knew better. This appeared to suggest that the very basis of scientific authority and right to be called an 'expert' was in doubt. This was typified by the following idea, that "If you listen to the experts it's the difference between life and death".

TF: Okay, so how important is eating to our health then?

PETER: If you listen to the experts it's the difference between life and death. If you eat the right stuff it fights off cancers, it stops heart attacks, it seems that it's the be all and end all of the world for you. But however, I believe that experts quite often get it wrong, erm.

A further characteristic of how respondents talked about 'expert' advice, was the way in which they often combined different issues together and criticised what they thought the 'experts' were saying en masse. When respondents were talking in this general way, the 'experts' were commonly referred to as "they", which revealed how lay criticisms were sometimes compacted together. By exploring these themes in more detail, it was possible to identify that lay respondents were talking about a range of different issues and different 'experts'. Here for example, issues about animal injections were mixed with a concern about the naturalness of food and a discourse on cancer. Deborah's main concern however, was centred on whether these 'experts' could be trusted, because she asked "How d'you know it's no' gonny kill you?"

DEBORAH: Plus puttin' aw these things in 'y animals an' that, the cow doesny want ti pumped up, I mean it's out in the field eatin' grass, that's what it's there for, it's eatin' somethin' natural, no' to come in an' get an injection full 'y somethin' ti make it fatter for 'y go an' sell in the market. How d'you know it's no' gonny kill you, get cancer an' all the rest of it. I mean you do get cancer, I mean they canny cure it, half the time they canny cure it anyway... But I mean I suppose they're not supposed to tell any lies, but you don't know if they are tellin' any lies, but I really don't always believe.

In attempting to understand why respondents did not appear to trust the 'experts', a common explanation which they put forward was that their advice was confusing and contradictory. Often referring to the anonymous 'they', many said that they are always changing their minds or that "one day they say one thing and the next day they say the next" (Ted). Such views were often spontaneous and again appeared to be preconceived. It was very rare that respondents would weigh up whether or not this may have been an unfair and stereotyped criticism and it was often implied that this view would be automatically applied to any new advice.

STUART: As I say, they're always changing their minds you know. What's good for you today, is probably bad for you tomorrow sort of thing.

As this second example suggested, it was not just that these criticisms would be applied to any new advice, but that these were concerns which had developed over the years. This notion of a long-term consideration of the confusing nature of 'healthy eating advice' may have been made quite legitimately, nevertheless, there was rarely any suggestion that some advice may actually stay the same.

SUE:...but I have noticed over the years that, er how it changes and how they go like, you know, the thing with the liver, oh no now it's not OK, all of that.

This female respondent however, was the only one who appeared to weigh up whether all advice was the same and felt that some messages were actually more consistent than others. Unlike most respondents, she was one of a very few who questioned the assumption that all 'expert' advice is unreliable. Thus she spoke of how some advice may stay the same, while other advice is changing. This therefore appeared to produce some uncertainty about whether "they" (the 'experts') are "trying to pull the wool over your eyes".

CAROLINE: Well sometimes. I think that's more you know the egg thing and things like that. Eat them, don't eat them. The only thing that really worried me and that's not why we don't eat red meat now. We didn't eat that much really it's just the mince for the chilli that kind of scared me a bit. I would say that's probably at the back of my mind when they're having the meat. Is it okay? They're trying to assure you it is. Things like that I don't know if they're trying to pull the wool over your eyes. I don't think they do change it that much. It's basically always the same isn't it. It is. I don't think they change the goal posts that much on those kind of things.

Analysing these accounts more closely also suggested that 'healthy eating advice' was felt to be confusing and contradictory because respondents were citing examples based on a long line of British food scares:

PETER: They've told them that beef was safe, then they gave us BSE. They told us eggs were fine, then they gave us salmonella. Erm, and the general public have just lost faith in experts, so-called experts in this country.

Respondents were well aware that there had been a lot of these scares, and they appeared to treat new ones with equal contempt, therefore they sometimes referred to the "next thing that they will be telling us to do" or "there's always something that they are going on about":

GARY: Its always on the news eh. The next thing, the latest thing, what's it called again, its ken mucking about with the crops?

TF: Oh genetically modified foods.

GARY: Aye that'll be the next thing eh. They're telling you now its bad for you.

Some respondents explained that the effect of so many of these food scares, was that they had now 'switched off' to what the 'experts' were saying. They spoke about how there was often very little point in taking it all too seriously, because it was often retrospective advice. Such accounts interestingly appeared to incorporate fatalistic notions, but this was presented as a matter of not trusting the 'experts', rather than not caring about their health. Here for example, this female respondent referred to the 'experts' ' advice as being "confusing", but said that "we've probably been eating it for years anyway":

SUE: Well because it's em, it's confusing isn't it, it's all the time I get like, you know, at the moment the big thing's organic. Eh, before that it was like hormones in chicken and cows and eh, then em, all this genetically modified stuff. Em, realising that by the time we hear about it we've probably been eating it for years anyway so eh, you know. And then eh, cause my bottom line on it is that I think "Oh well, you know, I won't know the truth anyway for: till I'm about sixty and then it'll all come out in the wash and I'll find out that I was eating all these hormones and it's too late now, you know" but.

I have argued that the majority of respondents criticised the 'experts' anonymously and homogeneously, but that their criticisms were generally directed towards advice that had been received via the media. In only one case did a respondent actually question the media's involvement, implying that in most cases they were not implicating them in translating what the 'experts' were saying. In this particular example, and when I probed about food scares, Noel did question the media's involvement in propagating truth claims and said that it is a "media circus" and he took "scares with a pinch of salt":

TF: Scares?

NOEL: Yeah, salmonella, apples are bad for your teeth.

TF: How do you feel about the scares?

NOEL: Yeah, I take scares with a pinch of salt. Scares are scares basically. A media circus, but I suppose there is some kind of foundation in all of that. It goes beyond scares and can become something that has to be dealt with.

In discussing the previous theme I revealed that respondents stereotyped the term 'healthy eating advice', by talking about how it was "all the same". Following on from this, it was also apparent that they were stereotyping those who were providing advice en masse, and with criticisms which were directed at an anonymous and generalised 'they'. This was noticeable by how they over-simplified the range of sources, how they frequently had preconceived ideas about trusting the 'experts' and also that their advice was always changing. However, whilst respondents asserted their own authority in challenging the impractical nature of following this advice, the role of the media was rarely considered. This revealed how they appeared to rely upon the media to translate advice that has originated elsewhere and which formed the basis for their understandings of 'expert' and scientific evidence.

9.3.3 Going your own way

I argued in the previous section that respondents often asserted their own authority when challenging the nature of scientific truth claims. This theme however, concentrates upon the relevance and practical aspects of following 'healthy eating advice', but develops the notion of 'trust' and 'awareness' identified earlier. There were two key elements to their view that you *had* to go your own way: The first of which was a need for pragmatism and the second questioned the relevance of 'healthy eating advice' - when it was thought that it should be a concern for the individual anyway. Fundamentally, I will argue that this idea of autonomy was a reflection of the perceived value of 'common-sense' notions of health and illness that I described in *Part I* of this chapter.

It was apparent that one of the ways that respondents spoke about the consequences of not trusting 'healthy eating advice', was a view that they did not take the advice too seriously in the first place. This was often presented as an issue which they said did not bother them, or something which they said they were not worrying about.

ROBBIE: Obviously the health fears over BSE and stuff like that. It doesn't really bother me very much.

In other cases, there was clearly a preconceived idea that 'healthy eating advice' could not be taken seriously and that it would not make sense to follow such advice to the letter because it was often impractical. Thus respondents asked for example: "what is a portion anyway?"

(Peter). Such accounts do help to suggest that this was an approach that respondents were already taking to making sense of these contradictions, especially because they rarely talked about applying different criteria to different advice. Indeed, the notion of 'going your own way' from the 'experts' was illustrated here by the comment that "you've got to realise that there is conflicting evidence and not to take too much notice of them."

TED: I would think it's only hard to follow if you take heed of what's been said, but if you are living your life by the studies that you hear it's going to be difficult if you only take note of them and don't hear much about them it's interesting to hear, but I suppose when you hear these studies you've got to realise that there is conflicting evidence and not to take too much notice of them.

I argued above that respondents claimed to ignore advice and 'go their own way'. However there was also a comment in these accounts that it was still interesting to hear what the 'experts' had to say or that it made them 'aware'. This does also suggest that the criticisms applied to the truth claims of 'experts' may therefore have been a way of managing uncertainty. The phrase "it doesn't help" for example (below), suggested that 'healthy eating advice' lost its value when it was contradictory:

TF: What about conflict?

NOEL: Again that's the sort of thing that makes you take health advice with a pinch of salt, cos they say this then that. It makes you aware, but it doesn't help. There was a phase a few years a go when there was a lot of it.

Moving on, another element of how respondents talked about 'going their own way,' was a theme based around understandings of the 'individual' and the relevance of listening to and following 'healthy eating advice'. Therefore, 'common-sense' notions of food and health (see *Part I*) appeared to be applied to 'healthy eating advice' with the effect that it was constructed as being generalised and untrustworthy. Some respondents explained that one of the reasons why they did do their own thing was that they had trusted their own knowledge more (although as I explored in *Part I*, this was often a matter of trust rather than truth). Here for example, this female respondent said that she had "never heard anything that's really made" her change what she was eating and instead hoped that what she did was "good enough".

AMANDA: Erm. Nothing, well I've never heard anything that's really made me change our eating patterns. Erm, I don't feel that our eating is particularly bad. Erm, it's to do with our lifestyle, and I don't know what could be said that would make me change anything. Erm, the mad cow disease and scare didn't put us off meat. Erm, I don't go reading labels to see about GM food or anything. From the knowledge I've got, I don't where, whether it was childhood or nurse training and all the rest about diet and

healthy eating, erm. Just try and hope that what I am doing is good enough.

In other cases, respondents talked about how "individuals are different" (Phillipa) and they spoke about how 'healthy eating' was approached instead by choosing what *they* thought was relevant. In some cases, respondents were more assertive and implied that nobody had the right to dictate what you should be eating, especially because they will not get anywhere. Here, this female respondent spoke of how "it's up to every individual themself, what they think is good for them, as well as what is bad for them."

RACHEL: There is a lot of things that they say is good for you, and there are a lot of things they say are bad for you. Then maybe a couple of months later they say well what was bad for you, isn't bad for you, it's good for you, so really they are going in a vicious circle. So I think it's up to every individual themself, what they think is good for them, as well as what is bad for them.

Finally, in some cases, these accounts also reflected those I explored in *Part I*, because respondents said that they knew how their bodies worked. So that if they (again meaning the 'experts') wanted to make a difference, then they would have to take up the 'challenge' of proving a direct link between their diet and their health.

LYNNE: That I eat what I like, and I really er am not fussed if someone's telling me it's no good for me, unless as I say, it affected my health directly. So if somebody says tomorrow you cannot eat another sweetie because it's bad for your health, it's affecting your liver, then I wouldn't eat another sweetie. And I can say that quite honestly, so I know, how I work.

9.3.4 Summary to Part II

It is important to recognise that respondents appeared to construct themes around the idea of 'going your own way' as a mechanism for both managing the practical uncertainties and evaluating the relevance of 'healthy eating advice'. While it could be suggested that they had preconceived and stereotyped views of 'healthy eating advice' as a concept, the criteria on which their criticisms were based were not superficial. The theme of 'going your own way' revealed that respondents were actually constructing 'healthy eating advice' in terms of their own and apparently more meaningful 'common-sense' concepts of 'healthy eating'. Thus, the notion that people were 'aware' of advice, or were willing to 'take it on board', appeared to symbolise how it did not practically assimilate with their own understandings of 'healthy eating', rather than that it had no relevance whatsoever.

In constructing 'healthy eating advice' as something which was essentially differentiated from 'common-sense' notions of 'healthy eating', respondents distanced themselves from it; they stereotyped the term through a number of preconceived and oversimplified views; and it was viewed hierarchically as being inferior. Rather than being merely a distancing process, the way in which respondents talked about 'healthy eating advice' therefore suggests an 'Othering' process was operating. Thus respondents appeared to construct the 'experts' as the *Other*, while their own familiar and 'common-sense' views were seen as the *Same*.

9.4 Part III: Reconstructing relevance: Contingencies of illness and 'risk'

Up until now, this chapter has explored lay understandings of 'healthy eating advice' from a perspective where respondents were defining themselves as 'healthy'. In this final theme, I want to explore how this concept of health and the issues raised in *Parts I* and *II* also related to the way that respondents spoke about inheriting disease, or talking to their GPs about food and eating.

In *Part I,* I identified that lay definitions of 'health' were often defined in terms of the absence of 'illness' and that this dichotomous definition of health provided the basis for how respondents distanced themselves from 'healthy eating advice'. The main conceptual point that I will make here though, is that these concepts and processes still appeared to play a key role in how respondents made sense of occasions when they accepted that 'healthy eating advice' may be more relevant. Thus a distancing process still seemed to provide a mechanism for how respondents evaluated 'healthy eating advice' which may have become necessitated by illness or an increased risk of inheriting disease.

9.4.1 Narratives of inheritance

Although not an extensive theme, a number of respondents did talk about inheriting chronic genetic diseases. This was normally because one or more of their parents were currently suffering from, or had previously died of, a heart attack or stroke. What made these accounts so interesting was that it was one of the few occasions where respondents talked about the personal relevance of 'healthy eating advice'. Despite feeling that they had a higher risk than some other people, it was apparent that both common-sense notions of 'health' and criticisms of 'healthy eating advice' still pervaded the way they talked about these issues.

Exploring accounts of how close relatives had died and also how respondents felt about these incidents in the actual interviews was usually an area that I tended to avoid. I felt that a deeper exploration would not have been appropriate considering how I had not recruited respondents to talk about this sensitive subject. Nevertheless, I want to begin by exploring a particular account from a male respondent whose father had died and also his wife's view on this same event. I will explore this couple's accounts in more depth, so that the themes which are raised here can then be identified in other examples later on.

In the following account, this female respondent explained that her husband's father and grandfather had both died of heart disease. She also said that because her husband was at a "high risk", they had spoken to the practice nurse at his local general practice. Elsewhere in

the interview, she told me that this had been a contributory factor to a period of mental depression and a leave of absence from his job.

LYNNE: Well we probably have taken advice, because of as I say, going back to the heart disease thing. Stuart runs a high risk, because Stuart's dad died of heart disease, and his grandfather died so. So when, er it was actually Sister Taylor at the surgery, actually spoke to Stuart and I about it one time, when we went for, it was when we joined the practice, and we had to have a health check, and she commented on Stuart's weight.

I was therefore conscious of this issue when I returned on a separate occasion to interview her husband. Despite trying to raise this event gently throughout the interview, it was not until the end that he did actually mention it. This was interesting for two reasons. Firstly it was surprising that this sensitive issue was raised so little when it might be assumed that it would be more important in an interview about food and health. This suggests that there was a desire not to raise this an issue, or also that it may have not been regarded as being relevant. The second interesting factor, was how this respondent explained how he thought he was at "higher risk" by talking about (after I probed him about genetic factors) these risks being "at the back of his head" and that he had to "look after [him]self a bit".

STUART: Well, my father died last year. So, er, I know how much pain you can sort of go through.

TF: Yeah, is that something that concerns you?

STUART: It does aye.

TF: Well people say it's genetic?

STUART: Yeah. Erm, I think it's at the back of my head. I have to look after myself a bit, because I suppose I am at a higher risk.

I decided to raise the issue of my own father's heart problems so that I could talk more empathetically about this issue (which was the only time I ever adopted this style of interviewing). Again, when he was evaluating how this "higher risk" may affect him, Stuart mentioned that it made him "stop and think" because he did not "want to end up" in a similar state of poor health. Yet in explaining how this related to actual eating behaviour, the relationship between "cut[ting] out chips" and his understanding of health was constructed tentatively as "I suppose in a way". This did not create the impression that a strong relationship was being conceptualised between his diet and level of health in the future.

TF: Yeah, I have a similar family history, my father has heart disease.

STUART: Well my father had a by-pass, about seventeen years ago. And as I say, it worked for the last seven or eight years, he had

been limited to what he could do. And as I say, it does stop you and think, well, I don't want to end up like that you know. I suppose in a way, it's like I cut out chips.

So in both these accounts, this family constructed genetic risk as "higher risks". However, there was a noticeable contrast in that the male respondent who was at "higher risk" appeared to play down the relationship between this understanding of genetic risk and his own diet. This tentative presentation of the relationship between health and behaviour also pervaded other lay accounts of genetic disease and illness. Therefore in Keith's account below, the act of giving up smoking was constructed as 'probably' being a result of his father's death.

KEITH: Well I stopped smoking, I've stopped smoking for eleven weeks and that prayed on my mind for a wee while because my father had a stroke and to see the way that he went downhill just wasn't, you know, and it was frustrating for me, it was frustrating to see the way he went, because he couldn't talk, he couldn't communicate, he couldn't do anything basically and it was just horrible to see. And I'm not saying it was cigarettes but the medical staff were saying that it just doesn't help. But that sort of made me think that I didn't fancy going through that.

However, when I asked more specifically about eating and health, the same point about how these risks made you "think" (because he had been 'told') was constructed again. Unlike the previous example, Keith also said that "I'm not saying I've done anything about it", so there was a distinct emphasis upon being 'aware' of these genetic risks and the benefits of "eating a wee bit healthier". Yet, there was no explanation of how this had or had not been adopted into any behaviour change and the benefits were constructed as potential, rather than actual ones.

TF: Okay. What importance do you place on eating, diet in sort of relation to health?

KEITH: Em, I've been quite ignorant to the fact I would say. It's more and more people sort of bringing it out, like today, you are here discussing it and it's em, on the telly and what not, it does make you aware, definitely. It's made me think, I'm not saying I've done anything about it, but it's made me think. Em, like if you could put an extra ten years, you feel if you could maybe get an extra ten years out of eating a wee bit healthier, keep me a wee bit more fitter, you know, it would be worthwhile doing.

In this final example, similar issues about 'awareness' and a modest account of how health relates to lifestyle behaviour were also mentioned. Hence the reason for cutting out crisps was tentatively explained as "probably" being because of their fat content. Like the previous example, this female respondent also presented her parents' poor health as making her

"think", but in contrast, she appeared to view her doctor's advice as having greater relevance for diet than for smoking:

TF: Okay, em, I mean what reasons did you have for sort of cutting out crisps?

TRACEY: Probably because of the fat, there is a history of heart conditions on both my mum's side and my dad's side. Which I feel well it's coming to me, I probably passed it on to the girls, because there is heart condition on Keith's side. My mum suffers quite bad from high blood pressure, em, was diagnosed angina, about October, November or something last year. She is just not fit enough to work full time now. Whereas my granny, my mum's mum, was like in her middle fifties, no her middle sixties, when she took the heart trouble, whereas that is my mum just fifty five with heart trouble and I'm thinking well am I going to be forty five, you know it seems to be going down ten years, and I think is it going to be me next, am I going to be a lot younger taking like heart trouble, high blood pressure, and it does make you think about the smoking as well, you know, Dr D's surgery.

Although only a minority of respondents talked about inheriting their parents' diseases or illnesses, the common theme was that respondents were 'aware' of their 'higher risks'. These 'higher risks' were presented as a tentative account of the relationship between future health and lifestyle behaviour, as respondents tended to talk with some uncertainty about how this was 'probably' why they had made changes, or that they 'probably' would be doing so in the future. There was also some evidence that this notion of 'higher risk' was influenced through medical encounters, although it was difficult to identify any particular sources in some interviews

9.4.2 GPs and the provision of 'healthy eating advice'

Towards the end of the lay interview schedules, I asked respondents how they felt about GPs providing 'healthy eating advice'. In this theme, I want to explore how the same distancing process, explored across *Parts I* and *II*, also appeared to form the basis for how respondents made sense and constructed the relevance of GPs talking to them about food and eating. One key finding which supports this idea, was that respondents thought that a GP's 'healthy eating advice' would probably be the same as other sources. However, these accounts were also complemented by the view that a GP can only legitimately provide 'healthy eating advice' when you are 'ill'.

This section is divided into two sub-themes: The first concentrates on the majority of accounts, which were *hypothetical*, because I was asking respondents to evaluate the potential of a GP providing 'healthy eating advice'. Nevertheless in the second sub-theme, I will

explore a few accounts where respondents said they had actually discussed food and eating with a GP.

Evaluating the GP's potential role

Only on several occasions did respondents express an overall negative opinion of GPs. On most of these few occasions, respondents talked about how GPs had lost credibility, or that they were not really capable of talking about food and eating because they did not necessarily practice what they preached:

CATHERINE: Yes, but then you see doctors that are overweight as well, and things like that as well

However, some criticisms of GPs were more complex and respondents appeared to draw upon a number of different discourses. This respondent for example talked about believing in GPs "one hundred per cent", yet at the same time, questioned how much they could be respected, because they were now losing their credibility:

JIM: They're good. I believe in the GPs one hundred per cent but I don't think doctors get as much respect as they probably deserve now. I think that's got a lot to do with computers and signing prescriptions. The first thing you see when you walk in the surgery is a computer and your prescription comes out a computer. If you've got an illness they'll look up the computer to see what it is. I think when they do that they're losing a lot of respect or credibility.

Nevertheless, in the vast majority of cases, GPs were viewed very positively, but *only* for a particular purpose. I had argued in *Part I* that respondents often defined 'health' as the absence of illness and it was apparent that this dichotomous view of health also pervaded the way they constructed their GP's role. When I asked respondents about their views on GPs providing 'healthy eating advice', they often constructed the GP's role "as the person you go to when you are ill" (Sue). Sometimes, this was phrased as being the only time they had seen their doctor and that they only went when they really felt ill or as a last resort. Alternatively some made a similar point, and said that the doctor is someone you see "to answer your medical problems" (Alison).

AMANDA: Helping with illnesses. Erm, I suppose dishing out antibiotics, hahahaha. That's basically if we've got an infection that we can't cope with. Don't tend to go about anything else.

Associated with the idea that the GP's role was about treating illness, was a common shared view that they were too busy to undertake 'healthy eating' work. Respondents often said that GPs do not have the time to advise people about what to eat or "they've got enough to

do" (Stuart) without having to talk about diet. Here for example, Annabel implied that 'healthy eating advice' was not felt to be a priority for GPs and should therefore not be a part of their role.

ANNABEL: I sort of think you shouldn't pester the doctor, you really only go if you are really ill, or you are really dying or something, you know if you are feeling really terrible. I'd have to be like, feeling like, really really desperate before I went to the doctor. I don't know why, but, that's the funny thing, a lot of my friends say go the doctor and they go the doctor for this, that and the next thing. I could never pester my doctor for silly wee things, like colds and things like that.

Such accounts also often implied what was stated in the following quotation, that normally dietary issues were a matter for individual decision and that the GP did not need to be involved. Some respondents for example talked about how they would know themselves when something was wrong. In this particular example, Catherine implied that for her children's diets, 'she knew best'. This autonomous idea of 'knowing' therefore, revealed a strong similarity with the theme I identified earlier of 'how the body works':

CATHERINE: To what I eat, I don't think the doctor would make a difference to be honest with you. But then I think their diet is fine, as I say I don't think there is anything wrong with their diet.

Constructing the GP's role in this way therefore, distanced respondents from the idea that GPs should be providing 'healthy eating advice', particularly because they were already 'healthy'. However, this definition of the GP's role was supported by the *contingency* that they should talk about these matters when someone was ill. Under this scenario, they could see that the GP did sometimes have grounds to provide advice. Respondents therefore talked about how if someone had a specific problem, then this was a legitimate occasion to provide advice, yet there was often very little detail about what they meant by 'specific'. Apart from the idea that you see a GP when you are "ill", respondents appeared to have more of an idea about how 'healthy eating advice' was generally not something they expected their GP to undertake:

CATHERINE: I wouldn't say they took a big interest in anything like that.

JO: He probably wouldn't [give healthy eating advice], unless you went to him with a specific problem. Because I see him so infrequently.

On a few occasions, respondents did elaborate on what they meant by 'specific' and talked about how GPs would probably give you advice if you were overweight, had a heart problem or high cholesterol. Furthermore, what they meant by something 'specific' was

often defined in terms of occasions when they thought that it would be *inappropriate* to be told what they should be eating. Having a "sore throat" (below) was the most common reason given to support this view, but others also suggested twisted ankles, the flu or coughs. Here for example, this female respondent said she would not expect her GP to talk about diet if she was consulting for an unrelated reason.

CAROLINE: I don't think if I went in and said I've got a really sore throat today I wouldn't expect him to say what have you had for breakfast today.

In contrast, and only on several occasions, did respondents think that a GP should extend their role beyond the treatment of illness. However, it was interesting that at the same time, they also felt that it would probably be impractical for them to do so, even though in theory, this was a good idea. Here for example, this male respondent felt that a preventive role was "a step forward", but he qualified this comment with a view that GPs are "inundated with work" and would therefore be distracted from their 'proper' role:

TF: So how would you feel about your doctor giving you healthy eating advice?

PETER: I think it would be a step forward, but the problem being that doctors are already inundated with work. If they start to take on that role, then they are not doing their role that they are put there to do. Fair enough, healthy eating may be important.

Reapplying the same criteria

It was apparent that respondents constructed 'healthy eating advice' as not being something that a GP should provide, because they also applied the same criteria that they applied to this type of advice more generally. One typical example, was that respondents often thought that GPs would provide the same advice that was available elsewhere, which also drew upon the stereotyped view that 'healthy eating advice' was all the same anyway:

TF: How would you feel about your doctor giving you healthy eating advice?

TED: No different from reading it in the papers or seeing it on the television.

TF: Why no difference?

TED: Because I would tend to think whoever is talking about it on the television or talking about it on the radio has researched it and has the same knowledge as what the doctor would have.

Further evidence of this stereotyping was also revealed in this account below. This time, the "professionals" were all constructed as being the same and Sue felt that there was little to

distinguish between any of them. However, there was again a contingency in these constructions, because a GP's advice could possibly be relevant if it was for a specific, rather than general reason.

SUE: I would feel like she was like all the other professionals, I would just go "Oh yes, yes, uhuh, I agree, thank you very much, goodbye" because unless she was giving it to me for a reason, like you know, I'd gone to her to say "Oh, you know, like food's going straight through me" or "I'm sick all the time" or something like that, I wouldn't see the point, you know in handing it out.

The most common response that respondents gave when asked to consider how their GP could make a difference to their diet, was to talk about how they would be prepared "to listen" to what they had to say, or that they would take their advice "on board". Such accounts again suggest that respondents were using this term because they felt 'healthy eating advice' had some positive meaning, but that at the same time was also a problematic concept. Respondents often expanded on the reasons why they were only prepared "to listen" to what GPs had to say, and this was often in more detail than they had done in the earlier stages of the interview.

One of the more pervasive examples of this phenomenon centred upon how respondents constructed the doctor's authority. The idea that a GP was someone you valued when you were ill was partially carried through into how they viewed their role towards the provision of 'healthy eating advice'. What such accounts also suggest (as was seen earlier), was that this then represented a dilemma, because respondents had to reconcile a conflict between their negative views of 'healthy eating advice' and their more positive views of the GP's role. Hence, such accounts were rarely spontaneous and were often only put forward after I had probed them for further information.

The GP therefore was "only doing his job" (John) if he did provide 'healthy eating advice', and some people said that GP's opinions on health had to be respected.

KEITH: Well, you respect a doctor's opinion on anything. I suppose if they are going to tell you to cut back on certain things you've got to take them serious eh…. Well as I say, I would be quite, I don't know. From my own point of view I would have respect and definitely sit up and listen to a doctor, so I would feel they did have quite a good influence, I would say.

On many occasions, respondents also talked about how they would be prepared "to listen" or "take on board" advice if they personally thought it was necessary.

ALISON: I'd take it on board if I thought it was going to do me any good. Do you know what I mean?

However, what they often appeared to imply by this idea, was that their advice would need to be practical and it would have to make sense. The same criticisms that were applied to 'healthy eating advice' more generally were again applied to the GP. For example, some felt that their advice would be "hard to stick to" (Jim). While in this particular example, this female respondent talked about how the 'five a day' (misquoted as four) message was just not practical:

> CATHERINE: You are supposed to eat maybe four pieces of fruit a day or whatever and so many vegetables a day, I just wouldn't do that, I've never done it and would probably never do it because I've just never felt the urge to eat four pieces of fruit in a day, you know what I mean. Probably it's more healthy for you but I just wouldn't want to do it, I just wouldn't.

Lay respondents felt that a GP's role was to treat sickness and that they could only legitimately provide 'healthy eating advice' when people are "ill". However, it appeared from these data that talking about GPs in the interview provided further opportunities for respondents to distance themselves from needing 'healthy eating advice'.

Importantly, these seem to reproduce the dichotomous view of health which I identified in *Part I*, especially because they were again able to imply that they were 'healthy' by distancing themselves from needing 'healthy eating advice'. However, the hypothetical scenario of being given advice when you are "ill" ironically reproduces this same distancing process, because it projects a positive image of general practice as a *resource* for illness.

Finally, although respondents argued again that 'healthy eating' was a matter for the individual, the idea that the GP is someone you 'have to listen to' presents a familiar dilemma identified earlier. GPs' roles were regarded as a positive resource, because respondents appeared to construct them as 'experts' for treating illness. Once again therefore, the idea of 'taking advice on board' appeared to be a product of the Othering of 'healthy eating advice' identified in *Part II*.

Receiving 'healthy eating advice'

As I explained in *Chapter 5*, one of the practical issues which had to be resolved in recruiting lay respondents, was that it was not possible to sample patients who had received 'healthy eating advice'. The main reason I took this step was that pre-fieldwork interviews had suggested that the term 'healthy eating advice' required exploratory work and so would not have been a useful way of recruiting lay respondents. However, several respondents did talk about encounters with GPs where they had spoken about 'healthy eating advice'. What such accounts appeared to suggest, was that respondents were evaluating the advice they had been given in terms of the same ideas about a GP's role that I identified in the previous

theme. I shall be working through each of these cases in turn and then summarising how they reflect the ideas discussed previously.

Several of the respondents spoke very highly of their GPs and said they had gone to see them because of a medical problem. This female respondent however, said that she went to see her GP because of a "weight problem". What made this account interesting, was that Phillipa implied there was some uncertainty about the legitimacy of this as a "medical problem", because it was more to do with her eating the "wrong things." She then tried to make sense of this uncertainty, by talking about how at the "end of the day" it is up to the individual.

PHILLIPA: Just probably how I was feelin' at the time. Like I say, there is times when I'll really like "Oh God, I should really do somethin' about it". But eh, that's not what took me round. Em, an' I do have a medical problem that can cause you 'y put weight on, but I'm no' sayin' that's what it is, cause I know I eat all the wrong things, but it doesny help, em. I don't think he could make any difference. I think it's down 'y you at the end 'y the day an' how you think an' I think there's no a lot you could do, really, unless I was considered maybe obese an' he would send me 'y a dietician or for further help.

This following example also provides some evidence of how respondents were willing to accept 'healthy eating advice' if they thought that a condition was a medical problem. In an earlier account, this female respondent had praised her GP for helping her family with a number of health issues. Contrary to the previous example, there was no doubt raised about whether this was a legitimate general practice discussion topic. Here therefore, the condition of "Ulceritis" had involved surgical procedures and had subsequently been supported by dietary advice in general practice.

LYNNE: Well, going back to Neil, Neil's had Ulceritis. And he's, what when he was 15 it developed, and unfortunately it developed so severe, that he had to have his large bowel removed, and it was the GPs at the surgery, Dr [Pauline] in particular that worked with us on the things that were good for him, Bur Dr [Pauline] gave us a lot of advice on what aggravated his condition, what was the best thing for him, what really set him off on bad days when he was really quite ill and that, so we had to watch what we were eating.

In this final example however, this female respondent presented a more negative view of an experience with a GP and reflected a point made in two other accounts. The respondent began by talking about how her husband had been to see his GP about a weight problem., but then went on to say that she thought the GPs were 'passing the buck' to the practice nurses because GPs were not really interested in this type of work:

NICOLA: I don't think they really do. Because I know in Peter's case he's been up to the GP and told, Peter you will have to lose weight. And he actually doesn't deal with the GP he deals with er a lady up there called Sister Taylor who is the practice something, nurse or whatever. But she does all the work involved in diets and weight loss, and cholesterol and whatever. It is not the GPs that do it. The GPs will see somebody and say, you have a problem, you need to lose weight or you need to get your cholesterol down or whatever. And promptly refer you to Sister Taylor. So she did it, and it's not something the GPs will, well they will tell you that you need to do that.

However, when I enquired further this issue further, Nicola justified why this delegation may have been necessary. This was because on reflection, she said that the nurse may have had more knowledge of weight management than the GP and also because GPs are probably too busy to deal with this area anyway. This suggests again, that respondents were evaluating these encounters around the same theme that GPs treated illness. Despite this being a negative experience, it again implied that respondents had decisive views on what a GP's role was. Talking about food and eating therefore raised uncertainty about the legitimacy of a GP undertaking this work, especially if they were "very busy".

NICOLA: Well she probably knows more about it than the GP does to be perfectly honest. A lot of them don't and GPs are very busy, and they really, well it's very difficult and sometimes you wait three weeks for an appointment up there and there's been big rows about appointment times and things like that, and appointments are few and far between. So I think it's more that the GPs don't know as much about it as they might like to do, purely because they haven't got the time.

Regardless of whether these encounters were constructed as being positive or negative experiences, they were still evaluated in the same way that respondents talked about GPs when they had not received advice. It seemed that all three examples draw upon an idea that GPs treat the 'ill' and not the 'healthy'. Whereas in the middle example "Ulceritis" was constructed as a being a serious medical issue, the other two accounts were pervaded by uncertainty about the GP's role in providing 'healthy eating advice'. Therefore in both these cases, weight problems were seen as being more open for review and the role of the GP was felt to be less relevant.

9.4.3 Summary to Part III

The main point I have made in *Part III*, is that a *distancing* process was also identifiable in accounts where lay respondents talked either about their GPs providing 'healthy eating advice' or the risk of inheriting family illness and disease. Yet, in all these themes, 'healthy eating advice' appeared to sit uncomfortably with the dichotomous definition of health as a state of either 'health' or 'illness'. So while genetic diseases might present a 'higher risk' to

health, the way in which respondents appeared to conceptualise health in the short term may then affect how they made sense of 'healthy eating advice'. Thus any notion of how 'healthy eating advice' might be applicable to their own situation, was still constructed with a degree of uncertainty and scepticism and concerned the relevance of making behavioural changes when you think you are 'healthy'.

The same appeared to be the case with views of GPs. On the one hand respondents talked about not needing advice because they were 'healthy' and for a number of reasons they spoke about how it would not make sense for a GP to undertake this role. Yet this represented a dilemma, because they also regarded the GP as someone you *should* listen to. However, even when respondents talked about going to their GPs to talk about a diet-related problem, 'healthy eating advice' again presented a similar dilemma.

9.5 Chapter summary

I set out in this chapter to unpack what respondents meant when they criticised 'healthy eating advice' for being impractical and not always relevant. However, the idea that 'healthy eating advice' was criticised for not making sense or not being necessary, appeared to be a preconceived and stereotyped construction. This suggested that respondents were not merely 'weighing up' this type of advice with their own personal and independent understandings of the relationship between food and health. Instead, 'healthy eating advice' was Othered as something which they *knew* about, rather than as knowledge which helped to practically explain and make sense of the complexities of 'healthy eating' in their day to day lives.

So while scientific and medical knowledge might influence lay concepts of 'healthy eating', it was apparent that they were being rendered to a different level of consciousness, therefore were only to be 'taken on board' or at best be 'at the back of the mind'. Nevertheless, this advice still had the potency and power to raise doubts about whether it could be dismissed completely. In terms of the general practice setting more specifically, although lay respondents showed some discretion in how they applied their concerns to GPs' 'healthy eating advice', what constituted a legitimate opportunity for providing advice in general practice appeared to be shaped by the idea that their primary role was to treat illness.

10 Representing prevention

10.1 Introduction

This and the following chapter explore the accounts of the 15 GPs who were also interviewed about 'healthy eating'. The aim is to explore how and why these GPs appeared to display contrasting degrees of enthusiasm towards the provision of 'healthy eating advice' in their consultations. However, to unpack these accounts, the analysis centres upon Caws' (1974:3) distinction between 'representational' and 'operational models'. Caws argues that these correspond to different levels of accounts, representing the way an "individual thinks things are" and the way they "practically respond or act".

This analytical approach was felt to be necessary, because it became apparent that the ways GPs spoke about 'healthy eating advice' were centred upon two contrasting 'representational models' of preventive work in general practice. Drawing upon Caws' distinction, the chapter will explore how these accounts may not necessarily reflect the way that GPs practice because they are 'representations' or "abstractions of clinical practice" (Williams and Boulton 1988:235). I will therefore explore the subtle influence that these 'representational models' appeared to have on the ways that GPs approached this area of work. Although it is not possible to assume through interview methods that these 'models' will influence how GPs practice, this chapter explores how they did appear to influence the way that they were evaluating their experiences of prevention.

10.2 Constructing 'representational models'

This first theme focuses specifically upon the representational content of the GP interviews and in the following themes, I will unpack the different ways that these 'representational models' were related to discussions about the provision of 'healthy eating advice'. This discussion will specifically concentrate upon how all the GPs appeared to orientate themselves towards two contrasting 'models' of general practice. It should also be noted that while the questions I asked were aimed at exploring views of 'healthy eating advice', all the GPs often talked more generally about prevention. Analysing their accounts was therefore a complex task because they often switched between many different levels of accounting. Hence in this section, I want to begin by examining how GPs accounts of 'healthy eating' work appeared to be underpinned by views concerning the theory of prevention in general practice.

It was apparent from the recruiting stage of this research (see *Chapter 5*) that many GPs had very strong views on preventive work and appeared to approach the interview as a welcome opportunity to make themselves heard. I will argue, throughout both this and the following chapter, that GPs' representations of general practice were, on the whole, polarised. This suggests there were two dominant 'models' which GPs were presenting to me and orientating themselves towards.

Before looking at each 'representational model' in turn, I want to begin by briefly indicating how these contrasting orientations were apparent in the initial stages of the interview. All of the GPs spoke about the important influence diet has on health. However, their accounts then departed from this unanimous position, because of the different ways that they went on to evaluate the role of general practice or their own personal involvement in this area.

For some GPs however, the interview provided the opportunity to challenge the idea that general practice should be a setting for providing 'healthy eating' or other forms of preventive advice. Some GPs appeared to adopt a defensive position from the beginning of the interview, which may have arisen from an assumption that the research had a specific agenda to encourage 'healthy eating advice' provision. The topic-guide had been carefully designed to ensure that this effect was minimised, however it appeared that the very mention of this topic was a matter for contention.

As this following extract typified, while this male GP felt food and eating had a "very important" relationship with health, he positioned GPs on the periphery of 'healthy eating' work because they were only "fire-fighters".

TF: Well to start off with, talking about food and eating issues in general practice, how important is eating to our health do you think?

MARTIN: Well, very important, I think one of the problems that we've got is that we are fire-fighters really, in the situation.

However, these initial accounts contrasted with the views of other GPs, who after acknowledging the importance of diet on health, appeared to assume that general practice *should* be providing 'healthy eating advice'. Contrary to many of their colleagues, they talked in more detail about how "many conditions are related to nutrition" (Robin) or that "if you do not eat healthily or sensibly then you can really deteriorate" (Michelle). As this following example revealed, the links between food and health were therefore felt to be "central" to "maintaining" and "achieving" health. This was symbolically complemented by this respondent actually taking an antioxidant pill in front of me.

TF: What important do you place on eating and diet in relation to health?

DAVID: [pause] erm, I'm going to try and not be too long-winded on this Tom. Erm, well I don't know if you get this from a lot of the interviews that you had. I do think that food is central, to not only maintaining health, er or achieving health. If you eat well you feel healthier, and you know along with other advice such as exercise-related advice, these are the central planks of health promotion. I'll just take my antioxidants now [takes a pill].

While it was apparent from a very early stage that GPs had contrasting views on providing 'healthy eating advice' in general practice, I want to now focus upon exploring their respective orientations in more detail. Each orientation will be taken in turn to identify how GPs constructed two contrasting 'models' of prevention in general practice.

10.2.1 At the core: a preventive-orientation

Approximately half, and mainly the younger and female GPs felt that prevention was a "major part" of general practice work (Michelle). This section will therefore focus specifically upon the GPs who appeared to be orientated towards a preventive 'model'. One of the key ways that these GPs talked about the role of prevention in general practice, was to construct it as being an "integral" part of primary care and that it was at the "core" of general practice work.

JANET: Well I think it's an integral part of primary care and health promotion work, most definitely. I think it's a core...

For other GPs who appeared to be orientated towards a preventive 'model', such general views on prevention were complemented by the more specific idea that 'healthy eating'-related problems themselves were a further key responsibility. As was typical of these accounts, there was often a view that general practice was not necessarily doing as much as it could do in certain areas of prevention and this was just one challenge they should be addressing:

TF: So how do you see talking to patients about food and eating as part of your role?

KAREN: I think it's a big part of our problems, people who are overweight certainly, again recent reports on diabetes linking it with obesity.

However, this male GP went further than most in terms of his enthusiasm towards prevention and talked about how he had a "fairly aggressive health promotion policy in the practice". He went on explain why he was able to adopt such a policy, which he related to having a practice population biased towards younger patients:

DAVID: Well we have a fairly aggressive health promotion policy in the practice, partly, because. Well mainly because we've got a younger population, and er we don't see a lot of chronic disease so we do have the time to commit to active health promotion.

It was also very noticeable that GPs were orientating themselves towards a preventive 'model' by distancing themselves from the way that other GPs or practices approached this area of work. As the GP above continued to argue, the way his practice approached health promotion, contrasted with others, because "we actually probably will go further than most with health promotion" (David).

Similar sentiments were also expressed in the following quotation from a female GP. Here however, I followed up a previous comment about her enthusiasm for preventive work and she appeared to distance herself from the suggestion that this area was not part of a GP's job:

TF Yeah, I mean some people say that reinforcing these messages is just not a GP's job, you know, saying: just repeating what you can get elsewhere is not a GP's job?

JANET: Well you're not going to get me agreeing with that.

TF Right, and why would you disagree?

JANET: Why, because I very much feel that maintaining health is part of our role.

On several occasions, the recognition of a contrasting approach towards prevention was explained as being a result of gender. In the majority of these accounts, female GPs focused upon different approaches that some male GPs took towards 'healthy eating' work. However I will be discussing these in more detail in *Chapter 11*. Nevertheless, one female GP did talk about how "male partners" tend to be orientated towards treating illness, rather than prevention:

MICHELLE: I'm maybe being a bit mean to some male partners, but they tend to react more as I say to illness and er try and do less preventive work.

Complementing such views, many of the male and female GPs who appeared to be orientated towards a preventive 'model', felt that providing 'healthy eating advice' was important as part of a wider approach to other areas of health promotion and that it should not be taken in isolation. 'Healthy eating advice' was therefore "just one facet of an approach to a healthy lifestyle" (David), or "part of a package" which implied that these GPs were constructing a holistic 'model' of health care. Indeed, it also provides an

explanation as to why GPs often talked more generally about prevention, even though the questions focused upon 'healthy eating advice':

LAURA: I think that there is a huge role for diet in general practice in lots of ways, and health promotion. I think it is all part of a package, if people are trying to get healthy, you have to look at the whole lot, and diet you know...

I was also keen to try and understand the meaning that these GPs were attaching to this preventive 'model' of general practice and why orientating themselves in this way appeared to be important to them.

One reason for the enthusiasm which they expressed towards prevention, appeared to be grounded in a desire to see less ill health. One female GP commented that she would "much rather not see the disease in the first place" (Janet) or for this female GP, she made a similar point that taking a preventive approach was sensible, because she would have to confront less disease in the future:

MICHELLE:...and because if we don't prevent disease developing then we are picking up the other end, and you see the amount of misery in ischemic heart disease and various other illnesses... I always give diet advice with exercise advice, because taken in isolation it is very difficult. I just feel if people are trying to eat healthily then they should be trying to live a bit more healthily as well.

A further way that these GPs expressed enthusiasm towards prevention, was by talking about the importance of "making the time" (Karen) to talk about preventive work or 'healthy eating' more specifically. Many of the GPs who appeared to be orientated towards a clinical 'model' of general practice (see following theme) also talked about the pressures on consultation times. The emphasis here however, was that this was something that you had to work at and overcome, especially to respond to patients' needs:

LAURA: I think it depends on how willing you are to spend the time when they do ask you it.

Indeed, related to this concept of 'time', was the idea that 'time' was holding GPs back from undertaking preventive work and as a result they were not able to provide as much of this advice as they would like. While this view differed from the concept of making time I identified above, this still implied that these GPs viewed prevention positively. However, the difference was that they spoke of how structural constraints were holding them back from their ideal 'model' of general practice.

ROBIN: I like talking about food but I don't have much time to. That's the main barrier, and I would talk much more about it if I had more time.

Finally, a further way that these GPs constructed a preventive 'model' of general practice was to talk about how prevention was likely to become a more important part of their role in the future. Some GPs therefore conceived a progression to this type of work as being an inevitable one and again expressed a concern that general practice was being held back from where they really wanted it to be.

PAULINE:...Hopefully preventive work is going to become a bigger part of our set-up. Hopefully in years to come we will become healthier as a population and therefore prevention will become a bigger part of what we have to do. I think that it is important.

Running throughout these preventively-orientated accounts therefore, was a particular representation of general practice, where 'healthy eating advice' was seen to be an important and holistic part of health care. While these GPs expressed personal enthusiasm towards preventive work, their accounts were only sometimes based on their own personal involvement and were commonly centred upon the role of general practice more generally. Additionally, although they often described the way that they or their practice approached health promotion it was also apparent, that on a more abstract level, they were talking about how general practice *should* be orientated towards a preventive 'model'.

10.2.2 At the periphery: a clinical-orientation

In this theme, I want to look more closely at the views of the older and male GPs who appeared to construct a contrasting and clinical representation of general practice. While they did not appear to dismiss a role for prevention in general practice altogether, their accounts centred around how they felt it should be on the periphery of their own personal role. This is an important distinction to emphasise, because these GPs' accounts were centred upon legitimating their own distance from preventive work and the practical difficulties of providing this type of advice. As I discussed in the previous theme, GPs who were orientated towards a preventive 'model' talked more about the role of general practice more generally.

It was apparent therefore, that for many GPs, preventive work was not seen as being a core or integral part of their role. Contrary to such suggestions by some of their colleagues, they talked instead about how they tried to reinforce advice when "relevant" (Barbara). Or similarly, they emphasised how they were too busy with other work and would only talk about prevention if they got a "chance":

MARTIN: Yep, I think it's part of my job, you know to encourage breast feeding. It's part of my job to encourage people before they become pregnant, to think about their food intake and how

healthy they are. Whether they are giving up things like smoking… So you know if I get a chance then I'll put over my views,

Indeed, in this following example, the suggestion that prevention was a peripheral part of these GPs' role was made more explicit. Hence prevention was something that this male GP bolted on to consultations as an "addendum".

LEONARD:…Talking about food, diet and eating is something that you do in the course of the consultation… you are left with a few postscript minutes to say what about you weight, what are you eating and concentrating on that area is very much a little addendum.

Explaining why prevention was not an integral part of their role, many GPs appeared to justify their approach by talking about how they were being expected to ūndertake preventive work. Such accounts often very clearly stated that they were challenging what was expected of them, because the majority of their role was directed towards the "treatment of illness". Here for example, this male GP challenges the idea of being expected to provide preventive advice, implied by his view that he was going against the "politically correct" preventive paradigm:

EDWARD: Well I think in practice, and this isn't very politically correct to say so, I think most of your role as a GP is the treatment of illness…

Similarly in this following example, this female GP also challenges the idea that the government were expecting GPs to undertake preventive work. Unlike the GP above, she talked more specifically about *who* was expecting GPs to provide preventive advice. She also captured the sentiments of several colleagues who felt that preventive work was being forced upon them and was not what some GPs described as a "medical scenario" (Liz). Therefore, prevention was an additional task to add to their core role, which was constructed as the treatment of illness:

BARBARA: The government seem to expect us to do health education and assess whether they are being physically and sexually abused, and everything else as well.

GPs who appeared to be orientated towards a clinical 'model' of general practice also commented upon the magnitude of the task that they faced. These GPs talked about how preventive work was far too big a problem for them to undertake or make an impact upon (and which one GP (Martin) who was quoted earlier referred to as being like a "fire-fighter"). Again, this revealed a noticeable contrast in the way that preventive work was being constructed and for this GP below, it should not therefore be a core part of his role. This was because he felt that GPs can "take too much" on their "shoulders" and he was only able to scratch the surface of the problem.

EDWARD: I think we can try and take too much on our shoulders as GPs if you like in responsibility for health matters, by saying we should be thinking about positive health.

Several of the GPs who appeared to be orientated towards a more clinical 'model' of general practice, argued why *they* in particular should be responsible for preventive work. Again, such accounts were based on the premise that diet was an important health issue, but they questioned whether the GP was "necessarily the best person" (Liz) to be providing 'healthy eating advice':

GILLIAN: I think it's an area of health promotion that we should be looking at. I'm not sure if it's necessary for it to be done by a doctor.

Furthermore, these clinically-orientated GPs also questioned their own role in relation to other professionals outside of general practice, whom they also believed had a responsibility for prevention and especially 'healthy eating'. This was felt to be an issue which should be addressed by the "politicians and not the individual GPs" (Martin) and in this particular example, this was a wider issue for "society" and other professionals such as "school-teacher[s]":

EDWARD: It is something which needs to be tackled by society, by schools, by positive intervention in many ways. Healthy living centres, all these things. I think everyone should be promoting positive health, including eating... But I get back to, well - all you questions have a sort of basic premise in them, which I challenge. Does the school-teacher say what are you eating? Why should I?

Like the preventively-orientated GPs, these GPs also recognised that they were talking about a different approach to general practice and which was in contrast to some of their colleagues. However, they evaluated the possibility of a different approach as being an acceptable feature of general practice, because of the idea that different interests can be accommodated in their profession.

MARTIN: Again, I suppose you are a product of your background and your training and who you have met, and who has impressed you. What do you observe as you go about your work.

Although within the idea that 'different interests' could be accommodated, the older male GPs also recognised that factors such as age or gender could influence how GPs practised. Interestingly, while such examples revealed how different approaches were felt to be inevitable in general practice, they also seemed to serve a secondary distancing purpose. So by acknowledging that "younger partners" may be "more into" prevention, these male GPs were able to legitimate their personal distance.

GRAHAM: Younger partners… may be more into it than I will be.

Some older male GPs who appeared to be orientated towards a clinical 'model' of general practice, also talked about how gender influenced the way that that female colleagues approached their professional work. Again, matters relating more specifically to 'healthy eating advice' will be discussed in the following chapter, but such accounts also represented another form of distancing. 'Social problems' were constructed as being within the realm of personal interest, rather than a legitimate concern for them personally. In the following example, this was explained in terms of how "some female GPs want to get very heavily into psychosocial problems":

LEONARD: Urm, well I think you know you will get some female GPs who want to get very heavily into psychosocial problems, and see their vocation in life as sorting out people's domestic difficulties, and they are people who in another world might have been social workers, or psychiatrists.

Another interesting contrast to the GPs who appeared to orientate themselves towards a more preventive 'model' of general practice, was the way that these GPs talked about 'time'. They appeared to use the concept of 'time' to support their view that 'healthy eating advice', or preventive work more generally should be on the periphery of their personal role. In this example, a lack of 'time' was used as a way of supporting their view that dietary advice should not be part of their core work. Therefore it was not a matter of wanting more time to undertake such work, but rather a reason to explain why it was not a priority.

LIZ: I don't feel I have the time… Erm, yes. Well. I think it is important. We do it a well woman clinic though, depending on how busy you are. We do give some advice about diet, we ask about diet.

These clinically-orientated GPs also talked about how preventive work was biomedically disruptive and was therefore inconvenient to their core role of treating illness. One GP felt that prevention could "take over our entire lives… and not leave us any time to see anyone that wasn't well" (Gillian). Additionally in this particular example, Edward felt that the "here and now" was deemed to be more important:

EDWARD: Okay, I mop up the bits when things go wrong so I suppose I have a vested interest in doing something about that. The more time I have on dealing with positive interventions, the less time I can deal with problems which are here and now.

Finally, and related to such views, was the notion that preventive work was unrewarding and boring. One GP below commented about how doctors are not really suited to such work because they "get bored" or as this second GP commented, "it tends to be a rather thankless task":

LEONARD: I mean doctors are far better at troubleshooting than they are at doing routine screening. We get bored.

LIZ: Erm, it tends to be a rather thankless task often.

Unlike the preventively-orientated GPs, these GPs' accounts of prevention in general practice centred upon their own personal involvement. Rather than talk about a role for general practice more generally, however, they orientated themselves towards an alternative clinical 'model', by talking about the practical difficulties of providing preventive advice in their consultations. Nevertheless, while they may have talked more about the practicalities of this type of work and their own personal involvement, they also appeared to be contributing towards a theoretical debate about the role of prevention in general practice.

10.2.3 Summary

Comparing these two contrasting views of prevention suggests that GPs were accounting for 'healthy eating advice' in terms of two contrasting 'representational models' of prevention in general practice. It was apparent that while GPs from either orientation sometimes mentioned the practical difficulties associated with prevention, their accounts were on the whole representations of general practice, or abstractions of how they thought it should be. Yet on a different analytical level, it could also be argued that because they were consciously aware that they were taking a particular approach and also one which contrasted with some of their colleagues', GPs were drawing upon two contrasting discourses about the role of prevention in general practice.

There was a meaningful contrast however, between the ways that GPs from either orientation were constructing these 'models'. Those who were orientated towards a preventive 'model' talked about the role of general practice/primary care more generally, while the clinically-orientated GPs talked more about their own personal involvement. There was also a meaningful association between these different 'models' and the GPs' age and gender. Hence I found that the younger and female GPs were orientated towards a preventive 'model', while their other older and male colleagues were orientated towards the alternative clinical one. Furthermore on some occasions, GPs did talk about these age and gender differences to legitimate their own approach and distance themselves from the other.

10.3 Operationalising

Although practical difficulties were mentioned in accounts of either orientation, I have so far argued that GPs appear to draw upon different 'models' to justify why general practice

should concentrate on treating illness, or alternatively, a need to overcome a number of problems so that a preventive 'model' could be fully realised. In this section, I want to explore the subtle contrast between the representational and operational content of the GPs' interviews. While their representational accounts appeared to mainly consist of ideas about how general practice *should* be, it was also possible to identify how these ideas were influencing the ways they were talking about the day to day management and practicalities of 'healthy eating' work.

As I mentioned at the beginning of this chapter, it would be inappropriate to suggest that when GPs were talking about the practicalities of providing preventive advice, they were actually revealing an accurate picture of their clinical experiences. However, in this section, I will argue that although there were some differences between these two levels of accounting, there was also a meaningful relationship between them.

10.3.1 Delegation

For the GPs who were clinically-orientated, the necessity for 'healthy eating' work to be undertaken by someone else appeared to be paramount. I also found that for many of the GPs who were preventively-orientated, they too spoke about the necessity of delegating this type of work. However, while this may provide an example of how their representations of prevention may be practically different from the way that they 'operationalise' them, there still appeared to a meaningful contrast in the way that they spoke about the practical need to delegate.

Most GPs, regardless of their orientations however, did also talk about how 'healthy eating advice' should be practically managed within general practice and primary care itself. The clinically-orientated GPs implied that there was a 'line' which had to be drawn and made delegation necessary because they could not or would not go into 'detail' about diet. These GPs constructed themselves as generalists and talked about how prevention and dietary work was a specialism which they did not have. So in this particular example, the dietician was regarded as being a professional who was best qualified to talk about diet in detail (this theme in the context of food more specifically will be explored in greater detail in *Chapter 11*).

LEONARD:…There's no point telling me this, because I'm not going to do anything with that information. The person that is going to do something with that information is the dietician… but the dietician will tell you how to go about doing it. She has spent five years studying diets, I spent five years studying everything.

Also reflecting the idea I explored earlier that 'healthy eating' work was boring or dull, comments were made by the clinically-orientated GPs about how nurses and health-visitors were better suited to this area. Some of these GPs backed these views up with comments about these colleagues having greater skills or better opportunities for undertaking this work:

GILLIAN: [it could be done by]...a nurse, or a health visitor. I mean if there's young children in the family, then the Health Visitor's got the perfect way in to discuss diet for the whole family.

Similarly in this second more direct example, this view was made more explicit, because this male GP talked about how doctors were not suited to "screening" work, implying that health visitors were better dealing with mundane or routine tasks:

LEONARD: The health visitors are far better at taking time to repeat the same message to lots of their patients ad infinitum.. I don't think doctors are very good at screening, it's not how their brains work.

Nevertheless, when talking about delegating 'healthy eating' work, there was a common view in either orientation that it had to be delegated. This therefore provided an example of how some 'operational' accounts were less polarised than 'representational' views of prevention in general practice. Thus, some of the GPs who were clinically-orientated talked about starting the process of dietary counselling and then sent someone to the nurse when they felt they needed regular follow up treatment.

GRAHAM: If I get someone going in the right direction I would involve Stella who is the practice nurse, on some sort of regular basis. They need some sort of regular follow-up, just because it encourages them that you are still interested, and that you are getting somewhere. If they are succeeding, and losing. Urm, then seeing them regularly, with reinforcing them whatever it is, keeps them going and you can begin, once they are feeling more positive about it, you can begin to talk about exercise. It's not necessarily a practical proposition, but just to burn up more calories in some sort of way.

Similarly with preventively-orientated GPs, it appeared that they too also felt it was necessary to delegate more detailed 'healthy eating advice'. However, the subtle contrast was revealed by how again, they talked about not having the amount of time they would like to undertake such work:

TF: How do you feel about it taking a back seat then?

ROBIN: Well I think we are probably aware of that and are trying to address it, a little bit in terms of having other health care workers being able to spend more time with patients talking to them about diet and nutrition, other than their GPs. And that's

certainly what happens here, our practice nurses and other staff are increasingly you know, patients are increasingly seeing other primary care staff about their nutritional state.

There was also a contrast in the way that the preventively-orientated GPs talked about the role of other members of the general practice team. Rather than passing on work which was considered to be dull and boring, as this next female GP typified, the whole practice team was said to share her enthusiasm towards prevention:

LAURA: All the team know what I feel about things, and most of the team are quite into it as well. So you are building up a team that are involved with it.

Finally, on the same point, some of the preventively-orientated GPs talked about how preventive work should be shared. So while these GPs may still have been delegating it, this was constructed as being a process of "reinforcement" with colleagues (David), while in the example below, this was presented as a "consensus" approach "to healthy living".

MICHELLE: We have a dietician who works with the practice. We have a couple of good practice nurses. I suppose, yes just a general attitude to healthy living, this is a good general consensus. We don't have any partners who aren't aware of the benefits for example.

In this theme, I have concentrated upon identifying the subtle contrasts in the way that GPs talked about the practicalities of providing 'healthy eating advice'. In the earlier themes in this chapter, I argued that the preventively-orientated GPs talked about prevention in general practice more generally, while the clinically-orientated GPs spoke about their own personal role. However, unlike these representational accounts and regardless of orientation, this theme focussed upon how all the GPs spoke about the their own personal level of involvement and the role of other members of the general practice/primary care team in providing 'healthy eating advice'. Nevertheless, although there appeared to be a need to delegate this type of work, the way it was constructed still appeared to be influenced by the GPs' respective orientations to different 'representational models' of general practice.

10.3.2 Constructing prevention

In this final theme, I want to continue exploring the subtle differences and relationship between the construction of 'representational' and 'operational'/practical accounts of prevention. Here however, I will focus upon the relationship between these two levels of accounting and what 'prevention' appeared to mean to them.

Consistently across both orientations, GPs talked about how in practice 'healthy eating advice' was usually targeted at patients where they could see that there was something

wrong (such as being overweight) and that they therefore tended to neglect non-visible ailments. So some said that "it would be much less common for me to make positive intervention if someone was the correct weight" (Graham) and that this tended to be a trigger for discussing 'healthy eating':

TF: Right, you talked about focusing on weight?

MICHELLE: Yes, that tends to be a trigger for me discussing it, we do have a lot of patients who are you know, have a high BMI, and are I quite often record height and weight and eventually work out BMI if I need to. Erm, so yes I tend to look at obesity as a fairly large factor and urm give them advice on the type of food to eat.

Linked to this point, a further common distinction made about the type of preventive advice provided concerned population-based approaches. GPs felt that there was a strong need to target advice, hence GPs were regarded as having little "impact on the state of nutrition for the majority of the population" (Laura), which necessitated a different approach altogether.

GILLIAN: I think health promotion in theory is very good, in practice, works reasonably well for targeted areas but I think you've got to be: you've got to be quite focused about it, or else you just end up giving out general information that people know already and that's not useful, they come to you for more, not just for more of the same.

Perhaps reflecting how their concerns translated into practice, the clinically-orientated GPs often explicitly presented the type of preventive work they were undertaking as secondary prevention. Advice was said to be centred upon patients with specific diseases and illnesses, such as diabetes, or it often came to late because it was provided "after the horse has bolted":

BARBARA: I suppose we almost do it after the horse has bolted, or whatever. Erm, I suppose we do it where, or if they've got high cholesterol or if they are overweight that sort of thing.

GPs who were preventively-orientated also talked about targeting advice to specific groups, but they appeared to differ in terms of what they appeared to mean by 'specific'. The key difference was that they talked about a more extensive range of diet-related illnesses. These included a range of illnesses and diseases such as alcoholism, lactose intolerance, or colic. Indeed as this example appeared to imply, there were many issues which could be encountered, if you were prepared to look for them:

TF: You said that it's something you get quite a lot of, being asked about advice, could you give me some examples of the sorts of things?

DAVID: Advice on diet? Well this morning I had, well a dietary referral for irritable bowel syndrome, and gave an advice sheet on that. Erm, last night, the last patient last night was newly pregnant and taking advice on folic acid supplement, and other dietary advice that you would give to a pregnant woman in the early pregnancy. Yesterday, a question about finding a contraceptive pill that did not contain lactose as an excipient, because of someone who had an extreme lactose intolerance. And there probably isn't one. It's something you wouldn't really think of when you are thinking of diet.

Such accounts help to suggest that whilst GPs may had different views on what constituted their understanding of 'healthy eating advice', that what they may actually be providing was to some extent focused on the treatment of diet-related illnesses. Furthermore, whether they explicitly stated it or not, their preventive role also appeared to be more typical of secondary prevention because of the types of opportunities they were identifying. However, like the way they talked about delegating 'healthy eating' work, there still appeared to be a subtle contrast between how these GPs talked about the range and types of 'healthy eating advice that they said they were providing.

10.4 Chapter summary

I began this chapter by exploring a very noticeable contrast between the way that GPs talked about the role of prevention in general practice. Although I had asked them to focus on the provision of 'healthy eating advice', it was apparent that their accounts were often based on views towards preventive work more generally. While GPs may have spoken about the practicalities of preventive work, these accounts appeared to be representations, because they were constructed to support different theoretical orientations towards a debate about prevention in general practice.

I made the point that while there was a distinctive polarisation between two different representations of general practice they all constructed, the way they talked about providing advice was often less polarised and the differences were more subtle. On this basis, it may be possible to suggest that their 'representational models' of general practice show greater polarisation because they were abstractions. So while the GPs I interviewed did talk about encountering many of the same practical difficulties, their different orientations appear to have some influence upon the way they talked about managing these on a day do day basis.

I suggested in this chapter, that GPs different orientations towards either a clinical or preventive 'model' of general practice were associated with their age and gender. I also identified several accounts which revealed that GPs were aware of these factors, and used them to account for their respective orientations. However in the following chapter, I will

continue to explore the influence of age and gender on the way that GPs talked about, and evaluated work involving food and eating.

11 Constructing professional roles

11.1 Introduction

Staying with the idea of 'representational' and 'operational models', this final analysis chapter continues to explore GPs' contrasting views on the provision of 'healthy eating advice'. Unlike the previous chapter, I will be focusing more specifically upon preventive work involving food and eating and explore how GPs legitimated their personal involvement and distance in this area of prevention.

The chapter will continue to argue that there was a relationship between these different levels of accounting, by exploring how GPs' different representations of general practice appeared to influence how they evaluated 'healthy eating' work. As identified in the previous chapter, I will also continue to develop the association between age and gender on GPs' respective orientations towards either a preventive or clinical 'model'.

However, underpinning the ways that GPs legitimated these 'models' were contrasting accounts of their professional 'expertise' in this area. Mirroring the format of the previous chapter, I will begin by discussing how their accounts were constructed in the abstract form and then develop the analysis on a different level, by considering the subtle ways that these representational accounts appear to be operationalised.

11.2 Constructing professional 'expertise'

Irrespective of the GPs orientation, they all spoke of how 'healthy eating advice' was not a topic they had been taught at medical school. In contrast to much of their 'professional' knowledge, they thought that it was either 'lay' knowledge or was a particular specialism of other professionals such as dieticians or health visitors. Before exploring how GPs evaluated their experiences of work involving food and eating in *Section 11.3*, this section explores the contrasting ways that they used the concept of 'expertise' to legitimate their personal involvement or distance in the area of 'healthy eating advice'.

11.2.1 Drawing a line

The analysis in this theme concentrates on the views of the older and male GPs. These were the GPs who, in the last chapter, were associated with a clinical 'model' of general practice

and felt that prevention was a peripheral part of their role. The key point which arises from these GPs' accounts on 'healthy eating' more specifically however, is that they felt they were not qualified to talk about food and eating with their patients. Therefore, because they said they had not been trained in this area, they explained that this was a legitimate reason for not providing advice:

GILLIAN: I think the one thing that probably, not inhibits, but I don't see it as a particular area of expertise. We weren't taught anything about that at Medical School. I don't really know any more about diet than anybody else. I mean I think we can give a very basic level of advice and information, but I don't think we're specialists in the area, at all.

Professional 'expertise' was a key theme in their accounts of 'healthy eating advice', because many GPs felt that detailed food and eating discussions were out of their remit because they were not 'experts' in this area. Some of these GPs did, however, talk about how they could only deal with very simple issues and perhaps provide a diet sheet where applicable.

TF: You also said a little about expertise as well.

LIZ: I suppose yeah, I can look at somebody's diet and say, yeah you're eating too much of that or not enough of that. Actually quantifying it and giving them advice. I mean simple things like diet sheets.

Similarly, other clinically-orientated GPs also talked about how patients expected them to be 'experts' in everything and again, while they may be able to deal with certain dietary issues, there were other issues which they did not feel they had the detailed 'expertise' to provide:

BARBARA:...they think we know absolutely everything about food and what everything contains, and what balance it should have. The relevance of all the trace elements, and everything.

TF: You don't?

BARBARA: I don't know where you can find manganese and all the relevant trace elements.

These accounts commonly drew upon the notion that GPs were 'generalists'. So these GPs talked about how it was important to recognise their limits and not provide advice in an area which they did not "feel very confident about" (Gillian). Indeed for this GP, "A good GP is probably one who knows their limits":

GARETH: If someone wanted to go into specifics, then I'd have to say that's not my field of expertise, I'm giving general guidelines, and if they want more information I'd have to refer on. A good GP is probably one who knows their limits. When it comes to diet, sure I've got a general knowledge, but I am limited in that knowledge.

However, there was also a different notion of 'expertise' in their accounts. This contrasted with their view that 'healthy eating' was a specialism, because they felt that some 'healthy eating advice' was available elsewhere. For this GP, 'healthy eating advice' was generally available in society, because people already "know the things you are [talking about]":

EDWARD:...I think that there's so much knowledge in society, that an awful lot of people know the things you are [talking about].

Furthermore, this view also appeared to be constructed on the premise that 'healthy eating advice' was 'lay' knowledge. Again, although this concern was centred upon the concept of 'expertise', GPs talked negatively about providing some types of dietary advice, because they felt the public probably knew as much as they did, implying that they had no authority in this area:

GILLIAN: I don't think I'm qualified to give dietary advice more than any member of the public, in many ways. I mean to specific groups of people, yes, as in your diabetics and your pregnant people and all the rest of it, these are people we've been given very targeted information on, with regards to what they eat... But in terms of the general public, they probably know just as much from reading their magazines as we do on the whole.

Similarly in the following quotation, concerns about authority and 'expertise' became more explicit, because this GP acknowledged that she did not want her patients to know more than she does.

TF: And do you feel whether or not you have the necessary skills to reinforce 'healthy eating advice'?

BARBARA: I think in general principles, yes. In as much as probably I don't necessarily want a patient to understand any more about it than I do.

TF: You don't want?

BARBARA: Well, I mean initially if you are teaching - I don't expect them to have much more information than I do personally, therefore presumably anything which I know is okay, therefore.

As I mentioned in the previous chapter, some older male GPs talked about prevention being a female interest. There was also an interesting gendered influence on the way that GPs constructed 'expertise' in relation to 'healthy eating' work. These older male GPs also argued that talking about food and eating was something that they did not know about because they were men. Thus for one older male GP, he said that he did not have a "clue" about cooking, because his wife did it:

EDWARD: So you're saying it's dead easy to whip up a lentil broth you know. How do you do it doctor (laugh), I haven't a clue (laugh)! You know, ha ha my wife does it (laugh).

Get your wife to do it (laugh), I am the wife!

Similarly in the following example, this older male GP also felt that because he did not have sufficient knowledge of cooking, then he did not know enough to advise people about 'healthy eating'.

LEONARD: I live about a mile from here, between N[removed] and R[removed], my wife she does our tea. I'm perfectly capable of not starving, I can use the microwave and I do, I can cook to a certain extent, but I don't know enough about cooking to advise other people.

This last example however, was linked to a further explanation of why food and eating work was not professionally prioritised. While he had already talked about how women were more qualified to talk about 'healthy eating', he also then implied that he felt this type of work had very little status. This following account appeared to be masculinised, because troubleshooting the practice computer system was presented a being a greater priority than with what was "going wrong diet wise":

LEONARD:...I have got far more other things to do, like learning my way round how to use a network in the surgery, and how to troubleshoot when the secretary comes to me and can't get some printer to print out properly. Or like two days ago, our internet connection crashed and I had to work out why it had, and erm, I have to admit that I find that more interesting than telling the 'nth' overweight patient where they are going wrong diet-wise. I can tell them they are going wrong diet-wise.

In this theme, I have explored how many older GPs talked about how they were not qualified to provide 'healthy eating advice'. By unpacking what they meant by 'expertise', it is possible to suggest that its definition was two-fold. Firstly, because they saw themselves as 'generalists', there was a concern about providing advice which should be provided by a specialist. The second concept was more negative and also more gendered, as these GPs felt that because some 'healthy eating advice' could be obtained elsewhere, this was an area that they had no particular authority over.

11.2.2 Personal experiences

This theme concentrates on exploring the accounts of the preventively-orientated GPs. Despite also agreeing that they had received no formal training in dietary advice at medical school, by contrast these younger and female GPs spoke of how they were qualified to talk about some forms of 'healthy eating' with their patients. I argued in the previous theme that one of the reasons older and male GPs put forward for not being personally involved in this area, was that food and eating was 'lay' knowledge or too specialised for them to provide.

This theme however, explores how 'personal' experiences of 'healthy eating' *were* felt to be a form of professional 'expertise'.

It was the female GPs who were orientated towards a preventive 'model' of general practice, who talked most about how their knowledge of 'healthy eating' had not been "accrued through... medical training" but "through... life experiences" (Janet). Indeed as the following older female GP typified, providing 'healthy eating advice' was not a matter of needing any special training, but it was "just a basic common knowledge that everyone should have". Like many other preventively-orientated GPs, she spoke positively about how the lack of formal training at medical school was not an issue, because 'healthy eating' was "common-sense" anyway.

PAULINE:...I don't have any special training, it's just a basic common knowledge that everyone should have anyway. I wouldn't say that I have that much greater knowledge than a lot of patients... I don't think that's gleamed from being a doctor, it's from common-sense...

When I talked to these GPs about the sources their 'healthy eating' knowledge had originated from, they continued to construct it as 'lay' knowledge by talking about their "personal experiences". In addition to some medical sources, these included the radio, television or magazines:

MICHELLE: I suppose bits and bobs of what I read in the GP rags, urm, occasionally I'll pick up bits from the BMJ, but there is not a lot in that. Er, own personal experience, and just an idea that er things like isachemic heart disease and diabetes are very largely related to diet and therefore you know things you hear on the radio...I don't really know where my bulk of knowledge comes from, certainly not from training. I listen to "Woman's Hour" occasionally (laugh) and er you know it's just from a lot of different sources and basically I think that a lot of it boils down to common-sense, erm as to what you should try and bulk your diet out with...

Implicit within the notion of 'personal experiences', was the idea that presenting one's 'self' within the consultation was acceptable. That is, these female GPs talked about how they felt that they could talk about their own health behaviour as way of facilitating discussions of 'healthy eating'. Here for example, this female GP talked about how her 'healthy' image added credibility to her advice, yet at the same time was complemented by a sense of humility:

PAULINE: I think that the majority of patients do respect what we say and think that we do tell them sensible things, whether they act on it and the other variables that come in. A lot of people, I mean I've been in the practice now for 15 years. I've done a lot of running. Years ago I was very competitive. A lot of patients

know that I am a runner and they assume that I have a healthy diet. It's maybe not. If they have ever seen my buggy in Sainsbury's, they may think differently… I think that it is easier to say well take a bit of exercise and erm try and lose some weight if you are somebody who does take exercise, and isn't overweight and doesn't smoke.

Similarly, this female GP talked about how she brought in experiences of her own diets into the consultation. This was again presented as being acceptable and by including her 'self' in the consultation, she also suggested that her advice will sound more credible:

KAREN: I consider myself a reasonable expert in a range of diets because I've tried a few and there are certain ones that I would recommend, they are actually ones from the slimming magazine, which are either the greatest amount of calories which is very good if you want to count up to a 1000, or fat units, which is where you count the fat units and you can do it very easily with pre-prepared food. And I usually say to them most of us have the same problem, myself included. I say that we take in too much food for our body and that's why we put on weight.

While it was possible to ascertain that it was the female GPs who were accounting for 'healthy eating advice' in this way, they also spontaneously offered gendered explanations for why they felt they took a more positive approach towards 'healthy eating advice'. This suggests that these female GPs were drawing positively upon their gender to explain why they did have the 'expertise' to talk about food and eating. Indeed, it also draws upon the same gendered concept that I identified in the previous theme, where some of the older male GPs constructed 'healthy eating' as 'women's knowledge'.

Several female GP for example talked about how they were a 'mum' (Michelle), which therefore gave them 'expertise' in this area. Yet for this female GP, being "maternalistic" appeared to suggest that she was constructing herself as caring for her patients, like a mother or a wife might do for her family:

JANET: Probably more, because I'm maternalistic. Well I'm a wife and mother as well as a GP and I know I've always used food as a comforter with my kids when they were wee. You know, "Oh dear, you've scraped your knee, lets give you a sweetie", I still: I mean I went to see a drug addict the other day and they… and I found myself saying to them, and they seem to accept this advice "You need a good square meal".

While the male GPs who were orientated towards a preventive 'model' of general practice did not distance themselves from talking about food and diet, there were notable contrasts in their accounts. However, some for example still talked about bringing "personal experience[s]" into consultations:

TF: What influences your professional approach?

DAVID: Erm, a number of factors, personal experience. Not personal medical experience, but personal experience, what I perceive from sources outwith the surgery, what I pick up in the news and then all the various sources of information through medical journals, articles, reviews. Erm, information from colleagues.

Yet male GPs who leant towards this preventive-orientation appeared in general to talk more about the effect this had on their practice style, rather than constructing their 'self' within the consultation. So as this male GP typified, his knowledge of various diets was constructed as helping him to inform people, especially if "they are misinformed about their attitudes".

ROBIN:...So, I am quite interested in nutrition, just because of my experience. You know, and the range of diets that I've had and the range of people that I have lived with over the years. So I just find it quite interesting and erm find that I feel as though I can usefully inform people a little bit about diet and perhaps, er well inform people if they are misinformed about their attitudes.

Unlike the clinically-orientated GPs, these GPs did not distance themselves from 'healthy eating' work completely. While it can be assumed that from the accounts presented in the previous chapter that they may have delegated some 'healthy eating' work, these GPs legitimated their personal involvement by constructing 'lay' or 'personal' knowledge of food and eating as a form of professional 'expertise'. However there was still a meaningful contrast between the accounts of preventively-orientated male and female GPs, because the female GPs talked more about bringing their own 'self' into the consultation.

11.2.3 Summary

Shedding light on the theme of 'Delegation' in the previous chapter, this section explored the relationship between GPs different 'representational models' of general practice and how they legitimated their involvement or distance in 'healthy eating' work by drawing upon their understandings of 'expertise'. While there was also a gendered difference within each theme, there was also a meaningful contrast in the relationship between these accounts and the GPs' age and gender more generally. In summary, it is therefore possible to suggest that it was the older and male GPs who expressed the greatest concerns about 'healthy eating' work, and some of the preventively-orientated female GPs who were the most enthusiastic. Nevertheless, as I argued in the previous chapter, these accounts also appeared to be representations, because GPs did not directly talk about the practicalities of talking to patients about food and eating. Hence in the following section, I will concentrate upon exploring how GPs legitimated their involvement and distance, by talking about their actual experiences of providing 'healthy eating advice'.

11.3 Evaluating experiences

In this theme, I will focus upon how GPs different orientations towards preventive work also appeared to influence how they talked about educating patients to change their diets and the effects this had on the doctor-patient relationship. While there was generally some consensus that better education would help to improve 'unhealthy eating', the way that GPs legitimated their own involvement and distance was constructed as the ability to be professionally effective in this area.

Changing the 'Scottish diet': Culture and education

Before exploring the relationship between GPs accounts of providing 'healthy eating advice' and their respective orientations, this brief theme considers how there was general agreement that cultural factors caused poor diets. Therefore similarly to the lay interviews, I asked GPs about the 'Scottish diet' and what they thought the term meant. While there was a similar view that the unhealthy Scot was a stereotype, most GPs did feel that Scotland had a much poorer diet than other countries, which resulted in higher rates of heart disease, stroke and cancer:

TF: Why is there so much talk about the Scottish diet?

EDWARD: Well (laughs) because it's a pretty bad. I mean Scotland has bad stats, for heart disease, and although diet isn't perhaps all of it.

Furthermore, when explaining why the Scottish diet was 'poor', GPs commonly felt that this was because of working class culture and a remnant of the days when people had more demanding manual jobs. By implication, GPs were therefore talking about how 'unhealthy eating' was synonymous with social class and simultaneously appeared to be distancing themselves from the idea that they themselves ate such a diet. Indeed, this suggests a very similar process was occurring to the one I also identified in *Chapter 8* for lay respondents.

TF And there's a lot of talk about the Scottish diet, what are your views?

JANET: Chips with everything. I mean it's: it's very much a social class thing. But you know indigenous sort of Lothian-belt working class people do seem to have the culture of pretty appalling stuff.

GPs elaborated further in their explanations of why they thought many of their patients were eating unhealthily. They put forward a range of social, cultural and economic factors, which they felt were constraining and preventing people from changing their diets. For example, several GPs emphasised that their patients' diets were indicative of certain

'cultural' barriers to eating a 'healthy' diet and caused by a culture of convenience, where it was easier to go and buy a takeaway meal:

GILLIAN: But if you've got easy transport to go out, or if you live somewhere where there are shops on every corner, you're probably more likely to either eat out or else to buy more convenience food that you can nip out, buy a pizza, shove it in the oven there and then, rather than think about what you want to buy for the week, have it in the house and have a sort of almost sequential plan of meals. So I'm sure that does influence culture.

There was an agreement that poor diets were caused by cultural factors and, regardless of their orientations, GPs appeared to universally assume that many of their patients had eating habits similar to the stereotyped 'Scottish diet'. Despite these common shared views however, the following theme will explore how GPs then departed in the ways they talked about their own efficacy in changing the 'Scottish diet'.

11.3.1 Changing diets

Reflecting their different orientations, this theme will explore how there appeared to be a meaningful contrast in the way that GPs talked about their own ability to change what their patients were eating. Although it was commonly felt that 'healthy eating' work was difficult, their respective orientations towards prevention seemed to influence how far they were prepared to go to make a difference and the way that they evaluated the practicalities of providing dietary advice.

Preventive-orientation

For the GPs who were orientated towards a preventive 'model' of general practice, it was generally felt that 'healthy eating advice' was not always well heeded, but that it was a matter of throwing enough mud until it stuck. Similarly for other preventively-orientated GPs, they also felt it was important to open the door to patients and to keep on trying even when it was difficult "to get their message across" (Robin). Such a tenacious attitude appeared to reflect their orientations and enthusiasm more generally, therefore for this GP, even though advice "is not very well-heeded" it was a case of focussing upon the individual and treating everybody as being different.

KAREN: Well I think that dietary advice is not very well-heeded. Erm, I think you can talk until you are blue in the face and not make a huge difference. Erm, I think that has been proven, erm but I think that is still worth a try, everybody is different. Statistics don't treat people as individuals.

However, despite this positive view towards educating patients and an assumption that cultural factors influenced poor diets, only one of the preventively-orientated GPs talked

about how her own social class was a potential barrier to changing her patients' lifestyles. Here for example, this female GP talked about how if 'you' (implying herself) were 'socially aware' then you could make a difference. Again, this appeared to invoke the rhetoric of a preventive approach to medicine, especially as it implied that some GPs are not aware of the social influences on ill health.

JANET: You see medical people get criticised very much for being a highly select bunch of middle class privileged people, which on the whole they are. And usually with a fairly narrow life experience themselves and who extrapolate, irresponsibly and most subjectively to other people and it's only the more socially aware ones who'll pick this up.

Clinical-orientation

However, I found that the clinically-orientated GPs presented very different accounts about their willingness to try and change what their patients were eating. While I argued in the previous chapter that they felt prevention was too big a task for them to tackle alone, this also appeared to apply to their view that they had very little influence over social and cultural cause of poor health. Constructing himself on the periphery of this problem, this male GP talked about how he was only able to "cosmetically interfere" because he worked in an area of high deprivation. Interestingly, the previous account was also from a GP working in the same practice, suggesting how these particular circumstances were being used to legitimate his personal involvement:

EDWARD: They want that consultation fulfilled, and er we have, we work in an area of high deprivation and therefore we are consulted more frequently, and er we are consulted, well the threshold of concern is very low, so they consult you very early on in the process. We should try and pack into that consultation advice on lifestyle, advice on diet and smoking… In reality, you would need an awful lot of positive intervention to be able to teach people how to cook. So you are really just saying buy more fresh fruit and veg, and eat less of cakes and things. That tends to result in a slightly more expensive diet… So upbringing and expectation comes into it, and then price and convenience and lack of education… And it is very difficult to see your role as a GP in being able to cosmetically interfere with that situation.

This same GP also explicitly said that his own background was a potential handicap. However, he was the only GP who appeared to construct this as a reason not to provide advice:

EDWARD: So there are cultural difficulties I suppose in, well all doctors are by definition middle class people. If you are working in an area where you have high deprivation categories, your own background is potentially a handicap.

However, in these accounts of clinically-orientated GPs, there also appeared to be a sense of helplessness and frustration in not being able to make a difference. GPs talked about how much health advice was a "waste of breath" (Graham) or that they felt they had no way of knowing if they had been successful, because it was hard to ascertain "how many of them have atrocious dietary habits" (Edward).

Yet for many clinically-orientated GPs, their negative views of patient education and dietary change were often anecdotal. They appeared to draw upon these narratives to justify their approach towards prevention. So here for example, the anecdote of there being "no fat people in Belsen", stood to represent that some people are just beyond help and are therefore not worth helping:

TF: Some people say that part of their relationship is that they are lying to themselves, but to you as well?

LEONARD: Well I remember, but I won't quote the consultants name, but I remember as a registrar in hospital, doing an endocrinology clinic, and the consultant I was working with was distinguished, never rude to anybody, very hard working. It was a rather long hot summer afternoon and we had this 'enormous' lady who came in out of desperation to find some reason why she never lost any weight, and of course of all the people I saw in the year that I was there, there were very few people who were overweight that actually had an endocrinological problem, and erm very few indeed. She was going on and on and on. She said she ate half an apple and virtually nothing you know, and the consultant, who as I said was never rude to anybody said that there were no fat people in Belsen... You can take a horse to water but you can't make them drink. You can present the facts, but you can't make people take the advice.

Similarly, this female GP talked anecdotally about how one woman had been given two cookers to try and help her cook better food, but she kept on selling them. Again, this implied a sense of helplessness and which appeared to lead to reservations about providing 'healthy eating advice':

GILLIAN: They don't want to know, I'm afraid. Some people do, but a lot of people don't, they're not interested.

TF There are people who I've spoken to who would very much welcome advice from GPs as well.

GILLIAN: There's a good anecdotal one.I used to cover the Darby schools and there's this lady in Darby who has the most obese child that went to Darby Primary School and Social Work were quite concerned and so were School Health and we looked into it and this boy eats from the chip shop every night cause his mother doesn't have a cooker, so this is absolutely terrible, did a bit more

investigating, she's been provided with two cookers, but she sells the cookers and buys the fish and chips.

In this section I began with exploring how GPs thought that the "Scottish diet" was typified in their patients' diets and explained that this was because of cultural influences. However, despite a general agreement on this point, the way that GPs presented their ability to make a practical difference in this theme appeared again to reflect their different orientations towards preventive work. The preventively-orientated GPs appeared willing to face the practical difficulties of changing their patients' diets, whereas their clinically-orientated colleagues used these difficulties as a reason to distance themselves from this type of work.

11.3.2 Doctor-patient relationships

The final theme of this chapter also explores how GPs drew upon their experiences of providing 'healthy eating advice', but focuses instead upon the ways they talked about their relationship with patients in this area. Despite some similarities in the practical difficulties which they all appeared to face, it was again apparent that their different orientations were subtly reflected in the contrasting ways they evaluated the links between this type of work and the doctor-patient relationship. This theme will explore these issues by identifying a number of small sub-themes, which demonstrate these findings and highlight both the contrasts between each orientation and the gendered differences within them.

Intervening

All GPs, regardless of orientation, suggested that talking to patients about their lifestyles could be a sensitive subject. While I mentioned this practical issue briefly in *Section 10.3.2*, GPs also related it to the effect on the doctor-patient relationship, because they felt it was necessary to 'tread carefully' so as to avoid causing offence when providing 'healthy eating advice'. For many therefore, they felt that it was only possible to intervene when symptoms were present, or patients asked for advice:

GRAHAM: But I would have to confess yes, if somebody walks in, middle, or young middle-aged man, who looked not to be overweight, and not to be significantly underweight, then it is unlikely that I would jump up with dietary questions unless they introduced it… It would need to be precipitated by symptoms that they have, probably rather than me interfering

Similarly, GPs also talked about the need for something to "trigger" advice (Edward), or to make them feel that they were able to intervene with good reasons. Issues such as sore throats for example were not viewed as suitable occasions to provide 'healthy eating advice', and "general" advice was not always possible because something had to "start off the train of giving advice":

MICHELLE:...people won't listen to general dietary advice very readily, unless there is a cause. But yeah, given time constraints I think that it's something that has to start off the train of giving advice I suppose... I would say reinforcing dietary advice when there is no specific cause for it, is a no-no because of time constraints.

However, despite these similarities, there were several key differences in the GPs' accounts, which appeared to be influenced by their respective orientations. Some of the preventively-orientated GPs for example, acknowledged that finding an opportunity to intervene could be difficult, but that this necessitated a degree of tenacity. For this GP therefore, it depended upon how "bolshy" she was feeling at the time:

TF: Would you make that distinction, people where there isn't something specific, and you have to wait for them to ask?

PAULINE: Yeah, I think again that it depends on what sort of mood I am in. If I am feeling bolshy, and I'm going to give them the advice whether they like it or not, or whether I am looking for their leads.

For many of the female GPs who leant towards a preventive-orientation, they suggested that they were able to empathise with their patients, particularly because of the issue I raised earlier concerning 'personal experiences'. Hence one female GP talked about how she was able to offer patients "an empathetic hearing", because of her "maternalistic" approach (Janet). A similar view was expressed in the following account because this female GP said that she could "sympathise" and "empathise" with patients as she herself "had similar problems":

KAREN: And I think that I can sympathise with them. I am not skinny model-like, so when they come in they don't think, oh she doesn't know anything about it, erm and I can empathise with them and say I have had similar problems. This is how I've tackled it, this is what works, and I can say to them, well I understand that you had a bad day, or if you have a bad day, you just want to go out and buy a bar of chocolate, fine.

On a similar theme, this female GP who also leant towards a preventive-orientation, talked about how she could build up a good relationship with her patients because she operated a single-handed practice.

LAURA: Also within the way of knowing them as a single-handed GP you know whether they are single, whether they are working, what their lifestyles are, so you can try and make adaptations there.

Constructing potential

However, one of the more notable themes, was that both the male and female GPs who appeared to be orientated towards a preventive 'model' of general practice, talked positively about how their patients saw them as providers of 'healthy eating advice'. One female GP talked about how patients "specifically come for our advice" (Karen), while another talked about how "our opinions are viewed with respect" (Janet). Indeed for this male GP, he felt that GPs were viewed positively because patients saw them as being a "reliable source of unbiased information", which echoed the views of another who felt that their advice was "impartial" (Michelle) in comparison to other sources:

TF: What role do you think patients see GPs as having with regard to food and eating?

ROBIN: Erm, I think certainly with respect to. I think they probably see the GPs as a fairly reliable source of unbiased information. I hope they would see it that way.

Surprisingly, only a very few accounts referred to the specific potential that the general practice setting has for providing 'healthy eating advice'. One preventively-orientated female GP talked about the positive opportunities brought by the "one to one consultation" (Janet), while this male GP felt that GPs were in a "privileged position" because he implied that a personal approach may be more effective:

DAVID: Erm, well the evidence I think is compelling for a lot… Well that's the opportunity a GP has, because you are in a privileged position, in that when someone is here, you can tag on the dietary advice, and they may actually take some notice. Whereas they might not sit down and read an article in the newspaper that tells you that high er cholesterol, or high fat diets are bad for you. So that may be the only opportunity that anyone will get to be given dietary advice.

Defining patients' needs

In contrast however, the GPs who were clinically-orientated did not think that it was necessarily suitable to discuss lifestyle issues with patients. This was because they implied that patients came for a specific purpose and so they might not welcome such advice. By implication therefore, they appeared to be suggesting that this could damage the doctor-patient relationship. This male GP for example talked about how there were often very few opportunities to discuss 'healthy eating', which made it unsuitable to do so when they "come to see you for a specific purpose":

EDWARD: But urm, I find it well, apart from specific fields of diabetes etc, where you would be liasing with the dietician anyway, the number of times you can bring in dietary matters to

the consultation aren't as many as you would think, within the time one has available for a consultation, and the time of problems that people in an area, where I work, tend to come to see you for a specific purpose.

Similarly for this female GP, she felt that patients did not really come for 'healthy eating advice', which showed a notable contrast with other GPs who felt that their patients did see them as fulfilling exactly this role:

LIZ: Well, I don't think, well I don't give health advice. I don't think many people really come to the doctor for that.

Finally for this female GP, her account of the doctor-patient relationship was explicitly a matter related to the concept of 'expertise' I referred to earlier in this chapter. She talked about how patients did not view 'healthy eating advice' as being a legitimate role for GPs, and would be more likely to come specifically for other forms of preventive advice. The implication of this view therefore, was that she was also defining her patients' needs by talking about the type of advice they wanted:

GILLIAN: But I think when it comes to diet, a lot of patients buy books or read magazines or seek help from other friends before coming to primary care.

TF: And why do you think that might be said?

GILLIAN: That they don't think we've probably got particular expertise in the area, or they don't perceive diet as a health issue. They perceive it as a kind of social habit issue, rather than something actually to do with: go to the Doctor cause I'm sick, don't go to the Doctor cause I want to improve my diet, if you like. I think most patients would probably regard GPs as a source of health advice on things like smoking and alcohol more than diet, so just looking for general advice. I think a lot of them would come to you if they felt they had a problem with drinking or come to you if they felt they wanted to give up smoking, especially now they know there's the patches and all this kind of thing.

11.3.3 Summary

Exploring how GPs talked about the doctor-patient relationship reveals their contrasting views on the consequences of undertaking this type of work. While all GPs appeared to agree that finding the right opportunity to intervene has its difficulties, their different orientations also seemed to influence the type of professional relationship they spoke of having with their patients. Again there were subtle gendered contrasts within these accounts, yet the preventively-orientated GPs felt that patients viewed them as a positive source of information and related this to their experiences of empathy. However, the clinically-orientated GPs felt that this type of work would damage their relationship, but

actually backed these views up with very few examples. Once again, this revealed the subtle contrasts between 'representational' and 'operational models' of general practice and the effect of their abstracted views on their accounts of actual practice. Indeed, this process was possibly evident in how the less enthusiastic GPs gave very few personal accounts of 'healthy eating advice' they had actually provided.

11.4 Chapter summary

In the first section in this chapter, I revealed a more distinctive contrast between the way that GPs talked about 'expertise' in 'healthy eating' work than in their accounts of actually talking to patients about their diets. Like the previous chapter, this chapter has also developed the idea that different 'representational models' of general practice have a meaningful relationship with the way that GPs appeared to approach 'healthy eating' work and the way they evaluated their experiences of talking to patients about food and eating.

However, the contrast between the analysis of this and the previous chapter, has been a more specific focus on food and eating. The way GPs perceived general practice more generally therefore appeared to also influence how 'healthy eating' was evaluated as a professional undertaking and how they legitimated their personal involvement or distance. While there was a noticeable contrast in age and gender between the two orientations, it was also apparent that gender appeared to have a specific influence on the way that all of the GPs talked about food and eating work.

At the extremes, it was the clinically-orientated female GPs who spoke most enthusiastically about using their own personal experiences with their consultation, while the clinically-orientated older male GPs distanced themselves from this type of work. As I mentioned previously, it is inappropriate to assume that any of the accounts in this chapter do reflect how GPs actually practice. However it can still be suggested from the evidence presented here, that the operationalisation of these different 'representational models' may influence how they do approach 'healthy eating' work and overcome the practical difficulties I highlighted in this and the previous chapter.

12 Thesis discussion

12.1 Introduction

By exploring both lay and professional perspectives on 'healthy eating', this thesis has aimed to identify the socio-cultural processes which are relevant to understanding the potential for general practice as a setting for providing 'healthy eating advice'. The general practice setting itself, however, was only one part of this study, because of a broader approach that located lay views in the context of everyday life. For the analysis of the lay perspective, this led to an analytical focus upon the concepts and processes which were relevant to understanding the meaning and priority of 'healthy eating' in respondents' everyday lives. This was then subsequently complemented by examining how these processes related to lay respondents' views on 'professional' forms of 'healthy eating advice'. The position taken with regard to the GPs required focussing upon both their 'personal' and 'professional' views towards this type of work and how this might influence the advice they do provide.

The aim of this chapter is to review the findings presented in the previous six chapters and discuss how they support and extend sociological understandings of food, health and health promotion. In this chapter I will begin by briefly summarising the research findings and then highlight a number of key similarities and differences to related research in this field. With regard to providing 'healthy eating advice' in the general practice setting, the second half will explore how the implications of these findings can also help inform health promotion theory and practice

12.2 Research findings

Summary: The findings presented here can be viewed as representing the three different levels of analysis that have structured the approach taken in this thesis. The study therefore revealed the following findings:

Food and health in everyday life. Chapters 5 and *6* revealed the gendered context in which family meals are provided. Through an exploration of lay accounts, these chapters show how in the majority of households, the role of 'feeding the family' was assumed by the female respondents, and where a tacit understanding of 'health' appeared to be construed as a form of 'caring for'. It was apparent that these women had to face a number of competing priorities brought about by providing meals. 'Health' was an issue that appeared to be

absent from these female respondents' accounts, where the priority was instead given to managing a number of 'inconveniences' by relying heavily upon pre-prepared foods. Subsequently this context helps to provide the background to unpacking how men and women constructed 'healthy eating', by applying a basic understanding of nutrition to the idea of a 'balanced diet'. However, such understandings were also deeply embedded within a broader understanding of a 'balance', which appeared to provide a mechanism to help them make sense of and manage, a number of different priorities concerning food.

'Healthy eating advice': Such understandings complemented how lay respondents also managed and made sense of the relationship between food and health, by drawing upon a 'common-sense' view, that what they were eating was supporting and maintaining their health. These ideas then appeared to form the basis for how they distanced themselves from 'healthy eating advice', including that given by a GP.

Professional views and 'representational models': Like lay respondents, GPs' ideas about 'healthy eating' work and the type of advice that should be provided in the general practice setting, were influenced by ideas about the purpose of general practice itself. However, unlike the lay respondents, GPs appeared to be orientated towards two different 'models' of general practice, which also appeared to influence how they talked about their experiences of the dietary advice actually provided.

12.3 Discussion of findings

Before discussing the implications of these findings, I will firstly explore how they relate to the relevant literature reviewed in *Chapters 2* and *3*. This locates these findings within a wider theoretical and empirical context. The primary aim of this section is twofold: Firstly I consider how each finding from this study supports existing ideas about lay and professional understandings of 'healthy eating' and 'advice'. Secondly, I consider the extent to which this study raised new ideas which may necessitate further investigation in future studies. Reflecting the structure of this thesis more generally, I will then discuss these findings in relation to the three different levels of analysis which I outlined above.

12.3.1 Food and the family

For the majority of families who participated in this study, the findings presented here still appear to bear a strong similarity with other earlier studies of food in the family context (Murcott 1983a; 1983b; 1983c Charles and Kerr 1988; DeVault 1991). This was reflected in both the way that women in this study were generally responsible for providing 'proper

meals', and in how this role was assumed and rarely questioned. Likewise, because the male respondents spoke of, and appeared to remain on the periphery of 'feeding the family', these men did not talk about the management of the many issues which this food provisioning role appears to present for their wives. In contrast, I also find that some men were responsible for providing some, or all of the meals eaten in the home, but there was some evidence that they were choosing cooking as a higher status domestic task (Gregson and Lowe 1993; Sullivan 1997).

Body image

As Charles and Kerr (1988) also identified, while the women in this study talked about prioritising the rest of their family's preferences, personal feelings about their own appearance also had to be incorporated into this equation. However, agreeing with these authors' view that food was seen as the 'enemy' seems an inappropriate way of describing how these women talked about just having to 'get on' with this role. This was because they viewed their own diets as being 'just' another need that they had to manage on a day to day basis. Y*et al*though few women spoke of resisting the pressure to 'look good', these pressures were presented positively because dieting was presented as a form of power and control. While this bears more of a similarity with Glassner's (1995) study of dieting programmes, an expressed need to resist pressures about their physical appearance was more common in the accounts of male respondents (Watson 1999).

'Inconvenience foods'

The gendered division of food provisioning supported the theoretical importance of the family setting, because it revealed how these structures lie at the very heart of explaining why people eat what they do. Concerns about health (especially food additives) were rarely mentioned in women's accounts of the day to day management of these roles, although as Thomas (1995:652) suggests, there was a tacit notion of 'health' in these accounts which was construed as a form of 'caring for' (see Bowlby *et al* 1997). However many of the day to day issues surrounding what was being eaten were often constructed as 'inconveniences'. A reliance upon pre-prepared foods was therefore constructed as a way of managing these on a routine basis. This is perhaps a further indication of how organisational problems faced "by the harried wife and mother have become more pressing" (Warde 1997:153) and managing and constructing time is a key feature of the use of pre-prepared foods (Warde 1999). Unlike Murcott's (1983c) study entitled "It's a pleasure to cook for him", there was an absence of any sense of pleasure in cooking from their accounts. These foods appear to have been viewed as having some liberating potential. However, this was one of several reasons given by respondents for explaining why, for them, pre-prepared foods were an

essential and 'normal' way of providing meals. Furthermore, this study seems to support the idea that these pre-prepared foods do little to alter women's roles and if anything appear to reaffirm their obligations and duties through the seductive nature of their ease and appeal (Cowan 1983).

Resembling the 'proper' meal

As Warde (1997) has found, the way that the women in this study evaluated their reliance upon such foods did appear to invoke a dilemma between the antinomies of 'care' and 'convenience'. This appeared to lead female respondents into expressing feelings of guilt, which Warde also identifies. Likewise, such feelings were not constructed as a reason to avoid or even reduce a reliance upon these foods. On further analysis, the feelings of guilt could be seen to arise as a result of their view that pre-prepared foods were not 'proper meals'. Therefore perhaps an explanation for why these foods were acceptable, was because they still resembled some of the values which these meals appeared to have and may be an example of the informalisation that is taking place concerning what a 'meal' *should* be (Warde 1997). The idea that these foods still resembled a 'proper' meal, was suggested by the finding that respondents spoke about how pre-prepared foods still allowed the family to sit down and eat a meal together. Yet it also provides an example of how such meals may still be seen as meaningful symbol of family life and gendered responsibility (Murcott 1997). Another further reason for why these foods appeared to be acceptable, was because they were constructed by respondents as being a compromise. Analysis suggested that respondents were evaluating different foods on a hierarchy and so these foods were said to be better than 'snacking', even though they were not 'proper' foods.

12.3.2 Lay understandings of 'healthy eating'

Findings which suggest that many women in this study were not concerned about the 'health' aspects of pre-prepared foods, need to be considered within a wider conceptualisation of health and that 'health' may be only one concern amongst many faced by all of the respondents in their day to day lives. In this study, there was considerable support for this idea and there appeared to be a range of different mechanisms which provided a way of talking about, and managing, a number of priorities on a day to day basis (Backett *et al* 1994; Lupton and Chapman 1995). Therefore, these processes form what Backett *et al* (1994) refer to as aspects of an active and autonomous management of health. So while respondents may have talked about different priorities, contradictions or uncertainties, these data suggest as Sellerberg (1991) argues, that most people are not anxious about their every mouthful.

Getting the 'right' balance

Lay ideas about 'healthy eating' were firstly presented in the general theme of *Chapter 8*, entitled *"Getting the 'right' balance"*. The findings from this study support Beardworth and Keil's (1997) view, that the 'balanced diet' is a common feature of British discourse on food and eating, yet the many meanings which it appeared to have also reflect Fischler's (1986) view that this is a much more complex term. Thus for Fischler, while nutrition plays a role in lay ideas of a 'balance', the idea of a 'balanced diet' was evaluated within a framework where nutritional 'health' must be balanced with pleasure and enjoyment. As Backett (1992b) has observed, adopting a certain position was also a moral requirement, because respondents talked about positioning themselves between the extremes of taking 'healthy eating' too seriously and letting yourself go.

The 'good' and the 'bad'

An intrinsic component of the way that lay respondents talked about "Getting the 'right' balance", was to dichotomously classify food into a 'good' or a 'bad' group. In making sense of similar findings, as Lupton and Chapman (1995) argue, a basic knowledge of nutrition did appear to influence these simple classifications. Yet they were rarely as Calnan (1987) found, based upon scientific terms. Such ideas do however provide an example of how lay understandings of food and health are based in part upon scientific concepts (Davison 1989) and appeared to form the basis for how respondents talked about a 'balanced diet' (Lupton and Chapman 1995).

I have suggested that perhaps the key reason why lay respondents talked so frequently about 'good' and 'bad' foods was because of the way that they were able to practically apply these concepts to the 'realities' of their day to day lives. As Beardsworth and Keil (1997) argue, the idea of a 'balanced diet' is a flexible one, and as I also identified, has the reassuring value that it can accommodate 'apparent failures'. Returning to the broader theme of stability, it was apparent that the resilience and immutability of this concept may be "powerful factor[s] behind the maintenance of a sense of confidence... in the course of day-to-day eating" (Beardsworth and Keil 1997:155).

You are what you don't eat?

It is also worth noting the way that respondents appeared to use the dichotomous view of food as being 'good' or 'bad' to evaluate whether or not diets were a healthy 'balance' and also to form the basis for how they constructed themselves as 'healthy'. Nevertheless, the idea that 'you are what you don't eat' follows a familiar theme identified in previous studies, however this study refined this theme further. The idea that a 'balanced diet' was

constructed through the absence of foods can be interpreted within Fischler's (1986) view, that ideas about balancing are open-ended and self-justifying and can mean quite different things to different respondents.

It is difficult to compare these findings with other work, but in a study of health-relevant behaviour in middle-class Scottish families, Backett (1992b) found that certain behaviours were constructed as 'taboos'. Backett also found that particular 'healthy' activities (such as exercise), were used by respondents to symbolise that they were 'healthy'. The adaptation of the old adage, 'you are what you eat' as an analytical device, therefore reveals some additions to her findings: firstly because these respondents did not talk about 'healthy' behaviours such as exercise; secondly because they used 'unhealthy' symbols to talk about being 'healthy'.

12.3.3 'Healthy eating advice'

Although respondents felt that they had to listen to what the 'experts' were saying, they appeared to distance themselves from 'healthy eating advice' because they prioritised their own understandings of the relationship between food and health.

Distancing from 'healthy eating advice'

The findings from this study support the ideas from a number of different studies that the public are distancing themselves from 'professional' advice, partly because they view health messages as being contradictory and confusing (See Lupton and Chapman 1995; Keane 1997; Backett *et al* 1994). More specific similarities include a tendency to view 'healthy eating advice' as homogenous, referring to the 'experts' as an anonymous and generalised 'they" (Keane 1997) and relying upon the media as a source of information on these matters (Lupton and Chapman 1995). While their criticisms were targeted mainly at food scares (Reilly and Miller 1997), they also viewed claims made by food manufactures with some suspicion (Lupton and Chapman 1995). This was surprising considering their lack of concern about food additives at other times; however they may have been more critical when they were asked to comment on 'healthy eating advice' more specifically.

Common-sense

Reflecting the work of Davison *et al* (1989) and later Keane (1997), the way in which lay respondents distanced themselves from 'healthy eating advice' provides a further demonstration of how they prioritised their current health. Therefore, analysis of accounts indicated respondents were weighing up costs and benefits to their health, by paying attention to short-term, rather than long-term consequences (Backett *et al* 1994). In

particular, the way that respondents talked about their own health not only suggested that this was a matter for the individual, but that their diets were already supporting and maintaining their health. Overall, there were very few accounts which indicated 'fatalism', rather instead the respondents were more similar to the respondents in Davison *et al's* (1989) study who did appear to view their 'lifestyle' as playing some role. However, these findings also reflect Calnan's (1987), who found that health is functionally defined as the ability to do things, or negatively in terms of the absence of illness. They also mirrored the different roles which respondents had within the family, because the female respondents talked more about the 'healthy family', whereas their husbands tended to focus more upon their own health. Relating these findings to the recruitment process however (*See Section 5.4.4*), it may be only have been people who were relaxed and happy about their diets who agreed to participate in this study. Different understandings of 'healthy eating' may have been constructed if the sample had not been self-selecting.

The imperative of health

Despite a general suspicion of 'healthy eating advice', there was, nevertheless, a view that even if the advice was not taken, it was important to listen and to be 'aware' of what was being said. 'Expert' advice did appear to play a role in lay health concepts; however this may be an example of what Lupton (1995) describes as the paradoxical nature of lay resistance to health promotion, and represents the point at which the power to 'resist' conflicts with a power to 'conform'. It was also apparent that such a process appeared to be carried through into the way that respondents talked about their own family health history and although some respondents talked about being more at 'risk', they still said that 'healthy eating advice' was 'in the back of their mind'. This bears some similarity with recent work by Hunt *et al* (2001) on family history of heart disease, which has also shown that 'professional' knowledge was deeply embedded within lay risk accounting practices.

12.3.4 Lay views of the general practice setting

Findings from this study suggest that lay respondents extend their general criticisms of 'healthy eating advice' to the more specific suggestion of a GP undertaking this type of work. As Stott and Pill (1990) also found, it seemed lay respondents' main concern, was that their lifestyle should ultimately be the responsibility of the individual, and that advice should be relevant to the problem they were presenting. However, the lack of enthusiasm towards this idea reflected a similar finding in the earlier studies of Stott and Pill, and Calnan (1987). As my sample was drawn mainly from lower SES groups, this supports their conclusions that social class appears to be one factor which influences lay views of prevention in general practice, although no comparative group was accessed in this present study.

Medical 'models'

Both Calnan (1987) and Stott and Pill (1990) found that working class respondents talked about the GP as someone who treats illness. This finding is supported by this present study, which also revealed that lay respondents talked about how general practice should focus on the treatment of illness. The findings from this study notably contrasted with the majority of respondents in both above studies, who did feel that providing preventive advice was an acceptable extension of their role. On the whole, there was very little enthusiasm towards the idea that GPs should be providing 'healthy eating advice'. Even on a few occasions when this was considered to be a good idea, respondents talked about "how busy GPs were". This also echoes Stott and Pill's findings that working class respondents were more likely to accept these as valid 'excuses' and not talk about how GPs should restructure their workload. However it may also be possible to suggest that a negative view of preventive advice in this study was more evident because of the specific focus upon food and eating. Cohn (1997)'s comments seem particularly relevant here, that lifestyle advice about food may be more open to review because food is viewed within the personal and social, not medical, domain.

Contingency

It has been suggested by a number of critics that the criteria used to evaluate one form of health advice may be different from those used to evaluate another (Lupton and Maclean 1998; Calnan 1988). This was apparent in this study as shown by many respondents stating that they trusted their GP's advice on other matters. However at the same time, they said they were not willing to accept the extension of the GP's role towards 'healthy eating advice' - especially because they felt their advice would be the same as elsewhere. This reveals the complexity of meanings that may underpin quantitative findings and which have suggested that more dietary advice would be welcomed by the public (Siliagy *et al* 1992; Buttriss 1997). Respondents appeared to be weighing up the idea that they trusted their GP's advice on other matters, along with doubts about the extension of their role in this area. As a result of this process, respondents again repeated the idea that they were prepared to 'listen' and take their GP's advice on board. So developing earlier quantitative work, the findings from this study provide an example of the complex social processes which have been said to structure the doctor-patient relationship (Lupton 1997a).

12.3.5 *Professional views on 'healthy eating' work*

Like the lay respondents, particular ideas about the GP's role appeared to be shaping the professional respondents' accounts of preventive work, but also the way that they were evaluating the 'healthy eating advice' that they did provide. Despite a similarity with

quantitative studies that have shown GPs view food as having an important influence on health (Morris *et al* 1999), the findings broadly confirm the earlier influential studies of Williams and Boulton (1988), who identified that GPs' enthusiasm towards preventive work was deeply divided. The findings from this study also suggest that some issues which were identified may be more particular to talking about food and appear to advance the quantitative work which has suggested there are many 'barriers' to providing dietary advice more generally.

Representations

Despite this research being focused on 'healthy eating advice', it appeared that many of the findings from the GP interviews were based around views on prevention more generally. So as Williams and Boulton (1988) also argue, different ideas about preventive work in general practice need to be understood as representations or abstractions of general practice (Williams and Boulton 1988). As these authors also argued, this study revealed a contrast between the way GPs represented general practice and the operational or more practical ways that they spoke about managing work involving dietary advice. However, these different 'representational models' also appeared to have a meaningful influence on the way that GPs legitimated their degree of involvement in preventive work more generally (Williams and Calnan 1994).

Disruption

Also reflecting these earlier studies, the different characteristics of these 'models' were apparent in how GPs in this present study talked about delegating preventive work, their relationship with patients and the social causes of poor health. Supporting Williams and Calnan's (1994:374) findings, the key distinction between GPs' views revealed in this study was the extent to which preventive work was viewed as being "biomedically disruptive". Hence the GPs who were more clinically-orientated spoke more sceptically of lifestyle counselling than some of their colleagues, who talked more about managing this area as a form of teamwork. Likewise, negative views were also associated with expressed concerns about how preventive work may damage their relationships with patients, especially because these preventively-orientated GPs viewed 'healthy eating advice' as a moral intrusion. Finally, it was also apparent that these GPs who expressed less enthusiasm, appeared to be 'victim blaming' because they were sceptical about their patients' ability to change what they were eating.

Generational factors have been attributed to contrasting views on prevention in previous studies (Williams and Calnan 1994; Williams and Boulton 1988; Bruce and Burnett 1991), but gender also appeared to be meaningful in this study. This may possibly be because of the focus on 'healthy eating', which raises particular issues concerning dietary advice for prevention but also for the treatment of illness more generally. While Williams and Calnan (1994) also identified that 'lay' knowledge was used by GPs in their consultations, GPs in this study legitimated their personal involvement by drawing upon the idea that some forms of 'healthy eating advice' were 'lay' rather than 'professional' knowledge. So, although like Moore (2000) I also found they described having had little formal dietary training, the younger and female GPs felt that it was acceptable and productive to draw upon their own personal experiences of food and eating. Notably this extended to areas outwith health promotion and included a range of dietary advice for prevention and treatment of illness. For Lupton (1997a) such findings reflect the 'reprofessionalising' approaches of younger and female doctors more generally, although this may also be an example of Brooks's (1998) idea that female GPs are trying to carve out a professional niche by feminising general practice.

However, as it was apparent that personal enthusiasm may be responsible for how GPs approached dietary work, this may explain why a recent survey by Glanz (1997) found that rates of 'nutritional counselling' varied so greatly. In contrast to the younger and female colleagues who leant towards a preventive 'model', the older and male GPs talked about how some 'healthy eating advice' was available elsewhere. This was either because it was considered to be 'lay' knowledge and was therefore not a particular specialism, or it was too specialised and they needed to delegate this work to dieticians. 'Expertise' appeared to be their main concern. Therefore, there was only some evidence to support the idea that these GPs felt that lifestyle advice was more uncertain than other areas of their professional work (Williams and Calnan 1994).

12.3.6 Summary

Analysis of both the lay and professional interviews revealed that a number of socio-cultural processes appear to influence how 'healthy eating' was constructed and which subsequently formed the basis for the evaluation of 'healthy eating advice'. Generally speaking, these lay views on the day to day provision of food, on 'healthy eating' and 'healthy eating advice', tend to reflect the processes identified in other theoretical and empirical studies. The same can also be said for GPs' views on preventive work. However, there were some notable

contrasts in both lay and professional accounts, which may be attributed in this study to its focus on 'healthy eating'.

12.4 Implications

I have argued that on the whole these findings have repeated previous work on lay views on food and health, and also GPs' views on prevention. Yet there has been no previous indepth investigation into both lay and professional perspectives of 'healthy eating' which are relevant to the general practice setting. In addition to some similar processes identified in other studies, this section will explore what particular implications have arisen from focusing specifically upon 'healthy eating' in general practice. Therefore in this final section of this thesis, I will turn to explore the methodological, theoretical and practical implications raised by this study.

12.4.1 Methodological

In *Chapters 4 and 5* I outlined the research methods applied to this study, but this section briefly analyses how they influenced the construction of the interview data and subsequent impact on these findings.

Grounded theory and the relationship with the data

Reflecting on the demanding analysis phase of this research, one is inevitably drawn into a debate concerning the relationship between data and theory. This is especially because of the issues I raised in *Section 4.6* concerning how grounded theory has been labelled a positivist method, but also because of the fallout between its founders. The original version of grounded theory which I have tended to emphasise in this thesis, stressed how the analysis of data items using the constant comparative method would lead to the emergence of conceptual categories (Glaser and Strauss 1967). According to Melia (1997), the debate between Glaser and Strauss over the procedures and direction of grounded theory centres on Glaser's (1992) belief that Strauss is encouraging a method which forces the data, rather than allowing the more natural emergence of theoretical concepts. Strauss and Corbin (1998) on the other hand, stress that a more elaborate framework is necessary to avoid the production of description, rather than conceptual categories.

On reflection, I would not have said that the process was as simple as Glaser suggests (see *Section 5.6.2*). Firstly I found myself occasionally relying on Strauss and Corbin's (1990) reinterpretation. Hence at times it was useful to re-read previous literature on this area, and

'test out' theories, as it helped me become more sensitised to what respondents had been saying. I felt that it was still possible to maintain a critical distance and reflect on their views by maintaining a spirit of induction and objectivity that I outlined in *Chapter 4*. Yet as Charmaz (2000:526) comments, a constructionist grounded theory requires looking at the data again and again. "Researchers" she says "can code data numerous times. Posing new questions to the data results in new analytic points." Hence re-reading other research often proved invaluable in raising new questions – not necessarily restricting answers and forcing the data into conceptual categories. The complex and demanding analysis which I undertook therefore supports Charmaz's version and call for a constructionist grounded theory.

Nevertheless, the constant comparative methods reiterated by Glaser (1992) was attractive because of its simplicity, yet it does tend to imply that one method can simply be applied to all the data. As Mason (1996) writes, qualitative research is a creative process which can benefit from a consistently applied methodology – yet the reflective researcher is often left to make difficult decisions and should use their chosen methodology as a guide, rather than as a set of rules which dictates their every move (Melia 1997). Examples of such creativity were apparent in this thesis by how I felt it was necessary to draw upon a number of theoretical concepts in often very different ways to help explain, and engage with empirical findings.

In some cases the use of different analytical approaches and also more abstract theoretical concepts had a strong influence on shaping the way I set about analysing the data. A more abstract style could certainly be applied to the distinction I highlighted between representational and operational models in *Chapters 10* and *11*. In other cases however, theoretical ideas were less explicit and shaped the way the research was framed and the data collected in the first place (Seale 1999). Examples of this include the choice of the family setting and a focus on the gendered division of labour as the background to lay understandings of 'healthy eating'. Finally, following Denzin's (1989) method of interpretive interactionism, analysis was for example sometimes biographical. Hence when analysing accounts of family health history (see *Chapter 9*), I often drew upon biographical details to contextualise respondent's understandings.

Whilst theory shaped the data collection process in different ways, it should not be forgotten that I always placed an emphasis upon theory emerging *from* the data, and the plausibility of theoretical ideas capturing the respondent's point of view. The reflexive attitude that I adopted accepted that it was not possible to verify or be inductive in the positivist sense. Instead, I accepted that that the *a priori* assumptions which characterise

deduction can be acknowledged and challenged, while rigorous techniques were employed to ensure that theoretical concepts were an appropriate and relevant 'fit'. Data was therefore inevitably going to be influenced by theory and vice versa. Yet the *spirit* of induction (see Seale 1999) and reflexivity I referred to in *Chapter 4*, aimed to introduce a degree of quality in this qualitative research which has been empirically grounded and theoretically informed.

The Interview as a test

Only rarely did respondents dismiss the importance of the relationship between food and health, and despite their strong criticisms of 'healthy eating advice', there was still a feeling that they had to be 'aware' of what health professionals were saying. However as I was presenting a certain image of myself as a interviewer, it was perhaps inevitable that lay respondents felt that they had to present a 'healthy' image of themselves to me. Although concepts such as 'truth' remain outwith the milieu of the constructionist's position, these effects could be viewed negatively, because there may be a fundamental difference between the way that they present themselves to the interviewer, than they do to others or even themselves. For Backett (1992a) however, these processes should not be viewed as troublesome, but as important features in way that lay health concepts are constructed interactionally. Indeed, in *Chapter 9*, I argued that lay respondents appeared to associate the provision of 'healthy eating advice' with a sick role. The practical point that arises from this distancing process, is that if health professionals are to provide 'healthy eating advice' in general practice, then they need to more fully understand the implications of why the public do not want to be seen as 'unhealthy'.

Developing the 'pantry-study'

The 'food inventory' included in this study was an innovative method developed for this research, and as Anderson (1995) observes, all approaches to collecting data on what people are eating have their respective benefits and disadvantages. I was pleased that this method appeared to have no negative effect on the data. Although I found no evidence which suggested that it may have made people think about what they were eating before I spoke to them, I felt to the contrary that it enriched the study. This was especially because it revealed that most respondents did not appear to routinely question what they were eating. It therefore helped to understand that food choice was a matter of routine and provided a basis for discussing and exploring the relevance of this in the interview. For Anderson, major food and dietary issues can be missed if we do not contextualise this type of data. So from the way this process facilitated the qualitative interview, this particular method may help enrich other studies because it does help to provide a more insightful perspective on the assumptions underpinning why people eat what they do.

12.4.2 Theoretical

Although I have argued that this research has identified similar findings to other studies, previous work has neither attempted to explore GPs' views on 'healthy eating advice', or explore lay views of this topic within the general practice setting. This section therefore analyses both the theoretical implications which have arisen from the different approaches this research has taken and also how the findings develop existing theories.

'Personal' enthusiasm

I have argued that there are benefits to listening to both lay and professional views within the same study. However Popay and Williams (1996) suggest that if health advice is to be successful then there is a greater need to develop our understandings of how both perspectives are structured. While Popay and Williams make such a point on a theoretical level, and perhaps revealing a degree of 'sociological imperialism' (Strong 1979a) I found that this reflexive approach had been empirically biased towards the lay perspective. Very few studies therefore have approached the views of health professionals with the same degree of reflexivity taken here. For Williams and Boulton (1988), doctors are also enculturated within a wider social domain as well as a medical one and do not necessarily present a united front. For Balint *et al* (1993) there is an even greater need to complete the research picture by also theorising how the doctor's 'personal' views are brought into the consultation. By encouraging GPs to talk about their own diet, this study revealed how 'personal' views on food and eating did appear to play a role in how this type of work was evaluated. Currently there is very little theoretical work on this topic. This may have therefore been the impetus behind a recent criticism by Gotthill and Armstrong (1999) that currently the doctor's position is located in a *proto-space* where the conflict between the 'personal' and the 'professional' can be played out.

Professionalism

Applying a sociological critique of professionalism to general practice, Calnan and Gabe (1991) argue that as general practitioners as a profession have grown in confidence, they have increasingly attempted to establish the kind of dominance traditionally exercised, according to Freidson (1970), by their hospital colleagues. Indeed, some of the themes that Calnan and Gabe (1991) and Calnan and Williams (1995) raise based on Freidson's work can be identified in this present study. In particular, all of the GPs appeared to pay particular attention to how much they controlled their working conditions, especially by controlling the content of their work. More specifically, clinically orientated GPs appeared to have particularly strong views on delegating 'healthy eating work', whilst their

preventively orientated colleagues utilised their colleagues support when it was considered to be necessary.

Friedson (1988) has also suggested that if the power of professional dominance is waning, then it is more likely to be at the rank and file 'micro' level than at the 'corporate macro' level. Indeed, this present study did reveal that the clinically orientated GPs were challenging the views of their professional bodies and policy makers. Their wish to sustain the clinical 'model' may therefore be an example of how they were responding to a threat of not only deprofessionalisation, but also protelarianisation (deskilling into a non-medical area). On one level, this challenges Armstrong's (1979) claims that health promotion in general practice can be seen as a further example of 'creeping medicalisation'. However, this may not be the situation for their colleagues. As I mentioned in *Section 12.3.5*, for the preventively orientated GPs, it may be more the case that they were constructing work involving 'healthy eating' as a process of 'reprofessionalisation' (Lupton 1997a) and therefore an attempt to further develop their professional status. Although this status can also be theorised as being dependent on the patient granting GPs authority in this area (Strong 1980). For example, some GPs did talk about how patients demanding 'healthy eating advice'.

Finally, as Calnan and Gabe (1991) also discuss, there was little evidence here, that lay respondents felt that GPs were deprofessionalising. With the exception of a few lay respondents, GPs were viewed very positively. Indeed, GPs roles were viewed very similarly by most of the lay respondents interviewed for this study and very few seemed to be aware of any particular changes in the way they were practising or even expressed a preference for a less clinical style. However, it must again be remembered that their overall positive picture of the GP may be inextricably linked to how they were constructing themselves as 'healthy', especially as these accounts were mainly hypothetical.

The interface

Findings from this study support the idea that 'lay' and 'professional' knowledge cannot be theoretically divorced from each other (Blaxter 1990). This brings Popay and Williams to argue therefore that many health concepts are located "within the 'borderland' between 'science' and 'opinion' " (Popay and Williams 1996:766). From the findings presented here, this idea of a borderland seems to be relevant to how 'healthy eating advice' appeared to be viewed as both 'lay' or 'professional' knowledge. So, while GPs talk about drawing upon their own 'lay' experiences of food and eating within their consultations, lay respondents' understandings of 'healthy eating', are also based in part on 'professional' ones. However one theoretical concept that can illuminate the interplay in this 'borderland' between

'science' and 'opinion', is Cohn's (1997) ideas about the lay/professional 'interface'. Although Cohn was talking about the provision of dietary advice to diabetic patients, he argues that food lies at the interface of different medical 'models' and is evaluated differently in either a social or medical context.

Theoretically therefore, Cohn's idea of an interface appears to offer a useful perspective on a number of findings identified in this study. Firstly, it was apparent that some GPs and lay respondents were in agreement over the idea that 'healthy eating advice' should not be provided in general practice and it may be possible to suggest that they were in collusion (de Swaan 1990). There was little detraction from this view in the lay interviews, and the GPs' accounts, as Williams and Calnan (1994) found, were polarised between two contrasting orientations towards preventive work. Perhaps one reason for this clarity or lack of ambiguity from either perspective, may be that food is a prevention topic which is more legitimately 'open for review' (Cohn 1997). Food and eating may therefore lie at the interface of these different 'models' which may then influence both lay and professional understandings of 'healthy eating advice'. This useful theory may explain why talking more specifically about food and eating was not deemed to be acceptable in the general practice context, whereas other forms of advice, he argues, might be viewed less problematically.

The second theoretical point that this idea raises, is that it offers an explanation for why some GPs felt that they could talk to patients about their diets. I found for example that some GPs said they could empathise with their patients by using their personal knowledge. The idea that they could talk to patients about such matters who are from potentially different backgrounds, has been suggested as representing a conflation of the social and medical domains. This is because any 'barriers' between doctors and patients appeared to be ignored, such as contrasting accounting practices, or socio-economic differences. Thus, for Kelly and Charlton (1995), any break with the biomedical 'model' is more apparent than real; and they argue that the social 'model' is actually a 'partner in crime', because it is a system which *knows* what is wrong. This is clearly an under-developed theoretical area in terms of 'healthy eating', and there is a strong need to continue to theorise the relative benefits of GPs taking such an approach. Otherwise the enthusiasm behind this approach may be lost in a style of counselling which "is effectively to issue instruction, even though it uses a more amiable vocabulary" (Cohn 1997:197).

Reflections on the relevance of social-class

For authors such as Mennell (1985), the influence of social class is becoming less relevant in understanding why people eat what they do. This study focused deliberately upon a certain social class group. So how do the findings contribute to theoretical debates on the empirical

nature of social class as a concept and furthermore the argument that social class is declining as a factor which influences food choice? Firstly it must be remembered that in the design of the recruitment phase (see *Section 5.4.4),* I discussed how a number of different criteria were used to inform the sampling strategy for this research. Lay respondents were chosen according to an assumption that they were 'working class' (either by where they lived or the GP), which was subsequently supported by statistical measurement.

Yet recognising the argument that certain statistic measures of social class have given misleading views of social processes (Heath *et al* 1995), I had to find a way of addressing the methodological problem of sampling, collecting and then analysing data on the basis of 'social class'. By accepting the problems of measuring social class, I adopted a form of triangulation which examined the lay respondents social class characteristics in terms of a number of different class based measurement systems. Although I accepted that 'class' has no absolute value in a constructionist methodology, I was able to conclude that the sample did have uniformity. As is explained in *Section 5.4.4,* with the exception of income, other data based on the Registrar General's classification system, data on education levels and occupation of parents, did demonstrate the homogenous nature of the sample.

Nevertheless, bearing the epistemological problem of social class in mind, can the relevance and meaning of 'social class' still be extrapolated from the data? This may have been more straightforward to assess if I had compared two different social class groups. However, as this was not the case, it may be possible to make a claim for the relevance of social class based upon the relationship between the homogenous nature of the sample and the consistency of their views on food and health. Bourdieu's (1979) notion of cultural class 'distinction' for example, is based on the idea that social class is not just something which structures what people eat, but that by consuming food, the eater is incorporated into a culinary system (habitus) and into the group which practices it. Such a perspective provides a theoretical insight into the way that lay views presented in this study may be a form of social distinction. Examples include the appropriateness of the 'balanced diet' or the Othering of 'healthy eating advice'.

Indeed, the process by which respondents positioned themselves in relation to the 'Scottish diet' and did not talk about the cost of 'healthy eating', may be another active demonstration of social distinction. On the one hand, respondents said that the 'Scottish diet' was associated with people from lower socio-economic groups, yet on the other, they also spoke about some people (and possibly middle class) were often worrying too much about food and health. These views appear to reflect the sample characteristics (see *Section 5.4.4*) where most respondents were recruited in the middle social class groups (III non-manual – IV).

Despite the variation in income levels, and only some respondents earning over the national average wage, there was little discussion of sustenance (Williams 1983) as shown in other 'working-class' studies, or indeed of the inability to afford healthy food (Crotty 1999). This appears to confirm Crotty's argument that social class's influence on food choice extents beyond the economic and may impact on matters of 'distinction' as outlined by Bourdieu. However it is necessary to remember that respondents views on food and health may have been shaped unconsciously by their income, and in turn structured the way they then talked about food and health.

In some themes, there was more of a similarity with a study of 'middle class health beliefs' (Backett 1992a) than others which have focused upon 'working class' groups. Backett's study found that respondents talked about eating the 'wrong' types of foods, but also the need to be relaxed about one's diet, and avoid the extreme of letting themselves go. Again, this does provide a good example of how social class in the constructionist paradigm should not be theorised as an absolute measurement (Gergen 1999). However, the way that respondents constructed their accounts of the Scottish diet in terms of their own social status for example, suggests a further need to explore the processes by which social class may continue to exert an important cultural influence upon patterns of eating and upon nutritional ideas in 'healthy eating' practices (Calnan and Cant 1990).

Reconceptualising 'choice'

It is apparent from the discussion on social class above that a simple corollary between income and consumption is no longer applicable. However, to what extent do the findings from this study contribute to the idea that consumerism is increasingly prioritised in everyday decisions about food choice (Featherstone 1991)? There were certainly some themes in this study which did reveal consumerist tendencies. For example, as Lupton (1996) has shown, there were comments regarding body image, awareness of different lifestyles through the media and, discussions of how it was very easy to eat nothing but 'bad' or 'unhealthy' foods and also an awareness of food scares and media panics.

For Warde (1997: 203), claims about panic or uncertainty have been exaggerated by post-modernists and lay understandings of food are "deeper rooted" within a range of more stable and complex accounting practices. It appears therefore that constructions of 'choice' in this study lean towards Warde's theoretical position. This is because although there were some consumerist tendencies, the processes do appear to reflect the structural complexities which he suggests. Warde's theory that contemporary consumption is best viewed as process of constrained selection – particularly in terms of cultural antinomies was certainly apparent. One key example includes the dilemmas posed by dualism of 'health and

indulgence' displayed in the themes of balanced diets (see *Chapter 8).* A further example, the antinomy of 'convenience and care' pervaded female respondent's accounts of providing family meals, where women talked about being caught between the 'proper meal' and the need to resort to a compromise. In neither of these examples was anxiety presented and this appeared to be because of the necessity of maintaining a routine, especially one which could fit around a number of competing requirements.

Taking this last example further, although Warde's analysis draws partly upon the concept of the family, he does not consider the theoretical importance of the family or its relationship with theories of consumption. However, his idea that consumer culture is a process of constrained selection is particularly meaningful when also considering the theoretical importance of the family in understanding food and health. Nevertheless, the importance of 'the family' has been extensively considered by Gregory (2000) in her PhD on *Food, caring and illness in the family setting.* I argued in the introduction to this thesis that public policy has increasingly placed an emphasis upon the individual – yet as Gregory also shows, it is apparent from the findings presented here that understandings of 'healthy eating' are constrained by everyday family practices. Particular 'strategies' (Morgan 1996) therefore appear to be adopted to manage what may be construed as a responsibility to care (Thomas 1995) for other family members and where women's roles extended far beyond their own personal needs. As Morgan also discusses, negotiation can also be a tacit process and does not necessarily mean reciprocal actions or dialogue. Hence 'choice' in terms of sociological theory should be viewed as a structured concept. Agency in this present study on the other hand was presented as necessity and compromise (Finch 1993; Morgan 1996).

Finally, findings from this present study do not only reconfirm the importance of the family as a theoretical concept, but also how it can be enlightened by consumption theory. Meyrowitz (1985) for example argues that adults today are given greater licence to depart from former stricter controlled parental roles, an insight which was apparent in the way that many respondents in this present study felt that it was acceptable for children to be fussy eaters and eat certain pre-prepared foods. This may suggest a greater informalisation in daily life associated with the postmodern age. However, the family as a theoretical concept offers a further exploratory framework which can assist in demonstrating the structure and meaning of consumer 'choice' which appears to have pervaded 'healthy eating' policy *(see Section 1.1).*

12.4.3 Practical

As I mentioned in the introduction to this thesis, Scotland's poor diet and its relationship with undesirable mortality and morbidity rates represent a significant problem for health promotion in Scotland (Scottish Office 1993; 1996a; 1996b; 1997; 1999). If policy places the emphasis on personal responsibility (*see Section 1.1*), how can a better understanding of the social processes which appear to influence lay views on 'healthy eating' be used to help inform health promotion policy and practice in the Scottish context.

Changing the Scottish diet

A recent Scottish Health Survey press release (Scottish Executive Health Dept 2000b) paints a positive picture, by providing some encouraging evidence that the Scots are now beginning to heed the messages about the link between lifestyle and good health. However, the Survey's authors also suggest that there is still a long way to go before Scotland will achieve the level of lifestyle that will deliver better health to the population as a whole. Some of the findings presented in this thesis suggest that there may be processes which are operating differently in Scotland to other countries identified in *Chapter 2*, and may prevent people from making further changes to what they eat, because they already regard their diets as being 'healthy'. Importantly though, the strong media discourse of the poor state of Scotland's diet, and the stereotype of the unhealthy chip-eating Scot, did play a role in how respondents constructed 'healthy eating'. This was apparent in two findings (however it cannot be assumed that the respondents in this study were representative of Scotland as a whole):

1) Symbolism and 'balance': Firstly, many respondents constructed a 'balanced diet' around the idea that they were not eating chips, and it could be argued that the symbolism of chips as an 'unhealthy' food may have been based on health promotion messages. There was a strong view that such foods were 'bad' and respondents talked about how the absence of these 'bad' foods was a form of evidence that their diets were 'good'. While this process may have been related to a desire to be seen as 'healthy', it may have serious implications for health promotion policy. This is because there is a need for all those involved with food and diet in Scotland to think more carefully about the effects these messages may have. If people think they are 'healthy' because they do not eat these stereotypically 'unhealthy' foods, then they may be complacent about making further changes.

A second related concern is that the concept of a 'balanced diet' itself needs further clarification for two reasons. For Warde (1997), a nutritionally 'balanced diet' should include a variety of items with none to excess. However, he argues that people do not have the

means to monitor their intake to ensure a nutritional 'balance'. The idea that a 'balanced diet' did not contain, chips, in this study, is perhaps an example of Warde's concerns. So if health professionals are going to talk about 'balanced diets', they need to understand the complex processes upon which these concepts are based. A second point is that health promotion policy also has to recognise the multiple meanings which these respondents attached to this term. If these are more widespread in Scotland, then there is a need to clarify what exactly a 'balanced diet' should consist of. The term clearly meant more than a balance of food groups and therefore health professionals need to understand how the term is deeply embedded within the day to management of food and eating.

2) Othering: Earlier in this thesis, I argued that the 'Othering' process appeared to be a stronger form of distancing than has been identified in previous studies. However, there has been very little development of this concept in the wider field of social science and medicine. The term's origins lie in social and political studies, however this may be shifting, because in a recent health study, Kumashiro (2000) usefully argues that an understanding of this process may help to develop approaches to 'anti-oppressive education'. The implication for health promotion in Scotland appears to be that it draws further attention to the divergence between health promotion discourse and lay heath behaviour in the context of everyday life (Backett 1990). Although it has been argued elsewhere that the public rely upon the media to translate medical advice (Lupton 1995, Karpf 1988, Backett *et al* 1994), it may be possible that the Scottish media may play a key role in contributing to this *Othering* process. Perhaps by perpetuating the stereotype of the unhealthy 'Scottish diet', the media appeared to influence how these respondents distanced themselves from 'healthy eating advice'. This seems to be an example no just of how lay respondents were sceptical of this mediated professional opinion, but that respondents have preconceived ideas about the trustworthiness of advice on food and eating.

Can GPs provide 'healthy eating advice'?

It was claimed prior to the implementation of the new GP contract in the 1990s (Hopton 1996) that general practice was a 'natural setting' (Calnan and Johnson 1983) with 'exceptional potential' for health promotion work (Stott and Davis 1979). However despite contrasting enthusiasm in GPs' accounts, these findings suggest that in practice, GPs may be facing many of the same 'realities' when talking about diet. While on the one hand it is necessary to accept that GPs' accounts of preventive work were in part 'representations', I have also argued that these are in some way linked to how they may be operationalising different medical 'models' in general practice.

So, it appeared that irrespective of their orientation, they still talked about how they had to be sensitive about when to intervene with dietary advice. Such a view appeared to be based on a common opinion that they needed something to 'trigger' a reason which could legitimate a discussion of diet, a view which was also reflected in the lay interviews. It was also difficult to ascertain what type of dietary advice GPs were providing, and as Boulton and Williams (1986) found in their study of GP trainees, there was a tendency amongst GPs in this present study to talk about advice which was largely disease-orientated. Fundamentally, this may mean that health promotion policy in general practice will remain inherently problematic, if GPs try to provide general advice on good health which has been advocated in recent government policy documents (Scottish Office 1998). The challenge for health promotion therefore lies in facing up to a number of issues, which I will now discuss in more detail.

1) Changing the culture: The first of these concerns trying to address why despite many years of health promotion policy focussed towards general practice, GPs and the lay respondents from this study still see the setting as a site for treating illness and disease. For example, both lay and some professional respondents were united in the idea that the 'social' domain was not a legitimate area for general practice. However this should not necessarily be taken as a reason not to provide 'healthy eating advice' altogether. One problem with accepting this finding is that the lay respondents may have come to expect that their GPs will not have time for prevention because they think they are "too busy". Another reason is that while many of the respondents in this study had concerns about the GP's role in this area, other evidence from similar studies suggests that others may welcome preventive advice (Calnan 1987; Stott and Pill 1990). Finally, many of the GPs talked positively about their roles towards 'healthy eating advice' and how their roles could possibly be taken further. On a practical level therefore, this raises a further set of questions for policy makers and the general practice profession.

For example, how can general practice either broaden what types of advice will be accepted or improve the way that patients are counselled on dietary advice? Further still, does it need to change the culture of general practice to encourage both GPs and other primary care professionals to implement their acknowledgement of the crucial relationship between food and health? The findings from this study do suggest that there may be opportunities which could be taken up by general practice and in a way that may be acceptable to both GPs and the public. One key example was that GPs could provide advice to people who have a family history of diet related illness. Finally for Backett *et al* (1994), GPs can play a valuable role if they have better knowledge of their local context. Therefore a better understanding of the socio-cultural context of everyday life in the localities where GPs are working, may

help professionals in Scotland overcome the difficulties they show in providing practical advice (Murray *et al* 1993; McKie *et al* 2000).

2) Future of GPs' roles in this area: This study revealed that there was much debate about the theory and practice of health prevention in the GPs' accounts. Indeed, a key practical implication which arises from this study, is to consider who, within and outside the primary care team, should actually be responsible for improving Scotland's poor diet-related health record. The Scottish Diet Action Plan (Scottish Office 1996b) argued for *all* members of the community to be involved, y*et al*though some GPs felt that they had a key role to play, the less enthusiastic GPs often talked about how other members of society should be doing their bit and they questioned why *they* should be doing it all. Perhaps one key implication therefore, is that the government needs to ensure that not only is everyone playing an effective role, but that they make sure they tell GPs about what their strategy is.

Yet there was also much debate about what GPs' role should be within the primary care team itself. For Bruce and Burnett (1991:374), GPs should not necessarily be the "main agent" of change for the general population and findings from this study reveal similar findings to other recent work that GPs may be better placed to focus on secondary prevention, rather than provide more opportunistic and general advice (Lawlor *et al* 2000). Research constraints meant that I was not able to interview other members of the PHC team, and if this work is being delegated to practice nurses for example, then their perspectives also need to be considered indepth.

However since I began this study, it appears that government policy may now be focused upon "expanding the role of nurses and freeing up GPs to spend more time with those who really need their clinical skills" (Scottish Executive Health Department 2000a:42). The challenge may therefore lie in addressing other ways that Scotland's poor diet related health record can be addressed, both within and outside the general practice setting.

12.5 Conclusions

Analysis of both the lay and professional interviews revealed that a number of socio-cultural processes appeared to influence how 'healthy eating' and 'healthy eating advice' were being evaluated. Thus although 'lay' understandings of 'healthy eating' may be influenced by 'professional' concepts and vice versa, the way in which the relationship between food and health was evaluated should be recognised as different types of accounting practices. From the lay perspective, concepts of 'healthy eating' appeared to be deeply embedded within

their everyday lives. Consequently, a claim to healthiness was only one priority that explains why people eat what they do on a day to day basis. From both perspectives however, different 'models' of medicine appeared to influence lay and professional views on the legitimacy of 'healthy eating' as a topic to discuss in general practice. Therefore the implications for health promotion theory and the practical success of programmes to improve dietary inequalities focus on a need to understand the views of all the parties involved.

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Appendix

Lay interview schedule

Introduction

Currently in Scotland, there's not enough information about how people feel about what they eat, so we'll just talk about various things and if you have any specific questions about my research, I'll make sure there's enough time at the end so I can answer them.

We'll start off with a few background details, and then we'll talk about the food list that you've already put together for me. If at any time you want to stop talking or you feel uncomfortable about something, just let me know.

Background information

Use questionnaire
Who else lives in this house with you?

Questions

Can you tell me what you felt when you were putting that list together?

And tell me how you feel about what's on there?

This shouldn't be too systematic, that can come later...

So how do you feel it compares to what you actually eat?

Can you tell me a bit about what kinds of things might you eat on a regular basis away from your home?

Why do you think people eat what they do?

Are you happy with what you eat?

Are there things that people might say you should change about what you eat?
[anything else]
Are there things you would like to change about what you eat?
[anything else]
Can you tell me if you have ever made any changes in what you eat?
...Such as in the short and longer term
What reasons do you think there are for these changes?
How do you think things are different as you get older / now you're married [with partner] / have kids?

Some people say that tastes change as we get older?

Could you tell me about what you had to eat over the last few days....

today, yesterday, day before
probe for details on meals

Can you say a little bit about what food you would regard as a meal?

- so how would this fit into what you've told me about the food you've eaten last few days
- or what do you eat that you might not consider as a meal?

Considering the types of food you've told me you eat, can you say a little al daily routine of what's actually involved in getting to the stage where you c. food in your mouth, and who is responsible for it?

Planning (do you make a list?)
Buying the meal
Preparing
How typical is this?

Do you see yourself as a cook?

Can you tell me a bit more about what things you make yourself?
Can you tell me what you do when you have people around for food?

Some people would say that your kids might make a difference to what we

Can you say a little about whether you eat the same things or not?
How do you balance their needs with yours?
How do you think cooking for more people than just yourself makes a diffe
What would you make if you were cooking just for yourself?

When it comes to eating, are things the same or different for women?

In general
In your own experience

It's been said that there are more pressures on women
Why do you think some people think things are harder for women?

Some people feel that the pattern of their daily life affects what they eat – How do you feel about this?

What about your job (probe about how type of job affects what we eat)
Or even not having a job...
Social life
Activities
Leisure activities and hobbies

Some people also think that where they live affects what they can eat?

Can you tell me about where you do your main shopping?
And where else do you do your shopping?
How do you think it could be better?
How do you travel there?
How accessible to do you think these shops are?

Time would also be considered a factor affecting what you eat?

How important is eating to our health?

What importance do you place on eating and diet in relation to health?

Looking back at the food inventory, do you have any comments about it?

And does "healthy" come into what you've got there?
(this can be more systematic than previously)
Probe about any specific items on the list (any low fat, low cal, diet – why?)
Probe about types of vegetables consumed (any green veg?)
Probe whether veg is fresh, tinned or frozen

Part of my research is also looking at how people feel about healthy eating advice and information, how do you feel about advice you may have come across?

Where might you have seen or heard advice and information from?
What sort of messages do you recall hearing or reading about?
Can you say a little more about positive/negative advice?

I've also been talking to GPs about their views on eating, Can I ask you what you think about their involvement in this area?

How often do you see your GP then?
What role do you see them having (serious illness, advice etc)
How would you feel about your doctor giving you healthy eating advice?
Or even other types of advice?
(perhaps when not asked for)
How do you think your GP would be able to make a difference at all to what you eat?

Perhaps you can give me some specific examples

There's a lot of talk about the Scottish diet, what are your views?

Can you tell me why there might be a lot of talk about the Scottish diet?
How does it compare with anywhere else you may have lived or worked?
Have you any idea how Scotland compares with other countries
What things might be responsible for this?
Have you ideas about how you've arrived at that view?
What kinds of things have influenced your views?

We've talked a lot in the interview about your views on eating, but do you think tl there's one particular view you have which sums up how you feel?

- *and what about health in general*

Why do you think people eat what they do?

Money,
where they live (access/availability),
where they work (and how they work with)
Family
being a man/woman,
having children
tastes and preferences

How have you felt about being interviewed?

Perhaps there might be some questions you'd like to ask me?

Final questions on:

race
income

Pre/post interview Questions

Name:			
Interview Number:			
Address			Postcode
Gender	M	F	Age:
Length of interview:			

- Are you:

1 In full time education
2 In paid employment or self-employed
3 Waiting to take up paid work already obtained
4 Looking for work
5 Intending to look for work but prevented by temporary sickness or injury
6 Permanently unable to work because of long term sickness or disability
7 Looking after the home or family
8 Doing something else

- On average, how many hours a week do you currently work?

- What does the firm/organisation you work for mainly do (at the place you work)?

Describe fully – probe manufacturing or processing or distributing etc. And main goods produced, materials used, wholesale or retail etc.

- Enter a short title for the industry

- What do you mainly do in your job?

- Were you working as an employee or were you self-employed?

- Did you have any managerial duties, or were you supervising any other er

Responsible for how many people?

- Did you have any position, rank or grade in the organisation?

1 Yes
2 No

What position would that be?

- How many employees were there at the place where you worked?

1 1-24
2 24 or more

If Self employed

- Were your working on your own or did you have employees?

1 On own/with partner(s) but no employees
2 With employees

If Self employed with employees

- How many people did you employ at the place where you worked?

1 1-24
2 25+

- Do you own your house or rent it?

- Can you tell me what your parents do/did for a job?

Mother

Job:

Managerial or supervisory responsibilities?

Father

Job:

Managerial or supervisory responsibilities

- Are you currently studying for, or working towards, a recognised qualification?

1 Yes
2 No

If currently undertaking a qualification:
What qualification might that be?

- What is the highest level of education that you have completed?

1 University degree
2 Other professional or technical qualification or diploma gained after leaving school
3 Secondary school or earlier
4 Don't know

If other professional or technical qualification:

What qualification have you completed?

At what age did you finish your continuous full-time education at school or college?

AFTER INTERVIEW

Race

To which of the groups on this card do you consider yourself belonging to?

Income

Thinking of all the members of your household who have income from any s with who you share domestic expenses, and including yourself, into which o categories on this card would you estimate the usual total net income of the your household falls, that is after deductions for tax and national insurance, any benefits or pensions received?

Can you tell me which letter applies

➢ Attach field notes

Professional Interviews

Time: 45mins max

Introduction

As we've already discussed, I want to explore your understandings of food and eating issues in primary care and the research really came about because there's a lack of in-depth research of GPs views in this area and how they talk to their patients about food and eating.

Although the research is about food and eating, I am trying not to focus on the provision of dietary advice to people with chronic illness such as CHD and diabetes because this is really a separate research area.

Questions

Can we start with some background information?

When did you qualify as a Doctor?
And when did you start practising as a GP?

"First of all I want to find out about your work around food and eating in general practice"

How important is eating to our health?

What importance do you place on eating and diet in relation to health?

What are your views on talking to patients about food and what to eat in general practice?

Perhaps you could give some recent examples (e.g. in the past week)?
How often and of what type is advice given anyway?
How do you see this as part of your role?

What might be responsible for influencing your professional approach to talking to patients about food and eating?

Immediate colleagues
The location you work in?

Some GPs are more enthusiastic than others about providing information about what to eat, why do you think this might be?

Some people might say there are a lot of things that can get in the way?
(time, confidence, remuneration, the patient, professional interest)
How do you feel about the evidence and effectiveness of dietary advice?
Where do you fit into all of this?

What role do you think patients see GPs having with regard to food and eatin

And what about how they see you specifically?
How do you think your patients regard you as a source of information on hea advice?
Some people would say GPs are a respected authority on health advice?
And how do you think GPs compare to other sources of information? (and yo personally)

We've talked a bit about diet in general practice, but how does this fit into yo on health promotion in general practice?

"We've talked a bit about your work around food and eating in general prac now want to talk more specifically about the general public"

Why do you think people eat what they do?

Money,
where they live (access/availability),
where they work (and how they work with)
Family
being a man/woman,
having children
tastes and preferences

There's a lot of talk about the Scottish diet, what are your views?

Can you tell me why there might be a lot of talk about the Scottish diet?
How does it compare with anywhere else you may have lived or worked?
Have you any idea how Scotland compares with other countries
What things might be responsible for this?

"...and now I'd like to talk about your personal views on eating"

Can we start with some background information?

Who else lives with you?
Where do you live?

Can you tell me about your own views on what you personally eat

Can you tell me whether or not this relates to the advice you would give?

Examples of what you may have eaten this week
What about areas of conflict?

Are you happy with what you eat?

Part of my research is also looking at how people feel about healthy eating advice and information, how do you feel about advice you may have come across?

Where might you have seen or heard advice and information from?
What sort of messages do you recall hearing or reading about?
How do you think your patients feel about advice they may have heard?

"Just a few final questions"

We've talked a lot about GPs and dietary advice, but more specifically, how do you feel about reinforcing key healthy eating messages?

To what extent do you think that it's something you do?
How you might go around reinforcing key healthy eating messages if you were to do it?
How would you reinforce these messages, and what techniques or methods might you use to help people to change?

How do you feel about whether or not you have the necessary skills to reinforce healthy eating advice?

What extra skills may be required?

How have you felt about being interviewed?

Perhaps there might be some questions you'd like to ask me?

Letter to recruit GPs

Dear Dr _____

Following a brief telephone conversation with Dr xxxxxx we are writing to ask if the practice would be willing to consider helping with a research project on professional and lay views of healthy eating. We would wish to interview between 3 and 6 general practitioners (depending on what would be feasible from the practices perspective) and between 10 and 15 patients. The main workload would be participation in interviews (lasting 45 minutes) with some time spent helping to sample and sign letters of introduction to patients.

As this letter only contains a summary of the project, we would be keen to meet general practitioners or the practice team to discuss the project and answer any questions members of the practice might have before deciding whether or not the practice would be able to help. In particular, such a meeting could be used to explore whether there was anyway that the research project, or we as researchers, could contribute something useful to the practice. We will be in contact over the next two to three weeks to discuss the possibilities for such a meeting.

An outline and a copy of the proposal are enclosed, but it is perhaps worth drawing attention to some key points here. The study has been funded by the Scottish Office Chief Scientist Office and was prepared in response to the increasing attention given to diet, particularly 'Scottish Diet' and its reported poor quality. As ever, part of this attention has been a call for primary care professionals to 'do' more to promote healthy eating. Whilst there has been much survey work on the views and knowledge of professionals and lay people there has been little or no qualitative in-depth work which we hoped would form a more critical basis for understanding why promoting healthy eating might be difficult to achieve in practice and exploring differences or similarities in lay and professional views and understanding.

A further issue was to consider the impact of socio-demographic factors on both lay and professional views. In this context, we decided to sample practices which had patients from a wide range of socio-demographic (including ethnic) backgrounds. As such, the xxxxxxxx practice would be ideal.

Finally, it is also perhaps worth mentioning an issue which emerged during the piloting stage of the project. Some frequent responses of general practitioners we approached have been to explain that they know little about healthy eating and that it is difficult to imagine what could be said about healthy eating in an interview. However, the pilot interviews have gone well and from the research perspective, this reaction is one of the things which makes the research important and interesting.

We appreciate that the time commitment of taking part in such a project is not insubstantial. However, we would be grateful if you would be prepared to meet us to discuss it further.

Thank you for your help.

Yours sincerely

Jane Hopton
Research Psychologist

Tom Fuller
Researcher

Kathryn Backett-Milburn
Senior Research Fellow

18 October 1999

Research on understanding why and what people eat in Scotland

Dear Mr and Mrs [redacted]

This practice is taking part in a study about why and what people eat in Scotland. This letter is to introduce Tom Fuller, a researcher from Edinburgh University who is planning to talk to couples about their views . The researcher would come and talk to you and discuss your views which will last about an hour and will be at a time that is convenient for you.

I must stress that all information is strictly both confidential and anonymous, and that you are also free to change your mind about taking part at any stage. No information about individuals will be provided to the practice from this research, although a report of the study will help provide GPs in Scotland with a better understanding of people's views on eating.

I would be most grateful if you would consider taking part, and if you have any further queries, then please contact the researcher, Tom Fuller directly for further information on (0131) 651 1446. You may also like to read the enclosed information sheet. To help you decide if you would like to particpate, Tom will call at your home to dicuss the research with you further. If the time is not convenient or you would not like to participate, please tick the appropriate box on the attached tear off form below and return it in the postage paid envelope.

Regards,

Dr [redacted]

Please return in postage-paid envelope to Tom Fuller, RUHBC, University of Edinburgh, Medical School, Teviot Place, Edinburgh EH8 9AL - Phone 0131 651 1446 (I will call you back if you prefer)

Youmames:

Firstname: _____ Surname: _____

Firstname: _____ Surname: _____

Address _____ Phone _____

Please tick one box:

☐ We would like the researcher to call at _____

☐ We would like the researcher to call at an alternative time, my preference is _____

☐ We would not like to participate in this research

Information Sheet

Research project : *Understanding why and what people eat in Scotland*

Information for people taking part

The University of Edinburgh is carrying out a study of why people eat what they do.

Why have you been asked to take part?

The research involves talking to couples with primary school age children from the Edinburgh area. Both partners of the couple are being asked to take part in the study.

The study also involves talking to general practitioners about their views of why people eat what they do. Some of the general practitioners, including yours, have agreed to help us find couples who might be willing to help with the research. In order to do this, your general practitioner made a list of couples with children at primary school in the practice and then we are contacting a small sample of these to ask if they would be willing to take part. There is no special reason why you have been asked to take part.

What will be involved?

If you agree, the researcher on the project Tom Fuller will come and talk to you, to tell you more about the study and to answer any questions you may have before you decide whether to take part in the research or not. **This should take no more than ten minutes!** If the time mentioned in the letter is not appropriate, please let Tom know using the form on the letter or call him on (0131) 651 1446.

If you agree to take part, Tom will arrange times that suit you to come back and interview you both. The idea of being interviewed can seem off-putting. The researcher will have some questions or topics to talk to you about, but the idea is to find out what you think so you can say as much or as little as you wish. This will take about an hour, but it could be longer or shorter depending on how much time you have and how much you want to say.

Anything you say will be completely confidential. Although your general practitioner is helping with the study, they will not be asked about you and no information that you give will be passed on to them.

You do not have to take part in the study. If you agree to take part you can change your mind at any stage.

If at any time you wish to ask anything about the project, then you can contact Tom Fuller on (0131) 651 1446.

Should you wish to talk to an independent adviser, you can contact Professor Stephen Platt on *0131 650 6902* or write to him at *RUHBC, University of Edinburgh, Medical School, Teviot Place, Edinburgh EH8 9AG.*