THINKING, ACTING, REFLECTING: A
CRITICAL ETHNOGRAPHY OF NURSING

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Introduction

Nursing is an occupation that is female-dominated in constitution but has traditionally been subordinated to the male-dominated medical profession and so clinical nursing knowledge has traditionally been subordinated to medical knowledge. Medical knowledge is generally treated as objective, value-free scientific knowledge, a view which mystifies both medical knowledge and the work of the doctors who use it. This view of the value of medical knowledge has been legitimised by the state through legislation which accords specific responsibilities and rewards to doctors whilst legally subordinating the roles and responsibilities of other health professionals to them. This is an apolitical view which disregards the ideological component of medical knowledge and the way in which it is exercised as social control to reproduce and support the class and gender interests of doctors.

Nursing has supported this apolitical view by its over-subscription to externally derived understandings of nursing developed through the dominance of medical knowledge and practices. Historically nurse scholars and educators have accepted the superiority of the technical knowledge of doctors by appropriating both the forms of knowledge and the paradigm in which this knowledge is created. They have thus unwittingly perpetuated the oppression of nurses and of their clinical nursing knowledge. Technical knowledge, with its capacity to explain and prescribe, is used by doctors and nurses as the basis for instrumental action. However both doctors and nurses generally ignore the fact that this action is ideologically embedded within the socio-cultural world of health care practices which is subject to values, ethics, traditions, and the subjective and intuitive understandings of the health care practitioner.

The changed understandings of the roles and capacities of women within the community have been mirrored within the development of nursing knowledge. Critiques of the handsmaiden role of nurses and the exploitation of the doctor/nurse game has led to a desire to develop nursing knowledge which is distinctive to nursing. This emphasis on the need to develop knowledge to describe and explain nursing practice has predominantly been taken up by nurses who have worked to develop objective, value-free knowledge about nursing practice. However a growing emphasis has been upon the need to understand the practical knowledge which nurses have and use in clinical nursing practice. This knowledge is subjective, value-laden, traditionally formed, and contextually embedded in the practices of clinical nurses. Nurses interested in developing this knowledge have focused on the development of meaningful intersubjective relationships between the nurse and the patient which disclose the traditions, rituals and judgements that each brings to the situation. This process develops practical knowledge which enables nurses to make deliberate choices between alternative courses of action by subjecting their values, purposes and commitments to scrutiny in the light of the constraints and exigencies of the situation.

This approach has provided nurses with valuable practical knowledge of the intentions and meanings of their nursing actions. However it negates questions concerning the

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relationships between nurse's interpretations and actions and the structural elements of the health care situation. It enables nurses to examine intersubjective meanings but not the socially constructed reality through which these meanings are created and maintained. The focus is on clarifying individualised interpretations thus ignoring the power relations at work which shape and form the consciousness of the nurse and patient and which are open to contestation as a form of false-consciousness.

Feminist critiques of male created roles and structures have informed critiques of the male dominated medical profession and the implications of this dominance for nursing. Neo-Marxist and radical feminist analyses have begun to challenge the power relations at work in nursing as a basis for the development of alternative perspectives which value the knowledge and experiences of women. However these perspectives have not been well received by nurses because the analyses lead to alternate views of women's health issues and health practices which develop alternate structures that bypass the medical system.

Nurses are, however, beginning to recognise the need to examine the relationship between the manner in which power is experienced and exercised within nursing practice and the kind of knowledge which evolves from, and informs, this kind of analysis. According to Ferry:

Nurses must discover ways to effectively challenge the taken-for-granted explanation that the individual is "responsible" while the system merely exists; and to challenge the taken-for-granted dominance of one form of knowledge over another, and one set of values over another (Perry, 1987:9).

What this study sought to do was to meet this challenge.

**The Politics of the Research Method**

This study took the view that nurses are not "cultural dopes" who are unable to participate in and contribute to a collaborative understanding of clinical nursing practice. Rather it was based on the premise that nurses think and act in meaningful ways within the rich tapestry which constitutes clinical nursing practice. However it was posited that these ways of thinking and acting need to be the subject of scrutiny and contestation in order to uncover the taken-for-granted habitual actions and the contradictions between intent, meaning and action. This kind of critique endeavours to disclose the power relations at work which perpetuate oppressive and hierarchical structures in nursing practice and seeks to uncover the ways in which these power relations affect the daily lives of clinical nurses, constituting the limits and development of their clinical knowledge.

This study analyses clinical nursing practice through the process of an in-depth longterm engagement in case studies of the clinical nursing practice of five nurses. This engagement was based on the premise that an examination of nursing practices which attempts to challenge the contradictions in knowledge and action, which have been systematically distorted by history and ideology, needs to begin with thick descriptions of nursing actions.

In this study I compiled thick descriptions of clinical practice of five nurses and fed back the observations for ongoing analysis and critique. The process of sharing the ongoing research data and the emerging theoretical constructions with the nurses required them to engage in collaborative reflection and theory development. The process of problematising the everyday activities of nurses and the contexts in which these actions were embedded served to nurture a process of consciousness raising of the nurses engaged in the study at the same time as it worked to inform and transform problems and perspectives about clinical nursing formerly held by the researcher. These changed understandings formed the basis of changed actions.

**Theoretical Terrain: Enlightenment, Empowerment, Emancipation and the Power/Knowledge Dialectic**

As a theoretical background to the study Habermas' (1971) construction of emancipatory knowledge was taken as being constituted by a specific cognitive interest in rational autonomy. This knowledge is based on the assumption that through the process of reflection and rational analysis people can understand themselves, their histories and the mechanisms by which they collude in their own oppression; and by knowing, can change themselves and their situations. This process is based on the premise that enlightenment enables people to empower themselves. A concern with this argument revolves around the question of whether knowledge-constitutive interests are contingent or transcendental. Michel Foucault (1982), the French philosopher took the position that Habermas' interests in finalised activity and capacity (technical knowledge), communication (practical knowledge) and domination or power (emancipatory knowledge) were not separate domains of knowledge but transcendals. Foucault alleged that these interests are types of relationships which overlap, reciprocally support and mutually use each other. He contends that domination is found in each of these interrelated interests in different forms. These relationships of domination are not uniform or constant, they establish themselves in different forms in different circumstances and these varying interrelationships constitute a particular
model for a particular context. Foucault argues that the shape of these models are determined by "blocks" in the framework of capacity-communication-power knowledge. These blocks compose regulated and concerted systems through which the operationalising of technical capacities, the activities of communication and the relationships of power interrelate and adjust. These systems of relationships give different emphasis to power relations depending on the institutional framework in which it is constituted.

This concept of power relationships challenges the notion of a formal, theoretical and unitary scientific discourse by advocating the development of discourses based on differential, local knowledges which will, of necessity, be fragmented and discontinuous. Foucault (1982) suggests that the activity of developing these forms of discourse puts them immediately at risk of co-option by the power relations which they set out to challenge. The knowledge uncovered by these discourses is catalogued, accredited and used in ways which enable them to become recodified within the prevailing dominant discourse.

By reworking Habermas' concept of knowledge-constitutive interests, Foucault establishes a discourse which shifts the focus of an examination of power from questions of what power is and where it comes from to an examination of power relations through the question "How is power exercised?". By posing this question Foucault (1975) contends that an analysis which identifies power as the medium in which emancipatory knowledge is generated, separates power from knowledge. He asserts that knowledge and power are inseparable and interrelated, that they directly imply one another: that there is no power relation without the correlative constitution of a field of knowledge nor any knowledge that does not presuppose and constitute at the same time power relations.

Foucault states that the analysis of power/knowledge relations consist of processes and struggles of power/knowledge which determine the forms and possible domains of knowledge. This challenges the view that an engagement in an activity such as reflection or rational argument enables the subject to develop knowledge which is resistant to power. According to Foucault this is a negative view in which power and knowledge are external to each other with knowledge being related to truth and power being equated with oppression and repression. Foucault (1980b:84) labels this view of power the "juridico-discursive" and alleges that this view of power has been accepted into discourse for two historically-based reasons.

The first reason for the development of juridico-discursive view is the separation of power and truth for the "speaker's benefit". Discussion on a hitherto repressed topic places the speaker in a privileged position outside the reach of power. The speaker can then solemnly appeal to the future in a prophetic voice as the universal intellectual who judges present oppression against the promises of the new order.

The second reason for the acceptance of this view of power as oppression and repression is the unrecognised relationship between power and knowledge. This relationship is masked by the production of a discourse designed to locate power as a "pure limit set on freedom" (Foucault, 1980b:86) which disguises the power/knowledge relationship within a discourse on power that is in itself part of an exercise of modern power/knowledge.

Foucault describes this legitimisation of a schism between power and knowledge as a repressive hypothesis and argues that this enables power to hide its own mechanisms. For Foucault emancipatory knowledge must always be power/knowledge, the knowledge that is exposed when the question of how power is exercised, is addressed. This power/knowledge proceeds from power relationships which Foucault defines as a mode of action which does not act directly and immediately on others.

Instead it acts upon their actions: an action upon an action, on existing actions or on those which may arise in the present or the future (1982:220).

Foucault alleges that this set of actions acting upon other actions can be brought about by violence or consensus, by acceptance or seduction, by induction or inciting, but the end result is always action upon the action of others. The manner by which these power relations can be analysed is by focusing on carefully circumscribed institutions. This process immediately meets with problems. Institutions such as hospitals maintain their existence by a series of mechanisms which are productive and reproductive in function but which serve to mask the power relations at work. Analysing power relations from an institutional framework presents the risk of explaining the relationships in the light of that framework. Foucault argues that this risk comes from an apparatus or "dispositif", by which he means the use of concepts as tools, being put into contention against explicit and implicit regulations so that the power relations are reduced to descriptions of legalism and coercion.

An examination of power relations leading to an explication of power/knowledge requires that a number of points be addressed. Foucault (1982:223) begins the process with what he describes as the "system of differentiations". This enables the analysis to locate those knowledge differences that enable one party to act upon another because of their privileged access to economic, linguistic, cultural or social know-how, skills
or competence. The system of differentiations within health care would reveal the differences in access to socially legitimated knowledge, skills and practices that doctors enjoy over all other members of the health care team. From this Foucault moves to an examination of the "types of objectives" such as profit or status which are pursued by those who act upon the actions of others. The economic, cultural and social objectives of doctors in relation to nurses and paramedics would be examined. Analysis of "the means of bringing power relations into being" reveals the mechanisms such as surveillance systems, threats of violence or dismissal by which these objectives are achieved. Hospital administration, government health department, senior medical and nursing staff collude formally and informally in the production and maintenance of mechanisms which develop power relations in health care settings. It is necessary to pursue the "forms of institutionalization" that support these mechanisms such as the traditional, legalised institutional form of the hospital with its clearly delineated hierarchical structures, regulations and multiple apparatuses operating interrelatedly.

The final point to be addressed is the "degree of rationalisation" required to elaborate, transform and organise these power relations in terms such as technological inputs and refinements or economic arguments pitting costs against eventual profits. Rationalisations abound in health care settings when arguments can be mounted to rationalise activities such as the cost of high technology useful for very few patients by pitting it against the emotional appeal of saving a life (it could be yours or the life of your loved one).

This process provides a useful framework for the analysis of socio-cultural power relationships as a basis for revealing power/knowledge. However it is interesting to note that Foucault did not take up the challenge to engage in a power/knowledge analysis as the basis for an engagement in emancipatory action. Despite Foucault's (1982) charges against the "negative" nature of the juridico-discursive view of power his own analyses which are concerned with "writing the history of the present" portray a negative present world. Unlike the promises of a better world offered by an engagement with emancipatory knowledge, Foucault's power/knowledge unmask the current situation without providing any utopian hopes.

Dreyfus (1982:109) in his charting of Foucault's work comments

Subjection, domination and combat are found everywhere he looks. Whenever he hears talk of meaning and value of virtue and goodness he looks for strategies of domination.

Foucault (1980b:143) contends that power/knowledge has in fact become "an agent for transformation of human life" but he sees this as a collective potentiality and denies the possibility of individual subjects being able to take control of their own lives. He constructs his form of ideology-critique in unique ways. His early work was based on archeological methodology but he became dissatisfied with the limitations of this method and moved on to develop genealogies. Genealogies allow Foucault the opportunity to take the role of diagnostician who focuses on power/knowledge and the "body" in modern society. This genealogical method is supported by a search for discontinuities and shifts in meaning characteristic of his earlier archeological method. Balbus (1987) challenges Foucault's concept of discontinuities because he contends that beneath the apparent discontinuities present in transitory historical forms is the hegemonic continuity of male domination. He suggests that it is possible to speak of a patriarchal historical continuity of western thought which, once recognised, is more pervasive than the transitory discontinuities. Balbus develops this idea by suggesting that the will to power/knowledge is treated by Foucault as gender-neutral and so Foucault translates what is essentially a male orientation into a generically human orientation obliterating the distinctively female power of nurturance. Therefore he argues that Foucault has a historical continuity with his own history of discontinuity through a focus on the generic will to power/knowledge.

The study demonstrated the scope and limitations of the power/knowledge focus and argued for a dialectical relationship between power/knowledge and nurturance/knowledge.

The Unspoken Values of an Oral Nursing Culture

Power/knowledge can demonstrate the ways in which the oral basis of nursing culture causes nurses to continue to be oppressed because they are unable to move from individualism to collaboration, they are unable to document their clinical knowledge and practice for reflexion and critique, and they are unable to challenge the power base of the medical and administrative cultures articulated and perpetuated through means of written communication.

Nurse scholars argue that clinical nurses remain unempowered in an oral culture when they are unable to articulate their knowledge and expertise to colleagues, doctors and administrators through the permanency of written forms of communication or to document it for their own reflective processes (Perry 1987). They claim that the reluctance of clinical nurses to develop the skills necessary to communicate and receive knowledge through written forms gives them less access to the channels of power which, by
consequence, restricts and shapes their knowledge and their capacity to facilitate change. Benner (1984) argues the necessity for nurses to record their clinical practice in order to uncover the meanings and expertise inherent in it. Other nurse scholars argue that documentation provides the means by which nurses can challenge the medical/gender domination of nursing by the medical and administrative cultures.

These arguments are rationally defensible if the value of a culture based on written communication is legitimated over an orally based culture. However, clinical nurses have consistently resisted developing nursing as a culture based on written practices. Nurses who have moved from clinical practice into administrative positions expend a deal of energy directed at the development of the recording skills and practices of clinical nurses. At the same time they support and maintain the oral culture of nursing through structural practices such as the oral handover and the double shift time. These double standards provide mixed messages to clinical nurses and reflect a biculturalism in which administrators recognise the value of oral practices at the same time as they recognise the value of nursing records for the development of nursing and the protection of patients.

This biculturalness of nursing administrators has developed because they are able to recognise the limitations of the oral culture for the development of the discipline of nursing and for the development of the knowledge and skills of practitioners. Their response is to attempt to develop a written culture which co-exists with the oral culture. It would appear from the observations and discussions throughout the research that the constant and continuing resistance to administrative attempts to introduce a co-existent written nursing culture to the oral base of nursing, represents a counter-hegemonic movement by clinical nurses. This resistance is never formally organised but constitutes part of the "common-sense" knowledge of what it means to be a nurse. Nurses "know" that the recorded data is "a waste of time" and so passively resist by either avoidance or through deliberately ineffective records. The unspoken value of this aspect of clinical practice is the valuing of the development of oral skills. Clinical nurses emphasised again and again that their interests lay in providing quality care and that nursing academics and administrators appeared to them to be more interested in the recorded care than in the actual care.

A nurturance/knowledge grid placed over the map of nursing care would begin with a premise that the expressive capacity of oral communication leads to knowledge development which is passed on and developed orally through a number of structures. This premise values the intersubjective meanings within the relationships in which nurses engage continually with visitors, patients and staff. The valuing of the oral culture of nursing would challenge the legitimation of the written cultures of the male-dominated medical and administrative cultures and actively support the further development of the kind of descriptive and expressive oral skills which are generally the domain of women.

Legitimation of an oral nursing culture would only be possible if the challenges of nursing oppression exposed through ideology-critique were addressed. My personal experiences of tapping oral conversations with nurses for analysis and reflection demonstrated the sophistication of their skills of memory, description and analysis. Although these women were not confident of their skills of writing about nursing practice, I found that they were highly articulate concerning their views about themselves, their nursing practices and nursing issues. They were capable of maintaining continuity of thought despite constant interruptions and of constructing telling arguments or critiques through conversation.

The work of feminist social researchers demonstrates that it is possible to value the oral culture which supports the socialising and enculturing processes of our communal life and to value both the nurturant activities in which women in particular engage, and the knowledge which develops from and informs them (Oakley, 1986). Feminists have shown that it is possible to develop structures, such as consciousness-raising groups, which are explicitly political in intent, and content, in order to explicate the political implications of personal decisions. In other words women learn to value their culture through collaborative retelling of their experiences and knowledge and by researching their histories to challenge the ideologies which have devalued them. These oral processes have been supported through the work of feminist social researchers who have developed strategies for the compilation and analysis of women's oral histories (McRobbie, 1982).

The valuing of these unspoken values which support the oral culture of nursing would need to provide recording mechanisms by which this oral culture can be easily preserved for knowledge generation and analysis. Processes of preservation would need to be developed collaboratively with clinical nurses, in order that their transformative potential is not reduced to another insidious form of surveillance.

This process of empowerment of clinical nurses requires that they are able to challenge the bases of their adherence to the oral culture in the light of the legitimation of the written medical and administrative cultures. At present nurses adhere to an unspoken valuing of their oral culture through
knowledge and experience whilst devaluing it through their unexamined support for the legitimising practices of the recorded medical and administrative cultures. Clinical nurses experience the oral practices which constitute the oral basis of nursing as positive and enhancing but rather than challenging the legitimacy of the data collection strategies being developed by educators and administrators, these nurses continue to engage in counter-hegemonic practices which resist the imposition of new practices without actually empowering themselves or their patients in the process. Nurses need to collaboratively examine the basis of their oral culture and consciously engage in structured emancipatory actions which bring enlightenment to, and transformation for, their patients. Nurses need to move from a position of passive resistance to a proactive position which examines the values of data collection strategies and acts to develop positive strategies to document researchable descriptive data for analysis. This action is essential if nurses are to be able to systematically develop knowledge from practice, share that knowledge with others and use that knowledge to improve the quality of care provided for their patients.

The Unspoken Values of Temporality

A power/knowledge focus reveals those aspects of nursing culture which are constrained by temporality. A power/knowledge analysis reveals the rigidity of ordering of work times and shifts and the manner by which nurses are oppressed by these structures. Nurses rapidly learn that they have limited time within any shift to achieve all the tasks allocated to them and to be able to deal with emergencies. This emphasis oppresses nurses by creating regular stress related to the organisation of their work load. Nurses experience constant stress caused by the need to complete tasks, to cope with emergencies and to relate to patients. It appears that the capacity to organise tasks and the capacity to spend time in developing therapeutic relationships with patients are both unspoken values of nursing culture which often causes dissonance for nurses. However both of these values contribute to a valuing of problem-solving. Nurses who are trained to respond rapidly and competently to emergencies develop a problem-solving ‘quick fix’ response to both tasks and patient problems. The technical approach to problem-solving has led nurses to value the application of knowledge to solve problems.

These problems are taken-for-granted and nurses in the research assumed that they could then take the problem and apply their knowledge and experience to solve it. Power/knowledge demonstrates the reproduction of power relations in problem-solving approaches which do not question the politics informing the questions. Reflection and ideology critique enables nurses to begin to pose new questions and reframe old questions in new ways rather than relying on taken-for-granted questions which maintain oppressive situations.

Nurturance/knowledge demonstrates that when nurses are acting to transform the situation for their patients they often do create new questions but generally do not record the consequences of the planned action as a basis for collaborative analysis and knowledge building. This activity is perceived as a ‘waste of time’. These questions are unacknowledged and unexplored and therefore do not contribute to the development of nursing knowledge.

The Unspoken Values of Medical Dominance

A power/knowledge grid uncovers aspects of medical domination which oppresses nurses and patients. The legitimisation of medical knowledge, practices and ethics entails a concurrent devaluing of nursing knowledge, practices and ethics. Medical dominance perpetuates class-based rewards of status, high economic remuneration, professional autonomy, and state-supported spheres of influence over other related health workers. Medical dominance enables doctors to develop the cultural basis of health and illness through medical definitions which become socially acceptable and are followed by prescription and prohibition by doctors. The consequences of this dominance for nursing is a lack of professional autonomy as work is subjugated to, and regulated by, doctors. Nurses receive poor economic rewards for high stress work and achieve minimal status or influence. The subjugation of nurses is perpetuated through the disadvantages of class and gender. My observations would suggest that ancillary staff experience this subjugation through class, gender and ethnicity whereas patients in general hospitals experience medical domination by class, gender, ethnicity and age.

Although power/knowledge enables nurses to critique medical domination, nurturance/knowledge reveals the reciprocity in relationships between medical and nursing staff and demonstrates that most nurses believe that most doctors do value nursing knowledge and skill, even though they underestimate it or judge it against their own needs and medical criteria. This was particularly apparent in the areas of specialisations such as neo-natal paediatrics, critical care, obstetrics and oncology where nurses were more familiar than medical staff with the technology used and with the patterns of healing and dying through repeated exposure to these kinds of specific patients. In these areas nurses often suggested that they were a respected member of the team as medical staff took up their ideas, comments and suggestions on behalf of patients. All the nurses in the study valued their participation in team relationships with
doctors and found this team participation one of the rewarding aspects of their nursing. The nurturance/knowledge grid demonstrated the important role played by nurses in the doctor/nurse team through their skills of communication and intersubjective meaning-making for patients and doctors. In general discussions some nurses were particularly vociferous in denouncing nurses who were wanting to separate the nursing role from the medical role, claiming that they were “anti-doctor and anti-men” and wanting to make nursing into some isolated female profession. Although the nurses sometimes appeared to be powerless in my observations of their team interactions, they themselves perceived their situation differently because they experienced the interactive role as satisfying. The contestation and critique of these observations, and the meanings attributed to them by the nurses, revealed that the unspoken value by which nurses judged the team effectiveness was in terms of their capacity to collaborate with the medical staff to bring about the best result for the patient. A commitment to collaborative action which nurtured the capacities of their colleagues to bring about quality patient care was valued more highly than the competitiveness which I was disclosing through a power/knowledge analysis. Nurses who valued collaboration and their roles as team facilitators more readily tolerate the power plays of doctors, recognising the power games and ignoring them or changing the rules without attempting to resist them. This valuing of collaboration, and the capacity of nurses to develop intersubjective meanings within team relationships which enhance patient care, is overlooked in an analysis based on power and interests. Any analysis of the doctor/nurse relations needs to recognise the transformative actions which can occur even in situations where nurses are oppressed and that the limits to freedom, experienced by nurses, can contribute to their satisfaction and well-being because nursing culture values collaborative relationships over individual power positions.

The Unspoken Values of Nursing Role and Autonomy

A power/knowledge analysis of clinical nursing autonomy reveals the ways in which the nursing role ties nurses to shift work and to a role conducted at the bedside. By contrast doctors are seen to work in much more flexible ways and to be free to move throughout wards and other hospital areas. Nurses complain about their shifts and the inflexibility of their routines. However, it is apparent from nursing actions, that nurses value their interpreting role which emerges from the condition of being “tied to the bedside”. The situation in which nurses are powerless to move away from the patient and their demands defines and shapes the nursing role so that nurses become patient-focused and develop a role as interpreter, co-ordinator, facilitator and advocate on behalf of their patients. Nurses are able to engage in transformative action by virtue of their constant interaction with the patient. Therefore nurses play an active role in supporting the freedom and mobility of the medical staff whilst holding an unspoken value which supports the nurturance capacities of the bedside role and denigrates the medical mobility which means that the doctor “knows” the patient mostly through the charts and the nurse’s impressions.

Power/knowledge also demonstrates the way in which a commitment to objectivity within the nursing role oppresses nurses and patients. In the hospital studied, shifts are organised so that nurses do not have successive shifts with the same patient. The patient and their relatives are oppressed by this system when they have to repeatedly relate intimate parts of their life story to strangers, particularly when the nurse simply confided in yesterday is clearly visible in an adjoining section. Nurses are unable to pursue transformative action over time if they are expected to constantly relate to a new patients each shift. In this way nurses are robbed of the opportunity to work with patients to construct joint health goals and to work together to facilitate them. This lack of continuity militates against the capacity for nurses to research their own practice through reflection on strategic actions. In response to this limitation nurse scholars are developing strategies to enable nurses to engage in primary patient care where the responsibility for a patient is sustained over their entire stay in hospital.

This power/knowledge analysis and its subsequent empowering processes are resisted by clinical nurses who claim that these measures may not empower either the nurse or the patient. They suggest that it is unfair for nurses to have to provide continuous care for difficult or “heavy” patients over successive days. Others claim that their stress levels rise and they lose their capacity to think critically and creatively if they have too much exposure to patients who are emotionally exhausting.

The Unspoken Values of Nursing Resistance

Power/knowledge enables a process of ideology-critique which exposes the points of fragility in the structuring processes of hegemony in which resistance is possible or is active. Resistance in clinical nursing is strongest at the points where nurses believe that the best interests of individual patients are being overlooked, particularly when the unacknowledged ethics of nurses conflict with medical or administrative decisions and decision-making processes. Passive resistance occurs at points where the nursing culture designates that practices are inappropriate or unnecessary, such as the resistance to competency in written recording or the avoidance of medically or
administratively derived tasks or decisions. Ideology-critique reveals the technologies of power designed to produce docile nurses. However, this docility is partial as nurses respond through nurturance/knowledge to the intersubjective relationships with their colleagues and patients. These responses represent those acts of resistance which are shaped by the knowledge and experiences of clinical nursing care and are revealed in actions which transform the situations for others. Nurses discussing these acts of resistance recognize the reciprocity in the relationships and the contributions made to their own personal and professional growth and knowledge. Nursing resistance which is based on a power/knowledge analysis may be ultimately rejected if it causes nurses to experience too much dissonance with their personal and professional self-image of themselves as "caring" people. The self-image of "caring person" which is supported by the values of clinical nursing culture is reinforced through the positive experiences of nurturance activity.

A Critical Social Science for Nursing

Nurses are in the business of transforming lives through participation in the transformative healing/dying processes. Therefore the emancipatory focus of critical social science has an important contribution to make to the development of clinical nursing practices which are transformative. A power/knowledge analysis enables nurses to develop critical theorems about their nursing practice but this study demonstrated that the power/knowledge focus neglected the emancipatory nursing knowledge which develops from the experience of engaging in nursing care which is essentially nurturant.

The dialectic created with a power/knowledge analysis and a nurturance/knowledge analysis enables nurses to engage in an ideology critique which reveals the unspoken values of clinical nursing practice for contestation and reconstruction. These analyses and critiques will enable nurses to recognize the politics which constrain and oppress their clinical practices and to understand the mechanisms which maintain and legitimate oppressive structures for themselves and their patients.

This process of enlightenment requires that nurses participate in systematic learning processes of reflection and collaborative critique of their nursing actions, their socio-cultural context and the knowledge which informs and develops from these reflective processes. Collaborative discourse enables nurses to utilize the skills of their oral culture to engage in ideology-critique and to plan systematic counter-hegemonic actions which empower their patients, their colleagues and themselves. Other critical research methodologies such as journaling, critical case studies, critical ethnographics, action research and critical clinical supervision could provide individuals and groups of nurses with the processes by which they can engage in their own enlightenment and empowerment. These processes need to be structured into the nursing culture by clinical nurses and not imposed from above or outside, although all the nurses in the study suggested that an "outsider" to the situation could facilitate these research-based processes in a way that enabled nurses to break the habits of horizontal violence and to collaborate together in critique, action and reflection. This is essential if nurses are to move beyond the idiosyncratic and individualized focus of their transformative nursing practices and to work together to develop clinical nursing knowledge which is emancipatory and empowering.

References


