Written on the body is a secret code only visible in certain lights; the accumulation of a lifetime gather there. In places the palimpsest is so heavily worked that the letters feel like braille. I like to keep my body rolled up away from prying eyes. Never unfold too much, tell the whole story. I didn’t know that Louise would have reading hands. She has translated me into her own book. (Winterson, 1992: 89)

The body as site of interaction of material and symbolic forces is the threshold of subjectivity; it is not a biological notion, but marks, rather, the non-coincidence of the subject with his/her consciousness and the non-coincidence of anatomy with sexuality. Seen in this light, the body, far from being an essentialist notion, is situated at the intersection of the biological and the symbolic; as such it marks a metaphysical surface of integrated material and symbolic elements that defy separation. (Braidotti, 1991: 282)

Introduction

Feminist criticism, amongst other critical traditions, has argued for the fallacy of the distinction between mind and body as developed in Enlightenment thought (see for example Grosz, 1993; Nicholson, 1990; Braidotti, 1991). Even so, Bob Connell (1995: 59-60) has suggested that ‘Social theory for the most part still operates in the universe created by Descartes, with a sharp split between the knowing, reasoning mind and the mechanical, unreasoning body’. In the vein of Connell’s and much feminist work I wish to argue in this paper for a unification of these concepts and for the importance of agency embedded, or perhaps embodied, in this understanding. There are in other words bodily knowings – not just mental, cognitive processes – present in everyday life. Analysis of these can help us understand gender relations and the processes involved in ‘doing gender’. One way of tapping these bodily knowings is to use narrative. In the first part of this paper I will first expand upon certain concepts already mentioned, namely bodily knowing and narrative but even introduce the concepts of memory as well as situatedness (the body in space and place); while in the second part of the paper I will illustrate my theoretical concerns with narrative examples from two recent research projects I have conducted where I have looked at men and women in the medical and nursing professions and in ICT jobs.

Memory

Memory – understood as the individual’s perception, processing, storage and retrieval of personally experienced events and knowledge of the world – has been the subject of extensive research and theorizing by psychologists and neuroscientists alike and according to Alan Baddeley (1989) the physical and biochemical basis of memory is of considerable current interest. Even studies of collective memory have solicited considerable interest (see for example, Butler, 1989; Singh et al, 1994) and are important in understanding how knowledge is passed on from one generation to the next. While memory undoubtedly is sited in particular nerve cells in the brain and in their complex and matted interconnectedness, I want to ally

1 Please note that this paper is literally a first draft.
myself with those scientists who claim that memory is not simply a mental activity but is equally deposited and retained in the body; in other words, the body – seen in terms of organs, tissue, skin, muscles and the endocrine glands – also has a memory (see for example Pert, 1985, Ehdin, 2002). The body remembers, the body recalls – especially situations that are emotionally charged. It is a bodily knowing. It seems to me that this thinking, connected to an understanding found in alternative medicine, can be linked to Connell’s term, body-reflexive practices. In so doing, we can incorporate a more socially grounded understanding where gender relations can be problematised.

Body-reflexive practices

Connell (1995: 60) argues that while theories of discourse have succeeded in bringing the body back into social theory, the body is understood as ‘objects of symbolic practice and power but not as participants’. Instead of a perspective that is simply objectifying, Connell wishes to see the body as both the object and agent of social practices; as part and parcel of what others have called ‘doing gender’ (see for example, West and Zimmerman, 1991). As I have described elsewhere (Davies, forthcoming [a]) doing gender implies active performance and subjectivity – bringing our attention to the ways in which gender relations are (constantly) created, maintained and contested in interaction and daily life. The term lets us understand that gender and gender relations are not a static pre-given but moulded in ongoing actions where at least two partners need to be present. As an analytical tool, the concept lets us examine how others (willingly or unwillingly, conciously or unconciously) do gender when interacting with us, but equally how we are accomplices (willingly or unwillingly, conciously or unconciously) in the doing. But the active and continuous form implied in the 'ing' of the doing equally signals its transformative status, indicating that relations can be changed. The doing can and does change form (for better or worse).

Important then in doing gender are the body and body-reflexive practices. Connell bases his discussion on men’s narratives of sexuality. He argues that bodily interaction and bodily experience instigate new desires and new actions; at the same time he argues that it is not only a question of individual experience and agency, social relations and symbolism are also involved, large-scale institutions may even be implicated (Connell, 1995: 64). Connell further argues that

For men, as for women, the world formed by the body-reflexive practices of gender is a domain of politics – the struggle of interests in a context of inequality (p 66).

Body-reflexive practices is perhaps not a term that has gained wide-spread use and acceptance, yet I would argue that it is implicit in much narrative analysis that incorporates a gender perspective; it is obviously also linked to the question of memory and the body having a memory. A methodological strategy utilised in some feminist research is what is called ‘collective memory work’ (see for example Haug, 1987; Esseveld, 1999). To illustrate more clearly what I understand is meant by a body-reflexive practice I will use an example from my colleague Johanna Esseveld’s research (Esseveld, 2000). Participants were asked to write down a memory around the theme: when I felt good and when I felt bad. One woman wrote the following memory about getting an exam paper back:

After a class [at the university] we got called in to K's room one by one to receive feedback on an exam we'd done. I remember that I felt uncomfortable about going there because he was usually so arrogant and superior. He started by asking me in an aggressive tone of voice: “How did you revise for this exam?” I felt very unsure and didn't know how to answer. “Tell me now how you revised!”

It wasn't very nice at all. I told him roughly how I'd gone through the books and then was quiet. He then said: “It was an excellent exam paper. I wish everybody used your study technique.” Then he said that it was the best paper that he'd seen in this
subject. “I think you should continue your studies and go in for this subject. You know we have graduate studies.”

I left his room overjoyed, smiling. Felt that maybe the university had something to offer even me. This was something I couldn't tell my student buddies or friends since it would be showing off. But I felt really good, felt joy and strength.

Later the same day I was walking along the corridor outside the department and behind me was K. He came up behind me, grabbed hold of my bra at the back, pulled it out and let it snap back. He then laughed in a supercilious manner and rushed off. I was so shocked, insulted, that I was silent.

(Esseveld, 1999: 107, my translation)

The narrative clearly highlights gendered power relations and the body as the site of gender struggle comes to the fore. While bodily reactions are not spelled out as such in words in this narrative, one automatically imagines (and even feels oneself) how these undoubtedly change in this female student's day, leading up to what must have been muscular tensions, a possible headache coming on, the body diminishing in size, etc. And what were the consequences afterwards? We can only speculate (as the narrative does not give us more information): she never set foot in this department again; she lost interest in further studies; or: she contacted an ombudsman and the professor was accused of sexual harassment and subsequently lost his position; the incident was so deep-rooted and painful that she devoted her work career later to working for sexual equality, etc.

From this example it is clear that (an) individual memory is linked to wider societal structures; that body-reflexive practices are involved in the incident, and that agency as well as objectification are part and parcel of the encounter. Connell (1995: 231) asserts:

...bodily difference becomes social reality through body-reflexive practices, in which the social relations of gender are experienced in the body (as sexual arousals and turn-offs, as muscular tensions and posture, as comfort and discomfort) and are themselves constituted in bodily action (in sexuality, in sport, in labour, etc.). The social organization of these practices in a patriarchal gender order constitutes difference as dominance, as unavoidably hierarchical.

According to Thomas Butler (1989) emotion is a good bonding agent for personal memories. In other words, incidents that are painful, energizing or ecstatic can be easily brought to mind (if the incident is severely painful rather than marginally so, then there is a risk of course that we will repress the memory). Gender struggles, sexual harassment, ‘doing domination’, are of course all examples of painful and deeply unfair social practices. It is perhaps not surprising that these incidents are recalled and expanded upon in research interviews, as I will show in the second part of this article. What is interesting, is that just as the body featured – automatically – in a major way in the memory cited above (but where no specific instruction was given to write about the body in relation to the memory), individuals in the research projects that I have conducted similarly refer directly or indirectly to the body when illustrating unfair gender practices at work. On the one hand, the stories may relate to the body itself, i.e. how a woman’s body is seen, understood or constructed; on the other hand, the stories may revolve around situatedness, i.e. where individuals are placed/place themselves in the daily run of things. This latter term I would argue is a useful tool in understanding gender relations and doing gender. As Lesley Kane Weisman has written:

The appropriation and use of space are political acts. The kinds of spaces we have, don't have, or are denied access to can empower us or render us powerless. Spaces can enhance or restrict, nurture or impoverish. (Weisman, 2000: 4)

The body is of course implicitly implicated in this understanding of the use of space as political acts.
What I would like to argue then is that situations that revolve around the body in some way and that become a bodily knowing are the ones that ‘stick in the mind’ (and in the body) and are recalled in the research situation. They may be directly evoked by the researcher when asking about gender matters but may be recalled indirectly when discussing other or perhaps more ‘neutral’ matters, letting the researcher see the workings of gender relations ‘through the back door’.

**Narrative**

While narrative as an epistemological and methodological device has traditionally been the realm of historians and literary critics (Hinchman and Hinchman, 1997), it is also employed substantially today in sociology and other human sciences and not least of all in feminist work and ethnic studies (Singh, et al, 1994). Lewis Hinchman and Sandra Hinchman (1997) provide three reasons for what they call the astonishing “comeback” of narrative. The first issue they take up is the active, self-shaping quality of human thought which can be captured in narrative. Stories have the power to ‘create and refashion personal identity’. As Singh et al (1994) point out, no longer is our ‘self’ or consciousness seen in current academic discourse as a stable psychological entity (we no longer talk of ‘finding ourselves’). Instead, using Stuart Hall’s thoughts they argue, ‘Identity is not fixed but a dynamic construction that adjusts continually to the changes experienced within and surrounding the self’ (Singh et al, 1994: 17). The self is a continual ‘work in progress’. There is an important link then between narrative and subjectivity and in addition narrative provides a way of avoiding ‘mechanistic’ models of human behaviour.

Secondly, Hinchman and Hinchman argue that narrative provides the possibility for a plurality of different stories to be told. Cultural and ethnic difference are allowed to blossom and the master narrative is thrown into question. As Hinchman and Hinchman (1997: xiv) write: ‘Storytelling becomes for its supporters an act of resistance against a dominant “Cartesian” paradigm of rationality’.

Lastly, they assert that narrative allows for a richness and complexity in the research material that is not possible with quantitative and positivistic research methods. Narrative allows us to understand ‘why’ in a deeper sense. Explanations must be woven into the narrative tissue as Ricoeur would put it (quoted in Gergen, 2001: 251).

According to Hinchman and Hinchman (1997) the word narrative comes from the Indo-European root ‘*gna*’, which means both ‘to tell’ and ‘to know’. In feminist terms then, narrative provides the opportunity to tell ‘another story’. While the stories may be examples of ‘atrocity tales’ (see for example, Goode & Ben-Yehuda, 1994; Jacobsson, 2000) or see women as victim, narrative may importantly be used as contestation or protest, as examples of different ways of seeing and knowing. Narrative, just like body-reflexive practices, can ‘form the world’ or have an emancipatory potential. Indeed the ‘body stories’ told in my research projects were not related simply to uncover the victim but told in the spirit of paving the way for dialogue and change. It is not surprising that narrative has been an important tool in feminist research when one discovers that narrative also means ‘to know’. Feminist theory and research has challenged traditional authoritative modes of knowing and emphasised the place of experiential knowledge (see for example, Stanley, 1994) – even if certain feminists are wary of whether experience can be seen as a foundation for knowledge and can reveal ‘authentic truths’ or can constitute a ground for a new epistemology (see, for example, de Lauretis, 1984; Lazreg, 1994; Skeggs, 1997). Autobiographies, i.e. narratives of the self, aimed at understanding self-identity, have also claimed space in feminist work in recent years (see for example, Brodzki & Schenk, 1988; Stanley, 1994).

**What comprises a narrative?**

Hinchman and Hinchman (1997: xvi) provide the following definition:
…we propose that narratives (stories) in the human sciences should be defined provisionally as discourses with a clear sequential order that connect events in a meaningful way for a definite audience, and thus offers insights about the world/or people’s experiences of it.

Although it can be deliberated whether all narratives do in fact retain a sequential order. Questioning the sequential order can be an important tactic used by various ethnic groups to challenge master narratives, as shown in essays in ethnic American literatures (see, Singh, et al, 1994), and thereby to resist domination. Liz Stanley (1994: 145) gives this definition of a narrative:

‘A narrative’ is a story told by structural and rhetorical means in which there is an unfolding, a development or progression, a denouement and/or conclusion. In other words, in which there is a beginning, a middle and an end.

Polkinghorne (1988: 1) sees the function of narrative in the following way:

The primary form by which human experience is made meaningful… it organises human experiences into temporally meaningful episodes.

Regardless of which definition we take, it is probably essential, as Gergen (2001) has argued, that self-narrative establishes coherent connections between life events.

There are also, it would appear, narrative conventions:

An acceptable story must first establish a goal, an event to be explained, a state to be reached or avoided, an outcome of significance or, more informally, a ‘point’. (Gergen, 2001: 250)

Furthermore, as Hinchman and Hinchman (1997) argue, stories do not simply mirror reality. They involve selectivity, simplifications and a rearrangement of elements. And indeed stories need not be constant, they can change over time, changing with the individual’s constant re-making of subjectivity.

In mediating between the self and world, in creating order and meaning for the individual (Hinchman and Hinchman, 1997), narrative allows us to unravel, among other things, social injustice and gendered power relations. I have debated with myself whether all my empirical data could be classed as narrative according to the above definitions. Primarily the material I will be referring to in the second part of this paper consists of qualitative interviews with men and women working as medical doctors, nurses or ICT consultants. Many questions posed in the interviews invited the interviewees to describe their jobs or their relationships with co-workers. Their answers or ‘reports’ are frequently solely descriptive but ‘stories’ do creep into their accounts, illustrating points to be made and their understanding of why social relations are as they are – linking their individual tales (which should not be seen as solely idiosyncratic ruminations or private mullings) to the world at large. These stories perhaps capture more fully what is understood as narrative; but in a wide sense all their answers are narrative.

It is my experience that research participants often spontaneously recall incidents – as I have already noted – that are connected to the body or bodily experience. In other words, the body or bodily experience are important components of narrative. And indeed the body does feature centrally in analysis of narrative. Take for example Williams’ (1997) discussion of chronic illness, Elsrud’s (1998) discussion of back-packers, or Andreasson’s (2003) discussion of Swedish handball players. At the same time, to my knowledge, the importance of the body or bodily knowing is not highlighted in overviews of what constitutes or characterises narrative.

Before moving on to a presentation of my own material, I wish to take an example from Rita Felski’s fascinating book The Gender of Modernity (1995) to illustrate how, in my mind,
the body, bodily knowing, situatedness and body-reflexive practices are woven into narrative and ensuing analysis.

**Au bonheur des dames**

Modernity is usually associated with industrial production and rationalization and the consequences thereof for the fabric of social life. By shifting the lens to the opposite of production, namely consumption or consumer demand, Felski makes us aware of ‘another story’ and inserts gender in an interesting way, showing that femininity too can be located at the heart of modernity. The mid-nineteenth century saw the emergence of the department store in industrialised countries and since women were primarily responsible for purchasing goods and foodstuffs, the store became a sphere, a public space, populated by the female sex. It provided a space, outside the shackles of the home, where middle-class women could be safe, where they could meet their friends and enjoy taking refreshments, as Felski points out, referring to Elizabeth Wilson’s work. Felski (1995: 68) further argues that:

The department store, then, was a paradigm of a new kind of urban public space linked not to an ideal of political community and rational debate but to the experience of sensuality and the commercialisation of desire.

Traditional Left and feminist social theory might like to see women, according to Felski, as victims of the capitalist venture, as being hoodwinked by persuasive selling techniques, as objects rather than agents in the industrial enterprise, that consuming is an instance of irrational activity; but Felski (1995: 65) turns the analysis around and argues:

But what if the female pleasure in shopping was not as harmless at it appeared? Perhaps, once awakened, this appetite would have disturbing and unforeseeable effects, reaching out to subvert the social fabric and to undermine patriarchal authority within the family.

Felski takes three novels from this period to deliberate her thesis: Émile Zola’s *Au bonheur des dames* and *Nana*; and Gustave Flaubert’s *Madame Bovary*. I will refer only here to her reflection upon *Au bonheur des dames*.

Felski’s description of Zola’s portrayal of a Parisian department store is full of sensuality and desire. As a reader one feels how the women’s various bodily senses must have been delightfully ‘attacked’ by the wares on display and by the milieu and ambience that prevailed. Sexuality and eroticism – the women are ‘permanently breathless’ or ‘flushed with desire’ (Felski, 1995: 69) – abound the descriptions. But these feelings would not have been achieved (either by Felski or Zola) without representing the presence of real bodies, of bodily experience and bodily knowing and of situatedness. Felski (p 73) presents a citation from Zola that captures a ‘crowd of consuming women’ and the ‘ultimate instance of uncontrolled irrationality’ and then provides the following interpretation:

In this description of a busy sales day at Au bonheur des dames, an amorphous mass of feminine corporeality flows into the store, driven by an overriding and unstoppable desire to consume. The crowd exercises an irresistible attraction, enticing ever more women to attach themselves to it and allow themselves to be propelled forward by its inexorable momentum. Class distinctions are blurred by the women’s shared instincts and passions, by the common bond of primordial, desiring femininity. Yet, if class difference is minimized in the promiscuity of the crowd, gender difference is accentuated; the nervous and isolated men squeezed among the compress of excited female bodies do not share, yet are unable to escape, the feverish delirium that envelopes and threatens to suffocate them. Masculinity is hemmed in and restrained from all sides by female passion. (Felski, 1995: 73)
Such desires and passions may have thwarted what were understood as ‘proper’ relations between the sexes at this time (of domination and subordination) and can be seen as acts of subversion, Felski concludes. This instance of a gendered public space (that can be linked I would argue to the concept of situatedness) provided a zone where many men were made to feel ‘insignificant, helpless, or out of place’.

While the body, bodily knowing, situatedness and body-reflexive practices are implicitly central in the narrative – both in Felski’s and Zola’s – they are not discussed as such. Thus I would like more explicitly to draw our attention to the way in which both the individual and collective body are the site of struggle in gendered power relations. And by extension, by focussing on the body and bodily knowing in our analyses, we can, I would argue, gain a better understanding of gender inequality.

Narrative, doctors, nurses and ICT consultants
I will now turn to (a very small part of the) empirical data from two recent research projects that I have conducted. One project examined the (somewhat problematic) working relation between doctors and nurses in Sweden seen from a gender perspective and problematised more generally the situation of women doctors in the medical world.2 The other (ongoing) project aims to examine the reasons for gender equality in the ICT sector in both Sweden and Ireland.3

I will start by saying something very briefly about the research methods involved and the place of narrative in the studies. The hospital study was based on five months participant observation at the Departments of Surgery and Ophthalmology at a medium-sized Swedish hospital as well as forty-two individual interviews with doctors and nurses working at these departments as well as at other departments and one focus group interview with nurses. The main source of data in the ICT study are approximately eighty individual interviews with male and female consultants, technicians and managers working at fourteen firms within the tele-communication and ICT branch in Sweden and Ireland.4 Narrative is implicated in various ways in these projects. Participant observation captures informal narrative (talk) in the course of the day while ‘shadowing’ hospital staff. There are then the notes written up at the end of each day, where I construct my own narrative based on the sieving of ‘facts’, incidents, reflections, experiences and tales told to me – where, while not commencing from the starting point of testing a theory/hypothesis, theoretical constructs (consciously or unconsciously) and various discourses (consciously or unconsciously) mould the narrative that takes form.

I mentioned earlier (p 5) the use of qualitative interviews. The use of the term ‘qualitative’ was purposefully phrased in an evasive manner. While themes, rather than a battery of questions, have primarily directed my style of interviewing, some interviews certainly retained more the structure of a semi-structured interview when participants were less willing to expand upon things or when time-pressure was felt in the amount of time the interview could take. However, my aim in the interview situation wherever possible was to act in the way described by me in an earlier research project (Davies, 1996b: 232):

Together the interviewees and I would delve into subjects, events and thoughts; at the same time I really tried to listen to what they had to say, to understand their definitions of things, not to force their words and interpretations onto my incompletely formulated thought structure or to place hypotheses over their words. I would like to argue that the

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2 This research was financed by The Vardal Foundation and was carried out during the years 1997-2000 with the author as the sole investigator. More comprehensive discussion of the results can be found in Davies 2001; Davies, forthcoming a); Davies, forthcoming b). Examples that will be used in this paper as well as some of the text can be found in the previously mentioned publications.

3 This research is financed by the Swedish Agency for Innovation Systems (VINNOVA) during the years 2001-2003 with Chris Mathieu and myself as co-researchers.

4 Statistics are also being gathered for the industry as a whole and for the companies included. In addition a cohort study with women who started studying computer engineering or informatics – based on short telephone interviews and/or electronic questionnaire - is being carried out.
interview was created jointly. It wasn’t a question of simply enticing information from the interviewee; the interviewee was neither a respondent nor an informer in the traditional sense but rather a co-producer of important knowledge. (My translation)

When interviews took the above form, then there was more scope for narrative as outlined earlier in its more general definition (cf discussion in Hollway & Jefferson, 2000: 30-32). What this citation also importantly suggests is that narratives are necessarily co-authored (cf Williams, 1997; Gergen & Gergen, 1997).

I will now present some empirical data from my studies.5

**Bodily knowings**

*The construction of the woman’s body in the medical profession*

We have to take our starting-point in men as the norm – we have to adapt ourselves to their rules. We're only allowed in as guests. (Woman orthopaedic surgeon)6

They [the male doctors] want tough boys for this job because they were tough boys themselves. (Woman surgeon)

My department is like a military camp where the top dog gets unbelievable respect. (Woman physician)

While women in Sweden have significantly increased their numbers in the medical profession from around ten per cent in the fifties (Nordgren, 2000) to well over fifty per cent in current medical education (http://nu.hsv.se/nu/index1.html)7 the women doctors in my study related in a variety of ways how they were made to feel like outsiders in the medical academy, as suggested by the quotations above. The construction of the woman’s body and what it was capable of was one of the strategies used to bring this about.8

Within certain specialities in particular, being accepted as a woman is a hard fought battle and the female body is used at times as a reason for a woman’s exclusion, or at least for questioning her suitability in spaces that historically have been constructed as masculine, such as orthopaedic surgery and general surgery. It is the size and strength of the female body that is brought into question. It is not a body, it is argued, that can meet the demands of certain operations. Stamina may be lacking. It is not a body that commands authority and respect from staff assisting operations. Admittedly these were not opinions openly raised by the majority of respondents in my study – I would imagine that equality debate in recent years has inhibited what can be seen as open discriminatory talk. But the fact that it was mentioned spontaneously by a number of women doctors is evidence of its persistence notwithstanding.

A female orthopaedic surgeon showed the inconsistencies in the arguments put forward. Her example (narrative) to be outlined below clearly highlights how the female body is socially constructed rather than simply biologically determined. Orthopaedics is a speciality where the number of women doctors is especially low – in fact this is where, along with thorax surgery, we find the least number of women in Sweden; the figure for 2001-01-01 was 8%.9 It could be argued that the reason for this lies in not enough women choosing this speciality. However, interestingly, many of the women preregistration house officers told me that they found the speciality exciting and said that they could seriously consider making this

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5 The ICT data are not fully analysed yet.
6 Citations used in the second part of this paper have been translated from Swedish by the author.
7 Of course the higher positions are more likely to be held by men. Consultants (Sw: överläkare) consisted of 75% men and 25% women in 1995 (Nordgren, 2000: 70). 39% of women doctors were at the junior doctor level in 1998, while the equivalent figure for men was 25% (Nordgren, 2000: 70).
8 There are of course a variety of other strategies not discussed here.
their choice of speciality. Orthopaedics involves both younger and older patients, requires concrete skills and is felt to be rewarding since patients for the most part considerably improve following operation and treatment. Suffering – which is so prevalent in many specialities – is less evident here. For these reasons, the speciality is attractive. But is the speciality interested in keeping women?

The woman orthopaedic surgeon I spoke to described how women seldom stayed long – they disappeared into other specialities. Subtle forms of exclusion appeared to be at work. An example was given to show how the body is used to question women's suitability.

Recently a woman house officer had started and was required to carry out an emergency operation on a hip fracture. Second on-call was contacted. The operation does require some strength, it was argued by my interviewee, but this is not what is most important; it is rather a question of technique. The senior doctor called in though, commented afterwards upon the woman doctor's purported frailness. This caused my interviewee to react in the following way:

They start straight away by measuring her physical strength. And yet we've had guys here that are much more 'delicate'. So I said to him, “Have you thought about when we competed in the Vasa race10 the other day – here all the male doctors take part in this competition – that she beat them by two hours, she was much faster than any of the male doctors here – and you go around here and call her weak!”

Body size was also commented upon by the women surgeons I followed into the changing rooms before operating. Claiming space was not automatic in their rather small bodies it was argued. Showing their (extra) worth and competence were necessary if they were to be taken seriously in the operating theatre. And indeed operating equipment did not always seem designed with a slighter body and hands in mind. The women surgeons often had to stand on foot-stools to reach a patient comfortably.

It was not only in the operating theatre that the women surgeons felt at a disadvantage. Their 'wrong bodies in the wrong places' elicited wrong reactions from patients as well.

I don't know how many times – especially in the first years of course – when I've seen patients on the round twice a day, of which 75% by myself, I've admitted them, operated on them, discharged them, written prescriptions for them, signed their taxi receipts and sick leave forms, explained things to them and then asked if there is anything else they've wondered about and they say, “When is the doctor coming?” (Female ward surgeon)

While smallness was the theme usually commented upon, one woman doctor in the Department of Ophthalmology, who was rather large, mentioned her size as disadvantageous. She took too much space; something she felt contributed to her badly functioning relations with the nurses.

Regardless of whether comments about body size were openly aired or not in a department by male doctors and/or nurses, the women doctors were very conscious of their bodies – their fitting or not fitting into expected norms. They had internalised various cultural superschemas (Ridgeway, 1997) with regard to space-place-body. They were very much aware that they were seen as being the wrong bodies in the wrong places. 'Body' could be made less salient with time if their expert and experiential knowledge came to the fore.

Cassell (1996: 43) suggests that there is a double rebuttal that needs to be revoked, as summarised by one woman: "Either you're not a woman, you're a bear, a dog, or a lesbian; or you're not a surgeon, you're no good." The latter is challenged, as many of my respondents argued, by showing that they are good at their jobs – and not just good, better than average. With regard to being a woman, Cassell's respondents spoke of the importance of wearing lipstick so that it would not be assumed that one was a lesbian. 'One woman described how,

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10 The Vasa race (Vasaloppet) is an annual, international, long-distance skiing competition – the distance to be covered is 85.8 km.
as a medical student on a surgical rotation, when called to the emergency room in the middle of the night to attend to a gunshot wound, the older female resident would remind the two of them, "Oh, we have to put lipstick on!" (Cassell, 1996: 44).11

Women in ICT

For women in the ICT branch the body itself is not socially constructed in negative terms, at least not in the way we have seen above in certain medical specialities, since it is the mind – it is argued – that solves the problems.12 Indeed this is why this type of engineering, it is conceded, is suitable for women – you don’t have to be out on a building site, you don’t have to be out in the cold and wet, you don’t need physical strength. And by and large it was argued that women’s minds were just as good as men’s. Since traditionally it has been assumed that girls/women are not as good at maths and technical subjects, we could argue that there has been a definite shift in the general opinion or at least in the opinions of the people who work in this industry.13 Women are not excluded then (in the arguments given) because it is a typical ‘men’s area’ where men are better at this line of work. Even so, there were instances when the suitability of women’s minds were brought into question and where I would argue that the individual bodily knowing saw to it that the narrative reached our ears.

Let us listen to the words of a young Irish female engineer.

I’d been here about two months and as a new graduate you get someone more senior to you who looks after you, you know a mentor. The guy looking after me wasn’t the best at communicating. He wasn’t sitting anywhere near me but on the floor above. The guy who was sitting beside me, at the same desk, who was also working for this guy, he ended up telling me what’s what. But I went up to this mentor guy with a question once. While he was explaining, I stopped him and asked him to explain an aspect of what he was talking about in more depth. He got impatient by the question and answered abruptly: “I don’t want to have to tell you that again!” That really killed me. I was very fraught and didn’t come back to him for a good while. “Oh, god, I’m a real dunce.” A guy would have just said to hell with it and got on with it. My self-esteem was damaged. This was a terrible thing to say to someone who is brand new. There was no excuse. But it really shouldn’t have affected me in the way it did. And he would never tell you that you were doing great.

Stories of this kind were fortunately few and far between. In fact I would argue that the women working in the ICT sector felt more at home in some ways than the women doctors did in their area. This is interesting given the fact that the percentage of women working in the medical profession is greater than that for women in ICT companies – in Sweden the percentage for the latter group is around 25-30 per cent, while in Ireland the figure is around a low 10 per cent; women doctors, however, constitute around 40 per cent of their profession (and over 50 per cent in the medical education). Perhaps this indicates the way in which medicine is still staunchly patriarchal and hierarchical. The ICT sector, as a relatively new area, doesn’t have to bear the weight of traditional codes and social relations. But while I would argue that on one level women entering this branch do seem to find a milieu where gender doesn’t (seem to) matter, there is also evidence of gendered relations moulding the field of play as we will see.

11 In her study of women surgeons, Cassell (1996) reports that she found little evidence in her interviews of direct sexism or misogyny and reflects whether this is due to the fact that it is easier for a woman surgeon to cope with her situation by ‘forgetting’ such events. It was rather in informal talks when she related ‘shocking stories’ that women surgeons would admit that they had experienced similar events. My own material is not overflowing with misogynic stories either. Yet there is often a sub-text around such issues. Regardless, one such story is one story too many.
12 I am not of course arguing that the mind doesn’t solve problems in medicine as well!
13 Of course they could be expressing what is acceptable discourse at this particular point in history.
Most people interviewed in the ICT companies – both men and women – felt that sex/gender wasn’t of relevance in terms of discrimination, treatment, etc. At the same time many of the women had experienced differential treatment when in a new situation, for example in initial meetings with a potential/new customer. When the woman was accompanied by male colleagues, the men were the ones who were asked the technical questions. Scepticism as to the woman’s competence was something that was felt in the air. By working hard to show their knowledge and know-how, these original fears could be dispensed. This gives support to Cecilia Ridgeway’s (1997) and Charles Tilly’s thesis (1998) that the worker’s sex/gender makes a difference initially in work situations but can fade with time when gender becomes less salient. But what this means, and relating back to my ‘body argument’, is that whether people in the industry like to think it or not, the body, inscribed with its gender, does make a difference or does matter, at least initially. At the same time one wonders why so few women are found in higher management/leadership positions in the companies we studied, raising the issue of whether gender doesn’t matter in the long run as well.

To illustrate the way in which gender – especially in conjunction with young age – can influence working relations, let us hear the narrative of a 23 year old Swedish woman working in the industry, who already had advanced to project management (and who by all accounts was very good at her job).

KD: Does the fact that you’re a woman make any difference in this job? Yes, I would say so. Absolutely! As project manager I need to get everything moving along. They call me the ‘project führer’! Since I’m a woman and very young, they maybe can’t always take my decisions and instructions in the same way. I don’t think they would have called a forty-year old for the ‘project führer’ if he acted in the way I do – well not in the same way. I don’t think that I’m always taken equally seriously… I try to keep things at a certain level, otherwise I’m not credited with authority in front of the others in the group. But if I was being myself…

Another theme that was reiterated in many of the interviews was the men’s cockiness and the women’s lack of self-esteem. Let us return to the young female Irish engineer, who we heard earlier.

Men more generally are more willing to bluff their way through everything. They’ve got more cheek. Guys will ask girls they know, “How’s work going?” and the girls will say. “Oh, it’s going OK, like, but I’m not too sure how I’m doing.” And they’re probably doing way better than plenty of the guys there. But when the guys are asked, they say, “Oh, fantastic!” They’re just more confident. This would get me for a while. This company doesn’t give much feedback on that. I need to be told if you’re brilliant, it keeps you going, that works for me. My manager has a standard that everyone gets marked by on a scale of 1-5. Crap! Because you may not have improved in relation to others, but in relation to yourself – but you don’t get credit for it. I have a big problem with that. The informal slapping on the back doesn’t occur.

I suggested above that it was a question of ‘women’s lack of self-esteem’. Although it could perhaps equally be entitled ‘women’s reality principle’. Women consultants would relate how the men bluffed their way through initial contacts with new customers. Customers would ask for a specific requirement and the men would say “No problem, we can fix that.” The women would be more wary, admitting that their knowledge or experience didn’t stretch to that particular solution. The women would find out afterwards however that the men had little idea either of how to solve the problem. The women saw their behaviour in terms of being honest, the men in terms of catching the deal. Male managers suggested that women consultants needed to change their style if they were to succeed in the business, indicating that the women

14 The obvious choice of word here is perhaps not surprisingly linked to the body (and sexuality).
needed to assimilate into the existing ethos. Working on their own terms was obviously difficult.

Situatedness

The situatedness of doctors and nurses in the daily run of things

Earlier I gave examples of gender equality with regard to how women doctors were received and treated. In this section I want to move our gaze to the relations between doctors (regardless of whether they are men or women) and nurses. Historically medicine and nursing have been built on certain notions of masculinity and femininity (see, for example, Gamarnikow, 1978; C. Davies, 1995; K. Davies, 2001) and embraced ‘doing dominance’ and ‘doing deference’. Today, nursing staff – as a corps – oppose doing deference and the boundaries between the two professions are both shifting and are unclear at times. There is, it would seem, an equalising tendency where the medical profession unavoidably is losing some of its traditional power and authority, at least in Sweden, and I would imagine in other Western countries as well. But to what extent the nursing body can truly achieve an equal position remains to be seen. Boundaries are crossed but then reset, but is the resetting always to the nurse’s advantage? What can be agreed, however, is that the relations between the two professions are in flux and that change with regard to the professions themselves is firmly on the agenda. By using the concept of situatedness – how bodies are placed/place themselves in time, space and place – we can, I would argue, throw further light on these particular (changing) gendered relations.

Daphne Spain (2000) suggests that women's jobs are 'open floor' while men's jobs are 'closed door'. Her argument is primarily in relation to office work where women work overwhelmingly as secretaries and where a manager is more likely to be a man. The secretaries often work in an open office landscape, a Bürolandschaft, while the managers have their own offices where a door can be closed. Hospital work obviously differs from office work, but there are some underlying similarities with regard to the appropriation and use of space. Nurses' work is much more 'open floor'. Their work duties mean that they stay put more or less in one place during the course of the day (be it the ward, out-patients or the operating theatre), while the doctors come and go. On the ward, the nurses have no private offices. The nurses' station is shared by several and the glassed walls provide public viewing. A lasting memory from Gerd Lindgren's study (1992) is of the assistant nurses disappearing (hiding) into the sluice room for a short break and a chat. The spatial design of the ward, together with the assistant nurses’ gendered/class position, offered few other alternatives.

'Open floor' brings with it a number of demands or constraints. First, there is lack of privacy. As Spain (2000) points out, privacy consists of the ability to limit others access to one's workplace. The nurses' office is far from being private, indeed it appears to be a thoroughfare for one and all. 'Open floor' also signals the right to repeated interruption; something that the nurses wholeheartedly would argue characterises their work situation. My own observations, sitting in their offices, were that they seldom could sit in peace and quiet and fulfil a task. Doctors, patients, relatives, other professionals in the 'care chain', demanded immediate access to their time. Openness also means scrutiny and surveillance. The doctors are in no way exempt from availability – they can be bleeped at any time. But their spatial flexibility, symbolically at least, removes them from constant scrutiny. The

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15 Spain's work was originally published in 1985. I am aware that working life has changed considerably since then and that today women are much more likely to be managers, just as they are more likely to be doctors. The point is that the use and control of space is linked to power and position and gender relations have played an important part in this.
16 I am referring here to the different professionals that a patient/individual might come into contact with during the progression of his/her illness and recovery.
17 Walby & Greenwell (1994) suggest in their British study that doctors can find the bleeping system frustrating as they have to find a phone to ring back in response – in other words they can be more
nurses in fact, at least in surgery where the doctors are extremely mobile, find it frustrating that the doctors are always 'on the move'. It's hard to pin them down, get their signature, get their opinion. A doctor cannot be beeped for every small thing. In fact, the spatial separation of the two groups means that the two professions have hazy ideas about what the other is doing when not present. Doctors' tasks, in contrast to the nurses', can be carried out with fewer interruptions and they do indeed have an office (even if not much time is spent there) where they can go and shut the door. Although this may not apply to the house officers, indicating the hierarchical structure within medicine.

A nurse who worked on the casualty unit illustrated the differences in the following way:

The doctors have their own rooms where they can go and dictate and read – close their door. We have nowhere where we can sit down and do our case notes. All we have is a counter; there are telephones ringing, buzzes from patients, people asking things the whole time – and there’s so much noise constantly, questions again and again. We can never go anywhere and close a door and carry out something in peace and quiet. And you get stressed by it... The doctors take the time they need to take and close their doors... But we see everything with different eyes – how many are still waiting in the waiting room, all the phone calls, how the numbers are increasing...

After the morning round on a surgery ward, there is a lot of paper work to be done by both doctors and nurses. One observation that I made and which raised another gender aspect was that the women doctors were more likely to carry out this work in the nurses’ booth while the male doctors disappeared into small offices (where one might meet with patients on other occasions). I have no idea to the generalisability of this observation – it may have been the nature of the particular women doctors in this department. But it does raise the question of gender, space and profession. When asking the women doctors about the reasons for their behaviour, their answer was that the work goes faster, the records and files and forms they need are all available, the nurse is in sight if a query arises, they don't need to keep running in and out of the nurses' office. It should be noted that the nurses’ office is in reality quite small and the presence of an extra body diminishes space, although a joking, cosy atmosphere can be created if tensions are not apparent.

I interpreted the women doctors' behaviour in terms of efficiency but it could also be seen as diminishing distance between the two professions. Shared space implied a shared collectivity. As I have argued elsewhere (Davies, 2001; Davies, forthcoming b), the women doctors and nurses – while possibly at odds at times – could also form a different type of relationship, one where a feeling of mutuality and sympathy prevailed. Although one female doctor argued it was easy to fall into the 'woman-trap'. Doing the work in the nurses' office meant availability – to the nurses and their demands.

I probably have a tendency to be too nice. I take on extra work because I don't set limits in the same way as my male colleagues do. It's much easier for them [the nurses] to ask me, because I don't say no. (Ward doctor)

As geographers have pointed out, space is socially produced but it is also a condition of social production (see Rendell, 2000). Pingel and Robertsson (1998: 23) capture the heart of the problem with regard to the physical environment in hospital work when they claim:

easily tracked down, which can be annoying. Nurses, however, can now get a message to a doctor relatively easily. Walby & Greenwell also found that roughly 50 percent of nurse-doctor conflicts were due to time-space geography.

18 The men’s differing behaviour could be understood in terms of demarcating their status and position. There may also have been a wish to downplay the ‘risk’ of sexuality in the workplace, i.e. the risk of being accused of sexual harassment.
It is very obvious how badly the design of the physical environment meshes with ideas about modern work organisation, both with regard to facilitating the practical work tasks and in combating social stratification and professional territorial thinking. The localisation of outpatients, the doctors' offices and wards in different areas in the building reinforces the social barriers that exist between or that are experienced by nursing staff and doctors. The spatial allocation also gives signals about the status order. (My translation)

That space and status are tightly linked together is more than clear from the above discussion. There are *boundaries* that may or may not be crossed. A doctor takes it for granted that he or she may spend time in the nurses' station. And in the afternoons on the wards I studied, I saw how doctors would hold their own informal meetings sometimes in the nurses' office. The nurse, by contrast, has of course no right to let herself into the doctor's private office and make herself at home there. A re-negotiation of spatial boundaries and rituals though, would appear to me to be evident of current changes in the organisation of hospital work and in a levelling of status differences. The situatedness of bodies is highly relevant here.

The morning round can be taken as an example. Traditionally, space and place have unequivocally spelled out status and position. The long train of individuals trooping into the patient's room is not a haphazard formation. The consultant takes the lead, the lowest person in the hierarchy comes in last. Indeed, one problem I experienced in my fieldwork was to know where in this formation my own presence would be normatively correct; that I did not overstep a boundary, an invisible fence. I will discuss below another type of morning round to show how the situatedness of bodies in space can provide a certain sense of empowerment for the traditionally subordinate group. The round, described above, is still in full force, at least on some of the wards I studied. But it should perhaps be pointed out that it is a far cry from an earlier regime where patients 'stood (sat) to attention' when the consultant came in, where doctors did not talk directly to the patient but only communicated via the staff nurse and where even the paper baskets were emptied in advance so as not to offend the consultant!

On one of the surgical sections I studied, a different form of morning round had been introduced. Doctors (consultants, the ward surgeon, house officers and preregistration house officers) congregated in a room on the ward in the morning and seated themselves around a *round* table. Primary nurses – who were responsible for three or four patients – came in separately but in succession and also seated themselves at the table. Patients – their condition, their problems, their follow-up treatment – were then discussed. The nurse initiated discussion by first presenting a latest summary and appraisal of the patient. After the 'conference', doctors, unaccompanied by nurses, visited each patient.

Nurses were overwhelmingly positive about the new routine, doctors were more wary in their comments: “It takes too much time, we need to get off to the operating theatre”.* “You need an old-fashioned round, so that the nurses can learn.” In particular, the house officers felt they had difficulty in grasping the situation of all the patients. Some of the consultants drew out its advantages though: “We spend more time discussing the patient from various angles now, including social aspects and what will happen to the patient when he/she leaves the hospital – in addition to talking about various investigations and lab results. We can sit down and discuss more in peace and quiet”.

The nurses felt that they had won time with this form of round, especially as they did not accompany the doctors later into the patient (unless it was felt that there was a special reason to do so). Earlier they would waste time waiting in the corridor for the doctor to get to *their* patient. Now the doctors might have to wait if the nurse could not drop everything on the spur of the moment when it was time to discuss her patients.

As I understood it, it had been the nurses that had pushed for the new order of things. The nurse manager gave the following reasons for its implementation:

It's an attempt to minimise the number of people that are in the patient's room. What's the point of a whole flock? In part it's a question of confidentiality – when you're standing there in the corridor... And then the doctors, they get irritated when the cleaning trolley
arrives or when the food trolley is on its way out. They don't see themselves that they stand there and take up a lot of space [in the corridor] during quite a long period of time. When the new electronic case records system was introduced, it became obvious that the old routine wasn't feasible any longer. I tried to argue that sooner or later they need to sit down somewhere when all the medication and case records are on the computer. We can't do a traditional round with a lap-top and everyone trying to peer into it. You have to be able to sit down at a larger screen.

Nurses frequently emphasised their patient advocacy role in their work as well as their concern for the patient and this type of round, one could say, facilitates this. The following citation from a nurse working on another ward where a traditional round still held sway further explains why an advocacy role is difficult with a traditional routine:

> We just rush in and out. No meeting either before or after. I don't like this system. I'd like to see some sort of briefing before we go into the patient, I'd like to be able to say to the doctor, “This is how it's been for Mrs Persson this morning...”. Unfortunately the doctors discuss treatment strategies in front of the patient. The patient just sits there like a big question mark... And then it becomes extra work for me. I have to 'clean up' after the doctors on this type of round.

The nurses on the new round indeed argued that the method allowed them to 'charge themselves' beforehand, it allowed them to prepare their arguments. My own observations – and comparing these to 'presentations' or information-exchange on the traditional round – noted well-structured and well-argued presentations at the new round.

Improving patient care was an argument used by both doctors and nurses to justify a new form of round. Surprisingly, establishing more egalitarian ways of working between the two professions was not taken up by my respondents. And yet it seemed to me that this was one of the (unintended?) outcomes and an important one at that. Space was utilised in the traditional round to ensure medical authority. The culturally determined spatial rules, admittedly unwritten but none the less widely understood, saw to it that each person knew their place in the hierarchy (including doctors within the medical hierarchy). Sitting around a table, by contrast, places bodies on an equal footing and provides the opportunity for real discussion. Sitting down diminishes the importance of size (and dominance) – which may be of relevance in relation to male doctors.

*Situatedness and women IT consultants*

At my performance appraisal I tried to say that I like working on the help-desk, but that I’d like to do more than this. “But you do such a good job. You can’t finish there!” “OK, but I feel I could do an even better job if I was given more responsibility, I’d like to develop myself more.” “But think about the fact that you have a family and children, it’s very practical to have a job from 8 to 5.” “I don’t agree” is what I say. Why do they say this? Just because one has young children and are a mother? /…/ So I say to him, “There are all sorts of things I would be prepared to work with, tell me where you need someone”. They think this is very positive that you talk in these terms, “Fantastic… you’re so flexible… but what about travelling?” “Well, I wouldn’t want to be away the whole week.” – But then there is *nobody* who wants to these days. – So I say, “It’s no problem with the travelling, I’ll solve it.” And yet after talking for a couple of hours, they still say “yes, but don’t forget that you have a family!” They would never have said that to a man. If you’ve chosen this line of work, to be an IT consultant, this doesn’t mean that you should be a slave or do everything they demand. You *can* solve the travelling thing. If you’ve got a customer in Gothenburg, it doesn’t mean that you’ve physically got to be there every day, every week. One or two days a week would be enough. You can do a lot

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19 I am of course aware that spatial arrangements may not be sufficient to engender equal talk.
of the work here. Here we are, working in a branch where we can use the latest technology, and yet they can’t see the possibilities! They’re so tradition bound!
(Female IT consultant, early thirties, married, 3 children under 10 years)

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I’ve just had a talk with my boss, which wasn’t very encouraging. He asked me a question which I’m quite sure that he would never have asked a guy – he assumed that my mobility was limited, since I have children, he also assumed that I fix everything at home and that I couldn’t take a job where I’m stationed away at a customer all the time. I told him that I didn’t think that it was fair that he posed such a question. I have a partner. I’m divorced with two girls who are 8 and 10, but I only have them every other week. I told him that I thought he should look at the other side of the coin and think in terms of the fact that I can be totally flexible every other week – then I can go anywhere, as far away as you like. Of course I give my children priority, why wouldn’t I? The official policy at this company is that our lives should be able to combine a career and family. So why doesn’t this policy apply to me as well?! I think it was insulting to ask such a question. I said to him. “You can’t exclude a person because of this.” He got nervous and laughed, but I didn’t get a proper answer. My experience is if you’ve established a relationship with a customer, it’s always possible to solve the logistics one way or another. In fact I’ve never had a job where you had to be stationed at the customer’s the whole time. But what kind of consultant, regardless of who you are and what gender you have, would enjoy being away 300 days a year? The family wouldn’t survive the stress. Is it just young people, consultants of the male sex, who have a college/university education, who haven’t started a family yet, who we are looking for in this company? Or perhaps those who have a family but who have someone else to do what’s needed to be done at home? They don’t give answers to those questions.
(Female IT consultant, early forties, responsible for two children under 10 every other week)

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I work with support for an application that we have for Ericsson. I don’t want to do support, I’d rather do team management or project management. I’m good at the technical work but I think I would be even better at a job that involved managing the whole thing. Ever since I got pregnant in 97 I haven’t had more responsible duties, even though I was originally hired because they thought I showed initiative and had ‘go’, they liked my attitude. /…/ Very generally speaking, the ICT branch is full of boys in their twenties who hack away through the night. We [women] see technology as a tool. They see it as a toy. We put our families first – the majority of us – and we say this out loud as well. But then we don’t get taken seriously sometimes – this is what I experience when having conversations with bosses and the like. Being taken seriously is harder.
(Female ICT consultant, early thirties, single mother, two children under 5)

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These various narratives were expressed by women working at the same Swedish company included in our study. In many ways their opinions and experiences differ from what was expressed by women (and men) at other Swedish companies who argued that they assumed combining work and family would not be problematic. ‘Assumed’ is central here. The ICT branch is a young branch and in the majority of the companies we visited, the median age of the employees was low. Employees, especially women, had not started families yet. This is not surprising given that well-educated women in Sweden are postponing the arrival of their first-born until their thirties. Many of the Swedish companies in our study also displayed a ‘young, trendy image’ – advocating buzz words such as diversity, opportunity, flexibility, ‘no
old boy chauvinistic atmosphere here\textsuperscript{20}, they obviously wanted to disassociate themselves from what they saw as the burgeoning flotsam of traditional organisational life. They communicated a view of the company to the outside world and to their employees that ‘anything was possible’. The company where the women cited above worked did not exactly fall into this category. It had existed for some time and while having always specialised in technical areas, it was only in recent years that an ICT and telecommunication profile had been mantled. The median age of employees was also higher here and having families was a common occurrence. It could thus be argued then that the particular form of ‘doing gender’ that emerges in the above cited women’s narratives will apply to women in other companies later when the reality of combining work/career and children emerges.\textsuperscript{21}

I wish to focus our attention, however, on how the above narratives exemplify situatedness and what the gender consequences of this are. First and foremost, the tales show us that the women are constructed primarily in terms of carers. In no interview, with managers, men (or the women for that matter) is it stated, or assumed, that the women lack technical or other competency. They are, it is argued, just as good as men at their jobs. They understand and can solve technical problems. Technical knowledge or competence is not what is at issue here. What is at issue is that the work requires, it is argued, mobility and accessibility both in space and time. Having responsibility for children – at least for women – is assumed to jeopardize this mobility and accessibility. But the women strongly argue in the interviews that the arguments used against them are somewhat a ‘sham’. On the one hand, they’re not asked if they can solve travelling /being away from home ‘problems’ (it is assumed that they can\textsuperscript{22}); on the other hand they argue that new technology can surely mitigate logistic headaches (i.e. time and space are in a variety of ways ‘released’ with the new technology). They emphasise again and again in the interviews that solutions can be found – but that they aren’t given the chance to show their ingenuity. The result is that they get stuck in what they see as rather boring and dead-end jobs or work duties. They also point out that the male bosses don’t realise that they are being discriminatory or narrow in their thinking. On the contrary they say that the men argue that they are trying to take the women’s situation into account in a fair way. Even in Ireland, the woman would state that the men got ‘devastated’ if it was pointed out to them that they were being ‘macho’ or ‘doing gender’. They just didn’t realise that they were doing it.

The fact that they work as ICT consultants – and what this type of work involves – is perhaps of interest here. I asked a female technician (in her forties) who worked at the same Swedish company mentioned above if particular skills or qualities were needed to be able to do the job. I expected an answer that tapped into technical matters. Instead she gave the following response:

I’d never have been able to do this job if I’d had young children at home. It would never have worked if I hadn’t had a husband who I could ring and say “I’ll be home at 7 this evening” and then later at 7, ring again and say, “I’ll be home at 10”. At 10 o’clock I’ll ring again and say that it’s going to take all night.

If the company had sold an ‘ICT solution’ to a public authority, say a hospital, then the contract would state that – depending on the level of ‘necessity’ – a technical problem must

\textsuperscript{20} Willim (2002) found that in the young, fast-moving company Framfab, traditional and older ICT companies, such as Ericsson, were disparagingly called ‘respirators’.

\textsuperscript{21} Although it should also be pointed out that this was not the case for one fairly young and progressive, but rather small company that we studied. Several of the women we interviewed there were also young mothers and their careers did not seem to be affected by their motherhood role. Perhaps this was due to the leadership’s philosophy that was put into practice rather than only put down on paper. The MD – unusually – was a woman – with young children in addition.

\textsuperscript{22} Interestingly the husbands or partners of the women we interviewed in this company did not work in the ICT sector but often with less qualified jobs (eg. carpenter, pre-school teacher) and it was argued by the women that it would be fairly easy for their husbands to take a larger share of child-care. They were not hounded by ‘top-pressure jobs’. 
be solved within a certain time-limit. Lena’s job was to fix the problem. And as is well
known, problem shooting doesn’t limit itself to a neat 9 to 5 time-frame and problem solving
is not eloquently delineated temporally in advance. Solving problems requires ‘process
time’.23 Furthermore, the work has to be done in situ. In some ways then, being a woman ICT
technician is more difficult than being a woman ICT consultant.

The point that I have been trying to make in this section is that situatedness ensures that a
certain type of ‘doing gender’ is accomplished and that women’s work prospects can be
circumscribed or even put in danger, given that the branch is at the present time experiencing
considerable economic problems and lay-offs are rampant. The body enters the picture in two
ways. On the one hand the women’s bodies are physically and geographically – in the
managers’ eyes – locked in space due to the women’s caring function and this affects what
jobs it is assumed they can take (even if they are seen as being technically competent). On the
other hand it is their female bodies as such (as opposed to their brains, if we keep the
Cartesian split) which signals diminished capacities. They are reproductive bodies. The men
do not have reproductive bodies and thereby are not constructed as a certain type of worker
and in so doing they avoid certain assumptions and questions. Lack of competency may
hinder the men in their careers, but the male body, as such, does not.

In Ireland we did meet a number of women ICT specialists who had children but whose
careers did not seem stunted. This was not because the situation for women was easier there.
On the contrary, good, reasonable child-care was scarce, paternity leave was an unheard of
concept, and men’s active involvement in caring for children was not fired by an official
discourse as it is in Sweden. It was in fact this lack of official discourse that ‘made the
difference’. In our study it appeared that Irish women either gave up their jobs with the arrival
of children (or at least the second child), arguing that combining the two was an impossible
task and the cost of child-care didn’t make it worthwhile – some even stated that financially
they didn’t need to work (a comment that was never uttered by a Swedish woman24); or they
saw to it that having a family functioned (being prepared to pay for services, using extensive
help from relatives, etc) if they really wanted to stay on in their jobs. They neither expected
the company nor the government to help them out. It was their problem that they had to solve.
The Swedish women by contrast, I would argue, felt cheated in a society that ‘on paper’
lauded equality on a national and local level and where more or less everyone we interviewed
stated that sex/gender makes no difference in the job, but where a chasm between the official
discourse and the daily reality existed.

Concluding words
I have argued in this paper that bodily knowings are generated through experience. With the
help of illustrations from working life, I have attempted to provide some examples of bodily
knowings: the way in which one experiences how one’s body or mind is constructed by
others; the way in which one experiences situatedness and its consequences. Bodily knowings
are both the object and agents of social practices. They exemplify how doing gender is
accomplished but also show how women contest and oppose this doing and how subjectivity
is constantly remade by these bodily knowings. Narrative, building on memory and in
particular on ‘body memories’, is a tool that can help bring these various processes to light.
While narrative in an interview is linked to a particular person’s life-situation, I have tried to
show that collectivity is also involved. The point of the narrative is seldom idiosyncratic but
captures more general historical social practices. Quite simply, narratives can make us aware
of what is going on and how we can possibly bring about change. Being aware of and

23 This is a concept that I have developed in earlier work. See for example Davies, 1990; 1996a.
Obviously the women ICT engineers need to use process time in their work as well. While an
approaching dead-line can elicit extreme time pressure, my point is that there is more lee-way
otherwise as regards to when and where their work will be carried out.

24 The official policy in Sweden is that each individual is economically responsible for supporting
him/herself as well as his/her child(ren).
including the body, bodily knowings and body-reflexive practices in our analyses can help us in this endeavour.

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