# GROUNDED THEORY IN PRACTICE

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# Introduction

Grounded theory methodology and methods (procedures) are now among the most influential and widely used modes of carrying out qualitative research when generating theory is the researcher's principal aim. This mode of qualitative study has spread from its original use by sociologists to the other social sciences and to practitioner fields, including at least accounting, business management, education, nursing, public health, and social work. Its geographical spread is equally impressive. What this reflects is a great desire for theoretical explanations and, of course, the increasing use of qualitative materials and their analysis.

Most researchers who use this grounded theory style of social research learn its details from reading its specific methodological literature, including one or more of the following: *The Discovery of Grounded Theory* (Glaser & Strauss, 1967), *Theoretical Sensitivity* (Glaser, 1978), *Qualitative Analysis for Social Scientists* (Strauss, 1987), *Basics of Qualitative Research* (Strauss & Corbin, 1990), and *Handbook of Qualitative Research* (Denzin & Lincoln, 1994). Although many monographs and articles in the grounded theory mode are quite accessible, some are less so, and perhaps some people who use our approach do not seek out the substantive writing. From teaching research seminars, however, we know that students find invaluable, and probably essential, the study of substantive materials before they can become confident and skilled grounded theory researchers.

This book of readings is aimed at increasing the accessibility of such materials. The selection of published articles reproduced here is designed not so much to show the range of substantive topics or of the disciplines and practitioner fields in which grounded theory researches are written. The major principles of selection for these articles, aside from their generally high quality of research, is this: All of the authors (a) have studied directly with us,

and all understand very well our vision of this style of research; (b) have used some of our methods, whether or not discussing explicitly the details of their use; and (c) have themselves chosen to emphasize different aspects of grounded theory methodology and methods, including (d) use in their presentation of materials and theory-formulated interpretations. After all, people always select from the overall menu of their learning. They take whatever items make most sense to them at the time, in terms of knowledge and skill. With regard to research methods, they certainly do choose with reference to their immediate work and aims. Grounded theory methods are no exception to this general proposition. Even the differential emphasis on various aspects of the general methodology obeys it. So it will not be surprising if you find one or more of these writings much more illuminating or useful than others. In general, however, they should be valuable in filling out with fuller coloration the more abstract discussions (despite all the illustrations in our method books). We shall present each chapter with an accompanying commentary. There are of course many kinds of statements that could be made about each, but we have opted for emphasizing specific points that might be particularly useful for readers of *Basics of Qualitative Research* or *Qualitative Analysis for Social Scientists*. Sometimes we point to the combining of sources—interview, field observations, and historical (Adele Clarke); sometimes to special emphasis on a major technique—the conditional matrix (Krzysztof Konecki); to unorthodox but effective styles of presentation (Leigh Star and Geoffrey Bowker); to the linking of theoretical concepts (Isabelle Baszanger, Joan Fujimura); or some differences between articles by very experienced grounded theorists (Kathy Charmaz, Carolyn Wiener) and those by less experienced ones who nevertheless have written excellent articles (Lora Lempert, Celia Orona). There is something, we believe, to be learned from each, whether in technique, presentation, and presentational considerations, or . . .

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# Contents

# 1

# Deciphering Chronic Pain

ISABELLE BASZANGER

## *Commentary*

This important chapter by Isabelle Baszanger, a French sociologist, illustrates three research modes, informed by grounded theory methodology and methods, that we call to your attention in this brief commentary. First, her chapter is a superb theoretical ordering of very complex descriptive materials unearthed through her extensive and skilled field work and documentary search. Second, the chapter systematically develops a substantive theory addressed to the concept of "operational knowledge" apropos to pain and its management. This concept pertains to "the problem of medical knowledge, of making it operational. The connection from operational knowledge to regimes of doctor-patient relations. . . ." Dr. Baszanger's chapter makes another important point: It points to a broader theory about operational knowledge in general.

To those ends, she has used several aspects of grounded theory—namely, constant comparative analysis, development of theoretical concepts and statements, and theoretical sampling, as well as the usual supporting techniques

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of theoretical coding and memoing. She has woven in as necessary presentational elements much factual detail, both illustrative and persuasive, and a fair amount of quoted material. (Most of this we have deleted to save publication space. If you are interested in this material, please check the original publication.)

Isabelle Baszanger is one of the translators and the editor of a book of selected works by Anselm Strauss. She has also spent many hours talking with him during several visits to America, so her knowledge of grounded theory comes to her through this source as well as through reading its literature.

* * *

## Introduction

Chronic pain is, above all, a problematic reality. Pain is a person's private experience, to which no one else has direct access. Others have only indirect access to it. It has to be communicated by the person subject to it. But there is another reason why chronic pain is problematic: Because it lasts, it is lasting proof of a failure that questions the validity of actions and explanations, both past and future, of all involved, whether lay persons or medical professionals. Because pain is a private sensation that cannot be reduced by objectification, it cannot, ultimately, be stabilised as an unquestionable fact that can serve as the basis of medical practice and thus organise relations between professional and lay persons.[1] This fragile factuality increases the work a physician has to do to decipher a patient's pain.

The aim of this paper is to examine how physicians specialising in pain medicine work at this deciphering. This work is all the harder for them because there is no unified doctrine on which they can unhesitatingly and unreservedly rely to characterise a patient's pain situation. As I have shown elsewhere (Baszanger, 1987, 1990), these physicians are constructing chronic pain as an original medical entity that opens up a new field of clinical practice, which, in turn, justifies this entity's existence. This ongoing work of construction sharply divides this professional group about how to define standards of practice. Crucial to this debate is the question of how to draw up an authoritative definition of chronic pain for delimiting the specialty and organising practices. At present, no consensus is in sight.

This speciality is taking shape around two very different poles. At the pole we might call "curing through techniques," the aim is to cure pain by means

ranging from drugs and the simplest physical methods to ever more sophisticated neurosurgical techniques. Here, pain tends to be defined as a function of the technical possibilities for treating it. At the other pole, which we might call "healing through adaptation," the main objective is to control pain, which is defined as poorly adapted behaviour. To reach this objective, a global care must be provided that resorts to cognitive and behavioural techniques as well as drugs and physical therapy.

Two hospital centres specialising in treating chronic pain represent these two poles. Each of these centres has a heavy caseload, and is an entrepreneur. Their approaches have often set them at odds on important points, such as a pain centre's duties and educational role. By examining entrepreneurial activities and medical professionals' discourses in these two centres, I was able to reconstruct their very different conceptions of medical work on pain. These difficulties (the problematic factuality of pain and doctrinal debate) affect physicians' everyday practises and relations with patients. It forces them to work on the elusive information provided by patients so as to bring into being something called chronic pain. When doing this, they tap various, nearly incompatible, resources. In the case of chronic pain, they resort to strata of knowledge with which they are more or less familiar.

One is the widely accepted gate-control theory. This scientific theory is far from providing them with the means of regulating actual practices.[2] Although all pain physicians share this frame of reference, they are involved in an ongoing transformation of this theory as different maximalist and minimalist positions have been adopted. Actual practices are grounded in these contrasting options, as is the work of deciphering cases.

In addition to this theory, physicians also put to work knowledge of all sorts—about the environment, psychological behaviours, social factors, etc.[3] They also tap various scientific sources (biology, neurophysiology, anatomy, epidemiology, psychology, etc.) to forge practical knowledge for treating cases rather than explaining generalities.[4] The intellectual effort to "put odds and ends together" does not stop here. Another step is required: Medical work is performed on individuals, who are not "objective" data to be effortlessly read. People have their own ideas; they may change or resist change; they express emotions, fears and hopes. Each patient has a history. This has several consequences (cf. Strauss et al., 1982; and Wiener et al., 1980), one of which merits attention: During medical consultations, more is going on than just therapeutic and diagnostic activities in the narrow, usual senses. Indeed, many and different things are said ranging from body complaints to personal, family or work-related problems. Whether or not to listen to this information,

understand and use it as data (and how to do so) are decisions requiring more than merely the application of theoretical knowledge. They may be related to a practitioner's personal approach or to a professional procedure (cf. Silverman, 1983; and Dodier, 1990).

Here, I shall study the way these multiple resources are put to use by physicians as they form judgements about cases. Beyond the problem of practical knowledge, I would like to look at the consequences for patients. The ways physicians put their varied resources to work can help us understand how they stabilise, at least for a while, the problematic reality of chronic pain as they try to hold on to it. By stabilising this reality in an interpretation, they can organise interventions on patients. By using as a field experiment two pain centres with opposite conceptions and practices, we shall be able to see how physicians in each centre determine patients' pain situations and formulate advice to them. I shall examine how the characteristics of this work involve physicians in specific systems of relations with patients, and how these systems are related to dimensions of this work: either to a justification of physicians' actions or else to a confirmation, or realignment, of the initial doctor-patient agreement.

## Method

A grounded theory approach, as developed by Glaser and Strauss (1967), is adopted. The two pain centres were chosen after an initial phase of research, because I realised a comparison could serve to ground theoretical statements. Both centres are located in public teaching hospitals in Paris, France. They receive patients with similar pathologies, mainly pain in the skeletal system (low back pain, cervical pain, aftermath of back surgery), tension headache, migraine, neurological pain (phantom limb, postherpetic neuralgia, trigeminal neuralgia, . . . ), in fact any pain which has lasted for more than six months and has been resistent to all regular treatments. However, although these two centres admitted similar patients, they do not have the same approach to pain. Centre I has a "curing through techniques" approach. Treatment is considered to be a phase in a total medical process. On average there are three consultations followed by referral back to the patient's usual physician once the treatment is adjusted. One neurosurgeon and two anaesthesiologists who have acquired the specific techniques to cure pain are the entrepreneurs of this centre. The multidisciplinary organisation of the centre takes shape around

this "core of pain physicians." They are surrounded by consulting specialists to whom patients for whom specific treatments do not exist are referred upon arrival at the centre, whenever it is possible. It is different for the psychiatrist: After their treatments have been unsuccessful, "pain physicians" usually define the case as being beyond their jurisdiction and refer it to the psychiatrist. The second centre has a "healing through adaptation" approach which leads to the provision of extensive, integrated patient care. The average follow-up on a case usually lasts from eight to fourteen months. This follow-up necessitates team work and effective multidisciplinary organisation. The pivots of the team are those physicians, regardless of their specialties, who have adapted behavioural techniques for treating pain. Consulting specialists, including a psychiatrist, work with them in a perspective of total care; several doctors may simultaneously follow up a single case.[5]

I observed consultations with various physicians at these two centres for eight months. I was unable to alternate daily visits to each centre, since I wanted to follow up some cases and could not have done so without a steady presence in a single centre. After three months at the second centre, however, I did return for a few weeks to the first. As comparisons between them turned out to be fertile, I wanted to compare "backwards" and, by changing environments, limit the effects of excessive socialisation, when too much time is spent in one place. Besides observing consultations, I participated in group activities in both centres, and profited from conversations with physicians and, less frequently, nurses.

The constant comparative method of analysis and its coding procedures were used, first comparing items in each category, then drawing up categories and, finally, comparing categories. For me, these two centres represented a single field of research. A few remarks about field notes are relevant. It is hard to jot down everything said during a consultation with two, often three, persons present. Since my intention was not to do conversational analysis (which would have necessitated noting every word, silence and even gesture), I decided to proceed like an ethnographer. Because some exchanges seemed to be so important that every word needed to be recorded, I always kept a small notebook in full view on my knees. This was not unusual in the teaching hospital setting of these two pain centres and never caused problems. I wrote up selected exchanges verbatim, and noted the sequences during each consultation as well as turning points in conversations and arguments. For instance, I indicated the events preceding intense exchanges and noted whether the clinical examination took place early or late during the consultation. In other

words, I tried to signal links in lines of reasoning by jotting down key words so as to help me recall what had happened. Thanks to a physician at the second centre, I was allowed to tape some consultations. By taking notes while recording, I could later compare these two storage techniques and improve my note-taking. Here, excerpts have been taken from among the 326 consultations which were registered in notes or on tape, and coded.

## Centre I

"Look for, eliminate, verify, be sure of, make allowance for, determine, logically assume"—this rhetoric of action, which physicians at the first pain centre repeatedly used during consultations, provides an idea of how medical work is performed and made *visible* to patients. This logic, when applied, calls for surveying: What the patient says about the body, what is pointed out, has to be mapped onto the nervous system, turned into a percentage or average. The first task of medical work is to find out whether the pain can be projected onto a body-map, to determine whether "there's something or nothing." Although the terms in this alternative may have quite different contents necessitating different actions, both fit into a single perspective of curing through using technology.

### Establishing the Patient's Pain Situation

By this "nothing" they so often use when talking to patients, these physicians do not mean there is no pain. What they actually do is locate the pain, themselves and the patient on one side of the something/nothing alternative. This alternative, which we can use to analyse how they make decisions, is in fact used by them when they switch a patient from one side to the other. It is not horizontal, with equal terms, however. It is vertical, with terms in a hierarchical order.

#### *1. Easy-to-Decide Situations*

These physicians can usually determine a patient's pain situation quite easily. They normally receive, from the physician who referred the patient, a letter with a diagnosis, or clear enough indications, for initially defining, thanks to medical semiology and practical experience, the situation even

before meeting the patient. The problem is to verify this definition as they interview the patient and examine the medical records he has brought along.

The first consultation with a patient always starts with questions, either specific ("So you've had zoster? Show me where it bothers you now.") or open-ended ("What's the matter?" "What brings you here?" or "Start at the beginning and tell me about it."). If the patient begins talking about physical signs, the physician asks for details right away. Having already had several appointments with other practitioners, patients often use medical terms or talk about previous treatments. In any case, the physician puts the patient on the right track. A patient who said, "I sometimes have severe migraines" was corrected: "No you don't. You have a headache. Where? When? How?" When another started talking about his trigeminal, the physician interrupted, "No, now, tell me how you hurt." If a patient takes up the open-ended invitation and starts telling his story with all the facts, the physician, after a while, interrupts so as to lead away from the pain's context and back to the symptoms:

> *Patient:* I had an accident in 1984—fell backwards in the stairs, couldn't catch myself. Well, I was carrying a bucket. I was used to climbing up on a ladder. So I was laid up three months with infiltrations. I went back to working on roofs for almost a year. In 1985, when it was cold, that was when it was raw out, below zero—I don't know whether it's because of that—I had to stop again.
>
> *Physician* (cutting him off): So the pain runs down into your leg?
>
> *Patient:* Yea.
>
> *Physician:* Where?

The patient is not permitted to wander off interpreting his symptoms. When one patient began, "It all started when I fell two or three times," the physician interrupted, "Maybe. It's very hard to establish the cause." We can sense the determination to specify each party's domain. More importantly, we can see that the physician, at least when he already has the means of deciphering the situation (as in the last interview), considers the patient's causal explanation to be irrelevant.

Physicians look for patterns of pain by asking patients questions about their pain (e.g., what makes it worse or better—standing, sitting, etc.) and about the effects of previous treatments. Questions are not asked in any set order; they might come up before, during or after the checkup, as the physician reacts to the patient's spontaneous declarations. In easy-to-determine cases,

the aim is to see whether the referral letter's suggestions are of any use and whether the patient's declarations and medical records are in line with them. During the examination, the physician looks for evidence in support of these leads.

During consultations with cases that could be easily and rapidly determined, what the physician looks for is usually congruous with what the examination along with the patient's reactions and medical records enables him to see. This congruity may sometimes be delayed. In the case of a patient who came about a pain in his back and leg that had persisted since an operation for a slipped disk, the physician had received a letter from a surgeon with whom the centre frequently works. The letter diagnosed the case and requested a "symptomatic treatment." Not doubting this diagnosis, the physician asked the patient to point to where his leg hurt. As he did so, the physician interrupted him, "That's odd. You're not normal. The pain normally shoots up the front." While looking at the X-rays a little later, he said, "Uh-huh, it's clear to see. You have an L5, so that fits, everything fits." By using a means that objectifies the cause of the pain, the physician eliminated a deviation in the patient's experience. Since all the other evidence was congruous, this deviation from the norm could be dismissed as irrelevant.

What the patient says is but an indication. He is not competent to determine what he feels for two reasons. First of all, he has no means of generalizing: "You only know your own experience, while I know several cases." Secondly, he is subject to his sensations; he feels them rather than measuring them.[6]

During the first consultation, the aim is to identify the patient's pain by using both what objective examinations by previous doctors have established and what the patient says. In this effort to find out what the patient's pain corresponds to, the physician draws up, verifies or eliminates hypotheses so as to reduce the number of possibilities. The following case illustrates this process in full. During her first appointment at the centre, a woman stated that her leg pain hurt "like from burning or pinching." She had already gone to a rheumatologist, but a hip X-ray "didn't turn up anything." She thought that her thigh was swollen and that the pain was more intense toward evening. Saying "You think it's bigger?! the physician verified the difference by objectively measuring both thighs with a tape, and said, "We agree." Noticing that the veins were near the surface of the skin, he added, "There's a superficial vein problem, but is that what's causing you trouble?" This became the problem to be solved. The physician proceeded by reducing the number of

possibilities. Mentioning the X-ray, he eliminated a possible hip problem. Since he could not establish that the pain followed a nerve, "we can eliminate femoral cutaneous neuralgia." By asking the patient questions about her pain's periodicity and the factors that made it worse, he sought to know whether it had to do with the veins. Given that it stopped during the weekend but increased when she had to stand up for a long time (as she had to at work), he concluded, "So, that's it."

In this case, the only points dealt with were those directly related to the pain: Neither physician nor patient mentioned anything else. This holds for nearly all consultations when the pain situation can be easily identified as being "physical" or, as is said at this centre, "something." What is remarkable about such cases is that the physician nearly never asks questions about the patient's work and life (how it has changed as a result of chronic pain, what the patient can and cannot do, etc.). Many patients talk about the impact of pain on their lives and family relations. They say they are "fed up" or exhausted. Though they listen to them, physicians are not led to open a new line of inquiry or a new field for treatment as long as they can decipher the case by using other resources.

Physicians do not "work" on the information patients deliver about the pain's causes and impact on their jobs, moods, and deepest feelings of self-worth and self-identity. More precisely, when forming their judgement, they do not work on this sort of information as much as on the physical signs and symptoms mentioned by patients. Although these physicians adhere to a theory of pain that does not consider the first sort of information to be irrelevant or merely expressive of personal feelings, such information has a more fragile status than physical evidence because its validity as "facts" is open to question. The gate-control theory of pain fully takes into account both physical and psychological processes in order to explain the modulation of pain messages. It has thus opened the way to two different medical interpretations. As a frame of reference, it has forced all pain centres to construct a discourse with room for the psychological as well as physical aspects of pain. It also forces them to adopt practices that make room for psychology (for instance, by having a psychiatrist or psychologist on staff).

The pain centre under study interprets pain in a way that minimises cognitive and psychological processes. These take second place to physical processes, as the means of qualifying the causes of pain and as objects on which physicians must work. This is what I meant by a hierarchised nothing/

something alternative. This "nothing" is not synonymous with nonexistent. Instead, it refers to something else, the "inorganic side of pain" (as one physician at the centre said), which must be recognised because it opens a field for judging and explaining certain pathologies and can be used to determine difficult cases. This "something else" does not, however, entail specific medical work.

Before exploring a few such cases, we need to establish an inventory of the types of clues that point toward a psychological malfunction. Out of physicians' comments and my observations of consultations, I drew up the following list. It should be emphasised that this list is common to all pain centres—what differentiates centres is the weight assigned to various items.

One set of clues is directly related to the pain itself, or the patient's experience of it: a "wandering" pain ("one day here, the next, there"); a pain with several locations (e.g., cervical and lumbar pain); a pain that stops when the patient goes to sleep but starts again with maximal intensity when he wakes up; a "spontaneous pain" not set off by any traumatic or mechanical factor; more broadly, any pain that remains unexplained after repeated examinations, X-rays or biological tests; pains that a patient describes in very vague or even contradictory terms (e.g., when responding affirmatively to any and all suggestions the physician makes about sensations, or when describing symptoms before or during "a crisis" that do not make sense to the physician—as freezing cold in the lower back before the stomach starts hurting); and a whole series of visible physical signs physicians deem exaggerated (e.g., limping when the elbow hurts or continually touching a sore spot). Other items characterise the patient's relationship to medicine and the medical profession: proclaiming that the pain was caused by or lasts because of mistakes made by doctors or paramedics; being fussy with medicine (e.g., "Today, you hear there's no longer any reason to suffer. That makes me laugh."); and an excessive consumption of medicine (of both drugs and doctors) without any improvement. Finally, there is a set of items having to do with the context wherein the pain arose and, more broadly, with life circumstances: a job-related accident and its financial settlement; and destabilising events (such as unemployment, divorce, bereavement) and situations (such as permanent misunderstanding or constant fighting between spouses, the lack of a spouse, and problems at work or in the family).

For the physician, the clues in certain cases may be so numerous or apply so well that they fall into a pattern that leads him to form an a priori opinion. Hence, the physician retains as relevant the evidence that the patient produces