Chapter Seven

Conclusion

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In the end is my beginning.
T S Eliot

> The attempt to uncover a feminist ethic should be understood not as the quest for a superior standpoint from which to constitute a new morality representative of the feminine, not yet as the aspiration for a set of values designed to promote the interests of women as women. What matters, on the contrary, is to resist all and any formalisation, and to make instead an open-ended commitment to a plurality of values that cannot be determined in advance. (Shildrick 1997:211)

The aim of this thesis was to make a difference for people living with diabetes and people working in this area. The initial research question and sub questions were:

How do we learn about our bodies and what does this reveal about diabetes education?

- What is revealed about the needs of diabetes education when instead of examining behaviour we examine how the body is located in the world and how this impacts on the body and our learning about the body?
- How do we learn about the body and how do we construct knowledge about the body?
- How is the body constructed in diabetes education?
- What are the disjunctions and conjunctions in this intersection?
- What are the site/s of this intersection? Does the site have any relevance to these conjunctions and disjunctions?

As a result of the insights that have arisen from exploring these questions I have recast the research question to:

What are the sites where our learning of our body, our construction of knowledge of the body and the construction of the body in diabetes education intersect, and how does the site affect the disjunctions and conjunctions of this intersection?

I changed the research question because one of the underpinning findings of this research/study is that people involved in diabetes education are also involved in creating sites.

Sites

A site is constructed as part of our need to insert ourselves into the symbolic order. The framework provided by Lacan (Weedon 1997:49-53) in his explanation of the way in which our insertion into the symbolic order is based on the mirror stage is useful in understanding the fundamental fallacy of the site. The fallacy is created when a child first 'recognises' themselves in a mirror and constructs themselves as a 'separate' 'autonomous' and 'fixed subject' in order to insert themselves into the symbolic order.

A site is a device where some are included and others are excluded and consequently is a place where certain knowledge(s) are privileged over others. This is particularly evident in the medical site. In diabetes education the medical site exists in many places, for example:- the pharmacy; the doctor's surgery; momentarily in one's lounge room as the TV broadcasts a public health message. People with diabetes are necessary for the sites concerned with diabetes to exist, for the boundaries to be created, but are necessarily also simultaneously excluded from these sites.

We construct sites as a means to fix our sense of self, in an attempt to construct an essentialist view of ourselves or our identity. Because of this need to construct an essential fixed and continuous self it then becomes important for people who have linked their identity to a site to maintain the site. One of the contradictions is that people most privileged by a site often seem to *not* exclude people with diabetes. People more at the margins of the site seem to do the excluding. At the margins of the site there is a greater need to insist on fixing boundaries and knowledge. Here, at the edges, people, who fix their subjectivity by being included or excluded, in the site become the border guards to maintain the boundaries of that site. People at the margins of the medical site, may for example be nurses, educators, GP's, nutritionists. in non specialist unit settings. In order for them to position themselves closer to the centre of the site, and on the inside of the site, they exclude the person with diabetes from the site. This might be done through the mechanism of invalidating the expertise of the person with diabetes. This serves to establish, say the nurse's expertise, as medical expertise and more authoritative expertise, and consequently their right to be included within the medical site.

The relationship between sites and Lacan's mirror stage lies in the idea of the medical site as a fixed and 'real' thing. In an attempt to insert ourselves into the symbolic order people need to be a fixed self and that is the fallacy, because everything is shifting. The world and ourselves in it are based on change, unpredictable and cannot be fixed. We seek knowledge that is fixed in texts and ignore the fact that knowledge only comes alive through interaction in the reading. The whole other side of the meaning of a text is the reader, the body, the taking in, and the relationship. Similarly the assumption that a site is fixed, real and impermeable is challenged by the act of presentness and the refusal to be excluded or included.

As people with diabetes move in and out of multiple sites, they are potentially involved in multiple relationships, each of which offers the opportunity of learning the body anew, through a process of transformational learning. This learning occurs through the shifting of old and new knowledge, experience, theory and reflection into ongoing and new frameworks. This learning however is not a one way learning, but is potentially learning for all involved in that momentary relationship.

There is a tension that exists between the structures of fixed knowledge and the movement and fluidity of the creation of new knowledge and the ongoing process of learning. New knowledge is needed to deal with new situations. Multiple inputs of different knowledges and positionings are required, with the body necessarily remaining at the centre. The 'rightness' of any behaviour can only be measured against the individual contexualised life in which the manifest and lived body is central.

Fixed meanings

It became clear through the process of exploring these new and shifting knowledges, that I needed to include more writing genres than just an expository academic style. The tendency of the academic style of writing is to fix meaning in order to produce clarity. Fixed and past focused knowledge, which is very much the realm of decontextualised global knowledge, has its origins in other bodies, places and frameworks. These origins remain invisible and consequently not open to scrutiny. This excludes other ways of knowing and communicating knowledge that involves a creative act between writer and reader, audience and performer.

I wanted to include in the this writing the process of new knowledge creation that enables the knowledge that I have gained in my place, my body, and my location to be accommodated into an academic site, other bodies and against different experiences. Poetry, plays and short stories include the reader in shared meaning- making. The meaning is made richer through the inclusion of the multiple connections that can occur in these forms. The white spaces, silences, and disjunctions are as much a way of communicating knowledge as the words themselves. I have used these as well as interviews, journal excerpts and different authorial voices to create layers of writing. These layers build, resonate, provide harmonic echoes and dislodge each other moving always to open up the process of analysis and understanding

The processes of knowledge making

In the *Knowledge* chapter I looked at the ways in which we organise our thinking about knowledge, through definition and categorisation, which serves to privilege certain knowledges over others and makes invisible the contested nature of knowledge. This privileging contributes to the mechanisms whereby expert knowledge colonises the body, and makes the expression and legitimisation of embodied knowledge invalid. In the chapter I looked at the problems of mapping in particular, of which categorisation and definition are aspects. The map itself becomes the text, the representation then standing in for knowledge. Forces such as globalisation, technology, and economic frameworks co-opt this representation and the map eventually becomes accepted as being the thing for which it stood for. Consequently the ‘messy bits’, the actual context which is as much a part of the knowledge as the map of it, becomes invalidated and hidden.

I argued that if knowledge is how we know the world then knowledge cannot be fixed as it must follow a world that is in a constant state of change. Any fixed knowledge must simultaneously represent the conditions in existence at the time in which that knowledge was fixed, and those conditions can never be exactly reproduced.

This chapter set up a framework for conceptualising the relationship between local and global knowledges. Embodiment is central to this model of knowledge. I constructed a model of concentric circles with the most local, being the body, at the centre and the most global at the periphery. Overlapping and linking the centre and the periphery was the concept of sites. The concept of site linked local and global knowledges because it locates the place of potential exchange of knowledge from local to global and repatriation from global to local. The concept of site involved relationship and performance and embodiment. The concept of site involved the possibility of exclusion as well as possible exchange.

In the *Three Readings of Educational Materials* chapter I used discourse analysis as the analytical strategy. I set up as the privileged text the contextualised knowledge of two women living with and researching diabetes. I contrasted this to the representation of fixed knowledge about diabetes in the form of print-based diabetes educational material. The overlapping of these two made explicit the links to national and international public health policies, funding, politics, and the medical site. The third reading disturbed the binary through the inclusion of the body in the text. I think of this chapter as three different types of music, the echo of each resonating with the next.

The first reading was the conversations that Helen and I had. The first reading was about being firmly positioned as someone with diabetes having a look at 'what is wrong'. Then it moved to analysing the print based materials and being very "academic" and very safe.

The first reading was contextualised, the story of life. In the second reading I looked at the global. I used a disembodied academic voice to examine very 'proper' analytical texts disrupting this with commentaries, and interview excerpts. I layered this reading onto the first one, and it can be read against the understanding of having lived the story with Helen. I made clear the denial of the imperfect nature of the body, of death and of the processes of living. In the second reading I brought to the surface the complex intersection between sexed bodies and gender construction. This analysis makes visible the working of power structures through colonising discourses.

I found in the fixed texts of diabetes education materials that a homogenous, privileged world is represented in which there is no way for a reader to insert themselves into the text. The reader is marginalised, as is the context of their lives. In order to be able to insert themselves at all into these texts the person with diabetes must reconstruct themselves as patients, and as medicalised bodies, and are recast as consumers of the medical.

The third reading demonstrated what happens when you include embodiment in the writing itself. In this reading I introduced the concept of agency and disturbed the assumption of an autonomous essentialist self. I did this in part by including the constant movement and positioning and re positioning of myself as writer. In this reading what emerges are the things that get played out in my body and subjectivity. It was at this point that I accepted the ramifications of 'the personal is the political' in the act of writing a thesis. My body is the thesis. My resistance prior to this came from having been a subject in the medical site where my knowledge was treated as non-valid. The only possibility within that site, was to speak as if I were a medical or 'authoritative' person and hence assume an objectifying voice. The problem with this voice was that it also hid the very forces that are at play, which act as barriers to learning and change. It was at this point that issues of gender emerged and patriarchal, hierarchical structures of privilege and power became more evident as part of the mechanism that preserved (and still preserves) the status quo.

At this point I began to fully embrace a feminist post structural approach. I had resisted this approach because I had been concerned that men and women with diabetes are equally excluded from access to power and voice and had worried that a feminist post structural approach might exclude men. I then realised that for men (and women) there are many structures such as class or different gender issues that maintain the status quo in a negative way. Most important in this context was the myth of the imperfect body. At this point it became clear that feminist post structuralism allowed me to look at power, agency and difference. Using difference (as differànce) rather than sameness as an organising principle enabled an opening up of possibilities.

As each layer revealed itself I allowed the insertion of the researcher at the scene of writing to unsettle the layer further, allowing for a sifting of the traces of the positioning of the knowledge which had constructed the texts. The effects of globalisation could now be seen in action as they inscribed themselves onto and into the body. I revealed the sexed body and deconstructed the mechanisms of its prior denial. In this chapter the body is reconfigured as a site of contested global and patriarchal power.

The fourth chapter *Bodies* is both elusive and allusive and stands in for the body itself. This chapter is the core and the fulcrum on which the thesis rests. In this chapter I make manifest the body and place it at the centre of the research. I originally intended this chapter to be a review of literature about the body. It became instead an analytical chapter in which the body was the text, and the tool of analysis, revealed through the device of the body-at-the-scene-of-writing (see Somerville 1999, 2004).

In this chapter I explored and made explicit the importance and centrality of the materiality of the body. I found that diabetes education is about bodies learning about bodies. The importance here is the materiality of the body and the materiality of the person as body being made present, visible and felt, as opposed to it being abstract and removed as occurs in a lot of writing about the body (Somerville 2004).

What then emerged in this chapter was the relationship between the fixed and dead body and the fixed nature of disembodied writing. I explored the disjunctions between materiality, body and life. At this point the thesis shifted, and the methodology that emerged more fully was the use of an embodied writing as a device to bridge the binary divide between materiality and abstract thought; between fixed knowledge, as a point of reference and reflection, and the ongoing and future orientated fluidity of shifting and ever-changing contexts. Here the thesis hovered for a moment, balancing the temporal and the spatial, existing in place and in the moment.

The strategy I used for the Privilege: Site/Self chapter was the recasting of the data as stories, poems and other textual devices. I have included my own journal data, in its original form, and rewritten, as data. This chapter linked the individual, and the individual stories with the global. The global here referred to power and privilege operating on a global level and its ties to how individuals exclude and include other people and themselves. I made visible how global power is enacted at the individual level and how individuals resist that.

What then became clear is the way in which individuals become border guards for sites and how they fix their subjectivity by having a fixed site they construct. They thereby protect the privilege, which then creates a hierarchy for knowledge and voice, and that becomes the mechanism that prevents people with diabetes being the experts in their own lives.

I use the strategy of 'writing across the divide' (Somerville, 2004) to explore the relationship of power, privilege and knowledge in diabetes education. The chapter was a process of finding ways to express the in between and inhabiting the invisible space that occurs in the disjunctions. In this chapter people's desire and subsequent quest for a fixed essentialist self was thrown up in relief, like Plato's shadow in the cave. This desire is expressed through the fixing of sites, and the guarding of the arbitrary boundaries of those sites. The protection of privilege of those at the centre of a site was seen as a part of the quest for the fixing of self for those at the margins of that site. The resulting setting of rigid definitions and boundaries, and the exclusion of 'others' from that site, in this case patients with diabetes, serves to maintain patriarchal hierarchical systems of privilege. Furthermore the discontinuous and local nature of power, manifest in the regulatory state, means that both those within and without the site exercise these mechanisms of exclusion.

Playing the body is about the connection between play, learning, embodiment, resistance and theatre. In this chapter I further explored embodiment. Two concepts emerged as being important here: the lightness of being and present-ness. Materiality and embodiment, lightness of being, relationship, or a sense of connectedness, all of these things come together in the present and in that state, all things become possible.

I also looked at the idea of resistance. There is an imperative need to keep possibilities alive because even resistance can become co-opted by the patriarchal gaze. The very resistance to colonisation and reductionism can simultaneously become a site of regulation, whereby the resistance is harnessed by consumerist consumption. For example a resistance to the health message of control may become co-opted by the fast food industry or the pharmaceutical agenda.

Excess and private carnivalé are seen as sites of resistance. In order to escape the panopticon [1](Foucault 1980 71-73) of the medical site, this takes place in the hidden interstices of life. This then creates the conditions that, if this is co-opted by other agendas, can turn the excess into the means by which the body itself is damaged, erased and absented.

In order to disrupt this co-opting it is necessary to reinsert the body as the irreducible context and focus. The chapter is about the necessary movement of always coming back to playing and embodied lightness of being that enables the messiness of life, the laughter and the joy of life to resonate.

The play was intended to bring the chapter back to the joy of life. It is a device that opens up possibilities. The complexity of what I am trying to talk about cannot be captured in a singular academic text. The play enabled me to play with the audience. It is present, immediate, and involves the temporal spatial and material. It is about multiple sites and singular site. It is embodied, because even when reading it you have to bring the bodies into imagination in order for it to work. It anticipates a performance. It is about life which you can't write about, you can only live life.

Opening possibilities and learning

The process and strategy of this thesis is about opening up possibilities. When I look at what happens with people with diabetes and those engaged in diabetes education there is a lot of closing down of possibilities. This thesis is about trying to break that,

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[1] I am indebted to K. M. Power (2002) for her excellent analysis and application of Foucault's concept of the panoptican to minority groups, (in her example the indigenous early childhood arena)

to find alternative ways of becoming. One of the main findings is that it is the process of disrupting the 'fixing' that is important. Writing a conclusion is difficult because it is easy to be compelled into a 'fixing', a definite stopping point, yet the conclusion needs to state that it is about always keeping possibilities of becoming open.

The learning that occurs for people with diabetes is ongoing, as both the context of people's lives, the world, the lived body, constantly change. Beckett and Hager (2002) talk about the need for workers to learn the 'know-how' (5) to do their jobs, and the complexity of this in the midst of the 'hot action' of work (10). People with diabetes are involved in the 'hot action' of life. Given this, the provision of fixed and past focussed information is not enough to give people the tools to change their behaviours in appropriate ways. People with diabetes need not just 'know-how' but, as Beckett and Hager argue for people in the workplace, the 'know-how to go on' (2002 chapter 2). The 'know-how to go on', is the dialogue between skills, the ability to access fixed knowledge (past knowledge) and be able to change it to become new knowledge. Because new knowledge cannot by definition be known in 'know-how to go on' it has to be a process. That process is always involved in relationship – with other people, body, and world. This thesis reveals the need for people with diabetes to acquire the know how to go on with life in all its messiness and joy, its uncertainties, fluidities and with death as its end point folded back in as the only certainty.

'Know-how' involves asking how do I know whether something is right for me? Know-how is about embodied knowledge, it is the knowing of the body, through the body and with the body. It is the skill of being able to reflect back on your past experience and incorporate what worked in the past for you with the trying of new things. It is about trying and risking. Know-how is connected with wisdom, but the embodied wisdom of the crone. It includes mind, the cognitive, embodiment and so is the ability to have a dialogue between different ways of knowing the world.

Principles for teaching and learning in diabetes education

These principles can be usefully applied to any area of body learning.

1. The ability to learn, reflect and skilfully use embodied knowledge needs to be fostered, in the light of learning to be able to negotiate a discontinuous shifting subjectivity and context for living.

2. Life needs to become the focus rather than the avoidance of death. Not however a life in which the body is erased, silenced and denied, but rather life in which the aim is wellbeing, in which the body is manifest and central to the world.

3. Only the person with diabetes can be an expert in their own life. When this expertise is invalidated then the possibilities of a dialogue between different ways of knowing the body is immediately discounted. Not only must this expertise be recognised, but the structures, which prohibit the person with diabetes having the authority to match the responsibility of co-ordinating their medical care, must also be challenged.

4. The person with diabetes is increasingly being required to coordinate their own care while simultaneously being required to submit to greater and more pervasive forms of regulation. This contradiction acts as a barrier to learning.

5. The importance of the learning that occurs in the second site of knowledge production opens up the possibility of looking at the ongoing role of the multiple sites in the equipping people with the tools to go on. The need here is to be able to contextualise the theoretical concept of difference so that multiplicity of sites and relationships can be used to cater for difference rather than homogeneity.

6. The use of fixed disembodied and privileged knowledge is problematised against the need for an ongoing dialogue. The focus on regulated systems and

homogenous information is seen to erase the difference of the body, and the value of human relationships in learning.

7. Diabetes education is just as much about working with people involved in the process of education: nurses; doctors; nutritionists; other members of the public. If you want people with diabetes to change their behaviours, you need the people on the 'other side' to change their behaviours. Essentially the very idea of 'other' and 'other side' needs to be disrupted. So that for the I, with diabetes, the best way to get the most out of the educational experience is to challenge the people in the educational role to change their behaviours, and so disrupt the binary and open up an ethical open ended dialogue.

And now I am going walking...

The next step is to take the learning of this thesis and to incorporate it into future research. I want to further explore the effect of play and playfulness in body learning. I wonder what happens if the context of the life of the person with diabetes is radically and playfully altered for a short period of time. Would this enable a shift in their ability to engage agentically with opening up the possibilities of change when they re-engage with their 'lives'?

I can see myself walking on the Pilgrims' walk in Spain for six weeks. My body reshaping as the walk is incorporated into my very self. I can feel the sun just warm at the beginning of Spring, my eyes entertained by the wildflowers and the scenario. Perhaps there I will fall into a meditation as each step takes me further from home and closer to myself. My muscles aching and flexing, growing stronger with the terrain. When I go walking will that inscribe itself on my body, my self, so that I am changed and then more able to make changes to the context of my life when I return?

I think that yes! Yes! Yes! I will risk and try this.

...and now I am going walking.

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