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The Invisible Bodies of Nursing

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Abstract

Nursing practice is a very physical business. The work that most nurses do involves the use of their bodies as the primary tool of their work. Nurses take their physical selves to patients in order to carry out that work, the body of the nurse is often in direct contact with the bodies of patients that they care for. This thesis is about what I have called the ‘invisible bodies of nursing’, and I describe these throughout the body of the thesis. The physical body of the nurse, the body of practice, and the body of knowledge.

The physical body of the nurse is absent in most nursing literature, it is sometimes inferred but seldom discussed. My contention is that the physical body of the nurse is invisible because it is tacit. Much nursing practice is invisible because it is perceived by many nurses to be inarticulable and is carried out within a private discourse of nursing, silently and secretly. Nursing knowledge is invisible because it is not seen as being valid or authoritative or sanctioned as a legitimate discourse by the dominant discourse.

I approach these issues through an evolving ‘specular’ lens. Luce Irigaray’s philosophy of the feminine and her deconstructing and reconstructing of psychoanalytic structures for women inform my work. Michel Foucault's genealogical approach to analysing discourses is a powerful tool for exploring the history of the creation of the nurse and offers critical insights in to how nursing is perceived today. Maurice Merleau-Ponty’s phenomenology provides the flesh for my discussions about the embodied practice of nurses as beings in the world.

Nursing’s struggle for recognition is ongoing. I discuss strategies that nurses could use to make themselves more ‘visible’ in healthcare structures. The exploration of the embodied self of the nurse and through this the embodied knowledge of nursing is nascent. I hope to provide for nurses some food for both thought and discussion.
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Chapter One

Beginnings

In a 1982 interview Michel Foucault said the following:

The main interest in life and work is to become someone else that you were not in the beginning. If you knew when you began a book what you would say at the end, do you think that you would have the courage to write it? What is true for writing and for a love relationship is also true for life. The game is worthwhile insofar as we don’t know what will be the end. (Martin, 1988, p. 9)

When I started the initial work for this thesis I had a limited idea of where it was going to lead me and I did not have well-formed ideas of what my conclusions might be. This is a journey of exploration and throughout this process of research, thought, reflection and writing I am becoming someone other than I was at the beginning of this process. For me it is about articulating my-self, I am perhaps writing this part of my autobiographical-self.

I am a registered nurse and nursing lecturer and this thesis was originally to be called the docile bodies of nursing, until it came to me as a kind of epiphany that this was not a good place to continue to position nurses and nursing. I have grown weary of the mantle of oppression that nurses often shoulder, it is dark and grindingly heavy, not at all congruent with my way of being as a nurse, a feminist, a woman and a philosopher. I want within this thesis to promote a lightness of being, to claim the authority of knowledge that nurses deserve to have and should take as of right. It is tiresome for nurses to be forever positioned and to position themselves as subservient to medicine, as the marginalised ‘other’. Out there in the margins, life can be pretty good. The world moves forward and nursing can move forward as well. I want to push at the boundaries of knowing, and here I quote Foucault again who in the introduction to The Use of Pleasure states:
After all, what would be the value of passion for knowledge if it resulted only in a certain amount of knowledgeableness and not, in one way or another and to the extent possible, in the knower’s straying afield of himself? There are times in life when the question of knowing if one can think differently than one thinks, and perceive differently than one sees, is absolutely necessary if one is to go on looking and reflecting at all. (Foucault, 1985, p. 8)

So, this is a good place to start, with a passion for nurses and nursing and how they represent themselves in the world. I want to ‘stray afield’ of myself, to explore what is out there, to gain new and different understandings and importantly for me to put the knowledge ‘out there’, so that I can see anew what is ‘in here’.

Within the thesis I want to create the conditions, the possibilities for shifts within the culture of nursing. I see my role primarily as an enabler, getting the ball rolling, to set the scene for nurses to have conversations about ‘themselves’, and importantly to write about themselves and particularly their practice. Nurses are such interesting women and when one is immersed within the culture of the profession, it is often possible to ‘spot’ a nurse or a group of nurses when one encounters them outside of their work spaces. There is something intangibly wonderful about nurses, which from my perspective has nothing whatsoever to do with stale self-flagellatory myths of oppression.

I need to be clear from the outset that I will be writing about nurses as being women, this is partially because the majority of nurses are women. However the primary reason is that I am addressing nursing as being a feminine profession, possibly the most feminine of the professions. My having an emphasis on the feminine and feminisms is because I believe they have potential for making a positive difference for nurses. I am writing from my perspective of being a ‘female feminist’ (Braidotti, 2002a). To write about nursing as a feminine profession will help to make the thinking and writing in the thesis unique. I aim for my work to make a clear political statement about nursing within socio-political contexts and a clear philosophical statement about sexual difference and how nurses as women are represented within symbolic structures. Nursing has, I believe, potential to be at a radical new front of thinking.
I have reflected on the writing of this thesis for many years and thus it has become a labour of interest and love. I have observed over this time that the body of the nurse is invisible in nursing scholarship, that her body is inferred (Shakespeare, 2003) but rarely discussed. The body of the patient on the other hand is discussed frequently (e.g. Boughton, 1997; Gadow, 1980; Lawler, 1991 & 1997; Lumby, 1997; Parker, 1997; Rudge, 1997 & 1998; Wilde, 1999 & 2003; Wiltshire & Parker, 1996) and these scholars do write about nurses as having embodied practice. However, somewhere within this the embodiment of the nurse herself is invisible, and in addition to this her-self is invisible. Nurses do their work with their bodies, the work they do with patients is often about their bodies being in direct contact with the bodies of the patients (Shakespeare, 2003). This thesis will have as one of its foci an emphasis on the invisible presence of the body of the nurse in her practice, a presence that is not seen. In addition I will explore the ‘body’ of knowledge of nursing practice and how this is expressed in texts, both the texts of nurses’ verbal language and the written texts of patient records and scholarship. An understanding of how nursing is languaged will assist me to clarify how nurses are positioned within contemporary structures of health and suggest avenues for change.

Integral to my bringing forth the body of the nurse is a discussion of self and soul in nurses and nursing. I believe this is an area that is under theorised within nursing scholarship. An important component will be to go back in time to reflect on the life and work of Florence Nightingale and the contributions she made to the knowledge and practice of nursing. I am hoping throughout this work to consider ‘How to Conceive of a Nurse’, a term I am borrowing in a slightly altered form from Luce Irigaray (1985a) who writes about How to conceive (of) a girl (p.160).

Cody (2000) alludes to a ‘theoretical blank-mindedness’ in nursing research over the past decades and asserts theory is important to guide practice, and I agree with him. My personal philosophical beliefs guide my practice and my everyday life providing cohesion and enabling congruence, what Foucault (1984b) describes as ‘ethos’. This is important to me in the discordant and troubled world we inhabit where the only thing that seems constant is the landscape, which in Dunedin, where I am writing in the midst of winter, is one of dark and broody hills.
Seibold (2000) writes that any method chosen for research must be one that provides the most fruitful answers. The philosophical stance of the researcher is equally important and needs to be made explicit. Thus I regard myself as a feminist, a woman, a registered nurse who regards her position of *being-in-the-world* (Merleau-Ponty, 1962/2004) as significant to her practice as a nurse educator. I hold the view that having sound philosophical scaffolding is crucial to my work. I will use nursing practice to help me articulate a different theory and politics of nursing. I am drawing on a variety of sources from philosophy to inform and open up my work.

I will use as a primary derivation the woman-centred work of Luce Irigaray, philosopher, psychoanalyst, linguist, poststructuralist, woman. Within this vein I will also draw on the work of Rosi Braidotti and Elizabeth Grosz. Maurice Merleau-Ponty’s phenomenological *being* centred philosophy of the body will inform my writing about bodies and embodiment. Michel Foucault’s work will be invaluable for his critiques of thinking and social and political practises. I will explore the genesis of self and the body using his genealogical approach.

These philosophers provide fertile soil within which I will be able to till my work, and distil my thinking. As Swift notes in his wonderful novel *Waterland*, history is a “... lucky dip of meanings. Events elude meaning, but we look for meanings” (1983, p. 122). The process of exploring the history of nursing and how nurses come to *become* provides just this, a lucky dip with a cornucopia of possibilities for interpretation and re-reading, re-meaning, re-storying. Irigaray, Foucault and Merleau-Ponty’s philosophical works are compelling, and their multiple truths contradictory when lined up against one another. They could be said not to be cheerful epistemological mates. However, I need all of them to do justice to this project and hopefully to do justice for nurses and nursing. Turner (1992) writes of the challenge in theorising a sociology of ‘the body’ from one theoretical perspective only, and as I do, questions the need or usefulness of this. Epistemological divisions, which assume exclusivity, are not helpful. Turner believes a certain level of theoretical synthesis between post-structural and phenomenological approaches is possible, and preferable for a sociology of the body. What interests me is how the potential interaction between competing
discourses and the lived body could work together to explore development of self in nurses. An either or position does not suit my purposes and would not serve nurses well.

In Chapter Two I will discuss the theoretical approaches I am using to provide the supporting structures of the thesis. This will involve a discussion of Foucault's (1977) genealogical approach to analysing discourses and an exploration of discourse analysis. Following this I will address the phenomenology of Merleau-Ponty (1962/2004 & 1968) and his conceptualisation that subjectivity is embodied or incarnate. This has significant potential for an exploration of the embodied practice of nurses.

The richly complex work of Irigaray will be the focus of Chapter Three. Irigaray’s work will provide further supportive scaffolding for my work. In essence she will provide much of the theoretical structure to ‘flesh’ out this project. I believe her writing about and for women may prove valuable for nursing. Irigaray’s work is addressed infrequently within nursing scholarship and I aim to provide an extensive analysis of her work because it will be unfamiliar territory to most nurses.

Chapter Four will address concepts of the self and soul, primarily from a post-structural perspective, with an emphasis on Foucaultian theory and theory which is informed by Foucault. I intend to examine concepts of the self and soul to provide foundation stones for the later chapters that are nursing specific. In a similar vein within Chapter Five I will discuss the body and embodiment with an emphasis on phenomenological theory. I will as well draw on the extensive literature around the sociology of the body, in particular the body in medicine because this is where the literature is focused.

Chapters Six through to Nine are nursing specific. The aim of Chapter Six will be to provide a historical context for the chapters following and I will achieve this by writing about the work of Florence Nightingale, her work as a nurse and her work for nursing. I consider Nightingale to be one of nursings’ few documented heroines. Following on from this in Chapter Seven I will use genealogical analysis
to unravel iconic stories from the history of nursing, in particular Florence Nightingale, and subject them to a critique within structures of power and knowledge. I will explore how feminist discourses may offer the possibility for a stance of resistance and change for nursing. This will be further enhanced by exploring the importance of language used in the practice of registered nurses. By language I mean both what is spoken and what is written. Language is crucial in developing an understanding of how the self is conceptualised (Seibold, 2000). Language frames the self and I am interested in how nurses construct their sense of self as well as how it is constructed for them. Language is crucial in nursing because nurses have a long history of using narrative contexts both for learning and for dissemination of information to their peers. Nurses talk lots but I will be asking whether anyone is listening to them.

Chapter Eight will address the embodied self in nursing. The emphasis will be on the embodiment of nurses as women, as sexually specific female bodies and what this means for nurses in the contexts of their practice worlds. To explore the embodied experiences of nurses I will draw on Merleau-Ponty's phenomenological exploration of the body and how the body effectively acts as a 'hinge' to enable articulation with the world (Vasseleu, 1998). Exploring the self of women/nurses via Irigaray's theory of the symbolic re-representation of women and then enhancing this with Foucault's analytics of power, knowledge and ethics will assist me with my interpretation of the embodied self of nurses.

Chapter Nine will have as its focus a movement towards what I call thoughtful nursing practice. This will involve a drawing together of themes I will explore throughout the thesis, in order to conceptualise the possibilities of change, both for nurses and nursing practice. I will argue that substantial changes are necessary for nursings' survival as a profession and nurses’ personal survival as valued and valuable members of the healthcare system. Within this chapter I hope to 'stray a little afield of myself' and provide a different/alternative conceptualisation for nurses about the contexts of nursing practice, so that perhaps they will see their potentials for 'becoming someone else'.
I have a vision (which is a bit of a worry) of myself as a kind of Miss Marple, wandering and wondering about, eyeglass in hand, looking at what is going on in the world of nurses and nursing. My eyeglass is a speculum, and my use of speculum will be as a metaphor that will appear throughout the thesis. The concept of the speculum (which will be explained fully in Chapter Three) is derived from Luce Irigaray (1985a). Briefly, as an introduction, the term speculum is used by Irigaray to refer to a mirror, only occasionally does she make reference to the more common understanding of a speculum, that of it being a dilator used for internal examination. I will be using speculum as a mirror, the mirror of theory and discourse that within patriarchy has been used to define how women are represented and ‘seen’. I will propose alternate and creative ways that nurses could use speculum to re-look at their practice. My work will also be informed and guided by the textual voices of many other theorists, from whom I will ‘borrow’ ideas, concepts and words. Their voices are resonant in my thinking and writing as I embark on this journey.

In addition my writing is informed by my lived experience as a registered nurse, both as a clinical practitioner and as well the many years I have spent in nursing education as a lecturer. Much of my time in nursing education has been spent working with undergraduate students in a variety of clinical practice contexts, especially in mental health, although not exclusively. During this time I have worked with many registered nurses that are both clinicians and educators, and as well hundreds of nursing students. My collegial relationships with these individuals in both formal and informal contexts as well as the time I have spent with patients will have an important influence on the discussions throughout my thesis.

One of my desires for this work is for it to be useful to nurses. I will be attempting within this process to create a nurse friendly text, something that a nurse might want to pick up and read and find accessible, and perhaps useful. So as well as being a carefully researched thesis, I also believe in the importance of it being readable, as a story for dipping and delving in and out of.
The art of writing a thesis is for me akin to the process of gardening, which is a madness of mine. When I am starting a new garden, I am never sure how it is going to turn out. I look at the lie of the land, I put a plant here, and a plant there, and then start to fill in the gaps. I mulch and hand water and pull out weeds. After a while the plants start to grow, they take on a life of their own, and a thesis is a bit like this. After a lot of gap filling, weed pulling and nurturing, it will take on a life of its own, and sometimes I may be struck when I read it about how much of its own life it has assumed. It may have things ‘growing’ in it, which I never intended to put there, but which look perfectly fine where they have grown. A thesis comes into being, in similar ways to a garden. I will wander about in my thesis, as I wander about in my garden, and there will be secret places within it, as there are in my garden, places that perhaps nobody else will see (because I have tried to camouflage me/them). There may be paths and poorly constructed steps to catch out the non-wary, known only to me, the gardener. There will be angels in my garden-thesis as well, gardening/guardian angels who will watch over it all with a benevolent eye and gently remind me that I am a woman and that I should speak as a woman and as a nurse. And that is what I am setting out to do. Irigaray’s (1993a) angels are messengers of the divine. I have wondered and will continue to wonder who mine are. My angels are in part inspired by a print called Gardening Angels, which hangs in the School of Nursing where I work. I have always loved this piece which hangs in a poorly lit corridor and I imagine few others notice its existence. For me it has an aura of feminine magic. The angels are gardening by moonlight, as only a woman would do. I love to walk on crisp winter evenings moving within the cool glow of the moon, reflecting on my work, drawing inspiration and succour from the night, gardening by moonlight.

Helene Cixous in an essay entitled The Last Painting is describing for her the process of coming to know through writing:

This is our problem as writers. We who must paint with brushes all sticky with words. We who must swim in language as if it were pure and transparent, though it is troubled by phrases already heard a thousand times. We who must clear a new path with each thought through thickets of clichés. We who are threatened at every metaphor, as I am at this moment, with false steps and false words. (1991, p. 114)
Within this work of mine I am looking to clear a new path as both writer and gardener. It is to be hoped that readers will enjoy traversing this path and perhaps find something useful along the way for themselves.
Chapter Two

Theoretical Approaches Using Foucault and Merleau-Ponty

Introduction

I have chosen to use both poststructural social theory and phenomenology to guide me through my thesis. In using phenomenology and poststructuralism which includes using elements of post-psychoanalytic thinking, I could be seen to be using epistemological approaches which do not ‘fit’ together comfortably. Phenomenology is a foundationalist approach exploring the body and embodiment as lived experience (Grosz, 1994; Merleau-Ponty, 1962/2004 & 1968; Turner, 1992). Poststructuralism is strongly anti-foundationalist, rejecting any conception of the body as a read whole. Poststructural approaches suggest that the body is discursively produced (Foucault, 1977), that discourses that describe the body are not only texts of the body but also formulate its material realities (Grosz, 1994 & 1995; Weedon, 1987). Within this there is no singular body, there are instead bodies which are differently sexed, differently coloured and differently sized (Grosz, 1994).

In my study I am being flexible in my analytical approach, instead of tying myself down to something particular which does not serve the panorama of my research requirements. I agree with Lupton (1992 & 1994) and Turner (1992) that it is not useful to feel bound by epistemology and methodology, by conventional approaches to research. I do not believe the embodied practice of nurses can be explained by resorting only to poststructural approaches, there are important things to be said about bodies and embodiment without reducing them to the ubiquitous ‘social construction’. Likewise I do not believe phenomenology alone
provides me with the breadth of perspectives I wish to explore. It is my contention that the spurious barriers to blending theoretical perspectives are ‘truths’ worthy of interrogation themselves. Whose interests in the final analysis do these barriers serve? Lupton writes about this with clarity when she states:

There is much to be gained from an eclectic perspective which approaches the same research problem from different theoretical and methodological angles, while at the same time maintaining an awareness of the disciplinary traditions and rationale of the different approaches. (1994, p. 19)

I consider what I am writing is in effect an ‘intertextual’ approach and within this I want to encourage the ‘play of texts’ (Fox, 1993) upon each other. My work is also phenomenological in the sense that I refer to and draw upon the lived experiences of nursing and nurses. The body of the nurse and her felt and remembered experiences are also a text. As long as I remain clear about what it is I am attempting to do, I believe this approach to my research will be more useful to nurses and nursing than adhering to a single theoretical tradition would be.

Foucault's own work was influenced in a significant way by Nietzsche, Freud, Heidegger and Kant, to name but a few. Smart (1986) writes that Foucault’s work is interpreted as having parallels with any number of theoretical constructs, for example structuralism, phenomenology and hermeneutics. Foucault’s work did cover a broad range of interests and my reading of biographical studies of him (Eribon, 1989; Macey, 1993; Miller, 1993) suggests that his research interests were often generated by what was happening in his own life and by what I perceive as attempts to explore his own self. For me, Foucault’s life is reflected in his oeuvre, and how he led his life. His ethos was congruent with his philosophical beliefs. Foucault approached his work using a variety of theoretical/philosophical angles in order to interrogate an array of issues and interests. He set a precedent which others have followed, and which I am as well following. Turner holds the view that:

we should encourage research which will be open both to the idea of the body as lived experience...and to the discourse of the body as an objective presence. (1992, p. 57)
This ‘refiguring’ (Grosz, 1994) of bodies gives credence to both the lived body of phenomenology and the discursive body of poststructuralism. Importantly for my writing about nurses and nursing the body is perceived as a site of social and political inscribing, marked by both time and space. Bodies are both produced by cultures and significantly, as beings both in and of the world, are the stand out cultural product (Grosz, 1994). Within this chapter I will discuss poststructuralism, discourse analysis, genealogical analysis and the phenomenology of Merleau-Ponty, with a view to showing how each informs the analysis throughout this study.

**Poststructuralism**

Embodied subjectivity, self and soul are central to this thesis. Crucial to my exploration of these notions is an Irigarayan re-reading of psychoanalytic theory and immersion in feminist poststructural theory. This includes an appreciation for and repossessing of the relevance of the feminine, for what I suggest is the most feminine of professions, nursing. The symbolic repossessing I want to write about is reclaiming a positive representation of the feminine within the mythology of masculine psychoanalytic theory (Braidotti, 2002b). I will address the importance of sexual difference and borrow the strategy of ‘mimesis’ (which I will discuss in Chapter Three) from Irigaray to do this. Contrary to those who call for the ‘death of the subject’, the corporeal subject of my work, the nurse, will be present, enabled to emerge and the nurse will be embodied, hence my use of phenomenology. She will, as well, have a voice of her own. This is the derivation of the theoretical position for my work.

**Discourse analysis**

Burman and Parker (1993) point out that discourse analysis and the term discourse itself are not singular entities and can be approached from a variety of philosophical frameworks. What the approaches have in common, according to Burman and Parker, is paying close attention to language and how language structures meaning within our lives, not simply our personal meanings, but as well ‘social conditions’ which structure the forms of the everyday talk that is available
to us. For the purposes of my work I am drawing on the approach to discourse analysis as used by Foucault (1972, 1977, 1978, 1985, 1990) where plurality of meaning and subjectivity are emphasised within a theory that emphasises language and social power (Weedon, 1987). Foucault's approach to discourse analysis has as a central principle the deconstruction of 'truths' we take for granted in our day to day lives. So, why would I want to 'do' discourse analysis, and what do I understand this term to mean. Wetherell, Taylor and Yates summarise discourse analysis thus:

Discourse analysis is probably best described as the study of talk and texts. It is a set of methods and theories for investigating language in use and language in social contexts. Discourse research offers routes into the study of meanings, a way of investigating the back-and-forth dialogues which constitute social action, along with patterns of signification and representation which constitute culture. (Wetherell, Taylor, & Yates, 2001, p. i)

Within that short passage are key words/themes significant for my journey through this thesis. These are 'the study of talk and texts', the investigation of 'language', investigation of 'dialogue', and investigation of 'patterns of signification and representation'. These are terms that have meaning and purpose for my work in progress. I am undertaking discourse analysis to provide a genealogical map of the development of self in nurses/nursing. My exploration of the complexities of the self begins in Chapter Four and continues throughout the nursing chapters from Chapter Seven to Chapter Nine. My research is informed and guided by the insights of Luce Irigaray who is providing me with the tools to wander through text, speculum in hand, to think and write about the everydayness of nursing practice.

Foucault’s primary concerns are with power, knowledge, subjectivity and discourse, these are concepts that are closely linked in his work. Foucault used genealogy as a method to explore these three concepts. In The Archaeology of Knowledge Foucault describes discourse as:

...a group of statements in so far as they belong to the same discursive formation; it does not form a rhetorical or formal unity;...it is made up of a limited number of statements for which a
group of conditions of existence can be defined...it is, from beginning to end, historical - a fragment of history...
(Foucault, 1972, p. 117)

What is important to take from this statement is that a discourse is a ‘fragment of history’, and history is not something that is linear and tidy. Discourses arise over time, and they alter and disappear with time as well, nothing stays the same (Fraser, 1997). Discourses are continually in motion, some will be important at some time, and then there is a shift and they move over, or get moved over, to make way for others.

Lupton (1999) points out that this understanding of discourse has significance for our ongoing understanding of phenomena in culture and society, and that discourses help us to make sense of our world. Discourses produce both knowledge and power, and they instantiate a particular perspective of something as being real or the truth (Ferguson, 1997). They are both ‘constitutive’ and ‘productive’ (Carabine, 2001). Discourses are constitutive in that they construct a particular perspective or subject and in so doing they become productive, they have particular effects. What happens is that a particular discourse gets linked to another one/some, so that together they are able to constitute a particular truth and reality. It is in this way that societal and cultural constructs are shaped and become powerful mediating influences in our lives.

For example, a discourse of nursing is that it is women’s work. If this constituted truth is linked with other discourses about women as being ‘other’, irrational and constituted by their essential selves, then what is produced by this discourse? In effect nursing is seen as something that women do because it is in their natures to do so. Further because it is women’s work, it may be viewed as not requiring specific knowledge or skills. Rather, it is something that nurses, as women, do ‘naturally’, under the specular gaze and direction of medicine. These ideas about women are produced as ‘normative’ and ‘common-sense’ (Carabine, 2001). Through this particular discourse of nursing, power is constituted in the curative hands of medicine, which is seen as being productive of power and knowledge. Carabine suggests that discourses “...can be powerful because they specify what is and what is not” (2001, p. 275). What is and what is not are descriptions that are
valuable to apply to discourses to gauge their influence, their power base and the way they order our worlds of experience.

To understand discourse we have to see it as intermeshed with power/knowledge where knowledge both constitutes and is constituted through discourse as an effect of power. If our study of discourse is to be more than a study of language, it must also look at the social context and social relations within which power and knowledge occur and are distributed. (Carabine, 2001, p. 275)

A key place to begin an exploration of discourse analysis is with language. What exactly is language? Language is a great deal more than a tool to communicate with. Language is a dynamic system of communication and understandings which is constantly undergoing change. Language is not an impartial tool for conveying information, rather, language is constitutive: "...it is the site where meanings are created and changed" (Taylor, 2001, p. 6). Language both produces and constrains the meanings that are available to us in our lives.

For Ian Parker (1999), discourse analysis is primarily about being sensitive to language and having an appreciation of discourses operating within broad cultural contexts. Discourse analysis is also about hermeneutics, the meaning of what is being said both for the researcher and whatever it is that is being researched. While discourse analysis is about language, Parker reminds the reader that as well as using language "...we are also used by it" (1999, p. 6), and that language has meanings that effectively position us within power relationships. Analysing meanings of language is important (Burman & Parker, 1993; Parker, 1999). Burman and Parker suggest that “[l]anguage organized into discourses ...has an immense power to shape the way that people, ...experience and behave in the world...” (1993, p. 1). Lupton describes how, for her, discourse analysis is made up of two interdependent parts, textual and contextual. Textual refers to the structures of discourses and contextual “...relate[s] these structural descriptions to various properties of the social, political or cultural context in which they take place” (Lupton, 1992, p. 145).

When analysing any discourses Parker (1999) suggests that ‘contradiction’, ‘construction’ and ‘practice’ should be kept in mind. ‘Contradiction’ challenges
the reader to look for different meanings in the text, to actually look ‘through’ the text in search of contradictions. It is important to identify the truth claims of the discourse and to look for resistances and counter discourses. ‘Construction’ is about exploring how the text has been shaped to produce particular meaning for the readers. For example what strategies have been used to shape the text for readers so that it makes sense for them. ‘Practice’ leads the researcher to ask, “…what are these contradictory systems of meaning doing?” (Parker, 1999, p. 7).

What are the consequences of particular systems of meanings for different groups and which ones gain precedence in particular contexts. Practice is where the researcher is exploring issues of power and knowledge within the meanings and perhaps offering an alternate reading. According to Parker it is important that discourse analysts make their own position overt in the process. Burman and Parker (1993) contend that in discourse analysis it is not only the constitution of objects that is being explored, but also the construction of ourselves as subjects. What Burman and Parker mean is how we develop an idea of our-selves when we speak, and how this influences us when we think. This is an aspect of discourse analysis that is significant for my work, not only methodologically but also in my exploration of the development of self in nurses. Further, Burman and Parker contend discourse analysis is an important research tool for guiding political practice and resistance. They suggest that discourse analysis can help to uncover themes and truth claims of discourses, as well as identifying political values and who stands to benefit from the discourses (1993).

Also to be considered are what discursive strategies are to be employed. Carabine states that a discursive strategy “…is the means by which a discourse is given meaning and force, and through which its object is defined. It is a device through which knowledge about the object is developed and the subject constituted” (2001, p. 288). There has to be a reason for existence of a specific discourse, even if at first that reason is not immediately obvious. Finding the reason can provide evidence of how slippery power and relationships of effects of power can be. With my spectum in hand I am setting off on a mission of exploration, akin to lunar exploration. As I gaze through the perplexing lens of the spectum, I may indeed encounter a kaleidoscope of phantasmic proportions. The spectum I am using is a meta-speculum, examining and deconstructing the discursive technology of the
speculum that nursing is provided with to look at itself. The process of deconstruction will assist me to have a different view through the speculum.

I have increasingly come to the understanding that there are not as many 'real truths' in the world as I had thought. Within my research I will make links between the physical selves of nursing and power. I want to explore how power has been exercised on the 'body' of the nurse and the 'body' of nursing practice, and who has done the exercising. I will as well address why it might have been politically expedient for these particular exercises of power to occur. Foucault's (1977) concept of the docile body is asserting/inserting itself here, nurses and nursing have been and are 'docile bodies', but this does not necessarily reflect negatively on nursing. If I invert Irigaray's Speculum and turn it around on itself, throw out the accepted and internalised myths (read 'truths') of nursing as an oppressed group, I might excavate some hidden technologies. Indeed as I will e-Luce-ideate in Chapter Eight a 'technology of self-caring-for-others' may yield some potential. For genealogical analysis I will be concentrating on discourses of the body of nurses and discourses of the body of nursing practice. This keeps the field semi-contained but exciting. Alongside Grosz (1994) I believe in the importance of writing aporetically. For me to write aporetically means that I will in the course of my research come across challenges and have many questions, it does not mean that I will be able to or will want to provide all the answers. I may be wandering in pursuit of some forms of 'truth', but I do not claim to want to find them. I am more concerned about writing with a sense of optimism and potential for nurses and nursing, in order to generate conversations and debate.

I am not at peace with Foucault's (1980) notion of ridding the text of the subject. I will in Chapters Three to Five explore the female feminine subject (Braidotti, 1994a) and she will have a voice. In Chapters Six to Nine I will be exploring the voices of nurses and nursing. Hartsock (1990) describes the call by poststructuralism for the death of the subject as 'suspicious' and 'premature'. Continuing with this theme Benhabib is clear in her belief that poststructuralism does not allow for development in the project of freeing women because one of the theses of poststructuralism is that “...the death of man [is] understood as the death of the autonomous, self-reflective subject...” (1996, p. 553). Haber (1994)
on the other hand takes a more reflexive approach to the death of the subject and insists that poststructuralism does not necessarily preclude the presence of a subject. Haber states that:

Poststructuralism can be read - or adapted to read – as necessitating only the claim that there is no autonomous, wholly self-creating, or coherent in the sense of single-minded or one-track self. The self can be many subjects. (1994, p. 120)

In my work I will be writing about the embodied experience of the nurse, and within this it is important that I listen to the ‘voices’ of that body and also the silences. To do this I will draw upon texts written by nurses and others that have written about nurses. As well as this the texts of my experiences working as a registered nurse and nurse educator will help me to source both voices and silences. Where there is voice there is subjectivity even if it is not the voice of a transcendent humanistic subject, this is a more freeing position that that offered by Benhabib (1996) and Hartsock (1990) and with which I am at odds. It is as Haber states in the quote above that “[t]he self can be many subjects” (1994, p. 120).

Within Western philosophy scholars generally regard the category of ‘woman’ as a ‘problem’. From my perspective, as a ‘female feminist’ (Braidotti, 1991, 1994a, 2002a, 2002b) I will be exploring self and subjectivity in nursing, a position historically denied to nursing by the rational subject of the masculine profession of medicine. Medicine’s understanding/discourse of the body is that it is an object upon which can be effected a cure, based on scientific knowledge. Medicine ‘owns’ the body of the patient (Garmanikow, 1978; White & Su, 2000) and medicine is the discourse, which has the most powerful effect culturally, socially and materially upon nursing (Kelleher, Gabe, & Williams, 1994; Papps, 2001; Paterson & Phelan, 2003; Porter, 1992; Powers, 1996; Witz, 1994). I do not consider nursing to be oppressed by medicine, but I do assert that nursing is dominated by medicine within a complex series of discourses about medicine, nursing and the role of women in society.

Nursing’s understanding/discourse of the body is that the body is part of the whole self and individuals can be worked with, nurtured, cared for and that is as
valid as the body being an inscriptive surface, waiting to be worked upon (Lawler, 1991 & 1997; Parker, 1995 & 1997; Rudge, 1997; Short, 1997). Nurses do body-work, as do doctors. However, nurses do intimate body-work, using their own bodies as an integral tool of their practice. This is part of the self of nursing. Nursing practice is often messy. Nurses clean up the detritus of life; vomit, shit, blood, urine and anything else which is excreted from the body, including tears and misery (Lawler, 1991). Nursing is corporeal embodied practice. Nursing, Lawler (1997) stresses, has a uniquely private side, known only to nurses and their patients. Only a nurse knows what a nurse knows (Wiltshire & Parker, 1995), and this has been one of nursing’s downfalls. Only nurses know because nursing has a history of having an oral tradition, which remains unrecognised and largely invalidated. If you cannot quantify it, it is difficult in this day and age of randomised control trials to claim validity. I do not want to quantify nursing practice, but I do want to write about it using a different philosophical approach to those used by other nurse scholars. I believe nurses and nursing are wonderful, and I have as an objective of my work to try and explain what nurses do, how they do it and maybe why they have come to do their work in that way.

Genealogical analysis

What I am setting out to do is discourse analysis using Foucault’s genealogical method (not that he called it a method). As he became more interested in power Foucault wanted to explore the origins of discourses (Alvesson & Skoldberg, 2000). Genealogy was the strategy used by Foucault to trace the historical emergence of ideas, practices and beliefs. The focus of Foucault's genealogies are the relationships between “...systems of truth and modalities of power, the way in which there is a ‘political regime’ of the production of truth” (Davidson, 1986, p. 224). Foucault used genealogy for his critique of the modernist project and used it effectively for his exploration of prisons and discipline in Discipline and Punish (1977) and as well the three volumes encompassing the History of Sexuality (1978, 1985, & 1990). He is in effect telling a series of stories and as Couzens Hoy remarks, “Physician rather than philosopher, Foucault as genealogist lets his histories tell their own story” (1986, p. 7).
Within *Discipline and Punish* (1977) Foucault uses a number of different ‘stories’ such as ‘Generalized punishment’, ‘Docile bodies’ and ‘The means of correct training’ to explore the beginnings of a range of techniques for classifying individuals and populations that occurred at the end of the eighteenth century. The classification took the form of documentation of evidence in order to categorise individuals, different mechanisms of examination, the early beginnings of fixing norms for human behaviour (Davidson, 1986). It was the time when a new form of power began to emerge over bodies and led Foucault to wonder whether this was “…the birth of the sciences of man” (1977, p. 191). History Foucault (1984a) tells us has no hidden ‘essences’ and comes about by chance as opposed to something that was organised. In addition Foucault points out that history generally had ‘lowly’ beginnings, not the lofty ideals of individuals and organisations that we have been led to believe.

Genealogy is a form of critique. When Foucault does this form of analysis he is looking to turn the perceptions that individuals have about how they experience their lives upside down. Genealogy questions what individuals and communities have come to accept as ‘truth’ and disrupts what humans take for granted in how they act as subjects and how they have come to be. Foucault couches his critique within a nexus of knowledge and power. Brown comments that genealogy “…treats the present as the accidental production of the contingent past, rather than treating the past as the sure and necessary road to the present” (1998, p. 36). Our collective past does not dictate our present day condition. The aim of genealogical analysis is to call into question how issues have been constructed in/by history and bring about change in how individuals come to understand themselves and go about their everyday lives (Haber, 1994). The genealogist digs around the roots of social practices (Alvesson & Skoldberg, 2000) looking for the origin of claims to truth, and for Foucault the search was specifically for the claims and ‘truths’ of the human sciences (Davidson, 1986).

Foucault is at pains to point out that the knowledge the genealogist uncovers does not mean there will be stability in our lives and the world. We will not be able to suddenly grasp the truths of our origins. Rather, we may come to recognise that there are no hidden essences to unravel, that much of what has happened
historically came about by chance and not in an organised and coherent fashion. Indeed we may come to understand that we have been deluded by history (Foucault, 1984a). An example of the type of genealogical analysis used by Foucault is the history of diagnosing mental illness and in particular how ‘madness’ came to be seen as an illness and thus a social problem which made it the responsibility of the state (Foucault, 1965). A further example is the management of criminals within the ‘Panopticon’ of the prison (Foucault, 1977) and how this method of surveillance was extended and applied in the army, schools and hospitals (Sarup, 1993). Foucault’s analysis is intended as a form of critique to challenge so called self-evident practices that have arisen through history in relation to people as themselves, social institutions (medicine, justice, education) and societal practices (Haber, 1994).

The effect of power through Foucault’s lens is to normalise and to produce docile and useful bodies, which then become agents of political power. People have power invested in them by the state and as subjects of the state they have within them everything that comprises the power regime. People are not pawns within this; rather they are products of power relations. Foucault writes about power as being a relationship and describes it not as being something which acts directly on subjects, rather, “…it acts upon their actions: an action upon an action, on existing actions or on those which may arise in the present or in the future” (1983a, p. 220). Thus the general aim of Foucault’s genealogical analysis is to uncover the layers of power so that subjects are better able to be aware of the effects of power in their life and work (Haber, 1994). Power permeates through layers, from the bottom up (as flaky pastry cooks a layer at a time).

When Foucault writes about genealogy he presents his argument in terms of violence, upheavals, domination and opposing forces. What Foucault describes is not the linear teleological history we have become accustomed to but rather “…current episodes in a series of subjugations” (1984a, p. 83). Foucault dispels the myth that what we learn from history tells us about ourselves, introducing instead an element of dys-quiet by informing us that ‘effective history’ (genealogy) “…deprives the self of the reassuring stability of life and nature” (1984a, p. 88). Furthermore the self is uprooted from what it has known and any pretence at continuity or final completion is removed. This has the effect of
removing any sense of tidiness or comfort we may once have felt from reading our histories, whatever it was we thought were reading.

Smart notes that:

Foucault’s critical genealogical analyses of human experience, relations of power, and forms of knowledge effectively reveal that forms of social cohesion and hegemony have a precarious and complex history in human practice. (1986, p. 171)

Foucault emphasises that history and change does not happen with a hiss and a roar. Changes occur slowly and incrementally and ‘creep’ up on populations (Davidson, 1986). Foucault identifies a change in history alongside the emergence of capitalism. There was a change in relations of power, from the use of power as an oppressive and often violent force to power being seen as being productive. The change in stance was seen by Foucault as an attempt by governments to retain control over populations, but to do this in such a way that individuals would perceive of this as a good thing (Smart, 1986). Perhaps as Foucault (1978) suggested, they started in an innocent enough manner with the noting down of a few facts. This then developed into systems for maintaining records, especially about people and from these came normalising truths, used to regulate and discipline bodies. Why have a frightened population when you can have a ‘docile’ population that is much more useful for political ends? In a practical sense a government is more likely to get good results from people who are not in fear for their lives (Smart, 1986).

A genealogical approach to discourse analysis requires the search for patterns within wide contexts of society and culture and the power relationships that operate there. I will be going back to the nineteenth century looking for patterns within the culture and society of nurses and nursing, and the effects that these patterns have had and continue to have on the representation of nursing. I am seeking to explore how language practices within nursing have served to constitute nurses and nursing practice. It is important to recognise my own position within this, as I am not the disinterested neutral observer of empirical science. I am a woman, a nurse and a nurse educator and as such I have a keen interest in the position of and positioning of nurses within a broad cultural
context. Nurses are part of what Little, Jordens and Sayers describe as a specific "...discourse community" (2003, p. 73), in that they share a profession and that supports common ways of speaking, thinking, being and doing nursing. Nurses are also part of a subjugated discourse where the meta-narratives of biomedicine regulate their world.

Haber (1994) discusses the absence of a 'we' in who Foucault's work is addressing. Foucault has been criticised for failing to provide directions and answers for a 'we' to follow. Haber argues that what Foucault does is make a space via genealogy for the 'we's' to form and appear, but that he is not prescriptive about this. Smart (1986) proposes that what Foucault did was provide the working tools of analysis and a guide to exploring policies and practices for the act of uncovering them. His intent was to provide those who were affected by policies/practices with a framework to act within and on their own behalf, rather than provide guidelines for agents of the state (Smart, 1986). What Foucault was trying to do was encourage individuals to think for themselves. This is surely preferable to being dictated to. I believe that the plethora of text generated from his work suggest he has succeeded in his goal. What makes him different and refreshing compared to other philosophers is not what he did not do, but what he did actually achieve. Foucault was engaged with/to his work, which was his life and he left a legacy for those who have followed him of original and creative thinking and writing. The effect of this is those who are happy with the status quo may find little of value in Foucault's ideas, whereas those who are the 'other' and are outside looking for a way to get in will find his work most useful (Haber, 1994). This is probably what he intended because it fits with his ethos. Foucault's work is liberating and transforming by means of ruthless dissection and exposure of the illusions and blindesses that shape us.

McNay (1991) discusses Foucault's anti-essentialist concept of the body and how this can be usefully integrated into feminist explorations of women's oppression. Foucault's work can be understood as a rejection of dualism where mind and body are seen to be separate entities. He explores these ideas initially in Nietzsche, Genealogy and History (1984a). Within this essay Foucault discusses genealogy at length, however he does not say what it is but instead "...what it defines itself
against, what conventions of history and metaphysics it aims to disrupt" (Brown, 1998, p. 34). As with his approach to discourses, he is more concerned with the practices of what people actually said and did as opposed to the processes of what happened and as Veyne notes "...he shows it as it really is, by stripping away the veils" (1997a, p. 156). Foucault explains a process as being for example when a "...colonial people tries to free itself of its colonizer, that is truly an act of liberation, in the strict sense of the word" (1988b, pp. 2-3). However what Foucault points out is that what is necessary in addition to this act are the actual practices of liberty which will be necessary for those people to have a just society. In other words it is not enough simply to say that we want to be free, we have to define the 'practices' of freedom through which we can define what freedom means.

In stripping back the 'veils' what Foucault does is examine in detail the practices and languages of people's lives. His genealogical method traces the path and emergence of a body that is imprinted and inscribed by history. Genealogy is effectively about bodies and the way they are shaped into patterns of reaction and action by the disciplines applied to them. The body of the woman is conceptualised by feminists from a variety of perspectives. Some see it as part of the scaffolding of patriarchy and for others it is part of the core of feminine identity. McNay (1991) stresses it is important to look at the construction of female identity, via the body. She states that:

...it is by mapping the way in which the body circumscribes subjectivity that feminists can begin to describe how gender is constitutive of identity, while at the same time, never determines it completely. (1991, p. 130)

The above quote demonstrates to me the importance of exploring the histories of female and male bodies while remembering any such exploration is closely linked to and cannot be seen apart from anything else that is going on in society. Foucault's oeuvre is marked by the absence of women. McNay (1991) acknowledges this but does not see it as problematic, and I agree with her analysis for a further reason than that which McNay uses. She is concerned with Foucault's concept of power and the effect this has on his concept of the body and what this
means for feminist scholarship. In addition I have come to think that in leaving women out, Foucault leaves women with space to write about themselves. He has provided a theoretical framework about power and an understanding about bodies as being sites of political struggles and women and feminist scholars can choose to use this knowledge.

Genealogy is used as a method both to track down where discourses came from, and the reasons why they arose within specific historical contexts and gained prominence when they did. Veyne (1997a) makes the case that history, as a whole tends to change practices, rather than is commonly perceived, that there was one significant change, or as Kuhn (1966) asserts that there was a sudden ‘paradigm shift’. With this understanding the genealogist can build up a picture of how discourses have changed over time because of social effects, and where they have come to today, if they still exist. Within genealogy, language is central to the analysis, as is the body.

The body is the inscribed surface of events (traced by language and dissolved by ideas), the locus of a dissociated self (adopting the illusion of a substantial unity), and a volume in perpetual disintegration. Genealogy, as an analysis of descent, is thus situated within the articulation of the body and history. Its task is to expose a body totally imprinted by history and the process of history’s destruction of the body. (Foucault, 1984a, p. 83)

The passage means that the self can be dissociated from its biological body by having configured itself to do things that by studying nature one might not associate with it. Foucault is as well denying the possibility of the phenomenological body. Dreyfus and Rabinow in discussing Foucault’s perspective of genealogy make the case that for Foucault, “[t]he world is not a play which simply masks a truer reality that exists behind the scenes. It is as it appears. This is the profundity of the genealogist’s insight” (1983, p. 109). Genealogy is about history, but it is not about the traditional approach to history assumed by some historians. There is no ‘real history’; there are no absolute truths’. Genealogy could be described as a play on the so-called seriousness of ‘real history’. Foucault in his application of genealogical methodology was seeking to disrupt what we have become comfortable with, in believing that
having history implies linear progress. Dreyfus and Rabinow state that for the genealogist:

...there are no fixed essences, no underlying laws, no metaphysical finalities. Genealogy seeks out discontinuities...finds recurrences and play...records the past of mankind to unmask the solemn hymns of progress...avoids the search for depth. (1983, p. 106)

Perhaps in genealogy what you see is what you get. More significantly from Foucault in *Discipline and Punish* comes the following passage, which provides the essence of what he was doing as part of genealogical analysis:

I would like to write the history of this prison, with all the political investments of the body that it gathers together in its closed architecture. Why? Simply because I am interested in the past? No, if one means by that writing a history of the past in terms of the present. Yes, if one means writing the history of the present. (1977, pp. 30-31)

The last sentence of the passage is pertinent for my work. I am not trying to understand the past to explain the present, but what I am trying to clarify is ‘the history of the present’. Similarly to the prison, structures of health, particularly hospitals have political investments in the bodies of their workers, especially doctors and nurses. I am interested in the ways nurses have come to be regarded as objectified bodies within discourses of health and how has this led to nurses and nursing as being subjectified as ‘other’. It is also important for me to explore whether this is really what has happened or have other things occurred I have not yet recognised, or are perhaps hidden underneath a nursing ‘cloak of invisibility’ (Classen, 1998). For me this is about ongoing critique and being open to possibilities. I have to acknowledge that at times I will be surmising and making assumptions. I do not know for example what happened in Nightingale’s era, I rely on historical data which has been altered by the subject positions of whoever wrote it, as will be anything that this subject writes. This thesis is written within the limitations of an accumulation of positionings, of which mine is pervasive. The work is a collective of ideas that have been informed by others and not a definitive history of the present. Indeed there is no such possibility according to Foucault. Genealogy assists the endeavour through analysing modalities of power via a speculum fitted with a historical lens. These analyses will help to uncover structural, social, economic and political elements as forces that engender
genealogical processes. An aspect of genealogy that is important for nursing is to examine power that it situational and locational and can result in nurses believing they are power-less, which they are not. Genealogy is written in the light of current concerns. The concerns for this work are the invisibility of nurses' bodies, their practice and their knowledge.

What stands out for me in my research is the realisation that much of what has been taken for granted as historical 'truth' is more of a broad sweep over the processes of the past. Of the 'things' which happened as opposed to the everyday practices of people's lives, the minutiae of change in those lives and an analysis of the same, of the 'forces' and 'dominations'. A central element of Foucault's thesis is for me contained in the following, "...knowledge is not made for understanding; it is made for cutting" (1984a, p. 88). Foucault has taken a dissecting blade and carved a swathe through our accepted understandings of ourselves as integrated selves with a linear history that ends some place and in doing so he provides an explanation of how we have come to be, today. So much for that comfortable armchair. I believe however that there is a measure of comfort in Foucault's work because if we keep on pulling back the 'veils' and disrupting the known truths of history we come to the realisation that 'history' does not mean there is a definite prescription for what may happen in the future. For my study, how nursing was and how nurses were and are does not preclude the opportunity for change.

The phenomenology of Merleau-Ponty

In the preface to the *Phenomenology of Perception* Merleau-Ponty asks the question what is phenomenology?:

Phenomenology is the study of essences; and according to it, all problems amount to finding definitions of essences...But phenomenology is also a philosophy which puts essences back into existence, and does not expect to arrive at an understanding of man and the world from any starting point other than that of their 'facticity'. It is a transcendental philosophy which places in abeyance the assertions arising out of the natural attitude, the better to understand them; but it is also a philosophy for which the world is always 'already there' before reflection begins - as an inalienable presence... (1962/2004, p. vii)
Merleau-Ponty is saying here that the question about the nature of things cannot be answered independently of our acquaintance with them and our experiences within which they are encountered. He is also stating that the world is 'already there', thus it is prior to any philosophising (Priest, 1998). Phenomenology provides access to the intrinsic essences of the lived experience and these essences are of the world as opposed to the transcendental essences of the sciences (Lechte, 1994). What has significant appeal for me for my research is where Merleau-Ponty goes on to state that phenomenology can be seen as a 'manner or style of thinking' (1962/2004, p. viii), rather than as a philosophy to be applied to life. Alongside is the notion of the importance of 'experience' and that to understand you start with the behaviour of the actual person, rather than relying on theory to provide the answers.

Matthews states:

For Merleau-Ponty, philosophy is essentially humanity's radical reflection on its own situation, our attempt as human beings to get beneath the theoretical pictures that we create out of our need to explain the world for various purposes to the 'unreflective experience' that necessarily underlies those theoretical constructions and gives them meaning; in so doing, we understand better what their meaning is. (2002, p. 20)

'Radical reflection' is important, because when we do this we are actively engaging with our world, and we have to be embodied to do this. Active engagement for Merleau-Ponty has more validity than relying on theory to explain our particular situation. In Merleau-Ponty's view you start with the person. A human being is not a disinterested subject sitting on the sidelines impartially viewing a world of objects. Rather the subject is involved, and his/her body is in the world, meaning that the whole person is interacting with their environment. There is a unification of intellectual and perceptual senses, together with the body in motion, experiencing the world from a "...particular perspective" (Matthews, 2002, p. 20) and constrained by space and time.

The primary tenets of Merleau-Ponty's style of phenomenology make it clear that his is a philosophy intended for real people inhabiting a real world as opposed to subjects with 'transcendental egos' (Matthews, 2002). His theory favours the
"concrete and experiential" as opposed to being "abstract and theoretical" (Matthews, 2002, p. 42). Closely linked to this is his belief that when you put "...essences back into existence" (Merleau-Ponty, 1962/2004, p. vii), that this calls for a different relationship with empirical science, as Merleau-Ponty notes there is a "...foreswearing of science" (1962/2004, p. ix). This does not mean a rejection of science, but it does mean that science does not come first. Human beings and their experiences do. As he makes clear, our knowledge of the world comes first of all from our interaction with it, it is what helps us to make sense of our environment. It therefore makes sense to say 'if I do not have this 'experience' of the world from my particular perspective, the science is not going to make any sense to me'. To have a scientific understanding of the world, requires a phenomenological being-in-the-world (Matthews, 2002; Priest, 1998). What makes science possible, the human interaction with it, also sets its boundaries. Science helps us to understand the objective world of things, but can tell us nothing about what it means to be a human subject. Science has to be 'done' by a person, a person is prior to science and can not be reduced to being an object of science. In the preface to Phenomenology of Perception as he is outlining his 'style of thinking' Merleau-Ponty writes the following:

I am the absolute source, my existence does not stem from my antecedents, from my physical and social environment; instead it moves out towards them and sustains them, for I alone bring into being for myself (and therefore into being in the only sense that the word can have for me) the tradition which I elect to carry on, or the horizon whose distance from me would be abolished – since that distance is not one of its properties - if I were not there to scan it with my gaze. (1962/2004, p. ix)

Such a Proustian sentence and one that for me, captures the essence of his phenomenological intent. First one starts with the subject. The subject as 'I' is here, and moves out towards the world, to become actively engaged with it. Merleau-Ponty's 'foreswearing of science' and rejection of the metaphysical disembodied subject with a 'transcendental ego' implies a suspicion of grand theory (Matthews, 2002), and a critical perspective such as this is one poststructuralists should not have a problem with. He rejects Husserl's 'transcendental ego', which was considered by Husserl to be the origin of
consciousness. It is Merleau-Ponty’s thesis that because it does not appear to consciousness then phenomenology cannot suppose that it exists (Priest, 1998).

Merleau-Ponty’s subjects are humans, located in space and time and for whom history and culture are important. Individual subjects, attempt to sense-make their world, their being-in-the-world, both as individuals and as members of society. Merleau-Ponty states that “[t]he world is not what I think, but what I live through” (1962/2004, p. xviii). Individual subjects are active in their interaction with the world and this is what helps give meaning to life. I can gradually come to know the world and the objects in it by a process of what Merleau-Ponty calls ‘synthesis’ (Matthews, 2002), however I am never able to fully understand the world. The world, according to Merleau-Ponty, is ‘inexhaustible’ (1962/2004), but this is part of what it means to be in the world, and the world exists as do I exist. To a degree we, as subjects, are ‘inexhaustible’ as well, because we can never say that we know everything about ourselves, or that we can observe every part of ourselves, or as Merleau-Ponty states “...I am never quite at one with myself” (p. 404). He believes this is our ‘lot’ on earth, and the fact that we have been born means we are for all intents and purposes our own projects. This is a refutation of Descartes concept of the cogito, I think therefore I am; that ‘I am’ is never quite that clear. Merleau-Ponty describes it lyrically when he writes that the body or traces of it “...can become the eloquent relic of an existence” (p. 406). I like that. To me, it means that we speak through our embodied selves and we continue to speak as we continue to learn about and explore our ambiguous relationship with the world, our being-in-the-world.

One of Merleau-Ponty’s key ideas, and indeed a cornerstone of his phenomenology is that “[s]ubjectivity is essentially embodied or incarnate” (Matthews, 2002, p. 4) and that essentially ‘I am my body’. It is this specifically, which ties his phenomenology together. Matthews (2002) argues that although it was important to Merleau-Ponty to be positive about human worth, he was not a ‘humanist’ in the sense of the term that is used disparagingly by theorists such as Foucault. Matthews states that:

...although he stressed the importance of the subject, he was not a defender of the enlightenment conception of a human subjectivity
that is independent of the physical, social and historical situation of
the human being concerned. (2002, p. 1)

Merleau-Ponty’s subject is a ‘body-subject’ and does not perceive of itself as an
‘object’, “I am a physical subject” (Priest, 1998, p. 35). His subject is engaged
with the world. Human being, for him, is as ‘being-in-the-world’; a phrase of
Heidegger’s that he utilised (Matthews, 2002; Priest, 1998). Priest comments that
the term is hyphenated to reinforce that “…human existence, the world, and the
existential relations between them” (1998, p. 7) can not be separated. I am
dwelling in the world, the world provides the contexts for my life in order for me
to think about and respond to it. I, as a being, act on the world and am at times
acted on by it (Matthews, 2002). In being engaged with the world the subject is
also constrained to an extent by that world and the situation she is in, and as well
the effect of having a particular history. Freedom is not taken for granted and life
is ambiguous. As beings-in-the-world, subjects are also part of the social contexts
of that world, thus history and culture are as important as space and time.
Freedom becomes, therefore, not an individual pursuit but one mediated by the
fact that we live as part of a society with the historical influence of the social
mores of that society. Freedom becomes a product of our understanding and
deconstruction of those things that have moulded us. Merleau-Ponty’s
phenomenology encourages us to look at and understand the world and our
experience of it differently (Priest, 1998). It validates us as actively participating
in and perceiving our existence. It undoubtedly refutes orthodox scientific claims
to be able to uncover the meanings of our existence.

Vision says Merleau-Ponty is:

...a thought subordinated to a certain field, and this is what they
call a sense. When I say that I have senses and that they give me
access to the world, I am not the victim of some muddle, I do not
confuse causal thinking and reflection, I merely express this truth
which forces itself upon reflection taken as a whole: that I am able,
being connatural with the world, to discover a sense in certain
aspects of being without having myself endowed them with it
through any constituting operation. (1962/2004, p. 252)

It is through statements such as this that Merleau-Ponty makes it clear that the
subject’s embodied experience of the world is unified and thus also the perceptual
and intellectual senses are unified. Body and soul are unified, not as subject and object but in the fact of our existence (Merleau-Ponty, 1962/2004). When I am looking at something, I am not simply gazing upon it with my eyes being separate from the rest of me, I look and my body looks as well. I am interacting and responding to and with my environment. Seeing something with my eyes causes me to have both perceptual and intellectual responses. It is not a matter of the eyes seeing and the mind interpreting what it is seeing. I am enfolding what is seen into myself through the movement of my body, responding to it and reflecting on it. It is part of my lived experience. What I see in it is mediated by what can happen between my body and that thing, my vulnerability and potency vis a vis that thing. When I move towards a patient, I take my unified body and soul to them. I interact with the patient summoning all my resources to the forefront. My senses and intellectual responses are united as a perceptual whole. It is akin to being tuned in to them and it is part of the lived experience of being a nurse. It is in this sense that Merleau-Ponty asserts that we are phenomenological beings and as such there is “...one single, unlocalized knowledge, one single indivisible soul” (1962/2004, p. 247).

Much traditional philosophy does not share this phenomenological view. The ‘transcendental ego’ of the subject is for them perceived of as being able to stand back and view from an impartial perspective the world of objects, and through this come to an understanding. Mind is given precedence over matter. This is an empirical perspective. Merleau-Ponty believes that through communication with the world via processes of learning and exploring we come to perceive a better understanding of the world and our relationship to it, and also other people in the world. Our whole body moves out towards what is in our world. However this understanding is necessarily always incomplete, which means for us that the world remains an ‘ambiguous’ place. We can never fully comprehend everything (Matthews, 2002).

Summary

Phenomenology is about describing as opposed to explaining and it is within this that it has appeal for me in writing about nursing practice. Being able to describe
what it is that you do or that you see seems preferable to assigning doctrinaire theoretical propositions to it. It is because of the ability to carefully describe that I believe that analysing discourses and phenomenology can be carefully worked together. First you start with the nurse and her experience of being a nurse and nursing practice. How has she come to perceive of her world and her place in it? She is always an embodied subject, an immanent self and soul who is engaged with those for whom she cares. This process is then followed by careful deconstruction and critique within genealogical analysis to unravel some of the how’s of why nurses have come into being in a particular way. This seems to me to be a way of reconstructing something positive for nursing, of exploring some new options and having fun with them without creating new boundaries. I am stepping outside what is comfortable and known and taken for granted and which has thus far not been successful in moving nursing onwards from the crossroads where it has been situated for decades. I consider this to be a radical and I hope thoughtful rethinking of nursing.

My process of research is an essentially practical approach, which reinforces Lupton’s (1994) theme of exploring a research issue from different theoretical angles, in order to offer a comprehensive perspective. Furthermore I am reassured by the fact that many others have influenced the philosophers I have read thus far. Husserl, Kant, Sartre and Heidegger influence Merleau-Ponty’s work. Foucault is influenced by Heidegger, Kant, Freud, and Nietzsche, to name but a few. Irigaray is influenced by and engages with Freud, Lacan, Heidegger, Merleau-Ponty and Nietzsche, albeit in their absent voices. All have used eclectic approaches to come to their own blended perspectives, and this is how it should be, this is what makes philosophy useful and of the world. What is critical for me is to ensure that I remain cognisant of the central elements of the various theoretical perspectives I am drawing on. This will enable me to produce something of the-world, hopefully something nurses will find useful.

In the next chapter I will provide an analysis of the challenging and provocative work of Luce Irigaray. I will explore how her work could provide useful insights for nurses as female, feminine practitioners.
Chapter Three

Luce Irigaray

Introduction

Whitford (1991b) considers that Luce Irigaray’s work is significant because she explores and challenges the foundations and assumptions of philosophy. In addition, Irigaray challenges traditional assumptions of ethics and alongside attempts a reworking of the social contract, a monumental task in itself. Irigaray also undertakes an exploration of how a history, largely written by men, has determined contemporary discourses of philosophy and within her analysis Irigaray considers the conditions for real women’s lives in contemporary society. For Irigaray sexual difference is significant, both the sex of whomsoever is writing, who and what they are writing for and whose interests are ultimately being served. Sex has mattered to the extent that scholars who draw on discourses of patriarchy have tried to control and manipulate women’s sexuality for their own ends, but women have neither been considered nor consulted in these processes. At the end of the day, the bodies of women have been intended for reproduction, and their minds have been considered to be inconsequential (Irigaray, 1985a). Little wonder then that Irigaray’s work has caused uneasy stirrings within philosophy. Any one woman who challenges a dominant vessel of knowledge is going to meet with resistance.

There is for me, in wrestling with the complexities of Irigaray’s thought, a sense of achievement, and also a sense of coming home. I am not claiming to totally understand her work. I am not able to read French and one gets the sense when reading her translated texts how difficult it has been for the translators to communicate her complex intentions carefully. Irigaray’s work has an originality and resonance which for me rings true and clear and she forces me to think about things I have learned in the past. She has caused me to think in a different way for
which I will be eternally grateful. Irigaray is a woman whose philosophical ethos does not flinch under assault and she refuses to accept second best. Politically she causes ambivalence amongst some feminist scholars. It is my belief that these are women who are too willing to give away my rights to the patriarchy, for the sake of keeping the peace. Feminist scholars who accuse Irigaray of being 'essentialist' are either reading her through a narrow lens or being disingenuous.

Discussing Irigaray's work and making reference to Merleau Ponty's 'heap of sand' Whitford states:

There is no membership requirement for feminism: its diversity is its strength. Feminism is like Merleau Ponty's heap of sand; each grain individually is minute, but the total sandbank may block a river. (1991b, p. 5)

That statement rings true for nursing, individually nurses are voiceless, together they have the potential to bring about change by the force of their collective voices. In discussing Irigaray's style of writing, which can to the novice reader appear to be incomprehensible, Whitford (1991b) argues that this is not something which is negative, it can be a positive. I agree. I maintain that it is not necessary to immediately understand everything when becoming immersed in new ideas and a different way of looking at issues. Increasing clarity comes with time, and what also comes with time is often a change of perspective in previous understandings. What is important to me, is to persist and with persistence achieve an individual perspective, a coming to understand which may at times be at odds with others that have commented on Irigaray's work. She has been variously interpreted as reverting to the 'essential' (Hamera, 2001; Moi, 1985; Poovey, 1988; Young, 1985), and also lumped together with other French feminist writers as if they are a homogenous polyglot (Young, 1985). Whitford (1991b) refers to this tendency as Anglo-American criticism. As a registered nurse I would describe it as culturally unsafe practice. By culturally unsafe practice I mean that Irigaray has a legitimate right to be treated as an individual rather than being dismissed on account of being French and variously regarded as either 'different' or as the same as her compatriots, specifically Julia Kristeva and Helene Cixous. The works of these three women philosophers are substantially different from one another.
When reading Irigaray it is important to be aware that her work analyses a broad range of philosophers and psychoanalysts. In *Speculum of the Other Woman* (1985a) she engages in dialogue with, amongst others, Freud and Plato, In *This Sex Which is Not One* (1985b) Freud again, as well as Lacan and Marx. *An Ethics of Sexual Difference* (1993a) includes readings of Descartes, Spinoza, Levinas and Merleau-Ponty. Her work covers a broad array of theoretical approaches from phenomenology, structuralism and existentialism through to poststructural readings of subjectivity and identity. Sometimes when reading her, the work of others is so entwined with hers that it is a challenge to unravel. There is a definite blurring of the edges. I believe the blurring is a deliberate strategy on her behalf, a challenge thrown up to make her readers think and become engaged. As well, it is important to remain cognisant that Irigaray is a philosopher, a psychoanalyst and a linguist. These seemingly disparate threads run throughout the labyrinthine of her oeuvre.

Lacan especially is in evidence throughout her work. Even though Irigaray rarely mentions him by name he is there in her inferences and gestures. The evidence of her training as a Lacanian analyst is there, for example, in the use of the terms ‘mimesis’ and ‘speculum’ (which are an appropriation of Lacan’s concept of the ‘mirror’). There are, as well, the elaborate ‘speculums’ she uses, the themes of language and subjectivity; Irigaray’s primary mission is to expose the building blocks of patriarchy by challenging the principles of philosophy and undertaking the task as a woman.

Whitford (1991b, p. 15) describes Irigaray as a ‘theorist of change’, who is exploring ways of bringing about change in the symbolic order, the crossroads of “...body, psyche and language, where ...psychoanalysis and linguistics (or semiotics) meet” (p. 37). Her vision of what could potentially ‘be’ for women, can be described as utopian. However I consider her vision to be one of the strengths of her work and particularly relevant for what I am trying to write about and for nursing. What is wrong with Utopia anyway? It is important to have a vision of what could change and how things could be different or else we can lose all hope and give up. It is of significance to go beyond constant critique and generate new ideas, someone has to do these things, and Irigaray provides fertile soil to till. As
Whitford comments, "...imagining how things could be different is part of the process of transforming the present in the direction of a different future" (1991b, p. 19). I like to contemplate and dream about change, and in this instance I am dreaming about nursing. For me it is important and stimulating and generative of debate with colleagues, which is what Irigaray engenders with her work. Adaptation and change for nursing is vital, or we may fade away.

I believe that, as a feminist philosopher, Irigaray's work is the perfect lens through which to view that most feminine of professions, nursing. Nursing may be feminine, but without too much doubt it suffers a 'lack' in the area of feminisms and philosophy and this lack has I believe been philosophically and politically debilitating for nurses and nursing. Many nurses consider themselves as individuals, and the profession of nursing as a collective to be oppressed. (e.g. Cheek & Rudge, 1994; Clare, 1993a; Harden, 1996; Roberts, 1983; Spence, 1994). Cheek and Rudge (1994) point out that nurses could choose to refuse this role, say a definite no to being oppressed and lay claim to nursing knowledge and expertise being both valid and authoritative. I want to lay a red cape on top of the murk of oppression and outline some alternative perspectives for nurses, to act as a facilitator of debate in order for nurses to reconsider their position and perhaps step out from the murkiness, provided that they may want to.

There are a series of recurring themes running throughout Irigaray's work and I will discuss them individually. These are Speculum, Mimesis, Morphology, Becoming Woman, Language, Psychoanalysis, The Debt to Maternity, Sexual Difference, Woman as Subject and Vision.

Speculum

Lacan's (1977) mirror stage describes when the infant first looks at their reflection in a mirror and recognises the image of themselves, their 'specular recognition' (Grosz, 1990). It is then that the infant first begins to understand the idea that they exist. Most of us at some stage have witnessed an infant's gleefulness at looking at itself in a mirror, pulling faces and reaching out to try and grasp the elusive 'imago'. The mirror stage generally occurs before the infant is able to speak or
walk and the infant learns not only that they exist, but that they are an object for others. It is significant because the infant "...has to see the image as being both itself (its own reflection), and not itself (only a reflected image)" (Lechte, 1994, p. 68). It is Lacan believes of primary importance in the development of the ego. For Lacan the mirror stage is the beginning of the 'I', the ego, the origin of the construction of the human subject where the infant starts to become a social being. Irigaray's concept of speculum comes from Lacan's mirror stage and is based on her belief that:

...western discourse and culture displays the structure of specularization, in which the male projects his own ego onto the world, which then becomes a mirror which enables him to see his reflection wherever he looks. Women as body/matter are the material of which the mirror is made, that part of the mirror which cannot be reflected, ...and so never see reflections of themselves. (Whitford, 1991b, p. 34)

Women are the blind spot in the mirror. The concept of Irigaray's notion of the speculum runs as a theme throughout her work. Most of the time she is referring to a speculum as a mirror/ reflector, but just occasionally she makes reference to the speculum as being a dilator (Irigaray, 1985a, p. 144). In the main the term is a metaphor, and she is a talented wordsmith. The speculum is the mirror of theory and discourse. Speculum for Irigaray is a mirror that the male can hold up and through it form the images of the woman that he wants to see. In Irigaray's work the mirror is also used by the man to see inside her. The woman however cannot see as she does not recognise herself. Speculum as a metaphor is about the images of women created by Freud and Lacan that give eminence to the man and nothing to the woman. The speculum keeps woman as object, because man as subject uses it to reflect himself onto the other and define the conditions/terms of her being. The trouble being of course that he gets a false interpretation, and he can look into it, but he cannot really see. Irigaray contends that the male speculum cannot really know woman-kind. The male speculum will only ever define woman-kind as a lesser to that of man, a lack, in that a woman is not a man and does not have a man's body, and specifically, does not have the phallus, the primary signifier.

Speculum is also about the pupil of the eye being a mirror, the eye is a convex surface. When the image goes in through the pupil it gets turned upside down to
form a concave image. Berry proposes that the concept of the dilated pupil is a metaphor for ‘seeing’ the concave mirror as being able to “...obliquely and darkly delineate the other side of philosophical occulocentrism” (1994, p. 234). In addition Berry proposes that after the initial dialogue with Freud for the first 125 pages of Speculum, Irigaray for the remainder of the text “...uses a motif of descent into the darkness of the underworld or death realms” (p. 234). I am left wondering if perhaps Berry is ‘seeing’ more than is there. I do not see Irigaray’s work as being nihilistic. On the contrary what she outlines for women are a series of positive strategies for change, without being as prescriptive as some of her contemporaries. Irigaray engages with the Master discourses in order to evoke new horizons of women and femininity.

I consider The Speculum of the Other Woman (1985a) to be Irigaray’s seminal text (seminal is possibly a poor choice of word for her context), it is the source of her elemental concepts and her other work appears to me to derive from this. Speculum is where her themes are initially explored, they run over and into each other like water tumbling stones. The tumbling action over a period of time (and texts) causes the themes to be somewhat smoothed out. In This Sex Which is Not One (1985b) Irigaray clarifies many of her ideas from Speculum and she continues to do this throughout her other work.

The ‘specular matrix’ discussed by Irigaray (1985a) is significant, because it is about the sexual act, the act of penetration and orgasm. The man goes looking for something, he goes ‘looking’ via his speculum of going inside the woman, and he in effect is looking for himself. He does not find himself, because the speculum gives him an incorrect interpretation, he goes looking for himself and finds the ‘other’, and as psychoanalytic theory would tell us, he is driven to keep on looking, which is why he goes from partner to partner. The woman in turn is focused in her ability to satisfy the male need for reality by ensheathing or connecting the male with something or some one responsive. He is looking for the Name of the Father, and all he finds is the ‘other’, he continues to be lost and carry on his fruitless search. In looking for the Father he is looking for his soul which he will never find because he is mortal.
The concept of the Name of the Father derives from Lacan (Lechte, 1994) and is part of the Symbolic Order of psychoanalytic theory. The Symbolic Order according to Lechte provides the world with a series of meanings and laws, specifically “...the order of signs, symbols, significations, representations, and images of all kinds” (1994, p. 68). It is within the Symbolic Order that the individual becomes a subject. Women are both absent and excluded from the Symbolic Order because they are represented as being material, immanent and from nature, as opposed to men who are represented as being transcendent. The Symbolic is an Oedipally derived construct, foundational to the structuring of subjectivity. Whitford explains that the Symbolic is the “...junction of body, psyche, and language,” (1991b, p. 37) and is structured monosexually. In order to be a subject requires the taking up of a male position in the Oedipus complex and to identify with the law which is represented in the Name of the Father (Whitford, 1991b). There is no space within this representation for women as women, there are no specific ‘essences’ according to Lacan for what it means to be a woman (Lechte, 1994). There is no language for what it means to be a woman. In fact for Lacan ‘woman does not exist’. The Symbolic Order is both masculine and patriarchal and “…speaks the imaginary of men” (Lechte, 1994, p. 161).

It is interesting to use medicine and nursing as an analogy for the Name of the Father, using the speculum as a lens to provide a different viewing. I have a vision of medicine holding up a speculum to nursing to try to define the terms of nursing practice, as a means of controlling it. Medicine as being all-powerful and all knowing, and nursing being the ‘other’, the lack. Representation sends powerful messages and nurses need to be able to get over being other, get over them-selves and recognise that nursing practice in the borders of other-land can be ok. The other side of the story would be how nursing goes about subverting medicine’s power, because it is subverted and the specular reflection medicine receives is not an accurate picture of nursing practice. As Hutchinson (1990) points out nurses do bend the rules for the benefit of their patients. Unless you were a nurse you might not understand what was going on. Sedition can be as powerful as symbolic representation.
The speculum of medicine, defines illness, claims cure, can be dualistic, is all powerful and all knowing, has a clear image of itself, it is the phallus. The speculum of nursing, sees itself as a lack, uses medicine as a binary, subverts medicines’ speculum, tries to blur the image, has access to some power but is not always well positioned to use the power. The institution of medicine perceives nursing through a specular gaze that defines nursing as women’s work, and therefore nursing is seen as being derived from, and defined by, medicine. The ‘other’ of medicine.

Nursing’s speculum has a blurry image of itself, does perhaps not understand what its self is and needs to be able to define and position itself/ themselves, both as individuals and as a group so that nurses are able to participate as self conscious individuals. Nursing may benefit from being able to define self and not continue to submit to medical constructions/destroctions of nursing self-knowledge. Nursing needs to find itself. If nurses were able to achieve this they may develop the self-belief to feel able to claim what they do as authoritative and based on valid knowledge. Strong belief in self together with increased socio-political understanding could mean that nurses will have stronger self esteem and be better positioned to support each other within their practice environments (Cheek & Rudge, 1994; Code, 1991; Speedy, 2000; Spence, 1994; von Dietze & Orb, 2000).

Mimesis

Irigaray writes about mimesis as mimicry:

Properly speaking, one can’t say that she mimics anything for that would suppose a certain intention, a projection, a minimum of consciousness. She (is) pure mimicry. Which is always the case for inferior species of course. Needed to define essences, her function requires that she herself have no definition. Neither will she have any distinct appearance. Invisible, therefore. (1985a, p. 307)

The word mimesis means imitation, or to copy, thus comes Irigaray’s use of the term meaning to mimic. As I read Irigaray’s conception of mimesis (1985a & 1985b) it becomes clear she has a particular strategy when she writes about it. Her
strategy is to express that women, when they are doubling themselves via mimesis are for all intents and purposes symbolically killing themselves in order to meet his needs, to please him. Mimesis is something she has become skilled at, an art, but it is to her detriment and his gain. Via mimesis she supports his world. However, for Irigaray there is another way of looking at this situation. Mimesis can be used as a tool to undermine the ‘master discourse’ (Marsden, 1993).

Braidotti (2002b) conceives of mimesis as being a potentially positive strategy for women, a way for women to repossess their images. Women have been denied their own images and representation in the symbolic order, they have only ever been allowed to see themselves as the male subject has visioned them, via the reflection of the speculum. He has formed the image of her as being other. It is necessary for women to reclaim and work through the images so they are able to present themselves on their own terms. Braidotti describes reclamation as:

...collective repossession of the images and representations of Woman such as they have been encoded in language, culture, science, knowledge and discourse and consequently internalized in the heart, mind, body and lived experience of women. (2002b, p. 171)

Such a good quote. What Braidotti is saying here and what Irigaray also says is that women have to learn to speak and think for themselves. Previously they have not been permitted to. Their images were created for them as other both in the real world and in the symbolic order by the masculine subject. As Irigaray hammers home in Speculum Woman as such has never really existed, because she has only ever been present as a reflection of his mirror. So when she sees herself, she does not know what she is looking at. The non-existent Woman has been extrapolated to include all women, and who are they these women? The task for Woman is effectively to create herself, and for Irigaray this creation has to be a corporeal, embodied subjectivity. She has been “The Blind Spot Of An Old Dream Of Symmetry” (Irigaray, 1985a, p. 11), but she needs now to establish her own feminine subjectivity, standing asymmetrically to the masculine (Braidotti, 2002b, p 171). My interpretation of the ‘blind spot’ is that this is Woman. She looks in the mirror and sees the image created for her and she does not recognise herself. There are no origins for this image and no connections to the symbolic order. She
stands beside him in perfect symmetry with him, as he intended as the knowing subject. However, the symmetry does not resonate with what she knows of herself.

In *Marine Lover of Friedrich Nietzsche* (1991g) Irigaray is addressing Nietzsche from the perspective of water which she believes is absent in his text. The French title for the text ‘Amante Marine’ is more evocative than the flattened effect it receives in translation. Water and metaphors for fluid are part of Irigaray’s vocabulary and philosophy of the feminine:

The other has yet to enlighten him. To tell him something. Even to appear to him in her irreducibility. The impossibility of overcoming her. And if, to the whole of himself, he says “yes” and also asks her to say “yes” again, did it ever occur to him to say “yes” to her? Did he ever open himself to that other world? For him it doesn’t even exist. So who speaks of love, to the other, without even having begun to say “yes”? (Irigaray, 1991g, p. 190)

The passage is a reflection of Irigaray’s double take on mimesis and speculum, turning in and on themselves like a mobius strip. How can she take him seriously if he does not stop to consider her? She plays along with his game, mimesis, and maintains her own interior surfaces, her infoldings, her private world, while maintaining her public facade, a show for all the world to see. This is nursing and medicine, the real ‘doctor-nurse game’ (Stein, 1967; Stein, Watts, & Howell, 1990) that medicine sees through a monocular lens, and which for many nurses remains obfuscated. I am beginning to understand obfuscation as the hidden self of nurses. Hidden perhaps because of mimesis and also hidden because nursing knowledge remains dis-embodied and increasingly eviscerated by structures in health (Lawler, 1997; Walker, 2000 & 2003a; Witz, 1994). The self of nurses is hidden from themselves as unknowing subjects. It is hidden from others because of misperceptions about how it is to be a nurse. Nursing is dominated by medicine who hold up evidence based practice as being the panoramic mirror nurses must ascribe to, the medical eye/I.
Morphology and isomorphism

Morphology and isomorphism are terms used frequently by Irigaray. Morphology is the study of the form of things, and isomorphism is about something being similar in form and relations. Irigaray uses morphology to escape biology and concentrate on social and psychic relations. Irigaray claims that there is an "isomorphism between male sexuality and patriarchal language" (Grosz, 1989, p. 111). Essentially one reflects the other, and there is no female sexuality or language. Women are left speech-less and sex-less, only ever defined as other, or the other of male language and sexuality, and the unconscious. She may even be the unconscious for him, she is certainly the body for him, and the envelope for the phallus both psychically and literally. Mimesis starts seeping in to Irigaray’s work, via isomorphism.

When Irigaray is writing about morphology she is taking great care to avoid being seen as essentialist by not discussing anatomy or ‘nature’ (about men’s and women’s natures). Grosz writes:

Her concepts of the body and corporeality refer only to a body that is structured, inscribed, constituted and given meaning socially and historically- a body that exists as such only through its socio-linguistic construction. (1989, p. 111)

The statement clarifies that Irigaray is not reverting to essentialisms. Irigaray is writing about the female body only in how it is wrapped up in and represented by language. What Irigaray is saying is that between male sexuality and patriarchal language there is a form of isomorphism, from which comes the effect of weaving and mirroring of Western discourses, logocentrism and phallocentrism working together to enshrine male sexuality. A phallocentric representation within patriarchy subjects women to “…models and images defined by and for men” (Grosz, 1989, p.xx). This representation means that for all intents and purposes there is no female sexuality. Freud and Lacan say as much in their work that all sexuality is defined from a position of phallocentrism. A woman thus becomes a

\footnote{The logos literally means the word. Grosz states that the logos “…represents a singular and unified conceptual order …Logocentrism is a system of thought centred around the dominance of this singular logic of presence...[Phallocentrism] is a form of logocentrism in which the phallus takes on the function of the logos” (1999, pp. xix-xx).}
no-sex, a non-sex, inert and castrated, this is not a biological occurrence but it is about the "...social and psychical meaning of the body" (Grosz, 1989, p. 111, italics in original). Irigaray’s critics, who claim that she holds an essentialist position, are not reading her adequately according to many theorists. (e.g. Braidotti, 2002b; Grosz, 1989, 1990 & 1994; Martin, 1997). Irigaray very carefully proposes an alternative position for women at a psychic level, as opposed to a physical level. She is proposing women’s bodies as social signifiers, carrying messages, meanings and mores. Irigaray contends that women do not have an unconscious and that in effect they operate as the unconscious for men, as well as being the body for men. If the unconscious is structured as a language as claimed by Lacan (Lechte, 1994), this links with Irigaray’s beliefs about women being non-speaking subjects, of their having no voice.

* Becoming woman *

If the earth turned and more especially turned upon herself, the erection of the subject might thereby be disconcerted and risk losing its elevation and penetration. For what would there be to rise up from and exercise his power over? And in?
(Irigaray, 1985a, p. 133)

The earth turns, on her own axis and looks at herself, by herself, she no longer needs him to tell her what she looks like, and how she should be. She is making creative use of the speculum. She is in effect becoming woman. Irigaray can indeed be as Whitford (1991a) describes her, a writer of sibylline prose.

Irigaray (1985a) is inviting readers to reread Plato’s cave myth as representative of a womb, deeply inside woman. The story of the cave detailed in *The Republic* (1955/1987) demonstrates the difference between what is knowledge, what is real and what are illusions. Within this section of her text she is engaging in dialogue which is critical of Plato and Socrates. She is also using Freudian concepts to interrogate Plato. It is at times like these that it is useful to have read *The Republic* and as well to have an understanding of the tenets underlying psychoanalytic theory. Otherwise all would be somewhat lost in the labyrinth of her work, needing more than a thread to get out.
Irigaray is contending that the use of the cave metaphor here is a form of sleight of hand, in order to disappear the other. For her the cave is speculum, and she describes the eye, mirrors and images of space and time. Irigaray is suggesting the cave functions under a guise of mimesis, to confuse its male inhabitants, in order to keep them prisoner. Because the cave is speculum, it acts as an opaque reflector and the inhabitants are only able to see blurry reflections/shadows projected onto the back wall of the cave, these shadows they take for real objects. They are not able to turn their heads and see what is actually happening behind them which is the mechanism by which they remain there, they are kept dumb by optical illusions (Irigaray, 1985a).

Irigaray’s conception is that within Plato’s work the Earth is ‘her’, is the Mother, is matter, is material. In addition the sun Plato writes about is the son of the Father, and is a celestial body who refuses to become matter and gives birth to fire. Fire burns in the cave and gives rise to the reflected but blurry images that are controlled by the whim of man. The fire reflects the importance of light to the world, because without light there is no sight, no vision, no eye, no I, no pupil, no reflector. Without light there would be no ocultocentrism to maintain the patriarchal discourse of philosophy, the master discourse. The cave is a matrix thus Irigaray’s concept of speculum as the ultimate reflector. The shadows are images in a mirror, mimicking Plato’s forms. In the cave behind the prisoners is the paraphrasm, a small wall built by the men. The wall has a veil over it, which is never opened, and for Irigaray the wall represents the virgin’s hymen and relates to women being commodities. The path into the cave represents the vagina that Irigaray also calls a sheath or an envelope-passage. The path is the connection between the outside and the inside that the prisoners are not to be permitted to recognise. The lack of recognition reinforces her concept of speculum.

Irigaray combines the myth of the cave with concepts from Freud and Lacan, especially the Name of the Father. The father she argues is always and has always been immortal. The father is eternal because he has never been born. Furthermore Irigaray is suggesting that woman, who is tainted by being inside, is therefore not able to sully him. His representation however never changes and therefore he is the good, truth and beauty, he is immortal, divine and all-powerful. He comes
from the sun/son (of the father) and therefore he controls light/sight. The sun as descendant of him has as his purpose to make all of life, and especially 'being' clear to view. The sun/son is responsible for sustaining and generating life on the planet, no sun/son, no life. The sun/son also controls vision, and is thus able to control and manipulate images, in his own reflection. The reflections the men see in the cave are but copies (mimics) of the originals, which are the forms; the Father has fooled them. The Father allows the sun/son to produce images of him, as it is in the best interests of both of them, even though they are imitations of the original (Irigaray, 1985a).

The story of the cave may seem complex, but for me this is a crucial part of Irigaray's work to understand, containing as it does a particular and enduring representation of women within philosophy and psychoanalysis. When Irigaray is ripping apart Plato's cave myth, her work has the sense of an echo. Her words bounce around me off the surfaces of the cave and there is no escaping her. The reader is forced to hear and feel and see the images. It is little short of assaultive. The poet Gerard Manley Hopkins in his poem Felix Randall wrote, "Dids't fettle for the great gray drayhorse his bright and battering sandal" (Hopkins, 1998, p. 136). Irigaray's work reminds me of this line, the resonating echo of rime.

In This Sex Which is Not One (1985b) Irigaray explores her assertion that woman is a commodity of the market, but remains as private property and is not sold on the market, a fairly direct critique of Marx. Woman is more valuable unsold, because then he is able to own her, as his private property and exploit her in order for him to be able to reproduce himself. She is of value primarily as a mother, and reproducer of children.

Irigaray is discussing philosophy, which she argues has been responsible for the ongoing domination of women, culturally, politically, economically and sexually. For her own work she is trying to make use of other forms of language, trying to step outside the language of philosophy while remembering that to critique it, she is implicated in it. Trying to effectively use language that is outside of the dominant discourse is a challenge that nurses face in their everyday nursing practice. The multiple voices of nurses are effectively silenced and disembodied
within a discourse that perceives the patient to be an object of assessment and inspection (Aranda, 2001; Arber, & Gallagher, 2003; Lawler, 1997; Short, 1997). Irigaray comments that she has had to "...accept the condition of silence, of aphasia as a symptom - historico-hysterical, hysterico-historical - so that something of the feminine as the limit of the philosophical might finally be heard" (1985b, p. 150). Irigaray is referring to women’s inability to speak intelligibly within a history of being dominated by philosophical discourse. Historically women are perceived as hysterical which has had the effect of conditioning their subjectivity.

In discussing Marx’s theory about women as a commodity Irigaray states; "[t]he society we know, our own culture, is based upon the exchange of women" (1985b, p. 170). She claims the laws which organise society are based on the sectarian validation of the desires and needs of men. By men, in men, for men, through men the symbolic structure that organises this is the Name of the Father, in the name of capitalism. Women start on the back foot within the system because they are not subjects and thus have no language and no speaking rights. They are only able to mimic a language not of their own, and not being a subject they remain without form. Women are shapeless matter, seemingly not able to conjure up a reflection of their own image as Irigaray elucidates clearly in the following quote:

- just as a commodity has no mirror it can use to reflect itself, so woman serves as reflection, as image of and for man, but lacks specific qualities of her own. Her value-invested form amounts to what man inscribes in and on its matter: that is, her body.
(Irigaray, 1985b, p. 187)

Irigaray warns women about seeking freedom through the masculine structures of society. Women can attain equal rights, equal pay, and can then possibly be just like men. Why she asks is it necessary for women to be like men? This is why she emphasises the development of the separate female subject, who is not a derivative of the male subject, who has her own discourse, language, structures. As opposed to taking second-best for the second-sex and compromising herself (Braidotti, 1991).
What does one see when one looks at a woman? One sees/ hears cultural inscriptions, cultural constructions, cultural representations (in language especially), what I have become accustomed to take notice of. Are women characterised by what is inside or outside or both, does one take precedence, does it matter? Is this an effect of discourses coming into play. When it comes down to subject and self, yes it probably does matter. The specular image reflects only the male subject who is able to look at himself. Women are false doubles of the masculine subject. Mimesis acts to constitute and reinforce discourses of domination. If women are able to themselves look through the ‘looking glass’ they will be empowered to shatter the illusions of these reflections and for once be enabled to assert their autonomy. Women can then use speculum as a tool to explore themselves and learn to represent themselves on their own terms. Use of speculum is a way for women to counteract the flat plane of the mirror and shape their own cosmos, moving beyond the sleight of eye of phallocentrism which has only ever allowed them to be other.

Whitford (1991b) discusses Irigaray’s use of the ‘imaginary’. The use of the term comes from psychoanalysis, from Lacan’s interpretation of Freud and it is about the mirror stage. When the infant looks at himself in the mirror, it is the beginnings of what Lacan calls ‘anticipation’ (1977). The infant can now begin to ‘imagine’ what he looks like as a unified form, rather than as something, which is ‘fragmented’, what Freud refers to as the beginnings of the development of the ‘ego’. Irigaray’s critique of Lacan’s mirror stage is that his mirror is flat, women’s (sexuality) can not be seen/represented in it, because they are in effect the componentry of the mirror. What is needed according to Irigaray is a different form of mirror, a speculum that can reflect angles and differences. A woman can use speculum to explore her-self, the inside of the other. By doing this she can evolve her own imaginary. Whitford points out that when reading Irigaray and coming across oft repeated terms such as ‘imaginary’, it is important to keep in mind the different contexts within which she uses terms. They are not indiscriminate rather they have a meaning and a point. Whitford (1991b) believes Irigaray is suggesting that in the ‘cultural imaginary’ of Western society women are symbolized in a particular way, that because women are perceived of as
'natural', they are therefore ahistorical, and outside the genesis of discourse. Irigaray is trying to create an imaginary for women and it is integral to her utopia.

The following excellent passage from Whitford helps to clarify the symbolic/imaginary and subjectivity/identity:

The question of the relation between symbolic/imaginary and subjectivity/identity can be formulated in this way: (1) subjectivity is a structure, or a position of enunciation. It is not identity; (2) but that structure would be empty without the imaginary: representations are what flesh it out. So the symbolic is structure (form) which is given content by the imaginary, and the imaginary pours itself into the available structures to form representations. Subjectivity, then, belongs to the symbolic, but it is empty without the imaginary, identity is imaginary, but it takes a symbolic (representational) form. Although it is possible to make a conceptual distinction, in practice the two overlap, because one never finds one without the other. Language (langage) belongs simultaneously to both symbolic and imaginary, so perhaps because Irigaray focuses on language it sometimes seems as though she conflates imaginary and symbolic, at the expense of the symbolic. (Whitford, 1991b, p. 91)

Can women choose how they are to be? Are women able to write themselves into their own symbolic order? These are issues Irigaray is exploring. She does not want women to fit in to whatever masculine colonising structures are already there, but for them to create their own; their own divine, their own angels, their own cosmos. Multiplicity is fine, but not until women have been enabled to claim their sexual difference (Whitford, 1991b). It is also important to consider that aside from symbolism and the imaginary the actual body has to ‘flesh’ out these aspects of subjectivity so that it has impact on or becomes sustaining for others through material and emotional interaction. Real bodies matter.

_Elemental Passions_ (Irigaray, 1992) is a tribute to her conception of mimesis. However, I think Irigaray is playing a game with the reader as well, almost as if she is wondering if she will be caught out. She is representing women as being nature, as being a flower, which he allows to bloom only in the way that is useful to him. Unfortunately he is breaking the rules of nature, and the flower does not bloom as it is supposed to and dies. What Irigaray is saying is that he is perverting the course of nature and is ending up going around in circles shooting himself in
the foot, which is what Freud believed about adult behaviour. He does not learn from his experiences, and he keeps repeating himself over and over again. What he should be allowing is for her to bloom as she wishes, in her own way, instead of trying to control her. Nobody gets anything this way, it is a zero sum situation. Irigaray writes here in what I would describe as a flirtatious or perhaps seductive manner. She is playing to ‘him’, flattering him, playing with him, pulling him into the specular matrix. She is also demonstrating alterity and creatively using her speculum to change the reflection from a flat plane. The sleight of hand she is using is about one of the problems she is continually addressing; that of women being represented as nature. It has become clear to me that within the text Irigaray is throwing women’s nature in his face until he gets sick of it/her, perhaps a political tool to try to bring about change. She is hurling mimesis back in his face, playing him at his game. Only for Irigaray it is not game, she is deadly serious.

Women and language

In Irigaray’s early work as a linguist she writes about psycho-linguistics and it is in this work where she began to explore the differences between the speech of men and women. Whitford (1991a) explains that what Irigaray is doing is examining the identity of the speaker within the symbols of patriarchy. One of Irigaray’s goals is to explore the ‘...expression of sex in language” (Whitford, 1991a, p. 4). Within Speculum and This Sex Which is Not One Irigaray shows how women have never been seen as knowing, speaking subjects within philosophy, they are denied voice and spoken for and through by others (Marsden, 1993). Whitford summarises Irigaray’s research by stating that woman’s language:

...turns out not to be a question of a totally different language, but more to do with socially-determined linguistic practices, sexual differences in the generation of messages and self-positioning in language vis-à-vis the other, all of which are possible sites for transformation, opening up the possibility of women’s distinct cultural identity. (1991a, p. 5)

All language bears the mark of the Name of the Father. The above statement by Whitford has possibilities for exploring the language of nursing, and how nurses position themselves within the patriarchal structures of health. This will be
discussed in Chapter Seven. Irigaray's work on language presents a challenging perspective, to both men and women. She argues that "...men are more likely to take up a subject position on language" (Whitford, 1991a, p. 4), and that women have a tendency to be unassertive in relation to this. They are more likely to let men or the world go first. Integral to her study of woman as becoming is her assertion that when women use 'I' they are not necessarily assuming a female identity. Women have not become used to representing themselves in language and have become accustomed to how men do this for them. In addition Irigaray is arguing that women place greater emphasis on communication, on an interpretive position and that context is important for them. She proposes that in women's roles as care-givers they are not required to have complex linguistic codes because what they are doing day after day is for others, men and children, rather than for themselves (Irigaray, 1985a, 1985b, 1994). Whitford concludes that Irigaray's research allows for the possibility of a separate cultural identity for women and this does manifest clearly in Irigaray's work. She is looking to create a politics of sexual difference that calls for change in how language is used. An example is the use of the neuter masculine 'man' to describe all human beings that she maintains has been an effective tool to subjugate the population of women. To discuss 'mankind' and 'peace and goodwill to all men' etc is to effectively deny the subject position of half of the interlocutors (Irigaray, 1994).

Irigaray writes extensively about language and uses two terms, langue, which refers to the body of language (i.e. whether it be French, English, Italian etc.) and langage, which refers to the language as it is used by the speaker. Meaning that within the same langue it is possible to distinguish between langages. Language and the use of language is an ever-present theme in her work (Whitford, 1991a). What she is referring to is the non emergence of woman as speaking subject, and it is not about what is said, but more about the identity of the speaker within the structures of patriarchy. Language is constitutive of identity and identity is sexed and it is within these premises that Irigaray is exploring the possibility of new structures, new genealogies which are premised upon sexual difference. Irigaray's use of the term 'parlez-femme' is the mode of speaking as a woman, which Whitford (1991a) distinguishes from speaking like a woman. To speak like a
woman is defined by patriarchy, to speak as a woman is to speak from the position of woman as subject.

What Irigaray is looking for (in fact demanding) is a position for woman in the symbolic as subject and this is fundamentally the essence of her thesis. Lacan believed there was no separate subject position available for women, except as ‘castrated men’ (Irigaray, 1985b; Lechte, 1994), and Irigaray’s critique of language is influenced by Lacan. Her intent is not to create a new theory for women (Chanter, 1995; Hekman, 1990; Marsden, 1993), but that of ‘...jamming the theoretical machinery itself’ (Irigaray, 1985b, p. 78). To move away from one voice to a plurality of voices. Women’s language is not one, as her sex is not one (Hekman, 1990). Irigaray (1993b) is critical of how gendered language serves to keep women in their place and how the gendering of language often devalues the feminine. Irigaray maintains that for women to be autonomous subjects on an equal footing with men they need access to the same conditions of subjectivity men have and expect as of right, and which are denied to women. The most important of these is linguistic equality. Language structures discourse and thus has an effect on social justice. If language is derived from the position of the knowing masculine subject this renders half of the population speechless, which is inequitable. The ‘conversations’ in Speculum are a clever tool for Irigaray to address her subject matter because she is addressing the main protagonists (Freud and Plato) directly, and they cannot answer back. She is in effect ‘jamming the machinery’.

In The Bodily Encounter With the Mother (1991a) Irigaray is discussing what happens at birth, the myth of Oedipus and psychoanalysis’ perceptions of how the male son goes about separating from the mother and she writes:

But the exclusivity of his law forecloses this first body, this first home, this first love. It sacrifices them so as to make them material for the rule of a language [langue] which privileges the masculine genre [le genre masculin] to such an extent as to confuse it with the human race [le genre humain]. (Irigaray, 1991a, p. 39)

The son’s first home and probably unconsciously what he regards as his last home is with his mother. However, he has to sacrifice this relationship to establish his
identity, his subjectivity within the symbolic order. A daughter on the other hand
has a passive role, as she does not become a subject. Her primary role is that of an
object of reproduction. The ‘sacrifice’ occurs via the mediating influence of the
Name of the Father. The quote is an example of Irigaray’s use of the word
‘genre’. For Irigaray ‘genre’ is most importantly used to denote kind as in
mankind and womankind, and she considers that there should be a world of
women, where women can develop their own identity, thus womankind
(Whitford, 1991a). Irigaray is making a point that she makes often and that is that
the male genre so often is taken to be definitive of humankind. For example the
use of the word ‘mankind’ in the English language is synonymous with people as
a whole, or so a male ‘speculum’ would lead us to believe. However in reality,
language privileges the position of the male ‘genre’, and there is little room for a
separation for ‘woman-kind’.

The privileging of language is held to be ‘common sense’ and within society not a
problem. However as Irigaray (1994) cogently points out if it is such an
inoffensive phenomenon, what would happen if by law, language has to change so
that one year it is masculine (as it is now), and another year it is feminine. That is
a smile-making idea, and it is akin to viewing the world through a woman’s
‘speculum’, so that what is represented has the flavour of women-kind. It is
important to remember that Irigaray is not seeking a space for women within
mankind, rather she is suggesting women are different and thus need to
create/have created their own kind. This is a challenging proposition. Irigaray is
not proposing changes to language from a position of lack, but from a position of
asserting the validity of a way of being for women in the world. The central
element is women being acknowledged by patriarchy as being the future of the
world, in that women are the sex which bear the children and they demand a
place, a voice within the symbolic order which has up until now been denied
them.

Much of what happens with language, with societal structures, is about control of
women, keeping women subservient to patriarchy, and I do not mean on the level
of a global plot. I consider this has become common practice and has been for so
long, that it is accepted by many as the norm.
Psychoanalysis

When Irigaray is discussing psychoanalysis she is, as much as anything, addressing the main protagonists themselves, Freud and Lacan. Irigaray’s primary critique of psychoanalysis is that it is patriarchal, lacks awareness of historical determinants and is ruled by a series of ‘unconscious fantasies’ (Whitford, 1991a). Irigaray’s engagement with Freud and Lacan represents a fracturing from philosophy and a rereading of subjectivity as it is represented in the ‘paternal metaphor’ of psychoanalysis (Braidotti, 1991). The male subject of psychoanalysis is the subject par excellence according to Freud and Lacan, woman is the object of his subjective gaze, eternally and irredeemably reduced to her role as corporeal other, or lack.

Lacan’s body is always a male body, for Lacan women’s bodies are ‘lacking’. Lacan believes in the primacy of the phallus as ‘the’ signifier but with his ‘mirror’ according to Irigaray, Lacan cannot ‘see’ what is specific to women, as he cannot see what is inside (Whitford, 1991a). Irigaray does however support Lacan’s assertion of the constructed as opposed to the essential basis of masculinity and femininity, thus woman is made and not born (Hekman, 1990).

Lacan’s absent presence in Irigaray’s writing resembles the “Name-of-the-Father”, his own concept of social identity as inscribed in the subject, male or female, through the assumption of a patronym within a patriarchal order. Her work, then, becomes, in part, an attempt to rename herself. (Burke, 1994, p. 41)

Lacan heavily influences Irigaray’s work, yet he is invisible by name an ‘absent presence’. Burke (1994) suggests that Lacan, in being her mentor for so long, was her symbolic father, her ‘patronym’ and that there are transferences in her unspoken relationship with him. In addition Burke speculates that Irigaray’s work is an attempt to ‘rename’ herself so that she is able to speak ‘as woman’ (p. 41), she is breaking free of the machinery.

Within Irigaray’s reading of Freud she interprets his position as phallocentric. By phallocentric she means Freud’s theory of sexuality is based around the masculine subject, and within this framework woman immediately becomes other, she is
only ever a “...version or a variation” (Grosz, 1989, p. xx) of male sexuality and representation. “If knowledges and systems of representation are phallocentric, then two discourses, two speaking positions, and perspectives are collapsed into one” (Grosz, 1990, p. 174). Irigaray notes that when Freud was developing his theory of sexuality he verbalised an idea that while implicit had remained unspoken, “...the sexual indifference that underlies the truth of any science, the logic of every discourse” (Irigaray, 1991e, p. 118, italics in original). Sexual indifference is clear in Freud’s definition of female sexuality, for in his theory there is no specific female sexuality. A woman’s sexuality for Freud is only ever in response to that of the male, and is therefore perceived by him as being a lack. When a woman undergoes psychoanalysis Irigaray (1991e) contends that it is synonymous with shaping her to a masculine culture. She proposes that Freud’s sexual indifference is a manifestly deficient way of articulating the unconscious. Irigaray’s argues that the analyst defines the terms of the relationship because they have decided what is determined by the unconscious. She holds the view that analysts come to analysis with a recipe for how the unconscious works and she comments that:

...once psychoanalytic ‘science’ begins to claim to have discovered the universal law of the workings of the unconscious, and once every analysis is no more than an application or a practical demonstration of that law, the only status the now complete ‘science’ can possibly have is that of an era of knowledge already over. (Irigaray, 1991c, p. 83)

In questioning what would become of the primary notions of psychoanalytic theory in a society where women were not oppressed Irigaray asks, “...what meaning could the Oedipus complex have in a symbolic system other than patriarchy?” (1985b, p. 73). Women need to be the unconscious and the body for men, because otherwise the symbolic system of the Oedipus complex would fail, which would mean that patriarchy would fail. Failure would render as void the Name of the Father, the psychically structuring principle of the unconscious and social world. It is Irigaray’s belief that the tenets of philosophical discourse must be challenged, because it is these that established and also maintain patriarchal structures, in the Name of the Father. And it is from the assumptions of philosophy that the principles underlying psychoanalysis derive. From thence
comes Irigaray's (1991c) notion that psychoanalysis is dangerous for women. Irigaray conceives of philosophy as the master discourse, because it makes the laws for all the others, is responsible for the composition of language and how it is used "...inasmuch as it constitutes the discourse on discourses" (1985b, p. 74).

Irigaray (1985b) discusses the work of psychoanalysts who attempted a re-working of female sexuality in order to decrease the emphasis on notions such as penis envy and also to challenge the masculine parameters of sexuality. Karen Horney is a psychoanalyst who was disliked and perhaps feared by the predominantly male analytic community. Horney was eventually ostracised for breaking the law of the Name of the Father because she criticised Freud. Horney proposed a model of women whereby feminine qualities were emphasised and valued, as opposed to Freud's model of women 'lacking' (Chodorow, 1989). Horney asked how could it be that a woman, who gives birth to a child and then nurses that child, could possibly be bothered with penis envy. For Horney, the idea was ridiculous. The only envy which could possibly result was envy of men being allowed a sexual freedom that was denied women, because woman's sexual role was carefully prescribed for them by men in order to keep them under control.

Foucault considers psychoanalysis to be an extension of the medicalisation of the subject, an attempt at regularisation and control that became increasingly overt in the 19th Century and has continued unabated since (Braidotti, 1991). Foucault reveals the travesty of psychoanalysis, which claims to be attempting to liberate the subject by 'allowing' them to understand unconscious, drives and motives. In effect what happens is the individual is subjected even more to technologies of knowledge and power. After all, it remains the role of the analyst as expert to unravel what the analysand is saying. As Irigaray (1985a, 1991c, 1991d) testifies this is why analysis can be so dangerous to women. How can it not be otherwise?
A daughter is speaking to her mother and she says:

And when I leave, is it not the perpetuation of your exile? And when it’s my turn, of my own disappearance? I, too, a captive when a man holds me in his gaze; I too am abducted from myself. Immobilized in the reflection he expects of me. Reduced to the face he fashions for me in which to look at himself. Travelling at the whim of his dreams and mirages. Trapped in a single function-mothering. (Irigaray, 1981, p. 66)

There are two clear strands in Irigaray’s writing about women as mothers/reproducers and the mother-daughter relationship. It remains for Irigaray a concern that in society women are still expected to marry, raise children and run the household and her other concern is the position of the mother-daughter dyad which she believes has an impact on women’s ability to have effective relationships with one another.

Whitford (1991a) discusses one of these themes of Irigaray’s work, that of the negating/ignoring of the maternal and the mother-daughter relationship. A central claim of Irigaray’s (1991b) is that the non-recognition of woman within the ‘cultural imaginary’ has far reaching consequences and theory then carries on the negation. This has profound effects in that common-sense thinking takes it for granted that this is how the cosmos works, and women continue to be ignored and silenced. Women, mothers, mother-daughters are ‘unsymbolized’, and here Irigaray means that there are not readily available positive representations of them within culture. As opposed to, for example, the mother-son relationship of which there are many images/icons. This effectively means that woman and her genealogical attachments are erased (Walsh, 2001). Women are usually represented as having little to offer outside the function of the maternal, which is a constricted perspective, useful to keep women silent.

A further theme for Irigaray is that Western culture is founded on matricide (Whitford, 1991a). The mother who gives birth to all children is symbolically ignored within psychoanalysis, and for Irigaray the ignoring is a form of
matricide. Matricide gives rise to Irigaray's use of the matrix in which men are
drawn to women like moths to a flame, in a way to find themselves, but it is an
ambivalent relationship, a loving/loathing. Men go to women to both find and lose
themselves, because it is from women that they came and it is women that they
yearn to return to:

Within the symbolic structure of psychoanalysis, subjectivity is
single sexed, i.e. male sexed. In this structure, to be a subject is to
take up the male position in the Oedipus complex, to identify with
the Father (the law), and thus, for women, to find themselves in
conflict, potentially at odds with their mother, other women, and
their self, for lack of an identificatory support in the symbolic order
that would confirm them as female subjects.
(Whitford, 1991b, p 38)

Because subjectivity is monosexual, so is language, they are bound up in one
other, and thus a woman remains as the 'other', devoid of anything she can name
as her own because she does not have her own language to name it.

Irigaray writes that, “[w]e live in a society of men-amongst-themselvesthat
operates according to an exclusive respect for the ancestry of sons and fathers”
(1994, p. 7). We live in a society that ignores the ancestry of women and the
importance of women to society for purposes other than reproduction and caring
for others. Ancestry and mythology are an important part of Irigaray's work. She
is advocating for the primacy of the mother-daughter relationship that in ancient
times reinforced the matrilineal line, before the patrilineal line took over and men
(e.g. Zeus) could sell off their daughters. Irigaray regards the splitting of the
mother-daughter dyad as a deliberate strategy to engender helplessness in women.
Helplessness results in women lacking the ability to bring about cohesion in their
lives. When in ancient times there was no form of marriage women were free to
live their lives and love as they pleased. The inception of patriarchy ended this
freedom with marriage to ensure male lines of descent, control of women's
property and control of their bodies.
**Sexual difference**

Psychoanalytic discourse on female sexuality is the discourse of truth. A discourse that tells the truth about the logic of truth: namely, that the feminine occurs only within models and laws devised by male subjects. Which implies that there are not really two sexes, but only one. (Irigaray, 1985b, p. 86)

A big problem, from the outset. Irigaray (1993a) understands sexual difference as being the pathway to a new link between women and refers to this link as 'becoming-divine'. Women are not yet, not women, not subjects, but they have the potential to become. Integral to this project is the appropriation of the divine, hitherto open only to the transcendental rationality of the male subject. Irigaray makes clever use of mimesis to take back from men what they have taken from women and manipulated for their own ends. She plays them at their own game. In addition she criticises feminist theory which simply berates the patriarchy without "...proposing new values that would make it possible to live sexual difference in justice, civility and spiritual fertility" (Irigaray, 1994, p. xiv). For a number of women scholars sexual difference is constitutive (e.g. Braidotti, 1991, 1994a & 2002a; Chanter, 1995; Grosz, 1994 & 1995; Hekman, 1994) and it matters.

Irigaray makes the case that woman has no gaze, and therefore she is not a subject. She is however subject to the implicit gaze of others when she uses language to articulate her life and being. This is a mantra repeated frequently throughout *Speculum*. Women are continually objects of the gaze of some one who is making evaluative comments about them. Because women are not differentiated in subject positions, they are for all intents and purposes, powerless. Men seek to find in women the source to refill/refuel themselves. As Grosz (1994, p. 22) suggests, within Irigaray's body of work, women are the body for men. Irigaray proposes that women by virtue of their subjective position are forced to wait to find out what the man wants, and then are compelled to fulfil his needs, which is why she is not subject. She is other, not able to be distinguished as a subject (Irigaray, 1985a).

But even as he struggles to fracture that specular matrix, that enveloping discursivity, that body of the text in which he has made
himself a prisoner, it is Nature he finds, Nature who, unknown to him, has nourished his project, his production. (Irigaray, 1985a, p. 228)

By use of delectable metaphor Irigaray helps us to see that ‘he’ is a prisoner of his own needs and desires. He wants her body for his own, her interiority, her foldings. The ‘specular matrix’ entwines the male subject whenever he tries to get away from it, but Irigaray is also saying that he does not really want to get away from it, such is his ambivalence. He is irresistibly drawn into the vortex of having to have sex/orgasm, in a fruitless search to both find himself, and also to lose himself. Oedipus-lost and searched for, not Oedipus-Rex.

Irigaray argues that ‘woman’ as such, does not exist as a single entity. As a sexual being she can touch herself, without having to touch herself, and this is something that he is not able to do. The central element of what she is discussing here is that a man needs some sort of lever to become sexually aroused, and in response he has taken control of language as discourse in order to have more control over his environment, and particularly women. He has painted himself into the picture as the subject. By having control over language he is able to define women's sexuality, in contingent terms of relating it to his own, on his own terms. She is not permitted to have anything of her own (Irigaray, 1985a). Irigaray suggests women have potential, through their own sexual desire to extend their boundaries infinitely.

To try and clarify what Irigaray means I consider the important word is potential. The potential is there if women are able to reject man’s specular making of her into an object. If she can symbolically say to him to take his reflection and keep it. That is not ‘me’ that you see, that is only how you want to see me, and I have to learn to see myself. Women would then have the potential to extend their boundaries, thus far they have been set for them. If women are freed from being the other of the reflection they become free to work on their subjectivity, to lay claim to their lives. Such change could work for the good of both women and men because potentially this change will also free men. Braidotti expresses this clearly when she writes that:
The key notion to understanding multiple identity is desire, that is to say unconscious processes. Psychoanalysis—as a philosophy of desire—is also a theory of cultural power. The truth of the subject is always in between self and society... Desire is productive because it flows on, it keeps on moving, but its productivity also enables power relations, transitions between contradictory registers, shifts of emphasis. (1994a, p. 14)

Desire however relies on what is happening to her not being corrupted by a phallic ideal, which seems to be symbolically inescapable. Or at least the way Irigaray weaves her matrix renders it thus. In which case all that would happen would be that 'she' would revert back to where she came from, woman as mother, the cycle starting over again, the maternal object/other.

Freud’s perspective was that female sexuality is derived from and in response to male sexuality, that woman does not have a sexuality or sex of her own. Women have nothing to compare with the ‘noble phallic organ’ (Irigaray, 1985b, p. 23). According to Irigaray woman’s sexuality is a “…hole-envelope that serves to sheathe and massage the penis in intercourse: a non-sex, or a masculine organ turned back upon itself, self-embracing” (1985b, p. 23). Her sexuality is passive as opposed to his which is claimed by Freud to be active. Irigaray repeats here a theme that appears in Speculum about woman’s ability to touch herself without physically having use some kind of lever and from this comes her proposition that woman has a sex which is not one, ‘autoeroticism’ (p. 23).

Irigaray contends that because woman’s sexuality is literally in touch with and within herself, she is ‘other’ within herself, and from being ‘other’ comes the notion men have of woman as being irrational, difficult to understand, changeable. Woman’s sexuality is plural, it is a great more than male sexuality, which is a singular entity that Irigaray contends men are fearful of losing in that infinite ‘hole’ which cannot be seen (Irigaray, 1985a), reinforcing the one-dimensional approach of Freud. If you cannot see something then surely it does not exist, and if one went looking in that ‘hole’, what might one find? There is a large ‘hole’ in Freud’s theory of the supposed absence of female sexuality, the ‘lack’, the ‘otherness’. Perhaps he was afraid of what he might find, and he did not understand female sexuality so it was possibly easier to claim it did not exist.
Irigaray (1985b) describes Freud's biological perspective about infant sexuality where he claims infant sexuality for both male and female children is derived from the male organ. Early drives have to be repressed in girls in order for them to become 'passive' sexually. For Freud, passivity is directly aligned with femininity. It is simple then for Freud to concur that if a woman does not become passive she can not be said to be feminine. This idea is astonishing in its monococular vision, and furthermore it is important to remember the influence Freud's ideas have had in Western societies, and the symbolic/imaginary and representations of psychoanalytic theory. How easy it was for him with the stroke of a pen to pervert the course of woman's sexuality. Freud continues the misogynist line of Plato, through to Marx about women primarily being a receptacle for the phallus and a valuable commodity to be kept as private property on the proviso she conforms with 'his' feminine ideals. The primary role of the woman is to be a reproducer of children, and a wife-mother for her husband. “The difficult course that the girl, the woman, must navigate to achieve her 'femininity' thus finds its culmination in the birth and nurturing of a son. And, as a logical consequence, of the husband” (Irigaray, 1985b, p. 42). I would add that thus it is that nurses nurture medicine. Nurses are the 'matter' for medicine, the bedrock and the speechless presence. Nurses are required for medicine to have its effect but are not acknowledged as contributing anything real, merely sheathing for the male acts of curing people.

Monogamy for women was believed by men to be essential to maintain patrilineage and the male line. Men couldn't have women having multiple partners, because they would not know whose children she was giving birth to, and it would in effect mean that they wouldn't know if their line was being continued, patronymic. Monogamous marriage Irigaray (1994) reminds us was primarily for the purpose of keeping women under control. Men could continue to behave as they wanted but women were denied this choice. Women were a commodity of immense value, but not to be exchanged within an open market.
According to Freud, this becoming woman is never finished... From his point of view, her becoming is effectively interminable, cannot be effected. It lacks a beginning and an end, roots and efflorescence, all memory of the event of their incarnation, all anticipation of their blooming. And so women are dispossessed of access to life and death as affirmative responsibilities, leaving their identity as free, living subjects in the trust of the other. (Irigaray, 1991d, p. 106)

What Irigaray in effect saying is woman lacks her own identity, defined by her, instead of as it is now, being defined by the other. It is her contention that their should be two ‘Others’, one female and one male, because there being two others is the only way that both sexes can be recognised as individuals and if they wanted to, harness their energies to form an alliance. What Irigaray means is that currently nobody wins, “...one always encroaches on the other, without fulfilling its own destiny, without finding the blossoming of its becoming” (Irigaray, 1991d, p. 106). Whitford suggests that the primary problem for women is that they are literally suffocated and with the man trying so hard to keep her under his control the end result is that “...he has blocked not only women’s fertility but his own” (1991b, p. 157). The difficulty is that there cannot be two ‘others’, because of the Name of the Father, a convenient position for patriarchy. Freud called the initial shots. Lacan reinforced them and women are expected to live within these sacred symbolic confines, forever destined to be un-representable within the named order of things, ideas that are as ridiculous as penis envy. Furthermore it does not have to be like this.

In An Ethics of Sexual Difference (1993a) Irigaray’s use of language continues to confound me and I am at times muddled by the ellipsis in her texts, as she slides about. She uses their language (e.g. Freud, Plato, Lacan, Merleau-Ponty) to conduct her assault on the canons of philosophy, and she mimics them perfectly. Irigaray is calling for substantial changes in both thinking and ethics if the work on the issue of sexual difference is to occur. She is calling for a renaming of nearly everything in the cosmos as she reminds us that what is written about the subject has always had a gender bias to the masculine. There is little doubt that when philosophers from Plato through to Foucault refer to ‘man’, that they are
referring to men. The subject of philosophy Irigaray reminds us is a man, there is no place currently for wo-man (1993a).

If traditionally, and as a mother, woman represents place for man, such a limit means that she becomes a thing, with some possibility of change from one historical period to another. She finds herself delineated as a thing. (Irigaray, 1993a, p. 10)

Women representing place for men is similar to what Grosz writes (1994), about women being the body for men, and the importance of shifting away from this position for her safety and well-being. No woman wants to be defined as a thing, an object, women are not blow-up dolls. If men define women as place then Irigaray (1993a) contends that for all intents and purposes women are lost. How is she to find herself, to get back to that place, or to create a place for herself. From the requirement for women to have a place for themselves comes Irigaray’s notion of women being representative of interiority. She turns on herself, and into herself in order to find herself, and in order to achieve this action she requires what Irigaray calls an ‘envelope’ or ‘container’ to establish her own identity. Irigaray (1993a) draws on Aristotle here and his thesis that everything that exists has a place and what then follows on is that place has a place as well. God creates space and is the master of time. Space is exterior and coded as masculine, time is interior and coded as feminine. The folds of time, ever dependent on the whims of space are controlled by the gravitational pull of space. Like the planets going around the sun, space is perceived of as controlling the orbit of time.

Irigaray (1993a) is discussing male love of self and is repeating the idea of the male yearning for the maternal-feminine, for a return to the mother, the woman who provided him with his initial ‘envelope’, the return home to and through her, as the other. This is another way of writing about speculum, because what he is doing when he wants to return to her, is in effect to find himself. It is akin to a nostalgic journey for something that he is not clear about, but which he appears to have to do. Some theorists, for example Freud, would see this journey as being a biological drive but I believe that is simplistic. He is driven by a kind of primordial energy but this is strongly connected to the specular matrix and his need to find himself in the matter that is situated there. It is crucial for him to make himself come into being by producing and having/holding a wife and
children and providing a home for them. In doing this he is creating an extension of him-self. Irigaray suggests that:

Love of self, for man, swings between three poles;
- nostalgia for the mother womb entity,
- quest for God through the father,
- love of one part of the self (conforming principally to the dominant sexual model). (Irigaray, 1993a, p. 61)

Love of self for women she conceives of as being more complex, primarily because women have been used for establishing men’s love of self. This is part of Irigaray’s primary critique in *Speculum* where she challenges the right of men to use women for their own ends. Women’s love of self comes out of her-self from the children she brings out into the world. She becomes cut off from herself because she is expected to love a man, and it is difficult for her to love someone if she is not permitted the space to love herself. Indeed how do you love someone else if you are not able to love yourself? Irigaray proposes that love of self for women requires a new set of conditions which would include women not having to participate in traditional roles in which they have been positioned. Furthermore there must be a relationship between mother-daughter, daughter-mother that does not result in the loss of the self of one in the other (Irigaray, 1993a).

Because women have not created themselves they are not able to ‘see’ themselves, they remain invisible, hidden in their interior foldings. Bringing about change would be a challenge. There would be a process for women to go through of learning to recognise themselves, to come outside of themselves, and being able to experience themselves as subjects who are ‘autonomous and free’ (Irigaray, 1993b, p. 48). Women would be representing themselves as themselves, and not as previously someone created by some-man else, they would have more hope of becoming self-assured. Similarly I am thinking of what happens when I hold my cat up to a mirror, she is not able to recognise the cat-ness of her-self.

The whole historic or historical analysis of philosophy shows that being has yet to be referred to in terms of body or flesh...Thought and body have remained separate. And this leads, on the social and cultural level, to important empirical and transcendental effects: with *discourse* and *thought* being the privileges of a *male* producer.
And that remains the "norm". Even today, bodily tasks remain the obligation or the duty of a female subject. (Irigaray, 1993a, pp. 86-87)

I would have never thought of this in terms of Cartesian dualism, but I should have. Bodily tasks remain the responsibility of women, because they have no language, no voice, it is all they are fit for. Not for women the dizzying heights of thought and philosophical contemplation, but instead the engaged and concerned realities of everyday domestic existence, those things which are perceived of as thoughtless. Lacking reason, women can therefore be labelled as irrational. These labels have historical glue attached to them, they have become cemented in place over the centuries. They do not have to remain in place.

A central element of Irigaray's work is to develop a theory of voice within which it is made clear what and where the position of woman is as a subject with a voice, as a subject with autonomy. She problematises the current status of there being only one voice heard, essentially a monologue, and the significance this has for woman. The monologue is particularly important when that voice is out of touch with the engagement in the realities of flesh that are intrinsic to women/nursing. To speak as woman means that there must be able to be many voices, polyvocality, a new source for production of discourse, a new source of representation for women. Representation is crucial for nursing in the specular relation with medicine. How does one go about conceiving of a nurse, and who will take the responsibility for doing this? I will discuss these issues in Chapter Eight. It has gradually become clearer to me that the project of philosophically conceiving of a nurse aligns symmetrically to that of conceiving of a woman (Irigaray, 1985a).

One of the overarching themes of Irigaray's oeuvre is that women are excluded, from the symbolic/social order. For Irigaray there is only one gender that exists in both the symbolic and the social, and it has served and continues to serve men well for it to remain that way. Patriarchy came into being for a purpose, to symbolically kill women, and to deny women's rights in the social. The purpose was to keep women under control, to ensure the continuance of the Name of the Father. And Irigaray writes this, and she writes it and she writes it and she keeps
on writing it in a multiplicity of ways, using a variety of methods to get her point across. She keeps coming back to the same theme. She is I suggest pleading with her readers to connect with her, and to be with her to take up the cause for women in the symbolic order and the social order. She is not merely writing how terrible women's lot is in life, she puts forth ideas for change. Having ideas for change is what helps makes her work revolutionary.

It is Irigaray's (1991f) contention that women are lost because of not being in the affirming position of having a values system that is of their own creation. The resulting effect is that women get stuck when they are looking for freedom from oppression because they have no internal referent of their own to guide them. As Irigaray (1993c) points out, women look in the mirror, and all they see is the other, they are unable to recognise themselves because there is no representation of them within the symbolic. She is not a subject so does not have the ability to place herself, in relation to her-self. She can only do this as the other.

According to Irigaray women lack a female God of their own, which is a hindrance in their struggle to become individuals in their own right. If women had a values system of their own it would be a 'divine project'. The divine for Irigaray is about women being empowered to have their own identity; "...as long as woman lacks a divine made in her own image she cannot establish her subjectivity or achieve a goal of her own" (1993c, p. 63). Love of her own God Irigaray proposes would lead to love of self and enable women to create their own ethical project. They would be able to define themselves as women in their own right/rite, instead of in relation to their roles as mother, partner, wife, the roles defined for them by men. Irigaray describes self definition eloquently in the following quote:

 Defined as the often dark, even occult mother-substance of the word of men, we are in need of our subject, our substantive, our word, our predicates: our elementary sentence, our basic rhythm, our morphological identity, our generic incarnation, our genealogy...As divinity or goddess of and for man, we are deprived of our own ends and means. (Irigaray, 1993c, p. 71)
Vision

Philosophy has a long history of privileging the position of ‘vision’, going back to Plato’s ‘eye of the soul’ and Descartes’ ‘light of reason’. Much of Irigaray's work is a rejection of this privileging, and the assumptions which run alongside of; ‘seeing’, rationality, cogito ergo sum etc. The emphasis on vision is a manifestation of Western culture. We live in a very visual world, a world of the ‘eye’. Modernity, Classen says, “...prides itself on its transparency: everything can be seen, everything can be known, nothing is withheld from our inquisitive and acquisitive eyes” (1998, p. 1). Irigaray uses the ‘eye’ as a metaphor for the ‘mind’, reflecting the usage of the eyes being the window to the soul. Being able to see means being able to know. I see and therefore I know is not much different from Descartes’ edict ‘I think therefore I am’. Irigaray devotes much space to writing about vision in Speculum. Grosz (1994) in a discussion about Lacan helps us see that the ‘mirror stage’ of infant development provides the infant with its first concept of ‘spatiality’ and its own being as a positioned object. The child recognises that it has a place in space, that it has boundaries and this is accorded to it by vision. A seductive argument from the great seducer.

Vision has primacy in philosophy, the occulocentrism of philosophy the ‘eye’ is equivalent to the ‘I’. The specular I, of Lacan provides me with an ‘eye’ into Irigaray. Lacan’s assumption about what was for him a male infant subject is fertile grounds for Irigaray’s critique. Lacan’s identification of the ‘mirror stage’ as the beginnings of the ‘desire for the other’, and the origins of the patriarchal complexities of Oedipus, and in addition The Name of the Father, obviously drove Irigaray to the typewriter in somewhat of a fury. However, hell hath no fury like the Oedipal rage of a mob of psychoanalysts. Regressing to the tactics of Zeus, Lacan’s response to Speculum was to arrange Irigaray’s removal from the University of Vincennes, where she taught psychoanalytic practice in the Lacanian tradition, but which she was intending to stamp with her own mark, as outlined in Speculum (Burke, 1994; Irigaray, 1985b; Whitford, 1991b).

Irigaray is discussing Merleau-Ponty’s The Intertwining-The Chiasm (1993a) where Merleau-Ponty is advocating for philosophy to return to a place of pre-
discursive experience, to enable us to explore how we come to know what we
know about the world. Redefining our understanding of subject and object
Merleau-Ponty appears predominantly to be referring to experiences of what is
seen, visible, the light.

The visible about us seems to rest in itself. It is as though our vision
were formed in the heart of the visible, or as though there were
between it and us an intimacy as close as between the sea and the
strand. (Merleau-Ponty, 1968, pp. 130-131)

Irigaray’s use of the word ‘chiasm’ is related to the optic chiasma, where the optic
nerves cross over in the medulla oblongata, or alternatively the other use of
chiasm in biology which is primarily about the crossing over and exchange of
‘strands’ of genetic material during meiosis. She is using Merleau-Ponty’s images
to create new ones of her own, which can make for slippery reading. What
Irigaray suggests is that the visible “...would have vision and could give it to or
take it away from the seer” (1993a, p. 153) and it is this conception of vision that
she is objecting to. Furthermore she claims that the ‘other’ (who is her, and in this
instance the mother) could disappear, or not be able to see him, recognise what is
going on around her, even recognise herself. So while Merleau-Ponty has
‘disappeared’ subject and object, he is still defining women’s position for them,
because she remains ‘other’ within his philosophy. Irigaray is clear that Merleau-
Ponty is guilty of solipsism in his perceptions about the ‘look’ (1993a).

In addition Irigaray is proposing that Merleau-Ponty’s ‘look’ has similar
properties to ‘touch’, which is interesting, in that the look can ‘envelop’ ‘palpate’
and adopt things in a fleshly manner. We can as well come to know our exterior
environment by touch, we can perceive of it without vision, as long as we are able
to touch it. I can come to know patients by touching them. I can come to know
myself by touching myself. One hand touching the other and vice versa, while
having similar sensations, will not be exactly the same. We come to know our
environment differently, whether by seeing, or touching. However what Irigaray
(1993a) is also stating is vision and touch are not reducible to each other, that they
cannot cross over (the chiasm) and one be exchanged for the other. Each is
implicated in the other, but they are not the other (Oliver, 2001).
Irigaray is refuting what she perceives as Merleau-Ponty’s solipsism and in addition she criticises his hypothesis of the reversibility of touch and the visible. She berates what she perceives as his occulocentrism (1993a). I do not agree with Irigaray here. For me as a nurse vision is integral to embodied practice, vision and touch are not exchanged for one another, but they do for me stand side by side. There is a symmetry to them in practice. When a nurse touches a patient she is generally looking at the patient at the same time, seeking a visual response to her touch, making a healing connection as well as using a scopic assessing gaze. Looking, touching, are not reducible to one another but are equally important, implicated in one another. Oliver critiques Irigaray’s interpretation of Merleau-Ponty, she asserts that for him “...vision is tactile in that it is analogous to touch and dependent on it” (2001, p. 77).

Irigaray and nursing

Irigaray’s work is challenging and multi-dimensional. She proposes a different reading of and for women in philosophy, and it is a refreshing approach that I find generative of ideas and possibilities for nursing. Philosophy for me is about thinking, and it is also about talking about thinking with colleagues and students. Because nursing has a fairly short history in New Zealand as an academic discipline, many nurses’ engagement with philosophy has been equally short. It seems to me to be important for nurses to consider themselves and their nursing practice from a variety of philosophical perspectives. Nurses could explore where they have come from and where they consider they might have arrived at now and perhaps where they might want to go in the future. Talking about philosophy demystifies it and offers opportunities for incorporating new thinking about nursing practice. Using Irigaray’s work to explore nursing knowledge and practice has the potential to greatly enrich nursing philosophy from a woman’s perspective, and that I believe is crucial for nursing.

Irigaray’s work offers the possibility for nurses to think about themselves differently. In particular she suggests that the collective voice of women can be a real strength to bring about change. Her work is complex and not an easy read but the scope and breadth of it has challenged me as a woman and as a nurse to re-
vision some of my ideas about nursing. Engaging as she does with an array of philosophers means that she traverses a range of theoretical approaches. A provocative re-reading emerges with Irigaray suggesting strategies that nurses could debate and choose to use.

Using *speculum* to ‘look’ at nursing practice through a different lens that is nurse-centred as opposed to being mediated by the dominant discourse has considerable potential. For such a long time nurses have seemed to find it necessary to define themselves in relation to medicine. The two professions are inextricably entwined in a matrix and the relationship between them is complex. It would be beneficial for nurses to be able to re-present themselves, on their own terms and in a manner that is defined by them. Re-presentation may help nurses to see themselves in a different light through a thoughtful speculum of their own creation, oh for a clear view. Being able to define themselves may also assist nurses to have effective, supportive relationships with one another. Thoughtful, thinking practice is important and I intend to speculate on possibilities for thoughtful practice in Chapter Nine.

Irigaray claims that women are in a contradictory position as subjects. In order to speak they have to learn to speak as men. When a nurse speaks as ‘I’ within the symbolic law of the Name of the Father she is possibly not speaking of herself as subject, because her-self and her role have already been defined for her by the dominant discourse. Little wonder that some nurses see themselves, their knowledge and their practice as some kind of pallid reflection of medicine. Irigaray’s conceptualisation of mimesis helps me to clarify this in my head for nursing. Irigaray notes of women that “[s]he (is) pure mimicry” (1985a, p. 307). Nurses function within the image that has been created for them and sometimes by them over time. I will explore some of these images in Chapters Six and Seven as being part of nursing’s genealogy.

Irigaray suggests that because there is no ‘space’ for women/nurses within the symbolic order they start off on the back foot. Nurses lack substantive things that medicine has of historical right and which nursing should be able to claim as of right. For example a separate identity, social status as nurses, public life as nurses
and occupational independence or partnership as opposed to their role being prescribed by others. Being acknowledged as having an authoritative body of knowledge is also important and I will develop these ideas further in Chapters Seven and Eight.

**Summary**

Irigaray’s oeuvre is complex and multi-faceted. Exploration of and coming to a greater understanding of her work has led me to the belief that the themes which flow through her work provide me with fertile soil to till in relation to nurses and nursing practice. Specifically the themes that interest me are the relationship of women to philosophy, women’s non-emergence as speaking subjects and the reasons for this, women’s status as subjects, women’s bodies, vision and touch, the politics of sexual difference and creating space for women. I am also drawn to Irigaray’s use of the four elements, air water fire and earth to explain her cosmology. These themes have particular relevance for nursing and will be discussed further in Chapters Six to Nine that will have nursing as their focus.

The next chapter will address aspects of the self and the soul with an emphasis on Foucault’s interrogation of the self, plus perspectives on the self drawn from feminisms. I will consider the importance of language in the social construction of the self. These discussions will provide me with a base from which to explore the self and soul of the nurse.
Chapter Four

Self and Soul

Introduction

My thesis has as one of its objectives an exploration and interrogation of the genesis and the genealogy of the self of nurses and nursing. Nursing scholars have written about the invisibility and silence of nursing practice. (e.g. Aranda, 2001; Bjornsdottir, 1998; Cheek, & Rudge, 1994; Chiarella, 2000; Colliere, 1986; DeVries, Dunlop, Goopy, Moyle, & Sutherland-Lockhart, 1995; Lawler, 1997; Speedy, 2000). However there is a paucity of philosophical writing that explores the genealogy of the self of nurses and nursing. The lack of writing by nurses and by feminists about nurses as knowing and authoritative selves is discussed by some scholars of nursing (Mulligan, 1992; Sandelowski, 1997; Speedy, 2000) and as well by Code (1991), grinding out the idea that nursing is invisible within modern healthcare.

One could deduce from the ‘lack’ of writing that nurses and nursing practice are not important. Nursing has to take some responsibility for this, as do feminisms, but nurses have to shoulder most of the responsibility. There is reluctance in nursing to get down and dirty and stuck into philosophical issues and as well there are tensions between nursing and feminisms, each regarding the ‘other’ with a disdainful or suspicious air (Kane, & Thomas, 2000; Mulligan, 1992; Sandelowski, 1997). Neither has a clear understanding of the position of the other much of the time and many nurses have a limited perspective of the powerful potentialities within the philosophy of the feminine. In New Zealand there are many thousands of registered nurses, although you might never know it by their collective ‘silence’. The exception would be matters relating to pay and working conditions. One can only imagine the political power of the collective ‘voice’ of
so many. Nurses must write themselves into history, they may perhaps benefit from practising the art of ‘writing the self’ (Foucault, 1997). This chapter will address the genealogy of the self and the soul, the self of nurses will be addressed in Chapter Eight.

The self

As selves we are composed of a series of ‘things’ which make us subjects. These ‘things’ are historical. They seem to be primarily social constructs, or perhaps occurring because of social contexts. Who and what ‘I’ am comes from somewhere to make up an ever-burgeoning auto-biography/self biography. I am writing my-self. I position myself and as well am positioned by the effect of power relations, within a specific set of conditions. The conditions of my-self, represent the biography of my-self as subject. As a subject, I am centred on the/my-self As things stand my entitlement to being a subject is a utopian fantasy. According to the laws of patriarchal philosophy because I am a woman I am not a subject, I am an object who is subjected. However, in accord with Irigaray (1985a & 1985b) I assert my right to speak as woman, as a subject, as a relational self. Irigaray’s critique of Lacan’s non-existent woman of the symbolic is significant here. For Irigaray the task for woman is to forge her own creation of a corporeal embodied subjectivity, the establishment of a feminine subjectivity that stands asymmetrically to the masculine.

It was Plato who originally posited the dualistic notion of human existence being split into two arenas, one side being body or matter and on the other side mind or ideal. The body was perceived as being of this world and thus not able to ascend to the divine. In traditional theory body is represented as feminine and mind as masculine. Descartes extended this notion, effectively scientising it, by declaring his maxim, *cogito ergo sum*, I think therefore I am. Descartes thus declared the arrival of the modern subject, man as machine, inhabited by a ghost. Because I am thinking, then it follows that there is an I, a *self*, something, which exists and helps to make me what I am as an individual. The following passage from Taylor illustrates the concept of the self that emerged with the Romantics:
There is a certain way of being human that is my way. I am also called upon to live my life in this way, and not in imitation of anyone else’s. But this gives a new importance to being true to myself. If I am not, I miss the point of my life, I miss what being human is for me. (Taylor, 1991, pp. 28-29)

The thinking, rational, free, self-directing subject is a product of modernity and existentialism and of the dawning awareness that knowledge helps mankind to have more control over their environment, power and discursive effects. The subject within modernity is able to ‘see’ everything, or they believe they can. Existentialism also challenges the essence of what thought is concerned with as a regulative idea, it emphasises that we have to get down and dirty and start where we are. Poststructuralism picks up the deconstructive and discordant strand of existentialism, it questions the certainty and truths of history and modernity and challenges the assumption of the rational, knowing subject.

_Foucault’s self_

In Foucault’s earlier writing (e.g. 1965, 1970, 1972, 1973) the ‘subject’ is constructed and constituted via a process of social construction. The subject is then subjected to domination and coercion by external agencies/institutions and has limited agency. In his earlier works Foucault places a heavy emphasis on the relationship between knowledge and power, the position of the subject being that to resist is futile. In his later writing (e.g. 1977, 1978, 1983a, 1983b, 1984b, 1985, 1988a, 1988b, 1990) Foucault’s ‘self’ is more active ethically and especially politically, rather than being a product of the system. Foucault maintains that with self-constitution all selves will be different and more or less politically able. One is more or less politically able because one has more or less seen the reality of self-inscription and self-formation through genealogy.

I wonder at times whether the silence of nurses and their apparent invisibility in the challenging politics of health is influenced by how they perceive themselves to be inscribed and the ensuing feelings of powerlessness which result from nurses believing they are not in a position to effect change. For me it brings to mind a roundabout, which keeps going round, and round, with the nurses who are on it being increasingly concerned about stepping off for fear of what might
happen to them if they do. Foucault is not writing a history of subjects so much as the mechanisms of subjectivization (Deleuze, 1988) which he believes have led to the contemporary conception of the self (Foucault, 1999a). Foucault’s subject is a socially constructed entity and he has at times been criticised for a perceived relativistic position which leaves the subject nowhere to go (Horowitz, 1987). Foucault's later works explore in more depth the relationship between the self and ethics, ethics as care of the self, and also the self and the truth (e.g. 1988a, 1988b, 1990, 1997, 1999a). I am exploring the mechanisms of subjectivization of nurses in order to identify and illuminate the self of the nurse, because I believe that currently the self of the nurse is, if not invisible, then very well hidden.

Throughout life the self is working upon itself, working towards freedom, "...where being free means not being a slave to one’s self and to one’s appetites" (Foucault, 1988b, p. 6), writing its own story along the way. In taking care of the self and in knowing how to do this as part of an ethos, one also takes care of others (Foucault, 1988b). Taking ‘care’ of others is a primary and expected role of nurses, in my experience nurses are less successful at taking care of themselves. What seems to be more pressing for Foucault is not to explain ‘what’ the self is, but more ‘how’ it is, which at the end of the day is more important. Of importance as well is how the self has arrived at what it is. Foucault's genealogical work explores the composition of the subject throughout history that has led to the modern day conception of the self. What Foucault makes clear in the introduction to The Use of Pleasure (1985) is that much of what he is doing revolves around thought and thinking. He is exploring different ways of thinking about issues, thinking about history in a manner that it frees “...thought from what it silently thinks...” (Foucault, 1985, p. 9) and in doing so enable the self to become liberated from its prison. Foucault primarily wanted to explore “...that which enables one to get free of oneself” (1985, p. 8), a challenging exercise. The statement itself is described by Deleuze (1988, p. 96) as being a 'searing phrase' in that it is akin to taking the skin off and sensitising the nerves beneath to the full force of their environment. The idea of freeing up thinking about nursing is for me liberating and empowering; it is also a noisy process as opposed to being silent. It is like standing in front of the southerly blast as it roars up Otago Harbour, straight from Antarctica.
Foucault’s ‘subject’ has a self which is ‘subjected’, and which is caught in its own subjectivity, trapped by the belief that it is rational, autonomous and free to make its own choices in life. Power relations cause nurses to become subjects, and they can then be subjected to the will of others. Rather than being merely instruments of power, nurses also use power as their selves search for their own truths and in this sense “[p]ower is productive as it recursively elaborates the self which seeks itself” (Frank, 1991, p. 57). The self emerges in Foucault’s genealogy in his works from the late 1970’s and early 1980’s when he writes about the technologies of the self.

Technologies of the self

‘Technologies of the self’ are what Foucault concentrates on in his later writings (1988a, 1988b). For Foucault the self does not exist a priori and what Foucault means by technologies of the self is that the self gets to do things to itself, to produce truth and be constituted within regimes of truth, what Foucault calls ‘truth games’. When individuals engage in ‘technologies of the self’, they are in effect looking after themselves. When individuals are looking after themselves they are able through an ethics of the self to make changes to themselves, both in what they do in their everyday life and also in their attitudes and from change comes the possibility of freedom (Foucault, 1988a, 1988b, 1990). Nurses as selves play a role in constituting themselves, they are also constituted through ‘regimes of truth’.

Foucault proposes four technologies; the first two are of production and sign systems and are concerned with science and linguistics. The third is concerned with power and domination. The fourth is technologies of the self, which is outlined by Foucault in the following quote:

...technologies of the self, which permit individuals to effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a
certain state of happiness, purity, wisdom, perfection, or immortality. (Foucault, 1988a, p. 18)

The technologies of the self are how humans go about constituting themselves as moral agents and are part of Foucault's (1983b, 1988a) genealogy of ethics which he derived from Greek and Roman philosophy. Happiness, purity, wisdom, perfection and immortality Foucault describes as being something to aspire to "...when we behave in a moral way" (1983b, p. 239). Doubtless one can attain a measure of happiness, purity and wisdom, however perfection and immortality would surely be the preserve of the Greeks and Romans who were concerned to take care of themselves and their souls in order to ascend transcendentally to a divine place.

It is the technologies of domination and self that Foucault concentrates on in his later works and which are as well significant for my understanding about the self of the nurse. The technology of domination and power is about a hermeneutics of how individuals interact with one another and how processes of domination come into being. Nursing is a practice discipline where effective interaction and communication are crucial. One of the issues I am trying to understand through an exploration of nursing genealogies is a perspective on how nurses have come to be dominated and perhaps a clearer understanding of why. The technologies of domination and self are the two primary types of technology individuals use to come to understand and control themselves (Marshall, 1997). Frank supports Foucault’s perspective when he writes, "...technologies of the self are the practices used in care of the self" (Frank, 1998a, p. 335). In caring for themselves, an individual gets to work on themselves, gets to transform themselves which is a productive way of using power, rather than power being seen as being all pervasive. The pervasiveness of power is something that Foucault was later in his career trying to move away from (Frank, 1991 & 1998a).

In discussing the differences between 'care of the self' and 'knowing the self' Foucault (1998a) comments that in antiquity taking care of the self meant that as an individual one came to know oneself. In contemporary society to know oneself has assumed greater importance, because knowing oneself, as a thinking subject is important for the development of knowledge and epistemology. Taking care of
oneself is misunderstood as not being a moral act. Morality is primarily seen as
between persons or involving multiplicities rather than concerned with selves.
However if self is conceptualised as being about identity then it is important the
individual has an understanding not of the physical ‘stuff’ of his environment but
instead of the axioms which underpin the use of the ‘stuff’. This is about the soul,
in caring for the self one takes care of the soul that in antiquity was a driving
force. The soul of antiquity was immortal and was man’s passage to the divine.
So, the best we can do is deconstruct and transcend the conditioning forces that
lock us into an order of things. To properly take care of oneself it is necessary to
examine the soul, which would seem to be important for nurses. Foucault says
that this “...serve[s] as a basis for just behaviour and political action” (1988a, p.
25).

Rose (1990) comments that ‘belief systems’ about the self are:

...embodied in institutional and technical practices - spiritual,
medical, political, economic- through which forms of individuality
are specified and governed. The history of the self should be
written at this ‘technological’ level, in terms of the techniques and
evaluations for developing, evaluating, perfecting, managing the
self, the ways it is rendered into words, made visible, inspected,
judged, and reformed. (Rose, 1990, p. 218)

Foucault in his writing about the ‘technology of the self’ (1988a) regards the
history of his project as helping to understand how an individual comes to work
upon himself, and also to take care of the self. This is essentially the same as Rose
is saying in the above quote, except that Foucault is placing greater emphasis on
the relationship between the technologies of power and domination and
technologies of the self, the dyad he refers to as ‘governmentality’.

**Looping knowledge**

The ‘looping’ of knowledge is an interesting construct explored by Hacking
(1995) and Gillett and McMillan (2001). What these authors argue is that there is
a certain way that individuals come to behave and think because of the effects of
socially constructed knowledge and practices on their lives. The looping of
knowledge could be proposed as an adjunct to the development of self. It certainly
brings to mind Foucault's (1977) notion of the disciplined body and how bodies are trained and made 'docile' to fit into a particular role, which has particular relevance to nursing and which I will discuss in Chapter Eight. If individuals have an embodied self, which I believe they do, then the looping effect of knowledge has real possibilities for further expansion.

Hacking (1995) suggests that humans are wont to behave in a manner that is expected of them. This behaviour is especially so when those who are doing the expecting are in a position of authority and promulgate the discourse that is valorised within certain institutions and in this part of our lives, for example teachers and doctors. Hacking calls this the 'looping effect of humankind':

People classified in a certain way tend to conform or grow into the ways that they are described; but they also evolve in their own ways, so that the classifications and descriptions have to be constantly revised. (Hacking, 1995, p. 21)

This is interesting, and makes me think of individuals as being chameleon like. In describing individuals as evolving as their own way Hacking is describing an individual who is using power in a productive way to resist classification. There are many images of nurses that have evolved over time and these images extended to a mode of classification of the qualities which were expected of nurses, especially those of loyalty and obedience to the hierarchy (Buchanan, 1999; Chally, 1992; Hallam, 1998; Rafferty, 1995; Reverby, 1987; Wand, 2004). In large part the imagery derived from what was expected of nurses as 'good women', especially in the Victorian era (Bashford, 1998; Garmanikow, 1978; Nelson, 1997a), but also images such as piety and chastity which aligned nurses with religious life (Nelson, 1997b). Military life was a further source of imagery and expected behaviour for nurses, the crisp uniform and epaulettes denoting rank being obvious examples (Chally, 1992; Reverby, 1987). I will explore images of nurses and the importance of their role in the construction of the nurse in Chapters Six and Seven. I will also consider whether nurses are able to resist images, which have been constructed both for and by them.

Gillett & McMillan are arguing against the concept of social constructionism and write “...[m]any writers who speak of 'social construction' oversimplify and
therefore caricature the relationship between the creation of a discursive device, for example theories about sexuality, and the realities that persons categorised by these theories experience” (2001, p. 146). The realities actually shape and mould people so that so-called social constructions are not merely ephemeral but inscribed in bodies. Hacking (1995) writes similarly as he describes his belief that the term ‘social construct’ is used out of context. Hacking is at pains to point out that describing something as socially constructed, can in a real context mean very little, and he asks, what does the term actually mean. What Hacking is more interested in is “...how that constructed knowledge loops in upon people’s moral lives, changes their sense of self-worth, reorganizes and re-evaluates the soul” (1995, p. 68). I would speculate this has significance for nursing as well. There is a construct of the nurse, in fact there are many, but what is important is how these constructs have impacted on the selves of nurses, their self-concept, their souls. How do the particular constructs of how it is to ‘be’ nurse, ‘loop’ in to have an effect on how nurses practice? This will be explored in Chapters Eight and Nine.

Self and morality

We are selves only in that certain issues matter for us. What I am as a self, my identity, is essentially defined by the way things have significance for me...we are only selves insofar as we move in a certain space of questions, as we seek and find an orientation to the good...the self’s interpretations can never be fully explicit...the language which can never be made fully explicit is part of, internal to, or constitutive of the “object” studied...[o]ne is a self only among other selves. A self can never be described without reference to those who surround it. (Taylor, 1989, pp. 34-35)

No person is an island Taylor is saying here. He is as well suggesting that the self has a moral impetus as it searches for the ‘good’. Taylor is at pains to point out that we can never be ‘selves’ on our own. The development of self occurs within a social context and is mediated by the influence of language, which is integral to culture. Language governs entry into subjectivity and some form of language is essential to thinking. As humans we think in words, pictures, smells and these require language to bring them forward. Taylor (1989) suggests our lives form a ‘narrative’ and are part of an ongoing ‘quest’ to explore who we are.
Taylor contends that having an understanding of where our ideas of the 'good' or morality have come from must initially preface being able to articulate what a 'self' is. He asserts that having a self and morality are enmeshed subjects and considers the "...respect for the life, integrity, and wellbeing" (1989, p. 4) of humanity to represent the overarching themes of our idea of morality and that these are representative across societies. To an extent these concerns are so ingrained as to be seen to be instinctive, but as well Taylor points out they are part of what defines us as being human, "...a given ontology of the human" (p. 5).

Taylor proposes three axes of moral thinking "...our sense of respect for and obligations to others, and our understandings of what makes for a full life...[and] the range of notions concerned with dignity" (p. 15). Use of dignity in this context is how others view the individual, the amount of respect accorded that person.

Self-awareness is an integral component of our lives. As individuals, we are aware we are on display and this is influential in how we present ourselves to the world, we can of course display a false picture. It is Taylor's belief we use moral frameworks to help make sense of our lives and that they are integral to our having agency and a sense of our-selves as persons. However I am reluctant to concur with Taylor that we all use moral frameworks, I am not sure how many individuals in reality use moral frameworks and how self-aware many are on a conscious level. However Lacan and Irigaray would affirm that individuals do do this unconsciously. Furthermore Taylor argues that frameworks that help us to position ourselves assist to define personal identity. These frameworks may include cultural and spiritual belief systems that often have within them mores that direct a certain path in life. Having a stable identity Taylor suggests helps us to be oriented within space and time, particularly discursive space and historical time. Spatiality and feeling grounded/linked to something in common with others is important to us as humans and would seem to be a significant part of the ontology of what it means to be human and to be part of a community. Nurses' personal beliefs and value systems do not arise from out of the ether. Nurses are informed by what they know and are kneaded and shaped by life experiences both positive and negative. Life is a tapestry of experience.
Rose (1996) challenges Taylor's concept of the self being linked to concerns of morality and the good. I tend to concur with Rose and furthermore believe Taylor's premises to be androcentric in that they ignore issues of gender, ethnicity and socio-cultural components. It is my belief he is writing with a perspective directed by his particular theism, which he does not make overt until the end of his text. I support theorists (e.g. Grosz, 1994 & 1995; Hekman, 1990; Irigaray, 1985a & 1985b) who assert that the gendered body is fundamental to any thesis of the self, and that to ignore embodied experience is to creep backwards towards dualism, if indeed we ever left it. The concept of the dis-embodied transcendental is designed to exclude women.

**Genealogy of the self**

Three domains of genealogy are possible. First, an historical ontology of ourselves in relation to truth through which we constitute ourselves as subjects of knowledge; second, an historical ontology of ourselves in relation to a field of power through which we constitute ourselves as subjects acting on others; thirds, an historical ontology in relation to ethics through which we constitute ourselves as moral agents. (Foucault, 1983b, p. 237)

Rose (1996) suggests psychology has played a significant role in the technology of the invention of ourselves. While he believes we have been freed from religious and political dogma, we have become bound up in other dogma of just how it is that we should 'be' within our lifetimes. These new 'authorities' Rose claims are more subjectifying than the old ones because they appear to us as if they are something that we really want, and need to aspire to if we are to find out who we truly are. Thus there is a plethora of personal psychology available for us to find our true and authentic selves. These tools are frequently prescriptive and generally include a component of structuring and disciplining the self. Foucault would laugh, loudly. We believe we are so free, in reality we are more governed than ever, plus we engage in many practices of self-surveillance. We surveil ourselves on behalf of some valorised discourse that has persuaded us that it holds the key to what is best. We have become in essence a self-monitoring 'Panopticon', where each individual becomes their "...own overseer, ...thus exercising this surveillance over, and against, himself" (Foucault, 1980c, p. 155).
Rose (1996) contends our justice systems, political systems and moral belief systems are based around the notions of individual responsibility, intentional action and individual rights, choices and freedoms, these particular constructs marginalise and alienate groups within society. Hall (1999) suggests that people who are marginalised in society lack a heard voice, which can result in their not being able to access healthcare resources. In turn this can lead to their being vulnerable to health risks because of discriminatory practices, not having adequate information and feeling alienated from healthcare services. Rose (1996) further suggests that a unified, unitary conception of the self, which is a fiction, leads people in Western societies to believe they are ‘psychological beings’ and that there is ‘something’ within them akin to the secret of life. They are expected to find the secret in order to be able to lead a good and authentic life. The having of a good life is of course not a new thought, for Plato it was the task of the philosopher Kings in their search for the forms, the ideal representations of the good.

Rose (1996) discusses Foucault’s conception of ethics, and the differences between ethical practices, which are what Foucault considered humans do every day in regulating the conduct of their own existence, and morals which tend to be codes, imposed by others, particularly by society. Rose critiques Foucault’s conception as being narrow, especially in regard to Foucault’s emphasis on humans relating to themselves in terms of sexuality, which Rose seems to not agree with. Rose offers an extension of Foucault’s analysis, and what appeals for my work about nurses is Rose’s suggestion for exploring “…corporealities or body techniques” (1996, p. 31). What Rose suggests is that there are particular ways of walking and positioning the body that cannot be reduced to the effects of gender, they are instead “…regimes of the body that seek to subjectify …inscribing a particular relation to oneself in a corporeal regime” (p. 32), and the regime is taught and enforced.

In line with his genealogy of subjectification Rose suggests that “…different corporeal regimes have been devised and implanted in rationalized attempts to produce a particular relation to the self and others” (1996, p. 31). This is of interest to me in relation to nursing, because I believe it happens in nursing. There
are codes for how nurses should behave. Nurses' 'being' is entwined with what it means to be a 'good woman', the identity which has been 'created' for women within patriarchal societies. This conception has contributed to the creation of the disciplined body of the nurse. Buchanan (1999) contends that a physical posture of docility, obedience and aligned subservience was created for nurses by Florence Nightingale, and has carried over into contemporary practice. The original authority came from Nightingale and is carried on by medicine and also by nursing’s structures of surveillance. In New Zealand for example the Nursing Council of New Zealand carries this out. Part of the technology of the self of nursing is the physical moulding/sculpting of how nurses are to ‘be’ in their practice. I intend to discuss regimes of the body of the nurse in Chapter Eight.

It is telling when Rose suggests that emphasis on the self and identity, instead of being a positive, can be perceived as a negative, as an obstacle to critical thought. Some groups do not accept, or take at face value the identity and the concept of self that is written for them (Rose, 1996). Not accepting is about ‘resistance’ however the dominant discourse can be distorting and deprive a person of the means to articulate their resistance. While Rose’s work is interesting and informative, for a study of ‘self’ I consider his work deficient in the sense it remains blind to the idea of sexual difference. Despite his discussion on the ‘genealogy of subjectification’, my interpretation of Rose’s work is that he continues to hold up the speculum of the masculine subject, the ‘real self’ to his story of self.

Grosz suggests that “...culturally specific grids of power, regulation, and force condition and provide techniques for the formation of particular bodies” (1994, p. 142). In nursing, the self that is constructed out of these grids, which becomes the subject nurse, is required to conform to a particular authority, that of medicine. Conforming of nurses has a long and complex history bound up with subservience to patriarchal institutions. In addition, ‘private practices’ have evolved which are hidden from the specular gaze of the ‘other’, which for nursing is medicine. Some of this practice is because of shame, and some of it is about keeping what nurses do private, under wraps, away from the ever-present specular gaze of the institution. The ‘space’ of nursing is significant; the differences between public
and private space and who gets to control/administer this space. This is what I have come to conceptualise as a ‘technology of self-caring-for-others’, an ethical claim for nurses, where nurses care for the self of others by caring, protecting, advocating, and applying knowledge, expertise and experience. I will explore space and the ‘technology of self-caring-for-others’ in Chapter Eight.

Self-surveillance

The more we discover the truth about ourselves, the more we have to renounce ourselves; and the more we want to renounce ourselves the more we need to bring to light the reality of ourselves. That is what we could call the spiral of truth formulation and reality renouncement which is at the heart of the Christian techniques of the self. (Foucault, 1999b, p. 183)

This is a thoughtful statement by Foucault which in essence says the more we try to find out about ourselves as subjects, the more difficult the task becomes, an interesting thought to ponder in the search for an ethics of self creation. Finding the ‘truth’ about ourselves also links into the care of the self that Foucault (1988a, 1988b) drew on from Greek philosophy. Certainly Foucault did not believe that acquiring such knowledge about themselves would liberate subjects. However he did believe that in striving for self knowledge and self awareness, self-surveillance was an effective form of social ordering, albeit self governed. It ensured individuals continued to participate in socially controlled institutions of health and education, thus reproducing the prevailing social order. Spitzack (1992) suggests that for Foucault, self-surveillance in the arena of health is deemed necessary to maintain the status quo in society, and also to maintain individuals roles of being patients. This is an example of bio-power under the control of medical and governmental institutions.

It could perhaps be postulated that nurses’ current obsession with reflective practice (Greenwood, 1998) is a way of getting to know themselves. I suggest that the ‘reflection’ needs to be informed by deconstruction and the kind of self-knowledge that Irigaray makes available, creative use by nurses of an alternative speculum. Foucault (1988a) remarks that Greeks and Romans used the art of practising writing in the form of keeping a personal journal in antiquity for this
purpose. For nurses the practice of keeping a professional journal could be understood as a way of ‘writing the self’ (Foucault, 1997) and also I suggest is a useful technique for ‘governing the self’. It is my personal observation that many nurses feel more able to keep a professional journal, which remains in the private domain, than they feel they are able undertake writing that becomes part of the public domain. Maybe they have ingested the binaries, which exist between nursing and medicine and position nursing as ‘other’ and have themselves become living proof that these are incontrovertible ‘truths’. Keeping a journal maintains nurse’s silent presence and more significantly their invisibility, maintaining the realm of the unthought by the thoughtless. Keeping a journal is also dependent on the tools and discourses in which nurses’ reflective techniques take their origin.

**Autonomy and freedom**

Patton (1998) discusses Foucault’s understanding of human being in terms of power and autonomy, and also freedom. According to Patton, for Foucault freedom is “...the ontological precondition of politics and ethics...the contingent historical condition of action upon the actions of others (politics) and of action upon the self (ethics)” (1998, p. 73). Patton asserts that the quantity, and I would add the quality, of autonomy that individuals have in respect of their individual lives, has a direct effect on how dominated those individuals are. Foucault believes those who are dominated will inevitably resist, and that resistance is a necessary condition of human freedom. The ongoing capacity of humans to struggle for freedom is why Foucault is distrustful of humanism which he believes sets limits to human freedom (Martin, 1988). For Foucault humanism traps freedom into a particular kind of ethics which constrains human action, because it is romantic and existential.

In Western democracies in the 21st Century there are disturbing perspectives on autonomy and freedom which are driven by governments with a particular bent towards the ideology of global domination. The government of the United States of America is a case in point. It purports to be the moral authority on what, supposedly, constitutes autonomy and freedom. For the United States freedom is about economic independence and individualism. Freedom for American citizens
empowers their government to detain at will and without charging or bringing to trial, those individuals who are suspected of being terrorists. Being suspected is enough to deny those individuals any form of human rights. These actions are carried out in the name of the American people and in my opinion are examples of extreme dogmatism. This is what Foucault (1988a) warned against, power being used to dominate and with those incarcerated having little possibility of resistance. Smaller governments who challenge the domination are threatened with the negative side of a powerful binary, friend or foe. Transgressions will incur the label of becoming the enemy and aligning with apparent forces of evil. These actions do not seem to be far removed from the fantasy world of Star Wars and the dark side. Many of us are led into believing we live in an enlightened world where we are able to exercise our right to autonomy, free speech and freedom. Darth Vader has forgotten his origin and is only sustained by his relation to the force which he has learned to control as a sorcerer or arch-image. These liberties which were fought for last century cannot be taken for granted, ever. The struggle for freedom comes from individuals having a positive relationship with power, in essence using power as a strategy to resist domination (Moss, 1998). The ability to have freedom is important for individuals to be able to work on the self, part of the technologies of the self. The example above is a potent representation of use of the technology of power and domination.

Language

The truth of the subject is always in between self and society. The truth of the matter is that, from the moment you were born, you have lost your “origin”. Given that language is the medium and the site of the constitution of the subject, it follows that it is also the cumulated symbolic capital of our culture. If it was there before “I” came to be and will be there after “I” disappears, then the question of the constitution of the subject is not a matter of “internalization” of given codes but rather a process of negotiation between layers, sedimentations, registers of speech, frameworks of enunciation. (Braidotti, 1994a, p. 14)

Language is pivotal to any discussion of the self. Alongside Braidotti (1994a) Foucault (1970) questions the role of individuals within language that has been around for millennia and which he considers is activated in us as a response to discourse. In effect he is saying we are used by language, as opposed to our belief
that we use it to direct ourselves. He problematises language by asking “[f]or can I, in fact, say that I am this language I speak...” (1970, p. 324). Foucault is exploring ‘man’s being’ and the relationship between thought and being. Language is one of the tools for a changing subjectivity for women, and for nurses. As I am exploring a theory of self for nursing it is important that it has as its epicentre an emphasis on language as the symbolic site of all interaction. When a nurse speaks whose language is she speaking and where does it come from? In my experience this is something nurses struggle with on an ongoing basis, that of having a voice and a language of their own and the authority to express themselves and be heard. Nurse’s practice is mediated by language, language is the source and site of identity, mediated and marked symbolically by the Name of the Father, and thus unavailable to nurses as women in an untainted form. Analysing language has been an important part of the feminist project. Hekman maintains that:

Language establishes and maintains the basic gender identity that creates female inferiority. It effectively erases the distinction between female and feminine that is central to an understanding of the nature of the oppression of women. (1990, p. 31)

It is Hekman’s belief that gendered language oppresses women because it is defined for women that they must speak in a certain way to be considered ‘feminine’. Closely associated with femininity, is the negative construct of irrationality. Hekman considers that women are left with an untenable dichotomy, “...either they can talk like women and be ‘feminine’ but irrational or they can talk like men and be rational but ‘unfeminine’” (1990, p. 31). Clearly a no-win situation for women and I am not sure if it is a comfortable position for men either. The construct of ‘gender’ is increasingly being seen by European feminists to be problematic as well (Braidotti, 1994a) with its overemphasis on the material and the social at the expense of the symbolic. Braidotti claims language is the “...cumulated symbolic capital of our culture” (1994a, p. 14). Reducing language to the effects of gender is reductive and leaves women with little scope for movement. I will discuss language and gender in nursing in Chapters Seven and Eight.
Poststructuralism challenges the idea of the human subject whom via will and reason creates his or her own reality using language. Instead poststructuralism suggests that language speaks through subjects and that individuals have little influence as to how this happens. This position is in alignment with what Foucault (1970) and Braidotti (1994a) assert. Hekman (1990) argues that the creation of language and reality is strictly a masculine endeavour and that when men use the generic term ‘man’ to include both men and women, they are doing it from a perspective of male reality. Hekman writes:

The postmoderns assert that the discourses that create knowledge create reality as well. The feminists expand this by arguing that that definition and that reality are exclusively masculine. The two critiques reinforce and strengthen each other. (1990, p. 33)

This creates the conditions for the possibility for women to move forwards and runs parallel to Irigaray’s (1985a & 1985b) beliefs about sexual difference.

Women are ‘governed’ both symbolically and in the ‘real’ social world by patriarchal structures. Nurses are governed in the same way, and nursing practice is further/Father mediated via the domination of medicine. The knowing self of the nurse is invisible, or perhaps hidden, because it has not existed independently of medicine. Medicine is the Father and the authority in the health care world, it owns and structures that world. Foucault argued that “[t]he way people act or react is linked to a way of thinking, and of course thinking is related to tradition” (Martin, 1988, p. 14). A challenge for me is to explore through historical genealogies of nursing, influences on nurses’ thinking and whether these have had an influence on nurses’ thinking and language in contemporary practice. Is it part of nursing’s tradition that leads nurses to believing they are powerless and not able to speak, invisible and silenced. This will be addressed in Chapter Seven.

The soul

Hacking (1995) contends a science of memory has replaced the ‘soul’, he describes the soul as having been ‘secularised’. The Christian soul is incorporeal and supposedly ascends to some place on death. The soul of antiquity such as
discussed for example by Plato and Marcus Aurelius becomes transcendent, the body is merely as a container for the soul. Hacking writes of the soul as follows:

Philosophers of my stripe speak of the soul not to suggest something eternal, but to invoke character, reflective choice, self-understanding, values that include honesty to others and oneself, and several types of freedom and responsibility. Love, passion, envy, tedium, regret, and quiet contentment are the stuff of the soul...I do not think of the soul as unitary, as an essence, as one single thing, or even as a thing at all. It does not denote an unchanging core of personal identity. (Hacking, 1995, p. 6)

I am beginning to think of the soul as an integral aspect of the self. There is an old saying that the eyes of a person are the windows to their soul, Confucius’ eye (I) of the soul and perhaps they are. It is interesting how on a subjective level we believe we can learn a lot about a person by looking at their face, and specifically at their eyes. Hacking’s (1995) soul is not the same as Taylor’s (1991) self, perhaps the self is the secularised soul. According to Hacking, Kantian ethics informs us “…that we are responsible for constructing our own moral selves” (1995, p. 264), and this is integral to individuals having autonomy. Gillett and McMillan explore Kant’s Transcendental Unity of Apperception which suggests there is a “…subjective aspect of the self which can take its own mental life as an intentional object and so becomes self-conscious” (2001, p. 162). In other words we can stand outside of ourselves and have a look at how we are getting on and perhaps explore the meaning of our own experiences, therefore directing the narratives of our lives, turning on our own axes so to speak. However, poststructuralism problematises the ‘outside’ and asserts that the objective gaze is an illusion.

Foucault’s soul

It would be wrong to say that the soul is an illusion, or an ideological effect. On the contrary, it exists, it has a reality, it is produced permanently around, on, within the body by the functioning of a power that is exercised on those punished - and, in a more general way, on those one supervises, trains and corrects, over madmen, children at home and at school, the colonized, over those who are stuck at a machine and supervised for the rest of their lives. This is the historical reality of this soul...The soul is the effect
and instrument of a political anatomy; the soul is the prison of the body. (Foucault, 1977, pp. 29 & 30)

A soul Foucault tells us ‘inhabits’ the man and writes the surface that the body presents to the world. A soul is inscribed by the events that befall the body within discourse and history. It is there, exercising power over the body, the soul contains those elements that construct the subject-consciousness, ethics, and morals, who the person is and becomes. These components come from power relations. Power produces the ‘soul’. Bernauer points out that what Foucault was trying to do in his work on the soul was in effect to ‘renounce it’, create an ‘alienation from it’ and to move the soul out of the dualistic prison that the history of human sciences has created for it (Bernauer, 1999, p. xii). It is Foucault’s belief that what is needed is a new relationship with the soul that has nothing to do with the spectral apparition that presents the soul as being the centre of the personal universe divorced from the body, the ‘ghost in the machine’. What is missing is a ‘cry of spirit’. Bernauer writes that “Foucault presents a necessary spiritual art, a duty of self-relation, of going beyond how we have been created to experience ourselves as animated” (1999, p. xiii). Spirituality is a way of being within a technology of the self (Foucault, 1990), which opens up a variety of avenues for self-exploration and relates to us beyond the immediate effects of power that shape us, giving us a hold on, or entrée into a world transcending the present.

On deliberation it seems to me that what Foucault is doing in renouncing the soul is establishing grounds for it to be re-thought and resituated within the individual as a whole, it is a rejection of dualism. In rejecting the ghost in the machine he is as well rejecting any concept of the transcendental soul. Foucault’s soul has to be immanent, corporeal, and real, of this world. In effect this is part of his project of the technologies of the self.

Rose (1990) argues that we are all governed and for governments, this has a specific purpose. All aspects of our-selves, who we are, what we do and who we do it with, are subjected to intense scrutiny and monitoring by those who govern us, the ever present and vigilant panopticon of the state. The level of information required about citizens has two levels. First so that governments can try and work
out what their citizens want and try and ‘fit’ these wants with their own political ends, and second for the most efficient management of the population. Regulation of subjects has in the 21st century reached a level where to an extent it can feel as if there is no longer any form of personal privacy, the machine of governing extends unseen into all aspects of our lives. And in amongst this is the expectation within liberal democracies that we will, as well as being governed, govern ourselves, regulate our lives within the norms and the truths which have been constructed for us. The effect of the discourse is to produce a regulated self. Power is exercised upon all of us, upon our selves and our souls. As the title of Rose’s (1990) text asserts, our souls are governed.

**Feminist perspectives on self and soul**

I am trying to move outside of a traditional linear way of thinking and knowing, to move out beyond the borders, to find a language that is not drowning in a pre-ordained manner, a female feminist way of speaking. Something that acknowledges the relevance of ‘other’ ways of knowing, that coming to know nursing practice is how nurses come to become, come into being, and create themselves in the process, both as women and as nurses. This is for me both a philosophical and a political project. To borrow from Foucault (1984b, pp. 374 & 377) the philosophical for me is about my ethos, a “manner of being”, and the political is about the “practice” of an ethics. I am considering a range of issues about nursing without necessarily taking them so seriously that the life and the fun get beaten out of them. I do not want a new set of rules to imprison nurses, rather I am exploring alternative positions.

As with Sawicki I believe it would be an error to assume that feminisms are “...capable of providing the ultimate and total account of social oppression” (1988, p. 188) of women. On the other hand as Code argues, feminist criticism of theories of knowledge and philosophy clearly demonstrates the exclusion of characteristics that are linked with being female such as “...emotion, connection, practicality, sensitivity, and idiosyncrasy” (1993, p. 21). It has not been for women to define the norms of behaviour and inquiry, these have been defined for them by the knowing masculine subject. I align my task with that of Irigaray
(1985a & 1993a) in that I want to learn to think differently, creatively, specifically about nurses' self and alterity.

An issue for nurses and nursing is the relationship between their identities, subjectivity and power. Nurses have many identities, as women and as nurses, and there are tensions between them, both real and symbolic. Nurses are present, they are real-life subjects, with real experiences, and nurses and nursing are a discursive field. Nursing is a/the quintessentially feminine profession, and there is a substantial historical absence, a discursive gap because the nurse as unknowing subject is coded female and to a large extent we are only able to speculate about what, how and why nurses 'became' in times past. Nurses' history, which mirrors the history of women, has predetermined their present. I am exploring nursing and nurses via a critical feminist perspective that for me is grounded in French critical, psychoanalytic, phenomenological and post structural theory.

The body is historically perceived as being problematic for the soul because it is appetitive, out of control and thus potentially leading the soul astray. Fearing for the soul is why men such as Plato, St Augustine and Descartes spent so much time and paper telling the populace how to go about getting the unruly body under control, in order to enable the soul to do what it should be doing (Bordo, 1988). The bodies of women were seen as being particularly perverse as they encouraged lustful thoughts in men and were responsible for leading them off the path of the work of the mind. Dualistic and misogynist perceptions about women have been present for centuries and to an extent remain a force to be reckoned with today, by women. The absence of the body in theories of knowledge production in favour of the privileging of the mind has left a tantalising space for feminist scholars to appropriate for women. Grosz (1993) refers to the space as the 'crisis of reason', and Shildrick (1997) argues that it is at base a male crisis. It is my belief that this space is potentially tantalising for nurses because nurses' bodies are the tools of their practice and integral to their practice being embodied.

Feminist scholars such as Braidotti (1991, 1994a) and Shildrick (1997) are rewriting the female subject and arguing for her corporeality. As discussed previously women's bodies have been traditionally used against them, almost as if
women have been perceived of as having an excess of body, too much he cried, too much. Men on the other hand have been disembodied, because this has been the only way for them to achieve transcendence. Within patriarchal symbolic structures nurses are not seen to have a self, they are 'other' and lacking. A refiguring of the female subject would incorporate embodying, enselving and ensouling the nurse, a revisioning of identity. Matter would matter, the embodied female subject would have a self whose identity was 'anchored in matter' (Braidotti, 1994a, p. 165). It is the very materiality of the body of the nurse that is inscribed by discourses and holds the cultural memories which gives rise to language, which is why bodies are important and no self-respecting subject should be without one! Language holds the 'symbolic capital' and as Braidotti suggests, constitution of a new female subject involves processes of unravelling the complex layers.

**Sexual difference**

Similarly to Irigaray, but using a different language, Braidotti is exploring alternative ways of viewing the subject, which stand outside of phallocentrism. Braidotti is attempting to bring into being a "...vision of female subjectivity in a nomadic mode" (1994a, p. 1), using a method of thinking/ writing she describes as *figuration* which is "...a politically informed account of an alternate subjectivity" (p. 1). Figuration is not the same as taking ideas from what is already there and adapting them. It is, for women, about developing different ways of knowing and seeing and having an emphasis on values that are significant to women such as connectedness to others and the importance of relationship. The self of women does not operate in isolation. The concept of 'nomad' comes from Deleuze and Guattari (1987), where nomadic thinking is about difference, change and moving about (Grosz, 1995), finding a discursive space that is habitable.

For Braidotti there are new figurations to replace old logocentrisms. The new figurations she is proposing include an emphasis on the corporeal, and the significance of sexual difference. Foucault does not offer anything like this within his work, where the subject is essentially slotted into quite specific immovable roles and which for Braidotti (1994a) is harmful to the feminine. For Braidotti, as
for Irigaray, sexual difference does make a difference, and any alternative theory of the subject for women must include a non-essentialized position on women’s bodies and sexuality. Seemingly reassured by the ‘dissonance’ in the positions of Foucault and Irigaray, Braidotti notes that the asymmetry in their philosophical beliefs may facilitate constructive debate between men and women and, in particular she acknowledges Irigaray’s understanding that “...conceptual thinking is not neutral but rather very sexual-specific” (Braidotti, 1994a, p. 134).

Braidotti is interested in new ways of thinking that step outside the corridors of logocentrism, into a whole new creative frontier, a ‘nomadic’ frontier embraced by women who want to make a difference. These are women scholars (e.g. Braidotti, 1994a & 1994b; Burke, 1994; Butler, 1999; Grosz, 1993, 1994, & 1995; Haber, 1994; Hekman, 1990; Irigaray, 1985a & 1985b; Schor, 1994) who dispute phallocentrism, maintain that language is marked with the Name of the Father, and for whom issues of gender matter.

As with Foucault and Irigaray, Braidotti challenges the assumption of the singular unified subject that is in charge of its own destiny. She considers the assumption to be an illusion. The subject is instead a pile of disparate parts, stuck together with what Braidotti (1994a) calls ‘symbolic glue’ which binds it to the phallocentric symbolic, the ongoing ‘truth games’ between Foucault’s (1988a) technology of power and domination, and the technology of self. Braidotti’s nomad is what she describes as a ‘polyglot’, an individual in between cultures and countries struggling with symbolic exchange.

Sexual difference is a critical issue for nursing and I share the positioning of Irigaray and Braidotti. For nursing, in particular, it is the sexual difference between nursing and medicine, one coded as feminine, and the other, implicitly coded within phallocentrism as masculine. This is what nursing in the 21st century struggles with, a seemingly endless battle. As Braidotti states “...it is our horizon and our utopia” (1994, p. 146). It is nursing’s horizon because nursing has been historically measured against medicine, nursing continues to measures itself against medicine and nursing has at times been complicit with medicine in
perpetuating its domination. It is nursing’s Utopia because if nurses want to acknowledge it, it could provide nursing with potential for revolutionary change.

My project is not about blaming medicine for nursing’s ills. Rather it is an attempt to move outside and acknowledge that historically nursing has been a subjugated discourse, and then attempt to move forwards. Medicine as a patriarchal institution has had certain knowledge perspectives and self-interests to maintain. What seems to me to be critical for nursing as a feminine body of knowledge is to first of all nursing knowledge as being different and then set about enunciating it in a way that affirms it as being authoritatively different to that of medicine, and perhaps sexually different. This does not mean that nursing knowledge is incommensurate with that of medicine. What nursing can observe in medicine is an understanding of the politics of their knowledge production, critical insights into a technology of power and domination, but I do not mean for nurses to carry out their project of knowledge in the same way as medicine. Nurses could learn to represent themselves differently. Furthermore there is a potential opportunity for freedom, an opportunity to come face to face with the embodied self and the soul of the nurse, to say ‘hello’ to a newly knowing subject. This is a radical project deriving from the rich work of Irigaray.

Summary

This chapter has explored a myriad of perspectives on the self and the soul and has primarily a Foucaultian poststructural flavour with additional sexually specific perspectives provided by Irigaray. The story of the self and soul of the nurse will be further explored in Chapters Eight and Nine.

For a long time one has known that the role of philosophy is not to discover what is hidden, but to make visible precisely what is visible, that is to say, to make evident what is so close, so immediate, so intimately related to us, that because of that we do not perceive it. Whereas the role of science is to reveal what we do not see, the role of philosophy is to let us see what we see. (Foucault, 1994, cited in Davidson, 1997, p. 2)

Here Foucault is encapsulating what it is I am setting out to do. I am not setting out to see something that hasn’t yet been seen, I am rather, looking through a distorted lens to re-interpret through a feminine speculum what is already there,
and to enable nurses to see themselves and nursing. I am looking for a clear view through a clear window, some reglazing and cleaning will be necessary.

The following chapter will address aspects of the body and embodiment from the perspective of phenomenology. The body and embodiment are central aspects of my exploration of the embodied practices of nurses.
Chapter Five

Embodiment

The anatomy and physiology of the lived body are always intertwined with the body’s intentionality in ways that undermine facile claims of priority. Just as our physical structure lays the groundwork for our mode of being-in-the-world, so our interactions with this world fold back to reshape our body in ways conducive to health or illness. (Leder, 1992b, p. 29)

Introduction

The concept of ‘Intertwining’, comes from the phenomenological theory of Merleau-Ponty. Leder (1990) writes with passion about the body and its apparent ‘absence’ in our everyday lives. He believes we take our physical selves for granted, paying scarce credence to how we sit, stand, move about, conduct ourselves within our every day lives. Yet our experience of the world in its entirety is mediated by our physical being. We are incarnate, we are our bodies. I concur with Leder that we tend to think of ourselves as something other than this, as if the physical material self, res extensa is somehow secondary to the real self, which for Western societies is bound up with res cogitans, the thinking self. We tend to feel that we ‘know’ the thinking aspect of ourselves more comprehensively than the ‘other’ parts, which are for all intents and purposes dragged along for the ride. I do not know for example, what I look like to other people when talking, walking, exercising etc, because I am not able to see outside of my contained boundaries. I am not able to observe my body so therefore I take my physical presence fairly much for granted (Merleau-Ponty, 1962/2004). This is a big blind spot of dualism.

As Merleau-Ponty writes, “[t]hus the permanence of one’s own body, if only classical psychology had analysed it, might have led to the body no longer
conceived as an object of the world, but as our means of communication with it” (1962/2004, p. 106). In this day and age where machines have replaced much of what we used to do in our everyday lives, we are Leder (1990) suggests less cognisant of our bodies, not as skilled at communicating with our bodies as we used to be. Email has dis-eased the rhythm of the communal workplace, technology we are told makes our lives ‘easier’; being incarnate would seem to be less of a requirement in the 21st century. Email and virtual reality technology increasingly mean that contemporary experience is disembodied. However, we have not yet managed to transcend our bodies, though goodness knows where ‘progress’ will have taken society by the advent of the 22nd Century. Like it or not we are embodied within a disembodied and discombobulated world.

Within this chapter I will discuss embodiment, couched within aspects of phenomenology and poststructuralism. Part of my overall thesis is that nurses come to themselves and their practice through the lived experience of their bodies. Nurses’ practice is about body-work. To provide a framework for this thesis I will discuss aspects of embodiment. The embodied practice of the nurse will be ‘fleshed’ out in Chapters Eight and Nine.

*What might a body be*

I am writing about the body of the nurse, thus it is important to outline what it is I mean by the seemingly straightforward term ‘body’, or if indeed I am able to do this. It can sometimes be a case of the more you read the less you know, or the less sure you become that you really know anything at all. Or as Shildrick writes, “...that a plethora of competing discourses resist any final closure on the question of the body” (1997, p. 13). The body has been ‘seen’ historically as something which is fixed in time, an entity of matter, as simply biologically existing with certain needs to keep it functioning and furthermore not subject to changes in society and culture (Csordas, 1994a). The body has often been conceptualised as a ‘thing’. The perception of ‘this’ body has changed significantly with the comprehensive writing of Foucault (e.g. 1977 & 1978) who challenges much of the received knowledge about the body.
Foucault has made us think about the body, and in making us think about the body, he makes us reflect on our-selves (Frank, 1990). Foucault has been followed by contemporary sociologists (e.g. Frank, 1990 & 1991; Leder, 1990; Turner, 1984 & 1992), and, not forgetting for the purposes of my work, feminists including Luce Irigaray who has written critical insights into the bodies of women (1985a & 1985b), and who does not follow anyone! Thus there is now a proliferation of literature on the body, both scholarly and also that which is part of popular culture. We are bombarded with images of bodies. As Frank notes “[b]odies are in” (1990, p. 131). Bodies are now regarded as being cultural artifacts, as having a history and crucially as being able to be made differently, able to be transformed and fixed. Capitalism, individualism and consumerism encourage fetishistic relationships with our bodies. One only has to look around to see that bodies are on display and sometimes the display is to enhance perceptions of us by other individuals in society, whether it be the muscled torso of the body builder or the exposed midriffs of young women in the midst of winter. We are but actors on stages. Image-based disembodied experiences of human bodies are becoming a prevalent mode of living and being. The body can also be, in line with Merleau-Ponty (1962/2004), perceived of as a form of communication with the world. Bodies are more than ever open to governance. Turner (1984) outlines four societal tasks in relation to bodies. These are:

...the reproduction of populations in time, the regulation of bodies in space, the restraint of the 'interior' body through disciplines, and the representation of the 'exterior' body in social space. (Turner, 1984, p. 2)

Turner has adapted these tasks from the work of Foucault in the *History of Sexuality* (1978). I perceive Turner's four tasks as being clearly linked to Foucault's 'truth games' of how human beings learn about themselves through studies of "economics, biology, psychiatry, medicine and penology", and his elaboration of these in the four 'technologies' (Foucault, 1988a, p. 18). I have somewhat clumsily linked Turner's four tasks to three of Foucault's technologies. Reproduction (technology of production), regulation (technology of power and domination), restraint (technology of the self) and representation (technology of power and domination). Some may regard these 'matchings' as reductionist, or as Frank notes perhaps my gaze has been "...conditioned by Foucault" (1990, p. 131).
Conditioned is a word I would resist. To be encouraged to question, reflect and consider shades of grey is perhaps more useful.

In reading and reflecting on the ‘body’ and ‘embodiment’, I am tending to concur with Turner (1984) that the body remains a ‘paradox’, known and yet unknown, Merleau-Ponty’s “…eloquent relic of an existence” (1962/2004, p. 406). In saying that the body is ‘eloquent’, this should be tempered with a reminder that when we are unwell or have a chronic illness we can feel dis-embodied, that our body becomes once again a ‘thing’, not operating as it is supposed to, not subject to our will, more subject to will not. Schenk asks; “[h]ow is it that we are able to grasp this body which is at once our very self and our greatest obstacle? It is at times our most willing servant, and at others our most feared adversary” (1986, p. 43), recalcitrant and alien. One thing is definite, and that is that it is always there, I am always here, I think...

Grosz (1995) writes about ‘rethinking’ the body and especially for women ‘(re)finding’ and ‘(re)situating’ women’s bodies within philosophy and culture. Women have had to endure being regarded as an ‘object’. There are many rituals world wide in relation to bodies, especially rituals linked to pollution and contagion. Douglas (1966) writes about the symbolic rituals of some cultures where one sex, usually male, is for a variety of reasons seen to be at risk from the unclean secreting body of the menstruating or child bearing or nursing female. Douglas argues that these body rituals help “…enact a form of social relations and in giving these rituals visible expression they enable people to know their own society” (1966, p. 128). Hence there is the social body and the political body. The body, Douglas suggests, serves as a metaphor for unity, prescribed limits and contiguity. Many theorists appropriate women’s bodies, especially when they are writing about them as being a ‘lack’ (Freud and Lacan), or being invisible and thus not written about (Foucault). Williams and Bendelow (1998) point out that still today the body of the man is used as the standard against which others are measured. Because it is not the standard the body of the woman can therefore be seen to be deviant and having to be interfered with. This belief is especially apt in the arena of reproduction and reproductive technology (Lupton, 1994). Irigaray
(1994) describes it as being part of the specular process where women do not have control of their bodies.

Csordas notes the proliferation of literature on bodies and asks the reader to think about whether there is any such thing as ‘the body’ (1994a, p. 5). The conclusion he arrives at is that if there is an ‘essential characteristic’ of what it means to be embodied, it is probably not known, or, as Merleau-Ponty (1962/2004) believes it is ‘indeterminate’. Thankfully there are not too many ‘truths’ of the body, although Descartes remains a truth for many. Too many ‘truths’ spoil the broth. There are multiple scholarly perspectives on what the body is or what it might be. (e.g. Braidotti, 1994a; Csordas, 1994a & 1994b; Deleuze, 1988; Diprose, 1994; Foucault, 1977 & 1978; Frank, 1990 & 1991; Grosz, 1994 & 1995; Irigaray, 1985a & 1985b; Mauss, 1973; Turner, 1984, 1991, & 1992) How the ‘body’ is described depends on the subject position, sex and the philosophical and political beliefs of the author. Descartes’ legacy of dualism has been significant for how the body is viewed both as subject and object. As well as being an organic physical entity, the body is also a ‘text’ (Berthelot, 1991), able to inscribe and be inscribed on. Bodies both assume positions and are positioned within structures and institutions of society.

Writers of sociology and anthropology for example (Csordas, 1994a; Frank, 1991; Turner, 1992; Williams & Bendelow, 1998) discuss Marcel Mauss’s notion of ‘body techniques’ which allow individuals to; “…do(ing) the body, that is the body appears as a collection of practices over which we might have a certain mastery or sovereignty” (Frank, 1991, p. 40). Mauss’s (1973) paper, ‘Techniques of the body’, is interesting and engaging, if now somewhat dated. It was first published in 1935. Mauss describes different ways people move their bodies according to age, ethnicity and sex, and expresses that movement is governed by an “…education in composure” (1973, p. 86), and in the main, consciousness. He is as well suggesting that how we move our bodies is dictated by the social groups of which we are a part as he writes; “I wondered where previously I had seen girls walking as my nurses walked” (p. 72). My reading of Mauss is that he arrives at similar conclusions to those of Foucault, in that bodies are disciplined, shaped and moulded according to requirements. Indeed as Lechte (1994) notes Foucault's
techniques of the self are derived from Mauss’s work. Contrary to Foucault, however, Mauss suggests movement is learned consciously. We learn to use our bodies in the most effective way befitting whatever it is we are required to do. Sometimes we are trained to move in a certain way, for example marching in the army, or doing gymnastics. I believe this perspective fits well with notions about embodiment, and the conscious intentionality of the body. The notion of Merleau-Ponty’s that we move consciously out towards what is in our environment as embodied subjects.

Turner suggests that there is much at stake in writing about the body and ‘bodiliness’ and that it is about “...control of the social relations of personal production” (1994, p. 28). Turner reminds us that the body remains a place of inequality and control in society. The body of the nurse has always been a site of control in how it is represented, clothed, shaped, touched, worked, and disciplined. However, in amongst control there is also subversion and nurses do resist control. Resistance helps nurses to ensure that they remain ‘free’ enough within their practice to perform an embodied dance of healing. The body of the nurse helps to fill in for or incarnate the skills that the patient temporarily lacks, too much control would not fit within an organic process of recovery.

*What might it mean to be embodied*

The concept of the ‘lived body’ comes from phenomenology and is fundamentally different to man-as-machine. Leder writes:

> Experientially, our body is very different than other physical objects in the world; in fact, its possibilities of sensing and moving, of emotion and cognition, give us our world with its characteristic form. Wherever we go, the body goes with us, constructing around us a spatio-temporal continuum fleshe out by sense experience, and charged with reasons of practical and emotive interest. (Leder, 1992a, p. 5)

Leder has captured the spirit or perhaps the soul of the body beautifully, especially when he writes that our bodies ‘give us our world’. My body as a tool gives me the world of nursing practice and the lived experience of being a nurse when caring for patients as the patients heal themselves. When patients are sick
techniques of the self are derived from Mauss's work. Contrary to Foucault, however, Mauss suggests movement is learned consciously. We learn to use our bodies in the most effective way befitting whatever it is we are required to do. Sometimes we are trained to move in a certain way, for example marching in the army, or doing gymnastics. I believe this perspective fits well with notions about embodiment, and the conscious intentionality of the body. The notion of Merleau-Ponty's that we move consciously out towards what is in our environment as embodied subjects.

Turner suggests that there is much at stake in writing about the body and 'bodiliness' and that it is about "...control of the social relations of personal production" (1994, p. 28). Turner reminds us that the body remains a place of inequality and control in society. The body of the nurse has always been a site of control in how it is represented, clothed, shaped, touched, worked, and disciplined. However, in amongst control there is also subversion and nurses do resist control. Resistance helps nurses to ensure that they remain 'free' enough within their practice to perform an embodied dance of healing. The body of the nurse helps to fill in for or incarnate the skills that the patient temporarily lacks, too much control would not fit within an organic process of recovery.

**What might it mean to be embodied**

The concept of the 'lived body' comes from phenomenology and is fundamentally different to man-as-machine. Leder writes:

Experientially, our body is very different than other physical objects in the world; in fact, its possibilities of sensing and moving, of emotion and cognition, give us our world with its characteristic form. Wherever we go, the body goes with us, constructing around us a spatio-temporal continuum fleshed out by sense experience, and charged with reasons of practical and emotive interest. (Leder, 1992a, p. 5)

Leder has captured the spirit or perhaps the soul of the body beautifully, especially when he writes that our bodies 'give us our world'. My body as a tool gives me the world of nursing practice and the lived experience of being a nurse when caring for patients as the patients heal themselves. When patients are sick
and geographical inscriptions...it is itself a cultural, the cultural, product” (Grosz, 1994, p. 23).

Without regressing to essentialisms, Grosz is convincingly arguing that the body is an irreducible link to the whole being, there is not one specific body ‘model’, and thus there is not one singular form of subjectivity. Sexual difference makes a difference. I consider Grosz’ claim that the body is ‘the cultural, product’, resonates clearly with Irigaray’s argument about the bodies of women, and the nebulous state of the self of women. Grosz (1994) argues that the way women’s bodies are perceived to be naturally unequal to that of men provides the justification to presume that women are not only unequal but inferior to men. Essentialist notions of the body code women as being more physically connected to the natural world than men, which leaves men with the freedom to explore the highways of the philosopher kings.

If Irigaray is correct and woman is not a subject, i.e. subject in the sense of the phenomenological subject detached and distinct from the object being thought about, then that leaves the self in a precarious position. Grosz discusses how within the work of Freud and Lacan it is a necessity that woman is seen as being lacking, and other, for the Oedipus complex to be successfully resolved, and that the psychic reproduction of patriarchy turns on this axis. According to Grosz, if women do not lack, then in the psychic world (and I would add to that, the real world as well), “...men cannot be said to have” (1994, p. 60). Making it clear why women have a battle. Psychoanalytic theorists such as Freud and Lacan could not see this, because they were not able to acknowledge they were operating from a privileged position within/inside patriarchy. They were on the outside, blindly waving their speculums about. A central aim of Grosz’ (1994) work is to ‘rewrite’ the female body from a position of being positive, rather than ‘lack’.

*Merleau-Ponty and being-in-the-world*

Turner writes that a large part of social identity is based on individuals having their own bodies, which they do not share with others (1984 & 1992). To be me, I need my body, my body moulds my experiences in and of the world. I have a
In short Turner notes that “...human beings are embodied, just as they are enselved” (1984, p. 1). Merleau-Ponty in *Phenomenology of Perception* (1962/2004) develops a conception of embodiment, which attempts to overcome the dualism surrounding mind and body. He suggests that the ‘higher’ mental functions are also body functions (Turner, 1992). Mind and body for Merleau-Ponty are entwined, the body is both immanent and transcendent (Grosz, 1994). “While the body has a subjective role, it is also a body-object, a material thing” (Leder, 1992b, p. 27). Merleau-Ponty understands the lived body to be an ‘intertwining’, intentional entity and material thing, subject and object, understood and understanding (Leder, 1992b). When Merleau-Ponty writes about the ‘chiasm’ and ‘intertwinings’ he is using them as metaphor, to represent how the optic chiasma crosses over in the brain stem. Thus we have a blending of images from both eyes in order to form a coherent vision of the world. Leder argues that this is what Merleau-Ponty believes happens in our interactions with the world, “...so the world leaps out of a ‘chiasm’ between subject and object, my vision and that of others, perception and language” (1990, pp. 62-63). Intertwining helps us to maintain a continuous relationship with the world. Through the intertwining of perceptions we are better able to synthesise our experiences.

It is in Merleau-Ponty’s last work, *The Visible and the Invisible* (1968) that he develops the notion of flesh, which he uses to indicate ‘being’ (Grosz, 1994). Merleau-Ponty in writing his conception of flesh states, “[t]he flesh is not matter, is not mind, is not substance [i]t is midway between the spatio-temporal individual and the idea,...[t]he flesh is in this sense an ‘element’ of Being” (1968, p. 139). Flesh for Merleau-Ponty is about perceiving and as well being an object of perception. The use of the word element is to reflect the idea that flesh itself is akin to the primary elements, water air earth and fire, it is fundamental and foundational. Merleau-Ponty is proposing flesh as an “...ultimate notion...thinkable by itself” (1968, p. 140). He locates flesh as part of the ‘intertwining’, being located midway means that it is both subject and object, constituted as opposed to being fabricated. Priest comments that “[f]lesh denotes everything that may be described phenomenologically; everything that is, so to speak, surface” (1998, p. 74). It is through flesh that is of both the body and the
mind that Merleau-Ponty believes we come to perceive our world, and the world comes to perceive us, we are body-subjects. It is also via flesh that there is unification of the body-subject’s perceptual and intellectual senses, which he makes clear when he writes:

...the flesh we are speaking of is not matter. It is the coiling over of the visible upon the seeing body, of the tangible upon the touching body, which is attested in particular when the body sees itself, touches itself seeing and touching the things...the flesh is...the dehiscence of the seeing into the visible and of the visible into the seeing...my body sees only because it is a part of the visible in which it opens forth... (Merleau-Ponty, 1968, pp. 153-154)

'My body sees’. Those three words indicate to me Merleau-Ponty’s clear commitment to his project of embodiment and of our being phenomenological beings, the notion of his of flesh being located ‘midway’. That we perceive of ourselves and the world in the way we do, and that the world perceives us, is because we are body-subjects (Priest, 1998). The body-subject and the world are mutually constituting, we are human beings in the world. (Grosz, 1994; Matthews, 2002; Priest, 1998). The concept of flesh folding and enfolding is a way of knowing by taking in, when something is taken in it is enfolded in order to sustain and nourish it. Merleau-Ponty uses the analogy to describe the double sensation of touching and being touched and also the relationship between the ‘seer and the visible’, being both object and subject. “Flesh is being’s reversibility, its capacity to fold in on itself, a dual orientation inward and outward” (Grosz, 1994, p. 100).

Vision is the sense that can be used to objectify. The object can be held at a distance, this is different to feeling, smelling, taste and hearing, which require the object to be literally taken in to the body so that they are able to be sensed, they are thus enfolded.

Irigaray is critical of what she sees as Merleau-Ponty’s privileging of vision over the other senses. She claims that he reduces touch into vision, whereas for her vision is dependent on touch, “...it remains that I see only by the touch of light” (Irigaray, 1993a, p. 165) on the eye. Merleau-Ponty writes, “...vision comes to complete the aesthesiological body” (1968, p. 154). Irigaray finds this position excessive and queries why the finishing task must be completed by vision and does he have the right to say when the body is in fact completed. She is
suggesting I think that what he is looking for is too tidy, totalising and closing everything off. I do not see that Merleau-Ponty is reducing touch into vision, I see him as attempting to unify perceptions and intellect within the 'flesh'.

Leder, as well, considers Merleau-Ponty’s conception of flesh to be incomplete. He contends that the conception of flesh refers to the surface body only, and ignores the depths of the body, specifically the viscera and that flesh remains primarily an “...ontologizing of perception” (1990, p. 64). I am not comfortable with that understanding because I believe that if we are embodied then we need our whole body in order to express that, which is what Merleau-Ponty intends. If Leder believes flesh is only about surfaces then the brain would be removed as well as the viscera and this is not Merleau-Ponty’s intention. The organs of sight and hearing are at least partially internal, as is the ennervation of the organ of touch, the skin. I find Leder’s logic faulty. I am reminded of a phrase of Pascal’s, *The heart has its reasons which reason does not know*. I am not saying Pascal was a phenomenologist, possibly an early existentialist, and the heart is certainly part of the depths of the body.

How might vision contribute to the experience of space? If vision is part of me, then it has an experience of space, even though qualitatively different to other experiences. Vision constructs virtual, that is unreal space, whereas real space is inhabited and moved within by my body. I look, I see, my eyes are part of how I consume space, I consume with my eyes, I touch and caress with my eyes, I fold the other in with my eyes, I sense with my eyes, vision and touch are intertwined.

In reflecting about vision I have been reading Nagel’s (1969) paper ‘Sexual perversion’, which is about Romeo and Juliet having a night out. Nagel is writing about desire, and how Juliet knew Romeo was looking at her and how he knew, that she knew, that he was looking at her. This suggests to me that vision can be used to sense, enfold and take in, it is not merely about holding something at a distance. Nagel writes:

...sexual awareness of another involves considerable self awareness to begin with-more than is involved in ordinary sensory perception.
The experience is felt as an assault on oneself by the view (or touch, or whatever) of the sexual object. (1969, p. 10)

These are significant observations. How is it we become aware sometimes that there is somebody looking at us, is it that we are able to feel the visual caress, the regardful caress, and the loving caress? As Nagel notes when it involves desire it can be interpreted as an assault on the senses. I understand vision as being more than simply looking, I regard it as being part of the phenomenology of coming to know, of how nurses come to know, how human beings come to know. As Merleau-Ponty says, “[t]he visible about us seems to rest in itself. It is as though our vision were formed in the heart of the visible, or as though there were between it and us an intimacy as close as between the sea and the strand” (1968, p. 130).

In her exploration of Merleau-Ponty, Grosz (1994) considers there are aspects of his work that are helpful to feminist theory. In particular his conception of the importance of experience, perception and the lived experience of the ‘body-subject’. These are issues, which are important to the production of knowledge within feminisms. Grosz considers Merleau-Ponty’s ‘interrelatedness’ of mind and body to be important as she writes:

The body and the modes of sensory perception which take place through it ...affirm the necessary connectedness of consciousness as it is incarnated; mind, for him, is always embodied, always based on corporeal and sensory relations. (Grosz, 1994, p. 86)

Nurses’ ‘experience’ and the experience of being nurse are produced by a variety of knowledges and social practices. Merleau-Ponty’s way of knowing is about knowing being interactive and inclusive, rather than standing back and objectively measuring, vis-à-vis vision. Nurses learn phenomenologically through the lived experience, which is interactive and intersubjective and which I speculate has significant impact on the self of nurses. This will be discussed in Chapter Eight.

Merleau-Ponty does not take on the concept of experience as an unproblematic given, as some feminist theorists have done. For example Belenky, Clinchy, Goldberger and Tarule’s (1986) text exemplifies uncritical essentialist notions and assumptions about women. Merleau-Ponty reminds us that experience is influenced by the same forces as other knowledges, that is social, cultural,
political and historical, and does not occur in a vacuum (Grosz, 1994). Grosz considers Merleau-Ponty takes experience seriously and considers it both important and meaningful for producing new knowledge and philosophical understanding. Merleau-Ponty:

...locates experience midway between mind and body. Not only does he link experience to the privileged locus of consciousness; he also demonstrates experience is always necessarily embodied, corporeally constituted, located in and as the subject’s incarnation. Experience can only be understood between mind and body -- or across them -- in their lived conjunction. (Grosz, 1994, p. 95)

Merleau-Ponty renders as problematic the usual binary polarisation between mind and body. To come to understand requires mediation between experience and perception. There is an irreducible link between what we do and how we think (Grosz, 1994). Perception is always an embodied experience, perception never exists as a thing in-itself. This understanding is significant for nurses and nursing, and provides greater weight for the significance of the lived experience of both being a nurse and being nursed. It is nurses’ bodies that come into contact with people and the world, not simply their minds and thus it is that nurses’ bodies constitute their lived experience. The idea of a knowing body that is contiguous with others and the world is important in the arena of healthcare today where evidence based practice has become a dominant force. Evidence based practice is highly abstract in its derivation and use of knowledge and removed from any knowledge about the individual needing care and healing. The knowing body is absent from evidence based practice, both the body of the individual patient and the bodies of those nurses who care for them in the context of a healing relationship. Merleau-Ponty’s ‘mutual mingling’ becomes negated.

Walker considers evidence based practice is predicated on an ideology that “...hard science (via empiricism, positivism, economic rationalism and pragmatism) is the best and only way to further our understandings and the practices which flow from these understandings” (2003a, p. 152). Walker believes evidence based practice is dangerous to nursing and marginalises nursing knowledge. I share Walker’s concerns and I am uneasy at how quickly and to an extent thoughtlessly nursing has embraced evidence based practice, without carefully considering its origins and the potential consequences for nursing
practice and contemporary healthcare of being subsumed to positivistic science. It is further evidence to me that nursing needs more strengthening in the area of developing nursing knowledge, which is about what nurses actually do, rather than risking being subjugated yet again by something which is not nursing’s. I discuss evidence based practice in Chapter Nine.

Genealogy and the body

Lash (1991) comments that genealogy is about knowledge, power and most importantly genealogy is about the body. The body is the site of power. Lash perceives of Foucault’s body as being passive and lacking agency whereas the body for Deleuze and Guattari (1984 & 1987) is active and desiring. Foucault’s body arises largely as an effect of discourses (McNay, 1991; Turner, 1992). However Lash does consider as potentially crucial for feminists Foucault’s ‘portrait’ of the female body and how it has been structured throughout history which Foucault writes about in Madness and Civilisation and The History of Sexuality, Vol. I. I ascribe less credence to this because Foucault’s portrayal of the woman’s body plays a small part in his work. The end result for him is a female body which is ‘docile’ and plastic and which has been inscribed with negative memories throughout history, akin to a tattooing process painful and drawn-out. Foucault does acknowledge in The Use of Pleasure that:

...women were generally subjected...this ethics was not addressed to women...[I]t was an ethics for men: an ethics thought, written, and taught by men, and addressed to men,-to free men, obviously. A male ethics, consequently, in which women figured only as objects or, at most, as partners that one had best train educate and watch over when one had them under one’s power... (1985, p. 22)

Here Foucault is clearly stating that women were subjected to the practices and gaze of men, objects to fit into the world of men. Foucault's self is inscribed by discourses. The specular gaze again, men created a female sexuality to fit their own purposes and also to suit their own sexual inadequacies and lacks. Much of it is misogynist, based on an insecure and ambivalent loving/loathing, fearing/desiring of women.
Deleuze and Guattari’s (1984) Body without Organs (henceforth BwO) is a body “...like the body politic, one that is always in the process of formation and deformation” (Lechte, 1994, p. 104). The BwO is a body without organ-isation, a body inscribed by politics, a body ‘territorialised’. Deleuze suggests with the BwO “...that we do not experience our bodies in terms of their biological organisation” (Lash, 1991, p. 269), and that if we do, then we should not. Fox describes how Deleuze and Guattari use the term to visualise the “...constitution of the self in the collision between the social world and desire” (1993, p 36). Braidotti conceives of it a little differently as she describes the BwO as emphasising the “...positivity of desire and the non-centrality of phallocentrism in the constitution of subjectivity” (1991, p. 114), which means that for Braidotti the BwO contains within it real conditions of possibility for women. Desire within the BwO is fluid and flowing, and is a social desire as opposed to being Oedipally derived, which is why it contains potential for women. The BwO is about body-self where Deleuze and Guattari conceive of human beings as being “...active and motivated” (Fox, 2002, p. 351). They engage with and enact history rather then just being inscribed by it. Above all the BwO is the body without an organised body, not disembodied but a desirous link between the unconscious of psychoanalysis and the political economy, representative of society (Braidotti, 1991).

Deleuze and Guattari in writing about the BwO are writing the non-gendered or perhaps multi-gendered body, but bodies as well as being gendered have sexual differences. Irigaray has denounced the view of feminine desire espoused in psychoanalytic theory as being negative, limiting and essentialised, denying women a place in the symbolic order, denying them positive representations. Irigaray’s feminine is a metaphor for political struggle and she is re-writing feminine desire back in to the script, reclaiming the turf of the symbolic, writing women in, writing in the body of women. As she describes it she writes ‘as woman’ (1985b) rather than for women. Emphatically a political act.
However admiring Braidotti is of Deleuze’s egalitarian theorising, she is less clear that what he is advocating is useful for women. Her primary critique is that what Deleuze does by collapsing sexual difference into desexualisation within the BwO in effect robs women of the foundations of feminist theory. And that means being able to control their own bodies and sexuality (Braidotti, 1991). In addition Shildrick (1997) comments that it is important to feminists that the body is perceived of as having substance, that it is a material entity and that it is sexed. The Deleuzean BwO has nothing to do with the actual physical body. Having an amorphous subject does not solve the problem. Irigaray’s analysis on the ‘desiring-machine’ of the BwO is similar to Shildrick’s. Irigaray problematises Deleuze by saying “[a]nd doesn’t the ‘desiring machine’ still partly take the place of woman or the feminine? Isn’t it a sort of metaphor for her/it, that men can use?” (Irigaray, 1985b, pp. 140-141). For Irigaray the BwO is how women have been positioned anyway, for men. However, I’m not clear I agree with Irigaray. I believe that within Deleuze and Guattari’s theory lie some possibilities for nursing, specifically in the arena of targeted resistance and embodied subjectivity.

Sexually specific embodiment

In a critique of the ‘becoming-woman’ as presented in some masculine text, Braidotti is at pains to point out that becoming she may be, but because she is not already here she is locked out of philosophy. Braidotti (1991) is dismissive of Derrida’s use of the term feminine believing it to be a continuation of the negative representation of women. Male appropriation of ‘feminine’ will only ever mean the specular refraction of woman, as he intended her to be, continuing as the other object. Braidotti suggests that the ‘feminine’ has been colonised by some male theorists within philosophy looking for a way out of the majority rulings of philosophy and that this colonisation does not bode well for women. If male theorists want to feminise philosophy, what then happens to the real life voice of women? Where does this leave the enunciation (the position of the speaking subject in the discourse or statement), of women, whence goes langage, as used by women. Whose feminine is this anyway? Braidotti makes a comment that is pertinent for nursing about ‘becoming’:
What is missing from these ‘becomings’ are women, not only as a revolutionary political movement, but also as flesh-and-blood human beings, engaged for personal reasons in a collective process of subversion of the images and status of women.
(Braidotti, 1991, p. 134)

The ‘becoming-woman’ of Deleuze seems for Braidotti to offer positive potential, the possibility for women to enact change. Deleuze posits that within society there are ‘organizing lines’. On one side there is the molar sedentary or majority, on the other molecular, nomadic or minority. These lines form ‘boundaries of thinking’ Braidotti writes “[t]he molar ones fix the utterances into logocentric statements, erecting discursive moments in the sedentary mode. The minority line undoes these territories, unifies and fastens the fortresses of subjectivity and truth” (1991, p. 115), and in doing so reveals the potential for change. Instead of the subject being a molar unit, for Deleuze the subject is molecular, composed of infinities. From this comes Deleuze’s reading of the becoming-woman, the nomadic minority, who has the potential to enact radical change within the social contract. The majority is already fixed and thus occupies a relatively powerless place in that they have already got to where they are going. The becoming for Deleuze heralds a new way of thinking, outside of logocentrism (Braidotti, 1991). This type of thinking could be seen to be gestural, rhythmic, inhabited rather than signified, fossilised and distanced into forms evident to an objective gaze which is more interested in how that which is thought is captured in a category rather than in how it is lived or played out.

For Braidotti and Irigaray women’s discourse arises from a ‘sexed specificity’ which is not de-neutralised by desexualising it or referring to it as a kind of yearned for ‘minority’. I concur with Braidotti. Real life nurses experience a medical/eyed view of their practice on a daily basis and they are a ‘minority’. It is the ‘molar’ majority that continues to wield power. The masculine has held women up to the world to reflect the values that are important to men. They do not really want change, thus the mis-appropriation of the feminine and the warming up of the language. I see this as akin to pulling a veil over the speculum, to obfuscate and produce a fuzzy image.
Both Irigaray and Braidotti lay down a challenge to Derrida, Foucault and Deleuze and state that it is all very well for them to declare the death of the subject, a world without gender and a desexualised body-without-organs. However, what does this mean for women who have been denied the status of speaking subject, whose sexuality has been defined by patriarchy as other and as thereby the mimetic reflection of masculine desire. Where is she? Precisely nowhere, in limbo, still being defined by him and what he feels he needs in order to bring some order to his chaos. According to Braidotti radical feminist positions (like that she holds), such as that of Irigaray have combined the important epistemological understanding of psychoanalytic and poststructural theory which is that bodies cannot be reduced to the "biological" or tied to "social conditioning" (1991, p. 219). This understanding creates a positive space for feminist thinking and writing about the subject. It brings attention to the body and also ‘fits’ with Merleau-Ponty’s body-subject.

Diprose (1994) considers that the experience of being embodied is different for men and women as each have been assigned different roles and functions in society. For example the reproductive body is a powerful political tool and women who are pregnant are subjected to intense public scrutiny, the ‘gaze’, within a panopticon of what have become normalised practices. Diprose contends that the woman who is pregnant becomes a public body because she has become "...the site of the reproduction of the social body” (1994, p. 25). Pregnancy can be conceptualised as the beginning of the medicalisation of a life that is destined for public spaces, and thus destined to be a disciplined member of society (Diprose, 1994). Shildrick (1997) considers that women’s embodiment is a subject of unease in society and leads to over-surveillance of healthy women, not just in the area of reproduction, but also menstruation, weight and appearance. Because it is the male body that is understood as the norm, women’s bodies are easy to pathologise and be seen as deficient.

The embodied practice of nursing and medicine

What does it mean for nurses to have embodied practice? What does it mean for both their bodies and the bodies of their patients? The body for nurses remains a
‘problem’ Lawler suggests because ‘our cultures and way of life have rendered the body private and unspeakable’ (1997, p. 32). While many nurses believe they practise holistically, I suggest that because of a variety of constraints they remain dualistic practitioners. Nurses’ practice is often mediated by powerful others and as well there are multiple constraints of time in contemporary healthcare. Talking with colleagues I am frequently reminded that there simply is not enough time to get everything done. A global shortage of registered nurses compounds problems of time, there are fewer ‘bodies’ to carry out the everyday work than there used to be. Nurses’ practice is mediated by healthcare ideologies such as the influences of managerialism and economic rationalism that drive healthcare and evidence based practice and which devalue much of what is perceived of as nursing care.

Diprose (1994) discusses the relationship between oneself, and one’s body, and postulates that if the body is unwell this may bring about change in oneself. Illness affects the self as a lived body because as Schenk writes the body ‘...is literally our selves expressed’ (1986, p. 46). Instead of the body being a thing we all have, some authors suggest (e.g. Diprose, 1994; Leder, 1992; Merleau-Ponty, 1962/2004; Schenk, 1986), that the body is what we are, and the lived body informs every aspect of our lives (socially, culturally, habits, history). We are our bodies, they bring us into being. What happens when someone becomes unwell is that the integrity of the individual becomes compromised. The body is part of the creation of the self, the lived body is central to ‘...one’s being in the world’ (Diprose, 1994, p. 108). Therefore, that I am a body is central to how I am, how I am defined and how I make space for myself in the world.

Lupton (1994) discusses nurse’s relationships and roles with medical staff. She contends that nursing work continues to be linked to attributes she names as ‘feminine’ such as caring, nurturing, softness and altruism. These feminine aspects she claims are part of what ensures the continued low status of nursing and the lack of power nurses have in structures of health. My perspective is a little different. I do not regard these attributes as negatively feminine, as Lupton appears to. What I want to try and do is frame them as positively feminine within a feminine and feminist praxis of nursing care. It seems to me that these traditional aspects of nursing are part of the representation of nurses’ embodied
practice and that they are an important component of what belongs to nursing. Part of what I am trying to write about is the importance of fitting icons like these into an informed nursing philosophy so that nurses will be more able to articulate their practice. Dismissing these attributes as ‘feminine’ and ascribing a diminished value to them is not helpful to nursing. Dismissal like that of Lupton’s may partially account for why nursing is ‘invisible’ in scholarly literature outside of nursing e.g. anthropology, sociology, feminisms and medicine.

What then is it that nurses do that is different to what medical practitioners do? I believe the differences in practices are about the lived experience (Merleau-Ponty, 1962/2004), and nurse’s practice is not as distanced, not so removed as the man of science’s practice is required to be. Nurses have a different way of ‘seeing’ the person to their medical colleagues. Why else is that nurses are so trusted? What is it that the community finds so appealing about nurses, and so forgettable as well. Patients do like nurses and appreciate the care they receive, but in my experience of talking to people who have been in hospital, they usually remember the names of their doctors but generally not the names of the nurses that cared for them. Sylvia Plath in her poem *Tulips* writes the following:

The nurses pass and pass, they are no trouble,  
They pass the way gulls pass inland in their white caps,  
Doing things with their hands, one just the same as the other,  
So it is impossible to tell how many there are.  
(Plath, 2000, p. 22)

One nurse is just the same as the other, a perception that in my opinion many patients have and perhaps in itself that is fine. However, nurses are the glue, symbolic or otherwise. They are often the interpreters of the man of science, the protectors/shields from a variety of health professionals, family and friends, the face that is there twenty four hours a day, seven days a week, the comforting ‘presence’ (Benner, 1984). From Plath’s *Tulips* again comes the following where she is describing nurses caring for her:

My body is a pebble to them, they tend it as water  
Tends to the pebbles it must run over, smoothing them gently  
(Plath, 2000, p. 22)
A simple pair of lines, but meaningful. I can visualise the nurses, gently touching, stroking, turning, washing, comforting, and communicating, the 'invisible' nurses bringing themselves to their practice. Perhaps when assisting with physical reintegration, the nurse is helping with healing of the self, of the soul, allowing the person’s lived body to recapture the nature of the subject/self, to de-objectify the body. Perhaps what the nurse is doing is ameliorating the 'brokenness' of the body and making it able to take care of itself with her help. Whereas the doctor delineates the way in which the body has failed to take care of itself and sometimes accentuates that by removing or renovating the bit that is 'failing', leaving it for the body to pick up the task of reinvigorating itself again.

Nursing education begins with the body although not in the same way as for medicine via dissecting of cadavers (Good & DelVecchio Good, 1993; Leder, 1992b; Lupton, 1994). Nurses come to know through their interactions with bodies; their own, nursing’s, their patients and their colleagues. The most important tool nurses bring to their practice is them-selves and they become increasingly skilled at using them-selves as time goes on. Nurses have metaphorical toolkits, which contain embodied knowledge. Nurses’ bodies are ‘shaped’ and ‘moulded’ by pedagogical processes and practices. Nurses need their bodies to nurse, their practice is their bodies. Nursing’s ‘body’ of knowledge is embodied, has validity, and is valuable. The relationship with the patient is stressed throughout nursing undergraduate education as being a fundamental of practice. This is in contrast to medical education where students have an array of scientific facts to learn and their education is based on the need to be able to diagnose illness and treat it accordingly (Lupton, 1994). The body for nursing is a lived body trying to reintegrate itself and make itself whole. The body for medicine is constantly being reduced and treated as a machine to be tinkered with by doctors.

Many nurses discuss their practice as being ‘holistic’; I believe holism to be a concept which some nurses take on board uncritically. Holism means to incorporate understandings of mind and body and the social context, looking after the ‘whole’ person. However, in dividing the individual into the sum of their parts, dualism is reinforced (Fox, 1993). The Foucaultian perspective is that the
body is a place for the exercise of power. Fox comments that “[t]he gaze ... is a technology of power, by which the object of the gaze becomes known to the observer” (1993, p. 24). Nurses are both objects of the gaze and gazers themselves. Nurses’ practice is subjected to the gaze of medicine via the specular mirror and the unconscious processes this entails, particularly desire (Braidotti, 1994a; Grosz, 1990). Nurses are disciplined bodies of the health care system, and as subjects they gaze upon their clients, both to make them known to them and also to discipline their bodies behind the aegis of expert practice, or as Lawler (1991) neatly puts it, ‘behind the screens’. All health care practice involves health professionals ‘inscribing the body’ (Fox, 1993, p. 25), whether by looking, touching, or cutting it up to get a really good look and as well by the naming of the person as ‘patient’ or ‘client’. Leder describes medical practitioners as ‘hermeneuts’, who are “…reading the text of the surface body for what it has to say about corporeal depths” (Leder, 1990, p. 51). Use of technologies such as thermometers, sphygmomanometers, electro-cardiographs, surgical incisions Leder notes, enables health professionals to get under the skin and inside the body, and significantly it changes their embodied practice. It may also result in changes for the body of the patient. It enables nurses and doctors to ‘look’ where hitherto they were unable.

The body of the health professional is inscribed by their practice, disciplined and trained into the required efficient shape (Foucault, 1977). Nurses are a prime example of ‘training’. There remains today a certain way for a nurse to ‘be’, from the wearing of badges of identity and qualification pinned to their breast, the uniformity of the uniform, the nurse’s ‘walk’ (fast and efficient), down to prescribed footwear, which is seen as being ‘professional’. The image has clear links to nurses’ history with the military (Chally, 1992). Contrast this with medicine and the power and status inherent in the ‘white coat’ and draped stethoscope. I can but smile as I observe medical students, stethoscopes casually ‘draped’ about their necks. It is a clear ‘sign’ they believe they have arrived somewhere and that the symbol of the stethoscope means something important to them. In effect it means status and power and that they have become ‘someone’ in the eyes of society.
Fox addresses professional care relationships, between carers and cared for and suggests the power/knowledge inherent in the relationship is "...inextricably associated with the body of the carer" (1993, p. 71, italics in original). Fox proposes that 'care is power' and that for the cared-for, to counteract this can be seen as refusing care and what carers are offering. To further explore Fox examines the caring relationship through desire and the unconscious and acknowledges the challenges in trying to liaise between desire and "...discourses constituted in reason" (p. 72). I consider Fox misses the boat here because he has made desire amorphous and the generic sexless carer blinds him. Desire appears as unthinkable and unknowable in logocentrism, until as Irigaray, Grosz and Braidotti do, you start to unpack it and particularly for my purposes, the unpacking and challenging of 'truths' and 'presence' is undertaken from a feminist poststructuralist perspective. As thoughtful women they are aware of the sexual bias in stories of desire, the voices of the 'authors' have been male, and feminine desire has not received an equal hearing from them. The men of analysis have peremptorily silenced the feminine.

Medicine according to Schenk is an embodied practice that "...deals with brokenness of the body" (1986, p. 51). While this perspective is correct for many aspects of medical practice, it does not apply to the whole and would seem to me a limited and limiting perspective of medical care. Primary health care for example is not about brokenness, it is about health education and preventative care, which helps to avoid situations of bodies needing repair. A considerable part of general medical practice is related to care of pregnant women and children and as Diprose points out "...pregnancy can hardly be thought of in terms of a collapse in the structure of the self" (1994, p. 111). When Schenk further describes medicine as being a practice that is responsible for "...caring for the bodies of others who can no longer care for themselves" (1986, p. 49), I am not at ease with the assumptions he is making. While he is claiming that he is writing about a phenomenological approach to medical practice he is essentially retaining a positivistic interpretation of the body which when it is broken, can be fixed/cured. This position ignores any possibility for the patient to be treated as someone who has experience and knowledge of themselves and can thus make a contribution to their healthcare. Schenk is assuming that the doctor knows and the
doctor cures without any thought given to the social, cultural, and historical contexts of the broken bodies he is working with and his perspective does not read to me like an account of embodied practice. What occurs to me here is the apparent blindness of some medical practitioners to their practice of medicine. Medicine is a powerful discourse, it could be a worthwhile challenge for some medical practitioners to consider how their embodied practices have actually shaped discourses of health and possibly contributed to some of the ‘brokenness’ which is apparent, not only in their patients, but in contemporary healthcare structures and attitudes, assumptions and approaches to ‘different’ bodies.

Leder (1992a) is discussing why he considers that medical practice has become desensitised to the needs of patients in the past century and believes it is critical to explore how medicine views the self and the human body. Drawing on Foucault’s work in *Discipline and Punish*, Leder uses the notion of ‘Man-the-Machine’ (cf. Descartes) to explain the body being seen as a machine. When the body breaks down it requires the intervention of science and technology to correct the fault. As medical practice becomes increasingly scientific and reliant on technology to intervene it has the effect of changing the relationship with patients. Medicine becomes more specialised with areas of specialty practice concentrating on a specific part of the ‘machine’ (Leder, 1992a). Medicine’s power is extensive with the increasing ability to understand, rebuild and, where necessary, totally change parts of the body-machine (Leder, 1992b). Leder suggests this power could paradoxically be medicine’s Achilles heel because when your understanding of humans is as inanimate machines, you tend to miss the point of what being human is all about. Where has the self and the soul gone? If we are ‘enselled’ (Turner, 1984) and ‘ensouled’ (Leder, 1992a) much of medical practice does not recognise this. The inheritance for medicine of a Cartesian perspective of ‘seeing’ the body is limiting and reductionist, both for medical practitioners and for patients. Foucault writes in *The Birth of the Clinic*:

> [t]hat which hides and envelops, the curtain of night over truth, is, paradoxically, life; and death, on the contrary, opens up to the light of day the black coffer of the body. (1973, p. 166)
In other words the living body hides the truth, the dead body can reveal it because truth has to be visible. Such a telling sentence with significance for medicine. In response to Foucault’s (1977) ‘anatomico-metaphysical register’ and the ‘technico-political register’, Leder (1992a) proposes a phenomenological and socio-political critique, to bring back the missing bodies and selves which have been extradited by dualism and the political need to have control of human beings (read bodies).

Summary

Nursing is a feminine and sense-using practice, as well as being practical and of the world. I am writing about nurses’ use of themselves in space and time, the experience of practising phenomenologically. For me it is about coming to become a nurse, of having alternative discourses of healing which are as valid as those of the dominant discourse of medicine. The world is about people, it is not about a reductionist view of the universe within which embodied subjects are seen as objects only, via the restricted view through a medical speculum. In a truly non-Cartesian manner Merleau-Ponty suggests the perceptual and intellectual senses are unified, one does not and cannot function without the other. There are a multitude of ways of seeing, hearing and feeling phenomena in the environment, which require of our selves to function as a complete subject, a body-subject. In experiencing something visually, I have at first to look before I can see, before I am able to understand, it is my body which helps me to pull it together as a single experience, and synergise it (Merleau-Ponty, 1962/2004).

What I am looking for are words to describe the embodiment of thinking, Braidotti’s (1991) ‘bodily roots of thinking’ and how to bring this perspective to the foreground for nurses as feminine practitioners. What I want to emphasise is that being an embodied nurse is an ethical subject position. Woman is a ‘problem’ in any theory of the subject. What I am hoping to articulate is an ethics (techne) of the caring self of nurses, the ethos of the everyday lives of nurses. Use of the self within nursing is akin to being a portal, as opposed to the self being the source. An imperative for me is to re-vision how nurses are visioned and made visible, fleshed out. Vision reveals reliable visual cues of what our body will meet
as it moves into a space and thus our vision is grounded in feeling and inhabiting space as a vulnerable, organic creature.

The following four chapters have nursing as a primary focus. The first of these, Chapter Six is devoted to Florence Nightingale, by way of providing a context for my writing in the following chapters about nursing practice. Plus, she has a chapter to herself because she is important and has had a significant and enduring impact on nursing.
Chapter Six

Florence Nightingale

Introduction

This short chapter, as indicated by the title, is about Florence Nightingale and serves by way as a lead in for the three chapters which follow and which are about nursing. Nightingale is important to nursing as she laid the foundation stones for contemporary nursing practice (Barritt, 1973; Bashford, 1998; Brennan, 1998; Buchanan, 1999; Cheek, 1995; Chinn & Wheeler, 1985; Rafferty, 1995; Selanders, 1993; Walker, 2000). She is one of nursing’s few documented heroines and as such deserves a space of her own. In my experience there have always been driven women within nursing who have maintained high levels of accountability both to their patients, to themselves and their profession and Nightingale is an exemplary model. Both the history of nursing and contemporary nursing practice today are strongly influenced by her. The influence today is not so much about the woman herself but the myriad of stories and myths that have grown up and around her. The myths have in a sense enclosed her within a matrix, which is not of her own creation. Myths are iconic stories in which we provide a narrative context for the attachment of certain values and lessons of wisdom to figures that have iconic status. For nursing the primary icon is Florence Nightingale.

Florence, a story

The Crimean War in the 1850’s, Scutari hospital at Constantinople. Such god forsaken places our youth go to be killed in the service of what, for God and country? Dulce et decorum est, pro patria mori, I wonder how truly sweet it was for any who went there. I cannot imagine what it was like for the thousands of young men to die on foreign soil, far away from home and loved ones, to lie in mass graves. I cannot imagine what it would have been like to ‘nurse’ there, let
alone fight a war there. These were times of pre-anaesthesia, pre-antibiotics, pre-
much of what is taken for granted in health care systems today. Mud, filth, stink,
and maggots, putrefying flesh, putrefying fear, putrid, unimaginable. This was
what Nightingale went to with thirty-eight women (Selanders, 1993) and this was,
as some ‘legends’ would have it, the ‘birth’ of modern nursing. It is from the
Crimean War that many of nursing’s traditional icons and the tangible links to the
military originate (Bunting & Campbell, 1990; Chally, 1992). Why else would
nurses have had medals adorning their breasts, epaulettes denoting rank adorning
shoulders, crisply uncomfortable uniforms, nonsensical hats and have inscribed
upon their practice and their bodies uncompromising hierarchies and chains of
command.

Florence Nightingale, a familiar spectre who continues to haunt nursing is one of
nursing’s heroines, alongside Edith Cavell and others (Darbyshire, 1995 & 2000).
Nightingale is perhaps, even after all this time, the mother of all heroines. Nursing
owes her a debt of gratitude and some other debts as well, for which after all this
time they are perhaps less grateful. Oh Florence where art thou? I have visions of
you in a long gown ethereally floating above the mire and gore of the Crimea,
bringing succour and hope to those who had little hope. Your lamp alighting and
illuminating your path amongst the mutilated and rotting bodies, the detritus of
war. The image many have of you is as the ‘lady with the lamp’, as this is how
you are portrayed. Your instructions to your nurses to be above all else, good
women. Your retreat because of declining health to your apartment after the war
and after you had established The Nightingale School. You were possibly
invalided, or perhaps it was a strategy for getting away from people and having
them come to you on your terms only (Selanders, 1993). Achterberg notes that
you “…wielded your pen as a weapon” (1990, p. 160) and indeed you were a
prolific writer and recorder. Today you may be said to have been experiencing a
post-traumatic stress disorder, then it was Victorian vapours, more seemly for a
woman. Unseemly for a woman to have seen and experienced what you did. Vera
Brittain (1978) in Testament of Youth writes of the ‘great war’, the great death the
great horror; the great waste and the ‘interminable war’, there is little that is great
about war.
The above images are images of Nightingale as she is represented in text, in stories, what Buchanan describes as historiography as opposed to history, producing “…myths about origins” (1999, p. 29). Myths serve a purpose, frequently a political purpose, the same person can be represented differently according to the purposes of the writer (Cheek, 1995). For some writers Nightingale is a heroine and for others she is not. There is a considerable hagiography surrounding Nightingale in how she was represented as a selfless martyr and heroic woman (Bashford, 1998), and as both the saviour and founder of nursing (Buchanan, 1999). Thus there are those who write about Nightingale as the origins of nursing as we know it today in Western countries (Barritt, 1973; Selanders, 1993), those who hold her responsible for inhibiting the advancement of nursing because she conceptualised it as being a profession for women only (Wand, 2004), and those for whom Nightingale’s perspective on what was a ‘good nurse’ continues to be problematic for nurses today (Buchanan, 1999; Walker, 2000). The ‘truths’ are blurred and there will never be a clear and complete view of Nightingale, no matter how ‘hygienic’ the viewing position is.

The ‘truths’ about Nightingale can not be known because she is dead, and even if she were alive they would still be storied. However, she was a prolific writer and correspondent (Barritt, 1973; Selanders, 1993) and historians of nursing have gleaned much information from her writing (e.g. Barritt, 1973; Bashford, 1998; Buchanan, 1999; Maggs, 1983 & 1996; Nelson, 1997a & 1997b; Rafferty, 1995; Selanders, 1993). My reading about Nightingale persuades me that she was an extraordinarily determined, formidable and powerful woman, a woman to be reckoned with, at times seen as a paradoxical figure. She was as well after the Crimea a woman whose image ‘escaped’ her control and was used for political ends (Bashford, 1998). It is important to recognise amongst the reading and writing about Nightingale that texts are often written to produce a certain ‘type’ of representation of her. The purpose of these strategies is to persuade readers to a certain political position of her in the history of nursing. Whether that is ‘good’ as in positive (Barritt, 1973; Kane & Thomas, 2000; Selanders, 1993) or ‘bad’ as in problematic (Walker, 2000; Wand, 2004) or with some authors, somewhere in between (Buchanan, 1999; Bunting & Campbell, 1990; Garmanikow 1978; Nelson, 1997a).
I suggest it is important to remember Nightingale within the social contexts of Victorian England in the 19th Century and the constraints that were placed upon women in this time. What she achieved was no mean feat, for anyone, notwithstanding the era. This is why when I read sentences such as "Nightingale we now see clearly, is such a disappointment; her views on women, like so many of her views, contradictory and quixotic" (Nelson, 1997a, p. 231), I am given to ask, what is it that the writer is disappointed about and does it matter if Nightingale was quixotic. Let the woman rest in peace, she has after all been dead for nigh on a hundred years.

Nightingale was born into a wealthy family in 1820 and received an extensive education, encouraged by her father (Barritt, 1973; Selanders, 1993). She decided in her mid twenties she wanted to be a nurse, which was looked upon by her family with considerable disquiet. The reputation of nurses who were not associated with religious orders was that of the 'Sairey Gamp' type of nurse as represented by Charles Dickens. The gin-soaked coarse haridan, a 'bad' nurse (Darbyshire, 2000). However Nightingale prevailed and 'became' a nurse, in the process of which creating what she was becoming. I write 'became' because she received minimal formal instruction, and that was at Kaiserwerth in Germany in 1850 and 1851, a protestant order, which trained Deaconesses in childcare and nursing (Bashford, 1998; Nelson, 1997b; Selanders, 1993). It was after this time in Germany that Nightingale began implementing her skills and knowledge in the area of nursing and especially nursing administration.

Nightingale was asked by the British government to go to the Crimea because the mortality rates were extremely high. In 1854, that is where she and a group of women went, for two years (Selanders, 1993). Nightingale’s knowledge and skill at implementing good practices of sanitation and nutrition reduced the death rates of the wounded from 60% when she arrived at Scutari Hospital, to approximately 2% (Achterberg, 1990; Selanders, 1993), and was little short of remarkable. She insisted on resurrecting order out of chaos. Barritt writes of Nightingale:

Mary of her Crimean woes and frustrations were caused by military authorities who would not make decisions on their own when they were unsure of regulations, priorities, needs, or precedents. For
human beings to suffer needlessly because someone was unable to make a timely decision was, to her, inexcusable. (1973, p. 20)

Nightingale was able to make decisions quickly. She was bright, innovative and a quick and clear thinker. She based her decisions on her knowledge and understanding of the situation at hand and she liked to be armed with the facts (Barritt, 1973). After the Crimean War Nightingale was involved in a variety of health reforms in the area of public health, sanitation and nutrition. Included in this was the reforming of the Army Medical School (Selanders, 1993). She seems to have been very organised with a talent for organising others and was responsible for installation of systems for keeping public health statistics (Barritt, 1973; Bashford, 1998; Selanders, 1993). This woman had a lamp and a brain and a steely determination to achieve her goals.

Of importance to nursing was Nightingale’s plan for the reformation of nursing education and practice. There was nursing education prior to Nightingale, but it required religious affiliation, usually belonging to a religious order of nuns. For example the Sisters of Mercy, a Catholic order established in Ireland in 1831 (Nelson, 1997b) and the protestant Deaconesses of Kaiserwerth in Germany. These nurses were bound to their work by a duty of care, and perhaps, considering the environments they often had to work in, blind faith in providence (Nelson, 1997b). There is a degree of sacrifice inherent in the stories of these women who put their own lives at risk in order to care for others. The concept of ‘sacrifice’ is an enduring image in nursing (Bashford, 1998). From sacrifice come saints, do they not? Nightingale’s plan for nursing education fulfilled her strong values and beliefs:

...serving god through serving mankind; educating women for a profession where they could become financially independent members of society; promoting better health for everyone.
(Barritt, 1973, p.14)

Improved nursing care would improve the health status of the poor, and this would be achieved through providing ‘probationers’ with a system of training where they would be taught in the classroom by other nurses as well as working in the wards. Nurses were also to be paid, as opposed to working for free as a form
of Victorian charity (Garmanikow, 1978). Nightingale believed in strict hierarchies and obeying of rules and regulations, her rules were rigid and uncompromising. Nurses were required to be “...sober, honest, truthful, trustworthy, punctual, quiet, orderly, clean and neat [as well as the need for] unblemished character, chastity, common sense and dedication to duty” (Barritt, 1973, p. 19). Part of this was because the reputation of nurses prior to 1860 who were outside of the religious orders, had been less than savoury. Nightingale knew that to raise the standards of the profession high entry standards were required (Rafferty, 1995) and that the nurses’ education would have to be very structured. The Nightingale Training School for Nurses was opened at St Thomas’s Hospital in London in 1860 (Barritt, 1973).

Nightingale achieved much over the period of her long life. She can be credited with having made important contributions to nursing and also with public health reform (Heslop and Oates, 1995). The Nightingale ‘effect’ has been world-wide and far reaching. Bashford (1998) and Nelson (1997b) both point out that the nursing reforms which took place in the mid-nineteenth century were about improving the health of the poor. Middle class women initiated the reforms as part of what Bashford (1998) calls their ‘philanthropic culture’. These were ‘good gentlewomen’, who set out to do well for the community. Nurses were responsible for making clean bodies and clean spaces and in order to do this they were required to be clean themselves. In so doing they aligned themselves with the cleanliness/godliness that was to become a dominant concern in healthcare. I start to see here the bodily inscriptions that are written into the practice of nursing. The nurse became a central player in Victorian concerns with dirt and contagion.

Bashford (1998) and Douglas (1966) point out the links between contamination and the female body. Grosz discusses this as well when she writes; “...my [Grosz’s] hypothesis is that women’s corporeality is inscribed as a mode of seepage” (1994, p. 203). Women were seen to embody disease and dirt, seepage and leaking. That is perhaps why the image of the nurse after the 1860’s is ethereal and angel-like, because it represents virginal purity and containment. A virgin is contained, and perhaps more containable and does not seep, except at predictable times. The concept of purity is congruent with the affiliation of nurses
to religious orders, and sacrifice fits alongside this. These ideas did not all originate with Nightingale however it took her to bring them together in a ‘contained’ package (Nelson, 1997b). Nightingale herself became the signifier of a certain position or possibility in the symbolic order of health care discourse.

Bashford (1998) uses Foucault's (1977) ‘docile’ body to describe how nurses were trained to be efficient and effective at what they did. Their training was as much about how to behave as ‘good women’ as it was about learning anatomy and physiology, and this is a crucial part of nursing history. Nurses were moulded into shape, to be useful for the organisations for which they were working. They were trained to be hard working and orderly with an emphasis on hygiene and ventilation (Brennan, 1998). The ‘probationers’ as they were called were surveilled at an intense level (internally and externally) and expected to surveil each other as well as their patients (Bashford, 1998). The surveillance took the form of nurses being required to be unmarried, and living in strictly controlled nurse’s homes (Barritt, 1973). They were encouraged for the purposes of good hygiene to keep their bowels open, keep themselves clean as a form of moral imperative (cleanliness being next to Godliness), have plenty of fresh air, and they were not permitted to go out alone (Bashford, 1998). This was a panopticon-like blending of religious piety and military hierarchy, plus ideas of health and sanitation/sanity both moral and biological, and what is more, it continued well into the twentieth century. I am uncertain as to whether I simply take this as read, as having happened, or if I am quietly appalled, possibly both.

Bowels always seem to me to have been an integral part of nursing practice, often accounting for the unrestrained and earthy humour which is evident in nursing (Savage, 1995). The initials B.M in the nurse’s record of the patient are a symbol of the reduction of a bodily reality to a functional abstraction and indicator of a dimension that can be assessed, as to quantity, form etc. I am smiling as I write this, the recording of the size of the ‘motion’ and whether it is well formed or loose, while necessary at times, does in hindsight seem a little mad. I guess I should be grateful, we were not expected to taste them. Most nurses have their own particular tales of ‘shit’ to tell, both metaphorically and in reality. Nurses are great story tellers, it is one of the ways they weave together the often disparate
threads of their practice (Walker, 1995b). Maggs (1996) points out that the emphasis on cleanliness and hygiene, both of persons and the environment, is one way that a science of nursing has been able to be subsumed under patriarchy and specifically medicine. Hygiene was always seen to be a woman’s domain, so it could be extrapolated from this that nursing was an extension of women’s work. Indeed the bowel motion is so offensive to the white-coated physician that a nurse has to deal with it in her quiet, competent, hygienic way. Shit and shed blood can be considered to be abject, they are unpleasant, not ‘nice’ and are symbolically linked to nursing. The images of mess and distress and the denial of their occurrence are part of what keeps much nursing practice under wraps, hidden in a private domain. Nursing could be said to have been making abject apologies for its abject status for too long.

There were certainly many mad rituals in nursing carried out in the name of a hygienic and ordered environment (Falk Rafael, 1996). Most have gone now but in the 1970’s when I was a student nurse, nurses did quite a few things that they could not provide a rationale for. The routine taking of vital signs remains largely an unquestioned, un-researched practice (Zeitz & McCutcheon, 2003). Indeed these practices were traditions and a part of what nurses were required to do, unquestioningly. For example, turning the sheet so that the foot end went to the head of the bed, as a student nurse I could never understand that and no one could provide me with an adequate answer. Bed wheels all pointing the same way, open ends of pillowslips pointing away from the entry to the room, mitred corners on bed coverings, barmy things they were. Some of these rituals I am sure were about maintenance of order, keeping order kept dirt under control. Rituals as Ekman and Segesten (1995) point out are woven amongst structures of social relations. Keeping order kept nurses under control. It focused nurses’ minds on the discursive requirements rather than the human and political meaning of the discourse in which they were subjugated and through these rituals ideology was both created and protected. In doing so a type of unquestioning thoughtlessness was evident. Everything in the environment had to be seen to be clean and neat, including the nurse. Image was everything. Order amongst chaos.
Buchanan (1999) addresses what she has termed 'Nightingalism' to explain how myths and images surrounding Florence Nightingale have served to produce certain 'truths' about who and what nurses are and how they should 'be'. It is Buchanan's contention that these images do not serve nursing well and continue to haunt nursing practice through to the 21st century. This is not so much the 'spectral' image of Nightingale herself, but it is about how she is perceived to hold the representative status for nurses, and the bearing this has on nursing, nursing practice and public perceptions about nurses. Some of this imagery is seen in popular 'nurse-doctor' type fiction where the heroine nurse is pictured as being beautiful, kind and generally chaste (DeVries, Dunlop, Goopy, Moyle & Sutherland-Lockhardt, 1995). She falls in love with the dark, broody, handsome and often rude at first meeting doctor who may have had a tragic past. DeVries et al. (1995) note the visibility of nurses in romance novels, as opposed to the general invisibility of nurse's actual work.

Nursing continues to search for the essence of what 'good' nursing practice is (Brown & Seddon, 1996). As a group, nurses appear unable to accept what they do as a given, as validated practice. It is as if nurses themselves go searching for the ideal nurse within themselves, and some of this I would suggest comes from how nurses, especially Nightingale are represented in 'text' (Cheek, 1995). I would query whether nurses know what it is they are looking for, and if they found it whether they would recognise it. I believe nurses have practised via a specular reflection of medicine for so long, that they do not know how to recognise them-selves. Nelson suggests that "...nursing history must recreate itself as professionally relevant...and a major contributor to the evolution of nursing as a discipline" (1997a, p. 235). Hallam (1998) and Darbyshire (2000) discuss image in nursing and how nurses want to be able to influence how they are portrayed. Hallam (1998) asks what would this image be, and how would nurses come to a consensus on this, and is this really what nurses should be worrying about anyway given the other problems which nursing faces in the 21st Century. For example the world-wide shortage of registered nurses (Walker, 2003a; Witz, 1994). If nursing is a dynamic profession then its imagery should be on the move, in a reflective and self-creative-self, discovering direction rather than the technologising of the dominant discourse.
Much of the imagery in the public eye is of the 'general nurse', that is the registered nurse who works in medical-surgical nursing environments (Hallam, 1998; Maggs, 1996). DeVries et al (1995) suggest that it is this imagery alongside the mythology represented in romance fiction that has sometimes encouraged young women to come nursing. While many of the images are not perfect, not how nurses want them to be, perhaps nurses could take more responsibility for telling the public what it is they do and who they are. The 'bad' nurse as portrayed by Nurse Ratched in One Flew Over the Cuckoo’s Nest is a case in point (Cheek, 1995; Darbyshire, 1995 & 2000). Furthermore the images of nurses who work in mental-health and community health are subsumed to that of the 'real' nurse. Nurses have to take responsibility for this, both nurses and the professional and political bodies who represent them.

The history of nursing has had a significant influence on how nurses perceive themselves today (Maggs, 1996; Nelson, 1997a). Maggs questions the significance of nursing history itself and wonders whether exploring the history of caring may be more effective for linking through to nursing theory today. This is reductionist and it is difficult to extricate the history of nursing from the act of caring, as they are interdependent. Reverby (1987) notes nurses were 'ordered to care', the history of nursing and caring are inextricably implicated in one another. Some authors consider nursing was vocational (Barritt, 1973; Bashford, 1998; Selanders, 1993) and that practitioners were bound by a duty of care. What is important for nursing, especially for student nurses, is that they are exposed to critique and careful analysis of nursing history, so that they are able to develop for themselves an understanding of the symbolic representations of nurses and what if anything this means for their nursing practice today.

Nelson claims nursing has been colonised by feminist discourse and she questions whether gender adds anything to nursing’s understanding of the complex relationship with medicine (1997a). I dispute that nursing has been colonised by feminist discourse, on the contrary nursing has been colonised by masculinist discourses for decades, especially those of the ‘hard’ sciences, those discourses perceived as being ‘real’ knowledge (Huntington & Gilmour, 2001; Walker, 2000). In writing about nursing history, one could assume that Nelson would have
greater socio-political understanding. I would say to Nelson that nursing being a female sexed profession should by now have clarified for her just why much of the history of nursing is documented in the way that it is, as if nursing were in the shadow of medicine. Garmanikow's (1978) work is an example of a view of nursing which represents all nurses as being dominated by medicine and she offers little possibility for change.

If nursing had been colonised by feminisms, nurses might have an increase in understanding of the issues which confront them in practice, and perhaps be better equipped with the critical tools required to bring about change in their practice environments. Even if the effects of 'Nightingalism' (Buchanan, 1999) have been far reaching, Nightingale is one of nursing's few documented heroines, she is an inseparable part of nursing's cultural heritage (Chinn & Wheeler, 1985). Heroines serve a purpose both politically and aspirationally. Nightingale wrote extensively, she documented what she did, she took responsibility for her practice and as well took on nursing with a missionary zeal. She may have got a bit caught in her own hagiography, for example Nightingale sent statuettes of herself around the world (Bashford, 1998). What I wonder is, where would nursing have got to without her, without her knowledge, drive and willingness to put her self on the line. Nightingale was engaged with her work, and this is a crucial part of her legacy. She was driven and determined. She cannot be shed like a pair of old socks. I do agree with Nelson (mostly) where she writes:

It is difficult to find an example of nursing historiography that does not assume an evolutionary march towards professional autonomy, that does not find in earlier nursing a backward and embarrassing legacy that it is anxious to shed. (Nelson, 1997a, p. 234)

Nursing is not alone in wanting to shed its history. Most orthodox histories as Foucault points out (1977 & 1984a) suggest a linear march towards betterment. Nelson's 'march towards professional autonomy' is a concept that will be discussed in Chapter Nine. There is much talk in health about autonomy and autonomous practice. This implies that practitioners are islands of individualism, working away by themselves, whereas in reality, they are not. Nursing history happened, as history does. This does not mean that it determines the pathway for
nursing into the future. However, exploring the images, icons, traditions and practices that nurses have carried with them over time will assist to provide a clearer understanding of how nursing has got to where it is today in the 21st Century. Furthermore I suggest that nursing need not necessarily remain the way it is, resistance and change are possible, if that is what nurses want. Exploration will also help to explicate and perhaps extricate the embodied self of the nurse, enable her to become more articulate and understood. As Cheek states “...the task is not to look for real and authentic representations of nursing, but rather to look for the speaking and representation that is done about nursing” (1995, p. 239). My task as I write is to recognise that my position as researcher is influenced discursively. I am not able to stand outside ‘texts’ of nursing and objectively analyse them. However, what I am able to do is acknowledge the multiple realities and ‘viewing positions’ (Cheek, 1995) that are available to me in the texts - to enhance knowledge and understanding.

Summary

Florence Nightingale, a heroine and sometimes anti-heroine trapped within a historiography largely not of her own creation. Her image is changed by re-reading and over-reading (Kaplan, 1996), depending on the socio-political intent of the author. It makes me think about how sand dunes change, at the whim of the wind, a life can be altered by the whim of someone’s pen. For example Achterberg comments that Nightingale had “...little patience or affection for humankind...[and that she] cared little for other women” (1991, p. 160), a damning and misleading picture. What some authors forget when writing about Nightingale is to keep her within the specific social context of being a woman in Victorian England and the strictures this placed on what she was able to do and how she was able to do it. While Nightingale had little time for the feminists of the 19th Century (Bashford, 1998) she was however very concerned for the plight of women who were generally denied their rightful place in society (Chinn & Wheeler, 1985). She chose not to align herself with the women’s movement and chose instead to get on and do what she could, for public health (which benefited women and their families) and nursing education (which was for the benefit of young women). She chose practical action over socio-political process and led a
long and productive life dedicated to the good of human kind. Nightingale was a revolutionary figure who through strength of will, intellect and determination forged change and fought and won battles. She is the one person who springs to my mind when I think about health care in the 19th Century. She remains an iconic figure and not just for nurses. She still stands as a representational icon of nurses in the thoughts of many in Western democracies. Many people know the image of the ‘lady with the lamp’, and indeed I think find comfort in this image. To me she is one of the great women of nursing history.

The next chapter will further address genealogies of nursing and how these have come to have an effect on nursing as it is languaged, both orally and in texts. Nightingale will retain an active presence in the next chapter, even though she has been gone from our midst for a century. The light of her lamp continues to cast a comforting glow.
Chapter Seven

Genealogies and Language in Nursing

Introduction

*The spoken word is a gesture, and its meaning, a world* (Merleau-Ponty, 1962/2004, p. 214).

Merleau-Ponty means that we need to go back to the beginning of time to find the origins of silence, to think carefully about speech and what it means for us as beings-in-the-world. He is relating the moment of the gesture to the world in which it has meaning. The spoken word for nursing has always been a gesture and it has always meant the world of nursing. What I mean is that there are multiple ‘silences’ within nursing (Aranda, 2001; Chiarella, 2000; Wicks, 1995). The difficulty for nursing is that the gestures as well as being understood by nurses need to be understood by others as well. Having an oral tradition has served nursing, to a limited extent (Walker, 1997a; Wicks, 1995). However, the power of the written word as a vehicle to communicate a body of knowledge should never be underestimated (Hall, Stevens & Meleis, 1994; Street, 1992; Walker, 1997a).

Nursing practice is inscribed in a variety of ways, both in how nurses practise and on their bodies (Foucault, 1977). Practice can be inscribed in other ways as well. A particular view of nursing practice is inscribed on the general public and on medicine (Falk Rafael, 1996), and furthermore on nursing by medicine (Reverby, 1987), but is this really a view that nurses want these groups to have. I would suggest perhaps not.

This chapter will briefly explore the history, as I have come to understand it, of how nurses have come to become, and here I concur with Buchanan (1999) who comments that writing a ‘real’ history of nursing is probably not possible. I will discuss historical aspects of nursing using genealogical analysis to deconstruct
discourses in and of nursing, and the effects these have had on nurses' language, thinking, writing and the body of nurses' practice. This chapter is about bodies of knowledge and it is about history, and how they are intertwined and articulated will be explored genealogically. The primary focus of the chapter is analysing discourses of nursing using Foucault's genealogical strategy (1977), but as well there will be elements of feminist psychoanalytic critique and phenomenology, which were discussed in earlier chapters. I hope within the chapter that by engaging in theoretical reflection I will be able to construct some creative 'senses' of what it means to be a nurse within the culture of nursing in the 21st century.

**Genealogies in and of nursing**

Nurses carry forwards with them all that has happened to their profession previously. Their history and genealogy provide a 'history of the present' a history of events that lead up to present day (Grosz, 1994). As Powers notes genealogies focus “...more on the historical component of a discourse” (1996, p. 208). Foucaultian genealogy as a strategy enables cutting into discourses, cutting into knowledge to disrupt the supposedly self-evident continuities and truth claims, which in relation to nursing, there are many. Papps writes that “[t]he notion of nurse has been likened to the notion of mother – a nurturer of others, with nursing seen as just an extension of what is natural” (2001, p. 7). Nurses carry from the past multiple symbols, images, icons, traditions that infuse their practice in ways that are positive, and some not so positive (Fealy, 2004). Wood (1994) tells a story of a nurse whose practice was directly influenced by Nightingale in a small way related to arranging flowers for her ward and the joy it bought to some of the patients. This was a small incident, but the story shows that Nightingale made a positive difference to this nurse’s practice. Another perspective, which is less positive, comes from Walker who states:

Nightingale’s philosophy on life and illness was ‘naturalist’ in orientation, but most problematic was her view of what ‘good’ nurses should be and should do. The strictures of Victorian bourgeois morality infuse her legacy to us and continue to shadow the ways we can think and act as nurses. (Walker, 2000, p. 54)
Nightingale being invested with ‘bourgeois morality’ is only part of the story. She appears to me to have been intelligent, determined and not constricted very much at all for a woman in the 19th Century. If she were so affected by being part of the bourgeoisie, she would never have lowered herself to the menial labouring of what was seen as a servile job for women from the lower echelons of society. There is perhaps another story that runs alongside the story of Victorian morality, and it is concerned with the politics of health in the mid-nineteenth century, the gendering of same and the emergence of Victorian feminism (Bashford, 1998).

One of the reasons Nightingale wanted nursing to be a women only profession was that she wanted something worthwhile for women. She wanted women to be educated and to be able to work and receive a salary commensurate with their qualifications (Barritt, 1973). Some authors (Bunting & Campbell, 1990; Reverby, 1987) suggest that because she was upper class herself, Nightingale had less empathy for women from the working classes and therefore believed that having paid work should be enough. They suggest she was not concerned with broader principles of women’s oppression. She was a very powerful woman. There is little doubt about this. However hindsight is a wonderful attribute, if only we had the ability to be blessed with foresight before we did anything, we would doubtless all be perfect. So she had failings, she was after all human, not a machine. There were some constraints for nurses and they were reflective of Victorian moral codes about roles for women.

Nightingale wrote about nursing that “[t]raining has to make her, not servile, but loyal to medical orders and authorities...strict obedience to the physician’s or surgeon’s power and knowledge” (Nightingale 1882, cited in Garmanikow, 1978, p. 107). Not to be ‘servile’ is important. I do not consider Nightingale wanted handmaides, she wanted ‘good women’, to work complementarily alongside medicine. The image of the ‘good woman’ is one that has stayed with nursing for over a century, it is discomforting but if nurses want this image to change they have to effect this change themselves, no one else is going to do it for them. Garmanikow contends that what happened with nursing “…created stratified health care and interprofessional inequality” (1978, p. 107) because of the gendered division of labour. However, there were other forces at work apart from
Nightingale. Medicine in the latter part of the 19th Century and early in the 20th Century, voiced loudly its 'concerns' about the increasing knowledge and power of nursing. They were concerned that the primary role of the nurse was to carry out the orders of the doctor (Garmanikow, 1978; Reverby, 1987). Furthermore Garmanikow argues that the division of labour was not confined to doctor-nurse, but was also about male-female gendering. The gendering established the triad of doctor as father, nurse as mother and patient as child, and subordinated the role of the nurse to that of medicine. Nursing could then be conceptualised as an extension of what women did 'naturally' within the home as mothers.

Nightingale had little time for the medical profession, she wanted nurses to be taught by nurses, and she wanted the two professions kept separate. She was opposed to women becoming doctors and she believed that practitioners of medicine were of 'questionable morality' (Bashford, 1998), which is possibly why she placed such importance on what she believed were important values for nurses. Doctors she believed were bad for patients. She based this belief on her experiences in the Crimea. Certainly her ideas about hygiene, 'clean' practice, and her 'naturalist orientation', which meant that with good hygiene and nutrition patients would be able to heal themselves, would not have been in alignment with the practice of medicine. Medicine in the 19th Century was much less 'refined' than it is today. As Bashford (1998) points out, having an approach to health that hypothesised 'nature' as the healer, aided by good nursing care, fitted neatly with Victorian ideas about women being natural and connected to the earth and thus the reinforcement of feminine values of nurturing and caring. On the other hand, medicine was being increasingly seen as the domain of the man of science, interventionist and in the 19th Century, relatively crude.

Little wonder that Nightingale thought of doctors as being unhelpful to patients. Nightingale perceived of care as "...a far greater value and was willing to delegate the less significant activity of 'cure' to the physicians" (Bunting & Campbell, 1990, p. 21). After all, she believed it was 'nature' that did the curing (Garmanikow, 1978; Selanders, 1993). The care/cure binary between nursing and medicine had begun, and it has continued since this time, although differently constituted, with medicine becoming an increasingly powerful discourse,
validated as scientific practice. I speculate that the care/cure binary took a firm
hold with the advent of 'cure' in the form of medicines that could be prescribed to
combat infectious disease, in particular penicillin. As Pryce notes, "...the
introduction and production of penicillin coincided with a transition in the
development of several issues: the ascendancy of medical heroism and laboratory
science" (2001, p. 158).

I believe nurses have taken on board what has been written about women's bodies
throughout 'history' (Williams & Bendelow, 1998). Herstory as a history of the
present is enlightening, primarily for myself for whom the body has long been a
source of interest. The body is the expression of the embodied self. If nurses had
increased understanding of the bodily (embodied) basis of their practice they may
in turn have increased awareness about how nursing is 'spoken' and clearer
understanding of the discourses operating within the contexts of their practice. I
am attempting to write her story, and it is a feminine story as opposed to what has
previously been claimed as a woman's story, a woman's body as defined by
his/stories. The culture of nursing inscribes itself on the bodies of nurses and the
body of nursing practice and if it can be said to do that then it also inscribes the
self.

Nursing carries with it images and icons from the past, these have an effect on
discourses of nursing practice and how nurses should 'be'. Images such as those
of sacrifice, purity, cleanliness, kindness, godliness and mute obedience all
contribute to an articulation of nursing today. Nightingale clearly believed nursing
as a profession was important in its own right and she conceptualised nursing as
being an art and a science, "[n]ursing was carried out by altering the environment
in such a fashion as to implement the natural laws of health" (Selanders, 1993, p.
21). An important part of her plan for educated nurses was that they would be
providers of health education for families. However, her original plans for
reformation of nursing education were altered, or perhaps hijacked, in order to
meet the requirements of the training hospitals. Student nurses were increasingly
used as part of the workforce, cheap directable labour. Nursing became an
apprenticeship model of learning with less time spent in the classroom than
Nightingale had wanted. This was not what she had originally envisaged. The
professional advancement and the authoritative voice of the nurse who was able to work alongside medical colleagues was replaced by a system where nurses became increasingly like handmaidens (Bunting & Campbell, 1990; Selanders, 1993) where deferring to physicians was emphasised (Kane & Thomas, 2000), especially by the physicians themselves (Garmanikow, 1978).

Reed notes, perceptively, that "Nightingale did not invent nursing...nursing processes existed in human beings, ultimately described by Nightingale as that which nurses were to facilitate by placing the patient in the best situation possible" (1997, p. 76). The fact that nursing care had always existed is an important distinction to make. What Nightingale achieved through the force of her intellect and drive was to formalise the processes for enabling nursing care to happen in an organised and thoughtful manner which was to benefit patients, especially the poor (Bashford, 1998). Indeed she was constrained by social contexts and rigidities in Victorian England which were more prescriptive than they are today, but her plans for nursing care set the standard for much that has come after her. Nightingale did not give birth to nursing, but she did lay the foundation stones for nursing practice of a high standard.

Images of nurses as being self-sacrificing, angel-like, pure, ethereal and quietly obedient women have been appropriated by a variety of media, often for particular political ends. Thus Buchanan's (1999) concept of 'Nightingalism' whereby myths about Nightingale are seen as producing discourses, in and of nursing, of producing certain 'truths' about nursing. These discourses are both 'constitutive' and 'productive' (Carabine, 2001). Nightingalist discourses are constitutive in that fragments of Nightingale's ideas about nursing are put together to create a certain perspective. For example the idea that nurses are 'good women' has become a naturalised 'truth' about nursing and this 'truth' then becomes productive. By and large it has taken on a life of its own and is a powerful and persistent construct of nursing.

Are nurse's socially controlled? Yes, without a doubt. B. Turner (1984) and T. Turner (1994) explore the contesting of just who and what gets to control the body in society. Some bodies are controlled and manipulated more than others.
The history of nursing includes the control of the body of the nurse within patriarchal institutions; the hospital itself and medicine have controlled the body of the nurse via assumed authority and knowledge. Nurses were not seen to have a body of knowledge of their own and any authority was ‘given’ to them but mediated by medicine under medicine’s terms. To an extent the mediation has always been subverted by nurses through what some authors have referred to as the ‘doctor-nurse game’ (Stein, 1967; Stein, Watts, & Howell, 1990; Turner, 1986; Willis & Parish, 1997). The ‘game’ involves nurses giving information/recommendations to doctors and carrying the game out in a way to make it appear that the ideas came from the doctor, so as not to be seen as usurping their ‘superior’ knowledge. Other authors (Brown & Seddon, 1996; Wicks, 1995) believe that nursing has changed since the publication of Stein’s (1967) paper because nurses have increasing levels of autonomy within their practice. This is partially correct although I consider that the practice of nurses remains mediated by medicine. I concur with Witz who argues that the:

...medical profession continues to play a critical role in shaping nursing futures. First it may do so directly through its response to nurse-initiated changes, either opposing or supporting these, and, second, it may do so indirectly through its response to government-initiated changes in the organisation and funding of health care. (1994, p. 34)

There is resistance by medicine to changes in nursing, especially when it concerns areas of increase in occupational independence and authority. The resistance revolves around issues of power and control and medicine’s belief that they have the knowledge and the authority to claim ownership of the body of the patient, medicine decides who is to be named as ‘patient’ (Garmanikow, 1978). Medicine will not give up that privileged position without a struggle. A recent example of ‘struggle’ is exemplified by the following quote;

Nurses remain defined by the doctor’s tasks, mediating between biomedical and lay worlds. In spite of the attempt of nursing academics to establish a professional nursing ethic, a central core idiom which can stand alone, this falters on the question of what it might constitute, Care? Communication? (Littlewood, 2002, p. 60)
Littlewood is a psychiatrist and I read his perspective about nurses with a fractured disbelief followed by anger. Littlewood’s statement is an example of one doctor’s use of the medical speculum, that medical eye/I which can be used viciously to eviscerate nurses and nursing. It is also a good example of how little some medical practitioners understand what it is that nurses do. One has to ask whose responsibility this lack of knowledge is? The concept of nursing ‘care’ I will discuss in Chapter Eight. Exploring feminine genealogies of nursing can assist nurses to learn about the women who have affected their history and contributed to the biographies of how nurses both represent themselves and are represented today (Muraro, 1994). For nurses it is about coming to an understanding of the richness and diversity of nursing’s cultural heritage (Chinn and Wheeler, 1985).

**Power**

Discourses of nursing and health have been responsible for producing certain ‘truths’ about nursing, often outside of the control of nurses themselves. These truths have become normative and common sense and purport to represent the ‘real’ nurse, whoever she may be. The real nurse is about as elusive as real history. The problem for nurses is not so much the truths themselves, but who is generating them, who is holding the position of power in relation to what is said about nursing practice and nursing knowledge. Understanding the truths will not however miraculously liberate nursing. As Foucault says:

...truth isn’t the reward of free spirits, the child of protracted solitude, nor the privilege of those who have succeeded in liberating themselves. Truth is a thing of this world: it is produced only by virtue of multiple forms of constraint. And it induces regular effects of power. (Foucault, 1980a, p. 131)

Truth and power are inextricably linked and truth is sustained by power relations. The significance for nurses about ‘truths’, which are spoken and written about them is to explore them in relation to the contexts that keep them in place, which sustain them. The hegemonies of health, including social, cultural and economic forces are examples of the ‘constraints’ Foucault (1980a) refers to. Discourses about nurses are well entrenched and it seems important to explore who is
benefiting from these discourses, what are the politics concerned. Who is speaking these truths and who is silenced. Who or what is silencing nursing, if indeed nursing is silent.

Wicks (1995 & 1999) considers that there are possibilities to re-vision nursing within Foucaultian concepts of power and knowledge. She contends it is too easy for sociologists and some feminists (and here I would include some nurses as well) to dismiss nursing as being in the too hard basket, too oppressed by patriarchal structures and medicine, a basket case. Too easy to write nurses off as being oppressed victims. For example Turner (1986) is addressing ‘complaining’ in nursing which he describes as related to lack of autonomy and professional status and he writes:

...[t]hese frustrations give rise to a system of complaint which has the consequence of binding nurses together into a solid occupational community. However, the capacity for nurses to mobilise collectively to transform their work situation is also limited by the gender character of the occupation as a whole. (Turner, 1986, p. 383)

Damned by gender as well. Accounts such as Turner’s are problematic because they give nurses no credit for having the agency or ability to resist structures within which they practise their healing craft. They are further ‘truths’ about nurses that have the effect of adding to the collective silence. Garmanikow’s (1978) analysis of nursing is an additional example, she represents nurses as being little other than a subordinated group of women. Painting a picture of nurses as being oppressed ignores the fact that nursing has always been and continues to be a ‘haven’ for powerful women who are able to practise authoritatively, despite the barriers presented to them (Kane & Thomas, 2000). Where there is power there is always the possibility for resistance as explained by Foucault:

...there are no relations of power without resistances; the latter are all the more real and effective because they are formed right at the point where relations of power are exercised; resistance to power does not have to come from elsewhere to be real, nor is it inexorably frustrated through being the compatriot of power. It exists all the more by being in the same place as power; hence, like power, resistance is multiple and can be integrated in global strategies. (Foucault, 1980b, p. 142)
Resistance through a Foucaultian lens offers nursing the possibility for change (Doering, 1991; Wicks, 1995 & 1999). The discourse of medicine has been able to marginalise the knowledge of nursing, because of its scientific status and the authoritative truth claims of the discourse Medicine is a dominant discourse (Cheek & Porter, 1997; Ekman & Segesten, 1995; Powers, 1996). Knowledge is an instrument and strategy of power within Foucault's regimes of power (Grosz, 1994). Knowledge and power are mutually constitutive, they feed into and nourish each other. Medicine is both constitutive and productive and produces and maintains its own dominance, like the monolith of all truths. Nurses are both constructed by and construct discursive practices, power is productive and available to us all. However somewhere along the line and in the decisions about who got to be at the head of that line (or even an equal first), the pathway for nurses became perverted. This does not mean that all nurses are disempowered but as Code asserts, "[i]t is rather that the power/knowledge arrangements of professional medicine legitimate an uneven distribution of speaking and knowing positions that usually works to contain the knowledgeable practice of a nurse within stereotypical female roles" (1991, p. 245). Within the structures of health nurses are not supposed to know, being credited only with what they know through experience. Hence the comments by Littlewood (2002) on page 145 of this chapter about nursing being mediated by medicine and not having a body of knowledge of their own. Littlewood's comments are an attempt to invalidate nursing knowledge via a technology of power (Foucault, 1988a). Medicine as a profession makes an assumption that its knowledge is objective because it is based on science. Nursing knowledge is perceived by medicine to be subjective, not based on specific knowledge and therefore able to be discounted as being less relevant.

_Languaging nursing practice_

Language seems to have paralyzed us, frozen even our words... The fact that female intelligence is still silent surely means that there are movements that must still be set free. The issue for women is ... to discover gestures that have been forgotten, misunderstood, gestures that are also words... (Irigaray, 1993c, p. 181)
A wonderful passage with Irigaray lamenting that women have no voice of their own and are, because of their silence, disadvantaged. Women lack subjectivity and have no form of their own, no morphology to call their own which would provide the supporting structures necessary for healthy living. It is Irigaray’s belief that because they lack rites and passages of representation, that women are sometimes not good with one another, thus the ‘misunderstanding’ of gestures. She suggests women misread one another, because they do not have a language of their own which in turn means they are not skilled at talking to one another. The language women use has been created for them by men within patriarchy and it is not of their own morphology, or their own genealogy. There is no structural or meaningful context within which certain attainments and knowledge points can be encoded.

Words, states Irigaray, “...have a sort of hidden sex, and this sex is unequally valued depending on whether it is masculine or feminine” (1994, pp. 54-55). Irigaray places an emphasis on linguistics and the use of language within culture, and this emphasis is a recurring theme within her work. She makes use of two words which are both translated as language but have different meanings. When using langue she is referring to the body of the language, that is whether it is French, English Spanish etc. When Irigaray uses langage she is referring to the language as it is used by the speaker (Whitford, 1991b). Langage within nursing is problematic and nursing could benefit from adequate language and terms to be able to articulate the rich tapestry of their practice and to have this validated as authoritative knowledge. Coming to know phenomenologically is not recognised in contemporary structures of health care, knowledge learned from practice is considered to be subordinate to that which is claimed to come from theory and research and is therefore more ‘pure’ (Code, 1991). If a body of knowledge does not have a language, it can be thought to be non-thinking, thoughtless.

For Irigaray, language as it is used denies the subject position of half of the interlocutors, that is women. The use of the so-called gender neutral pronoun ‘man’ has an influence on this position. Women have difficulty representing themselves as women, without having to refer to men, or masculine representations in language. The body of the language is in the domain of the
Name of the Father, and *langage* is in another domain, that of actual conversational participants. Irigaray suggests that in women’s everyday roles as caregivers they are not required to have complex linguistic codes. What women are doing day after day, is for others, that is men and children (and for the context of my work what nurses do for patients), rather than for themselves (Irigaray, 1994).

Irigaray is working towards significant changes for the status of women at ethical, ontological and social levels and to achieve change it is necessary to create a “...powerful female symbolic to represent the *other* term of sexual difference” (Whitford, 1991b, p. 22). At a seminar attended by Irigaray a participant comments; “I’m saying that beyond a certain point I simply fail to understand the masculine-feminine oppositions. I don’t understand what “masculine discourse” means” (Irigaray, 1985b, p. 140). Irigaray’s response is, “[o]f course not, since there is no other” (p. 140). That is a particularly telling response. I as a woman am not able to understand masculine discourse because there is no ‘other’ to measure it against, and as a woman I am ‘othered’. Nurses are ‘othered’. Canales (2000) writes about ‘othering’ and offers a perspective for nurses who are working with patients who are perceived to be different, and as well for nurses who are ‘different’, that is of a different ethnicity to the white majority in the United States. Interestingly for me, Canales has failed to acknowledge that nurses as a group are ‘othered’, perhaps she has not recognised this. I would speculate that a lack of recognition is in accord with the comments by Irigaray in this paragraph.

Crucially for what I am trying to give voice to, Irigaray states, “We [women] lacked speech...” (1991b, p. 51). In order to be able to progress in the world as a human being, one has to speak, women have to speak. Nurses would benefit from moving away from their genealogy of silence. To learn to speak and to be able to communicate their practice clearly would help nurses to claim their body of knowledge as authoritative vis-à-vis the speculum of nursing as a feminine profession.

Language and speech hold the key. How are nurses able to be autonomous if they are speechless? How can nurses claim an authoritative body of knowledge if they
are believed to be thoughtless? What ‘other’ technologies could nurses devise to get around structures that dominate them? Symbolic structures are unavailable on a conscious level, but the social structures are different, these are the ‘real’ world structures. Nurses are symbolically multi-lingual (or bi-lingual). Nurses speak the formal scientific language of the clinic in the public domain of fixed, ‘civilised’ and organised society, and they have another language that they take as ‘nomads’ looking for a space that will sustain their shared (thought and vocational) life as nurses, in the private domain of nursing practice. Nursing could be said to have its own language that is present within the private discourse of nursing practice. Nurses could be said to live within their language, within the world that is constituted as nursing practice. Having a nursing language could be a possibility to express difference within an environment largely constituted by masculine language, by a dominant public discourse, by a reductionist way of being and speaking. Nursing has been defined by a medical speculum, as an object of the masculine medical subject and as lacking its own corpus of knowledge. Nursing lacks the legitimation and valorisation of the doctor who is defined as hero. The private sphere of practice is nursing’s secret domain, which excludes medicine and other health professionals, and is between nurses and their patients. Nursing might be dominated but this does not mean it is oppressed, the terms do not necessarily walk hand in hand.

While discussing nursing having a rich oral tradition Parker notes that “...the ephemeral nature of the spoken word tends to reinforce nursing invisibility in the hospital context” (1995, p. 348). While the practice of the oral shift handover reflects nurse’s ability to articulate ‘how’ it is for their patients to one another, the richness of skilled practice remains private knowledge between nurses, held by individuals. Perhaps it is because it is in an alternative marginalised language, not scientific enough, not quite good enough, not legitimated and not in the language of the dominant scientific discourse. As Code notes it is “…difficult for women to claim acknowledgement as properly authoritative knowers” (1991, p. 228).

Aranda (2001) uses ‘tacit’ to convey what is not spoken and what is seen to be ‘wordless’ in nursing practice and she suggests it is because nurses do not have the necessary language to describe what they do, thus they are silent. Rolfe (1997)
offers a different perspective and suggests there is a tendency within nursing to claim that much about nursing practice is tacit and to value this. Nurses’ silence is evident in their patient notes, which tend to record that in medical-surgical areas for example, only the body is nursed. Aranda notes the “...weakness of the nursing voice” in comparison to the dominance and authority of the medical voice in the patient notes (2001, p. 178). Casey and Long (2003) writing about mental health nurses’ practice, suggest that because nurses are ‘participants’ in the biomedical model they are inclined to reconstruct patient stories to fit dominant, (i.e. biomedical explanations) which has the effect of suppressing patients attempts to make sense of their own experiences. Reconstruction I suggest also has the effect of suppressing the uniqueness of the nurse’s voice.

According to Crowe (2004) the nurse’s voice and knowledge in mental health nursing are marginalised because the effectiveness of the nurse-patient relationship is not supported by adequate evidence against the seductive-reductive power of pharmacological ‘treatment’ and specific neurological pathology. Crowe and Alavi claim that nurses who work within mental health have “…largely co-opted psychiatric discourse as the basis of practice” (1999, p. 32). The effect of co-opting they suggest is that mental health nurses limit the scope of their practice, make themselves dependent on an authoritative medical voice and restrict the possibilities for what they are able to offer their patients within nursing knowledge and a nursing voice. An illness-based model of practice is disembodying for patients within mental health services who call out for skilled, knowledgeable, thoughtful encounters, someone to listen, and someone to hear. These examples are evidence of nurse’s struggle against a powerful voice, medicine, the collusion with his voice and the consequent silencing and invisibility of her voice.

*Writing nursing practice*

Walker writes:

Nurses talk. They tell their lives and speak their bodies - words create meanings from desire and as they dredge sedimented knowledges in the ‘will to understand’ their lives, nurses’ narrative
rememberings become the archives of a culture. Words construct identities in their passing. (1995b, p. 157)

Nurses’ stories constitute the ‘archives’ of their culture, I like that, a metaphorical storehouse of rememberings. The trouble with storehouses however is remembering what is there and being able to find what is stored there. The language of nursing is spoken through the body of nursing practice, and amongst their peers nurses speak fluently and confidently (Wiltshire & Parker, 1995). However, in front of other colleagues this is not always the case. Nurses become muted, less confident, less fluent, less sure that what they are doing does in fact make a difference. Nurses are aware that what they do within their practice is not highly valued by society (Jackson, 2000), they have ingested this over a long period of time, and it silences them (Savage, 1995; Wicks, 1995). What nurses sometimes fail to see is that the non-recognition of what they do is compounded by their own practices of keeping what they do to themselves, keeping quiet and quietly getting on with what they do best (Street, 1992; Wicks, 1995).

Gordon (2002) notes that the invisibility of what nurses ‘do’ in their practice is often not helped by how nursing practice is represented by nurses in texts and that when nurses focus on themselves as providers of health care, the daily work that they do with patients is concealed. Writing about nursing practice using terms such as ‘patient education’, ‘safe practice’, ‘autonomous practice’ reduces the real concernful practices of caring to little more than an abstraction. The language that is used in these contexts can be seen as reductive and trying to ‘fit’ within the dominant discourse. However, if nurses are writing for themselves and for others in order to provide greater understanding of what they do, then it seems crucial to write beyond the borders of what they perceive to be accepted knowledge. Nurses work on a daily basis with patients who are sick and vulnerable and it is crucial that they write it down, document a record, explain both to colleagues and the public what it is that they do and how they do it. How do they keep patients safe, how do they attend to all the smallest details, how do they protect vulnerable patients. That is the knowledge that is tacit and which Greenwood asserts is ‘inarticulatable’ (1998).
One of the strategies nurses and other health professionals do use in trying to communicate their practice is by using metaphors (Rudge, 1997 & 1998; Smith, 1992; Walker, 1994). A common metaphor nurses use for describing their practice is about doing ‘hands on’, another is the giving of the ‘hand-over’, which is the verbal report about patients at change of nursing shifts. Metaphors are useful because they help to create analogies. Metaphors can as well be used to muddy the waters, which is when they can be less than useful. Overuse can cause incomprehensible abstractions, language is never as straightforward as we would like to imagine it being. Cixous describes writing as being like a process of painting and notes that writers “...must paint with brushes all sticky with words” (1991, p. 114).

Cheek and Rudge (1995) write:

...many nurses resist the pressures to document, considering it to be tedious, often trivial, and time consuming...while they resist the pressure to document, nurses fail to connect the source of such resistance as emanating from contestation between the dominant scientific-medical discourse, with its emphasis on so-called objective data, and the alternative but less powerful discourse of the subjective, oral culture of nursing. (1995, p. 324)

I agree with Cheek and Rudge, that ‘resisting’ documentation is a form of resistance, however I do have to wonder whose interests the resistance serves. While there is a seeming recalcitrance to document and write about nursing practice it seems to be of little value to nursing to stay silent. Stubborn resistance can earn nurses labels of being unprofessional, lacking responsibility and being their own worst enemy. A counter-hegemonic strategy it might be (Street, 1992), perhaps however not a wise one. I am thinking here about the parallels of what Walker (1995b, 1997a & 1997b) describes as an anti-intellectualism in nursing, where ‘doing’ practice is seen to be more important than writing about it. Another perspective is offered by Sandelowski (1997) who suggests that nursing has been hesitant about exploring the practical realities of practice because of a concern that nursing will once again be ‘seen’ as being made up of procedures. Sandelowski also maintains that because some nursing practices are difficult to put into words, they remain invisible and are not recognised as knowledge, either by nurses or by other health professionals.
I am drawn to think about what nurses might mean when they say it is a waste of time to document their practice in the patient records. What might this say about the self of the nurse and what might it say about the silence of the nurse and what are the effects that such resistance has on nursing. Is it a positive effect for nursing? Who or what at the end of the day is benefiting from nurses not writing or speaking themselves. In my experience nurses do not write descriptively in patient records because they are often told that that kind of information is not necessary and that they should limit themselves to the ‘facts’. Nurses use the vehicle of the oral shift handover to fill in all the ‘extra’ details. In this way their practice remains hidden to others, and also I suggest hidden to themselves. While nurses are passing important information to each other, what is not often happening is an analysis of what they are doing and why they are doing it that way. I have heard nurses comment to undergraduate students that doctors do not want to wade through all that ‘stuff’ in the notes. In my experience of working with students, they often write wonderfully about their practice, in their exemplars. Students ‘story’ their practice experiences with detailed descriptions of how and why they went about providing care and they can then share this information with their peers and lecturers. Storying helps students to make sense of their work, their being-in-the-world. I acknowledge that in the current healthcare climate with shortages of staff and acutely unwell patients that time is often of the essence, which can lessen the available time for documentation. On the other hand, if nurses want the phenomenological culture of their embodied practice to be recognised, then it seems important that they write it.

Street (1992) considers that not writing about practice may contribute to nurses’ powerlessness. Writing about nursing practice provides nurses with a powerful opportunity to talk about what they do and why they do it that way (Walker, 1995b). As well as this Walker suggests that such speaking and writing could provide a living archive from which nurses would be able to establish research processes so that they can start to “...tell nursing like it is” (p. 157). Telling it like it is would place more emphasis on the subjective data of nurses’ everyday practice. Telling it like it is may provide an opening to start to write some of the abject aspects of practice, the unsay-able aspects of being a nurse, which are invisible to most apart from nurses themselves. Telling it like it is may also help
nurses to include themselves in the stories of their practice, how they go about performing the healing dance of practice.

When nurses resist writing about and recording what they do, they lose a valuable opportunity, that of being able to analyse their practice (Street, 1992) and also of having their practice analysed by their peers, which is important for a flourishing profession. When nurses choose not to write about their practice they lose an important opportunity for collegial debate and critique of each other’s work. They also lose an opportunity to disseminate their knowledge amongst a wider group and challenge the dominant discourse. Street (1992) suggests they are also not able to move from practising as individuals to practising in collaborative ways, which includes collaboration with medicine (Henneman, 1995).

One of the challenges for nurses in trying to describe their practice is that there are some things which are seemingly impossible to describe, for example pain, suffering and misery (Lawler, 1997; Madjar, 1997). It is when trying to explicate these phenomena that the use of mere words can seem inadequate. There is no easy way for example to adequately describe the pain of abject misery. Lawler wonders if there is a space for nurses to articulate their knowledge as nurses, instead of believing that they have to conform to the detached, impersonal, masculine code of science. This code ensures that what is written is presented in distanced third person prose and Lawler (1997) notes that when nurses write like this they are unable to express their embodied practice. It might be difficult to describe and write about nursing practice, but it is an important task to try and do it. Writing according to Cixous (1991) is ‘terribly human’ and for nurses it is terribly important that they write their practice, because in writing their practice they will start to write their embodied selves. They will become visible, instead of forever being ‘invisible women’ who do ‘invisible work’ (Colliere, 1986).

In thinking about what is said to be unspeakable and unwritable about some of nursing practice I would suggest that nurses have to start somewhere. One way to move out of a masculinist discourse is to write within a feminine, embodied, non reductive discourse that forges a new beginning for nurses, and that provides the possibility of moving away from the logos, away from phallocentrism (Cixous,
Nurses create new possibilities for themselves within their knowledge and research when they move outside the hindrances of the positivist paradigm (King, 1995). The dominant discursive form about nursing practice is in the form of story telling, for example in the verbal ‘hand-over’ and in the stories about practice that nurses share with each other. It is knowledge that is taken for granted both by nurses and by others (Aranda, 2001). It is sometimes taken for granted by nurses I think because it seems so ordinary, so ‘nurse’. As Colliere (1986) notes nurses often underestimate what it is they do and couch their language in terms of it being ‘just my job’, ‘I did not do much’, immediately devaluing the worth of their work. However, if nurses think what they do is ordinary, others believe it is extraordinary (Gordon, 2000).

If it can be spoken, it can be written. For nurses to be able to describe and make sense of what they do would reify their practice and provide it with an embodied voice, with a space for their interpretive knowledge, skill and experience (King, 1995). Nurses can make the choice to stop being silent and move away from a position of passive resistance (Street, 1992), recording the ‘gestures’ of their practice, in their own voices, so that they better able to recognise themselves and also so that it becomes known what they do. Speech is immediate, usually unprepared, often unreflected. These are the spontaneous qualities of speech that help to make it so wonderful and sometimes, as most adults are aware, which can also make it a mine-field. For example being ‘tongue tied’ or putting one’s foot in one’s mouth. Writing is different, it holds within it the possibility for trying to express thoughts and feelings coherently, it can be rehearsed before it is given to anyone else to read, and it can be reflected on (Rolfe, 1997). When something is written, as opposed to being spoken, it is captured, it can become eternal. Someone can pick it up and read it and come to their own interpretation of what has been written.

**Thinking... like a nurse**

One of the main issues for women in contemporary philosophy is the need to speak about the bodily roots of the thinking process, of all human intellect, and to reconnect theoretical discourse to its libidinal and consequently unconscious foundations. (Braidotti, 1991, p. 8)
‘The bodily roots of the thinking process’ have strong links to phenomenology, especially the thought that we speak out of our bodies, from our embodied experience. I believe that for nursing it is important to conceptualise the possibility of a shift away from the abject gaze of medicine, that which is a male gaze and which has had nursing fixed in its speculative sights for long enough. Lauder considers that the relationship between what nurses think and do is an important arena of consideration within nursing (1994). He believes that what is missing is a link between thinking about care and the concrete practice of providing care, and that the “Holy Grail” of reflective practice is not necessarily going to cure nursing of what ails it.

This is a position similar to that of Greenwood (1998) who describes nursing as having gone ‘reflection mad’. Thinking does not necessarily tell nurses what to do or how to do it, let alone how to describe it in written documentation. Nursing practice is complex and context dependent. Nurses respond to situations, plan ahead, think about what they are doing and often never write any of it down, which is one of the inherent dangers of having an oral tradition. Walker would concur with this as he notes nurses’ privileging of doing over thinking (1997a & 1997b). Lauder (1994) considers nurses need to think about and explain the assumptions they base their actions on, and be able to articulate them philosophically. Lauder suggests that this process would provide an informed ethics of practice.

Public and private discourses/domains in nursing practice

Bjornsdottir (1998 & 2001) has identified what she describes as public and private discourses in nursing practice. The public discourse is detached and impersonal and is constituted by what nurses record in the patient’s notes, the discussion about patients at ward rounds, and reporting on how the prescribed treatment regime is being implemented. Problems discussed tend to be physiological and related to technical practices. There is Bjornsdottir notes little discussion or recording of the patient’s experiences or expectations of their care. The reductive approach of the public discourse is also noted by Lawler (1997). Practice in the public domain emphasises nurses being efficient, organised and getting the
required tasks completed by the end of their shift. The emphasis on efficiency has been present throughout the history and present day of nursing (Bashford, 1998; Brennan, 1998; Hallam, 1998; Papps, 2001), and is regarded by nurses as being an important aspect of their practice.

In Bjornsdottir’s research the private discourse became evident where nurses discussed with the researchers what their work meant to them in the context of their relationships with their patients. The relational aspects of nurses’ work such as spending time getting to know patients and coming to an understanding of the patients’ situations were seen as important (Bjornsdottir, 1998; Wicks, 1995). This work of nurses remains private and is not discussed in the public domain, it is part of the invisible work of nurses documented by scholars (e.g. Colliere, 1986; Lawler, 1997; Oakley, 1986; Wicks, 1995). It is worth noting that Bjornsdottir (1998) describes what nurses do within the private discourse as being ‘work’, rather than disappearing it under more nebulous terms of practice or caring.

Liaschenko (1998) discusses nursing practice as meaning more for nurses than carrying out a series of prescribed tasks. When nurses interact with patients their work has an effect on the well being of the patient. When nurses take themselves to the patient they are doing much more than carrying out technical tasks. The tasks are the vehicle providing access to the patient. How the tasks are carried out and the interactions that occur within the process are what in part constitute the private discourse of practice, the private domain of nursing practice. Liaschenko notes that when nurses’ work is perceived as the carrying out of prescribed care within the public discourse this has the effect of alienating the nurse from the object of her work, the patient as subject (1998). Nursing practice undertaken as part of the public discourse produces a particular type of subject, the nurse who is required to be efficient, orderly, task oriented, caring, and deferential. I suggest this particular view of the nurse is resisted by nurses within the private discourse.

Nurses are required within the public discourse to report their work using official, sanctioned language, which is objective, impersonal and detached from the experiences of the patient. The public discourse represents the dominance of bio-
medical knowing in health care and the resultant uneven relationships of power, where the knowledge of medicine is endorsed by its reference to scientific knowledge. The whole of nurses’ work and the different discourses they work within are thus not represented. Bjornsdottir speculates that:

...nursing practice seems to be shaped by ideology in two ways...the historically developed tradition in nursing of emphasising efficiency and getting the work done seems to undermine the value placed on human relations...nursing is shaped by ideology in that the work nurses do in relating to patients as persons, attending to their lived reality, is made invisible. (1998, p. 358)

Nurses exert power in the private domain, which is where they conduct their work, primarily unobserved. There they are able to speak their language, use their gestures, and interact with their patients as they wish. Turner again (1986) examines the private domain from the perspective of the ‘doctor-nurse game’ (Stein, 1967) and claims that in the ward nurses are able to do fairly much as they please as long as it does not overtly usurp the authority of the doctor. A partial and overly simplistic explanation but there is another ‘story’ as well.

Lawler (1991 & 1997) who has written extensively on how nurses work with the body of the patient, believes that much of what nurses do with patients remains secret and invisible because it is about the private body of the patient. It is private knowledge between nurses and patients. It is not recognised because it is sometimes intangible, sometimes messy and distressing. Those tacit ‘things’ that serve to make nursing a challenge to articulate. It is also not recognised because while nurses do demonstrate expertise in the private discourse using a variety of healing practices from touch to talk, for example; wound management, pain management, massage, therapeutic relationships, their skills remain unacknowledged within the public discourse. The knowledge is ‘silent’ and secret and the patient’s ‘ownership’ remains held by the doctor. Wicks notes that this “…reveals the silent power of the dominant discourse to make use of, but keep marginalised, the holistic approach” (1995, p. 130).
Nurses do resist domination within the private discourse, they do carry out their ‘work’ silently, secretly and sometimes subversively (Hutchinson, 1990; Lawler, 1991; Wicks, 1995). Foucault makes these practices crystal clear when he writes:

Discourse transmits and produces power; it reinforces it, but also undermines and exposes it, renders it fragile and makes it possible to thwart it. In like manner, silence and secrecy are a shelter for power, anchoring its prohibitions; but they also loosen its holds... (1978, p. 101)

Being secretive helps to create coalitions with other nurses, but it can also serve to enforce the marginalised status of nurses’ knowledge (Hall, Stevens & Meleis, 1994). How nurses conduct themselves in their practice sometimes changes when doctors arrive, especially senior doctors. Nurses are both silenced and silence themselves and silence causes nurses to be shadows of what they could be. The language changes to that of the dominant discourse of the public domain, where the doctor is seen to be in authority, ordering care as the holder of knowledge. Nurses believe that their ‘body’ of knowledge and experience, which is expressed in their language and work, is not valued or recognised. There is dissonance between what nurses do in their everyday practice and how their work is represented and valued within healthcare structures.

Language has been pivotal in shaping the role of nurses, and the development of self in nurses. Walker writes about nurses’ lives as being:

...inextricably woven out of narrative structures which work to impart a sense of coherence and order on the ‘rough and tumble’ of everyday life and practice. (1994, p. 165)

Nursing does indeed function within its own langage, which nurses learn throughout their practice life, making it their own, imbuing it with their own gestures and rhythms. In a way nurses have to have their own language, excluded as they are from the public discourse of being allowed to speak with authority. Nurses use narrative in the form of story telling amongst other nurses to clarify their experiences and to lay claim to their knowledge. The public discourse of health is the masculine preserve of medicine, nursing discourse being coded as feminine is different, it is ‘other’ and because of being other it is relegated to the
private discourse, as feminine speech always has been (Jones, 1988). Jones suggests that the feminine voice "...may speak in compassionate tones" (1988, p. 121) which are not heard by many listeners and this compassionate voice is heard as being non-authoritative, as "...gestures of the subordinate" (p. 121).

Code discusses this position further as she explores the "...stereotypically 'proper' virtues of a nurse" (1991, p. 248) which are associated with compassion and being responsive to patients. Because these are traits which are seen to be those women 'naturally' hold, their value as specific nursing skills are minimised as being 'just women's work'. That which is accorded greater value is the voice of authority, which is distanced from the patient and which is able to 'treat' a faulty part of the patient without having to refer to the patient themselves, this voice is accorded higher value, and is considered to be expertise. Within a public discourse compassion has no epistemic value (Code, 1991) as with other aspects of nursing practice which involve nurses taking themselves to their patients and 'laying on hands', both metaphorically and in reality. Compassion is held to be an essential component of nursing 'work', and as a moral choice in nursing (von Dietze & Orb, 2000). It is 'work'; it is not dallying around being 'nice' or 'pitying' to patients. Compassion is not about what nurses do for patients, it is what nurses do with patients, and there is a difference. von Dietze and Orb (2000) describe compassion as having a sense of 'solidarity' with patients so that the nurse is able to enter the experience with the patient and share the burden with them. To be compassionate requires knowledge, skill and self-awareness.

Savage (1995 & 1997) suggests that use of gesture and bodily posture can be interpreted as a strategy nurses use for maintaining areas of clinical practice as more 'private' domains. Thus sitting on a patient's bed talking to them, squatting down to talk to them, perching on the edge of a chair or desk are examples of a more relaxed posture which reinforces the ward as being the private domain of nurses, as opposed to it being a public space. This is an example of nurses creating and taking over space for themselves by claiming the environment as their own, which could be perceived as being a direct, yet unspoken challenge to medicine. Savage found in her research that this use of space altered when senior medical staff entered the wards, the nurses then reverting to a more formalised posture.
It is easy to say that the change in posture represents deference to medicine, but there are more complex issues involved. It is also about nurses making themselves 'invisible', putting on the appearance of something that is neat, tidy and homogenous, a group of nurses as opposed to individuals. It is subversive practice and represents a strategy of unconscious resistance. Whether nurses go beyond this point I remain unsure. As Weedon points out:

The degree to which marginal discourses can increase their social power is governed by the wider context of social interests and power within which challenges to the dominant are made. It may well take extreme and brave actions on the part of the agents of challenge to achieve even small shifts in the balance of power. (1987, p. 111)

Are nurses ‘brave’ enough to try to bring about change in the balance of power, I do not know. I am however ever hopeful that they are.

*Professional relationships: Talking the talk?*

Walby, Greenwell, Mackay, and Soothill (1994) comment that the relationship between medicine and nursing is complex, and Wicks (1995) notes that it is also often contradictory. The relationship lies between a number of factors which include “…difference and complementarity, on the one hand, and hierarchy and subordination, on the other” (Walby et al 1994, p. 12). Walby et al uncovered marked differences between the two professions, as would be expected. The concept of what it means to be a professional demonstrates how differently nursing and medicine are positioned within structures of health. In Walby et al’s research many nurses believed a professional was someone who was accountable for their practice, who worked within a defined scope (boundary) of practice and whose practice was ‘monitored’ by senior colleagues. The scope for their practice provided legal protection and boundaries. Medical staff on the other hand believed a professional to be someone who takes full responsibility for their practice and considered that being rule bound can be restrictive. In keeping with this understanding medical staff thought that nurses did not take responsibility for their practice while nurses believed medical staff could get away with practices that would be considered unprofessional in nursing (Walby et al, 1994).
These are widely divergent beliefs and are indicative of some of the dissonance that exists between the two professions. These are also issues that seem not to be discussed *between* the professions, leading to ongoing misunderstanding and miscommunication. Nurses talk about doctors, doctors talk about nurses, they often talk past each other. The varying perspectives on what it means to be a professional are indicative of the primary difference between the two professions, which is that medical consultants retain overall responsibility for patients when they are in hospital and general practitioners for patients outside hospital. Medical staff assert the right to have overall control over patient treatment protocols, and in effect also control the practice of nurses, within the public domain. However, nurses do not always accept being controlled (Walby et al, 1994). It is clear to me that the two professions ‘need’ each other to work effectively, it is equally clear that hierarchies of power and control have a considerable influence over what occurs in practice and contribute to disagreement and ‘structural inequalities’ between nursing and medicine (May, 1992a).

In an ideal world the two professions would work together for the benefit of their patients, each having respect for the knowledge and skills of the other. However, we do not live in an ideal world and medicine and nursing have a long and sometimes fractious history (Garmanikow, 1978). Medicine retains the right to diagnose and thus prescribe treatment; nurses’ practice remains mediated by medicine in that nurses administer prescriptions for care (Reverby, 1987). However, although the inequalities between the two professions are real and tactile, they are dependent on one another, nurses do direct some medical work, and vice versa. The relationship between the professions has to be flexible but will generally be structured via the ‘relative powers’ of the two groups (May, 1992a), and relatively medicine occupies a more powerful position.

In terms of what each profession has been able to achieve in professional status and occupational autonomy/authority, medicine has clearly been more successful, if indeed successful is the appropriate term to use. The differences in professional status have occurred partly because of what a number of scholars refer to as the gender division in labour (e.g. Garmanikow, 1978; Speedy, 2000; Turner, 1986; Walby et al, 1994; Witz, 1994). This particular history tells a number of stories
The story of the rise in status of medicine, of ongoing attempts by nursing to define a specific place and status within healthcare for themselves and how discourses of medicine and nursing have changed over the past one hundred and fifty years. It hasn’t always been the same and continues to change because society changes, social relations change, the contexts within which we conduct our lives change. History does not happen in a tidy linear fashion (Foucault, 1984a). Nurses have not continuously been subordinated by medicine. Where there is power there is always resistance and nurses do have and exercise agency (Wicks, 1995), albeit often quietly, within the private discourse of their practice.

Walby et al (1994) speculate that the gender divisions between nursing and medicine cannot be reduced to socialisation theories about gender per se. In other words, the two groups do not enter their respective education ‘knowing’ that there will be domination by medicine over nursing. Rather the division is structured within the unique and sometimes anachronistic relationships between the two professions, “[n]ursing and medicine are professions which shape the possibilities of their members, rather than this being primarily a result of the social psychological characteristics they bring with them on entry” (Walby et al, 1994, p. 74). The culture of the two professions has a significant impact on how they relate to one another.

How nurses communicate with doctors, how they get their messages across and whether they do get their messages across and understood are issues in a healthcare environment in which many of the workers are overworked and stressed. Nurses are sometimes accused by doctors of being indistinct/unclear in their message giving, of not using the correct scientific language. In reality nurses are speaking from one subject position and doctors are listening in another. The same applies to doctors speaking to nurses. There are two separate languages/languages, as you would expect. However, where a problem arises is in relation to ‘ownership’ of the patient, and whose language has primacy. Here the answer is straightforward. It is and always has been (since the advent of medicine and the rise of positivism) medicine which has primacy of speech and authority over what happens to the patient. In addition, structural difficulties in the
workplace compound difficulties ensuring information is shared between both groups. Documentation is important for sharing information, however at times it is not adequate or done in time and can lead to friction and ongoing miscommunication (May, 1992a).

Both professions have experienced different ways of learning, with nurses learning to emphasise the interpretive position, the meaning of the experience for the patient, whereas doctors are taught to be more focused on specific symptomatology. Neither position is better than the other, they are different, substantially different. Little wonder the two professions can find it hard to work together in a complementary fashion. Instead there is often tension, with nurses feeling they are undervalued and misunderstood, and some doctors paying little credence to nurses’ knowledge, opinions, feelings, thoughts or how ever it is they are presenting their positions. The language is poles apart and reflects the positioning of both professions.

Affidamento is a term Irigaray discusses (1991f). It is an Italian word meaning ‘entrustment’, whereby Italian feminists made a move to enable women to move beyond repression by recognising differences amongst groups of women. The idea is that links are created amongst women that acknowledge differences in how they experience the world. Irigaray cautions against creating groups that could become exclusive and thus be difficult for others to become a part of. She makes the point that it is not simply about acknowledging difference, but it is also about establishing another relationship. Women do not simply need to learn to accept themselves as mothers and women, but also what she calls “... our sexuate relationship with language [langage], ideation, idealization and becoming divine” (1991d, p. 195). She believes these elements are crucial to her conception of an alternative social order.

I see potential for these ideas in relation to nursing. The concept of entrustment is about having respect for one another, and having a clear conception of who, and where you are in the world, and sometimes nurses are not very good at this. von Dietze and Orb (2000) note that nurses lack in support and compassion for each other and Deans (2004) describes how nurses have a culture of not caring for or
about one another while Thompson believes that nursing has “...experienced too much horizontal violence and divisiveness” (1987, p. 37). These findings are paradoxical when considering that they reflect the very values nurses believe are crucial to their everyday work. If nurses are challenged by collegial relationships, what might this mean in the contexts of the relationships they purport to have with their patients.

Irigaray would say that nurses are not very good at trusting each other, and would contend that this happens because women are not identified as subjects, and they need to be able to claim this for themselves. Thompson (1987) contends that to resist divisiveness it is important for nurses to engage in a critical scholarship that explores power relationships and makes them more transparent, thus helping nurses to recognise themselves. Thompson identifies the need for open communication amongst nurses and the importance of having connectedness with each other as a professional group. It is also about nurses being able to place value on what they do in their practice and emphasising the positive differences (May & Fleming, 1997) and complementarities between themselves and medicine.

Summary

Language, both written and spoken, has been pivotal in shaping nursing discourses. Nursing has a long history of having an oral tradition of story-telling and nurses have not been effective recorders of what they do within their practice. Nurses’ discourses of healing remain marginalised to the dominant discourse of medicine, even though nurses do exert considerable power within the private discourse of their practice. Their power continues to be mediated by medicine who retain the authoritative voice and ‘ownership’ of the patient.

Florence Nightingale was pivotal in shaping nursing as well. She was a woman of formidable determination and was responsible for laying strong foundational bones for nursing knowledge and practice. The fact that her vision for nurses was hi-jacked by institutions that wanted a cheap labour force, and medicine who wanted handmaidens, does not make her responsible for the position of nursing today.
Because nurses are part of a specific discourse community, are supported by this community and are sustained by belonging to this community, there can be a tacit expectation that nurses are required to conform, in order to belong (Little, Jordens & Sayers, 2003). In other words, do not rock the boat. Speaking and writing nursing practice is I have suggested a method for nurses to inscribe their practice on their body of knowledge so that it becomes alive and real for themselves and others, making it in effect visible. These actions would represent taking the initiative, doing some taking for a change instead of seen as being giving and generous, to others. Being generous to them-selves.

A Foucaultian analysis of genealogies encourages thoughtful exploration of the political production of the subject, which within my work is the nurse, and how she is constituted through the instrument of power (Lloyd, 1996). Foucault reminds us that in themselves power relations are not inherently bad, and they are not going to disappear into nirvana because different groups develop the ability to communicate effectively with one another. Of greater importance is that games of power are played out with the “...minimum of domination” (Foucault, 1988a, p. 18). Exploring the discursively constituted subject nurse helps to elucidate the possibility for a nursing praxis which has at its heart the practical wisdom of the nurse and which uses as its vehicle the practical body of the nurse, the practising self of the nurse.

The next chapter will continue this story of nursing as I explore the embodied self of nursing practice and how the invisibility of the physical presence of the nurse has served to further obscure nurses’ practice, their body work. If Nightingale is a spectre haunting nursing, so is the invisible body of the nurse.
Chapter Eight

The Embodied Self in Nursing

Introduction

Nurses' physical use of themselves in their practice, granting this a place and a language, is one of the foci of this chapter. Body-work is part of the 'stuff of nursing'. Brown and Seddon (1996) propose that medicine's control over the body of the patient keeps nursing subordinated to medicine. It is too easy to say that nursing is oppressed by medicine and that because of this what nurses do has limited value. Ashley (1980) made a statement that for nursing remains relevant today, more than two decades later:

For many years we have heard that nursing is at the crossroads. Nursing never seems to get over being at a crossroads. (1980, p. 22)

Being at a crossroads should generate potential for change, but this does not seem to happen for nursing. There is a multitude of possible reasons for remaining at a 'crossroads'. The seeming inability of nurses to 'recognise' and thus 'rethink' themselves in relation to the content of their work is one reason. Also, nurses as part of a feminine profession practise via the specular reflection of what medicine as a masculine profession prescribes for them. Although, as Wicks (1995) points out, the authority of medicine is resisted and in some areas of practice nurses do have increased agency. Further, Kelleher, Gabe, and Williams (1994) note that highly skilled nurses appear to be moving towards defining a space for themselves which involves their having greater autonomy from medicine. Whether the autonomy is real or is an attempt to ensure professional survival within increasingly embattled healthcare structures and a global shortage of registered nurses is debatable (Kelleher, Gabe, & Williams, 1994; Walker, 2003a; Witz
This is why an exploration of self in nurses is important. Exploring the self may help provide an understanding of how it is that nurses practice and why they practice the way that they do.

I believe that what nurses do is valuable and that they are skill-full, knowledgeable, crucial and integral members of the health team. I have become concerned at the nursing/medicine dichotomy, which is held onto tightly by nurses and medicine and disadvantages nursing. Nursing is nursing, and medicine is medicine, the two professions could and should be complementary to one another. What nursing struggles to do is to provide an alternative to the medical model, with limited acknowledged success. There is something important which the reductive medical model of care cannot do but depends upon, the enhancement of the healing will of the patient as a whole and the conviction of the patient that she is being cared for.

I am a confirmed believer in the sheer physicality of nursing practice and the intimacy this generates between nurses and their patients. I do not believe other health professionals who work in hospital settings (e.g. mental health wards, medical and surgical wards, gerontology wards) replicate this practice to the same extent. Nurses provide skilled care twenty four hours of the day as part of an ongoing therapeutic relationship with patients. I believe nurses physical use of themselves in their practice is like a non-verbal language, and if this is indeed the case, then this language should be able to be brought into the light, brought into conscious being.

I am borrowing from Irigaray (1985a, p.160) as I write that this chapter is about 'how to conceive of a nurse'. The chapter will explore nurses' physical use of themselves in their practice and will draw upon the phenomenology of Merleau-Ponty, the work of Irigaray and elements from poststructuralism and psychoanalysis. I am going to write about selves and about bodies. I hope through my writing to enable nurses to develop an enhanced understanding of their embodied practice when they are engaged in their humanly connected work as enselved and ensouled practitioners of healing. It is my contention that nurses have slipped into an entrenched set of beliefs which has convinced them they are
the 'docile bodies' of health practice. I aim to explore how nurses can come to recognise the power inherent in their practice and use this to become directors of their chosen pathway, instead of feeling they are stuck at a crossroads. I will also examine how nurses might deal with the problem of their practice being subjected to the scopic vision of medicine rather than the felt knowledge of intimacy with the patient. The chapter is about making the invisible body of the nurse visible.

Women's body-self in nursing

Most of the scholarly work around nursing is written as though the body of the nurse is of little account, as if her body is simply there, taken for granted, doing 'its job', her body is tacit. The embodiedness of the nurse, as Shakespeare (2003) notes, is inferred, but rarely discussed. For example Short notes, '[n]urses use their own bodies as tools of their work and the patient/client's body is the site of that work' (1997, p. 9), and Wiltshire and Parker comment about nurses that "...dealings with the dysfunctional, broken down or transgressed body in turn afflict the nurse, and draw from her/his bodily capacities" (1996, p. 24). Statements like these are glimpses, shadowy potentialities of what could be written, to make the body of the nurse understood. As a woman and as a feminist my belief is that the body of the nurse in all its materiality, matters, and makes a difference. After all, a nurse couldn't do her work without her body. The body of the nurse is important, not just because of the work that she does, but also because nursing is predominantly a profession of women and women's corporeality has been a 'problem' throughout the history of philosophy.

Women have been perceived as 'just bodies', 'over-embodied' and 'different' to male bodies. The bodies of women are unpredictable, leaking and seeping and lactating and gestating (Grosz, 1994; Shildrick & Price, 1998). It was all too much for the philosophical Fathers. These appetitive messy bodies were certainly not to be allowed access to the divine. A messy body needs to be 'disciplined' (Foucault, 1978), has to fit within certain idealised constraints of how it is that 'that' woman's body should 'be'. Throughout history the bodies of women have been subjected to power in the form of cultural practices (Bordo, 1988; Douglas, 1966; Foucault, 1978 & 1985) inscribed on their bodies "...and their materiality, their
forces, energies, sensations, and pleasures” (Foucault, 1978, p. 155). The formation of the social body within capitalism. Bordo notes that the “...social manipulation of the female body emerges as an absolutely essential strategy in the maintenance of power relations between the sexes over the last hundred years” (1988, p. 91).

Women’s bodies have also been a ‘problem’ for feminist theory, perhaps this is one of the reasons why they were for decades ‘absent’ in texts, or stepped around gingerly in order to escape charges of essentialism and biological determinism, to escape the materiality of the body (Grosz, 1995). Shildrick and Price (1999a) describe early feminist writing as being ‘somatophobic’ in order for women to be able to be conceptualised as being equal to men while Grosz (1995) discusses feminist theorists who ‘sanitize’ and ‘decorporealise’ bodies by describing them as effects of discourses. Body what body? Shildrick and Price note that for feminists “… to acknowledge the centrality of the corporeal has seemed to mitigate the claim to full equality” (1998, p. 5). If one’s body is immanent and fleshy, then transcendence is denied, and transcendence within the symbolic represents the masculine ideal of ‘full personhood’ (Shildrick & Price, 1998) and rationality.

Significantly, as Shildrick and Price (1998) note, issues of embodied sexual difference are largely ignored. Sexual difference is more than material differences (Grosz, 1993), it is also constituted and traced by discursive practices (Butler, 1999). Sexual difference itself helps to produce a certain type of body, within certain norms. As Foucault (1977) describes it, a body subjected to domination and subordination. For Grosz (1993 & 1995) this has to be more than a biological account of the body. It must also be taken into consideration that there are sociocultural forces at work. A story of the body does not need to be biological or reductive in order to reconceptualise women’s position in knowledge production. Disciplinary controls help to produce a certain type of nurse’s body. The disciplinary practices of how that body was subjected and shaped are part of the history of nursing and the technologies of the self (Foucault, 1988a & 1988b) where an individual comes to know themselves and take care of themselves (Foucault, 1988a). The material body never adheres to all the prescribed norms,
there is always resistance or the possibility for change, to re-materialise the body (Butler, 1999), or re-figure it (Braidotti, 1994a), or to subject it to an ‘inspecting gaze’ of self-surveillance and confession (Foucault, 1980c). For feminist theorists, bodies are always “...sexually specific” (Grosz, 1995, p. 32).

Haber describes the self as a “…narrative construction” (1994, p. 4) and language as a system of signs which go on ad infinitum. Semiotics tells us that we live in a world structured by signs:

...a sign consists of two separate components: a signifier, or the acoustic image of the spoken word as heard by the recipient of a message; and a signified, or the meaning called forth in the mind of the recipient resulting from the stimulation of the signifier. The sign is three things: the signifier, the signified, and the unity of the two... (Gottdiener, 1995, p. 5)

Everything that we do, think and say has a meaning, which is often not clear to the individual but which also progressively structures the subjective body. Haber suggests that if we want to “…understand our social and cultural world, we must examine the network of relations which endow objects and events with meaning” (1994, p. 11). A poststructural perspective proposes the self is changing, subject to multiple realities and because of this, irrational. In discussing how power is accessed by groups, especially those who are marginalised or seen to be other, Haber makes the point that what individuals have to do is first recognise power and also realise that they do not exist only as individuals, but as members of a community. Speech, Grosz points out, is not confined to language:

Bodies speak, without necessarily talking, because they become coded with and as signs. They speak social codes. They become intextuated, narrativized; simultaneously, social codes, laws, norms and ideals become incarnated. (1995, p. 35)

For me Grosz’s statement represents a kind of embodied selfhood. In the becoming of self, I, my body and the materiality of my body are shaped by sociocultural forces, by my relationship not just to myself which would be solipsistic, but to others in my community, other bodies. My self and how I experience myself as embodied is located across biological, historical and cultural dimensions. What I think, how I feel, how I come to understand and make
judgements, that I am desiring, are reflective of an active body interacting with other bodies, and the world. My body is ‘narrativized’ (Grosz, 1995) with the story of my life and my collective experiences. Because I am not wholly an autonomous agent I am as well ‘intextuated’ (Grosz, 1995) with social norms and mores, the effects of power as a strategic relationship. Power acts upon my actions (Foucault, 1983a). Frank comments that discourses exist because of bodies and the techniques they use and stresses the importance of putting ‘...language back into the body, and to compel us to understand speech as embodied’ (1991, p. 91).

Grosz (1999) examines how psychoanalytic theory has enabled women to re-vision the body, to see it as other than biological and immanent and to see it as open to change in what it means and how it works, and as well, open to being re-signified. For Irigaray women’s bodies are inscribed by social practices, ‘spoken through’ by masculinist discourse and reflected on the flat plane of the speculum. Her bodies are bound up in a complex system of significations. Shildrick and Price comment that “Irigaray’s insistence on the sexed specificity of corporeality speaks not to the female body as such, but to a feminine morphological imaginary, the body that is never one” (1999a, p. 6). It is within the symbolic that sexed/gendered subjects ‘become’, however it is in the real corporeal world that the theoretical explanations for this conception originate, generally in some form of alienation from the mother. Irigaray describes this as ‘matricide’ (1985b).

Grosz argues for the body to be regarded as; “...a site of social, political, cultural, and geographical inscriptions, production, or constitution. The body...is itself a cultural, the cultural, product” (1994, p. 23). Grosz (1993 & 1995) proposes two different conceptions of the body. The first is whereby the body is perceived of as being a surface where social mores, values and morals are inscribed, the social body. This conception of the body Grosz derives from the work of Nietzsche, Foucault and Deleuze. The second she describes as being the ‘lived body’ of phenomenology and psychoanalysis and the body’s “...internal or psychic description” (Grosz, 1995, p. 33). For Grosz the lived body provides a story of how the body is “...experienced and rendered meaningful” (p. 33). Grosz is clear that she does not see the two approaches as being able to be synthesised, however what she does write is that “...each may provide some of the theoretical terms
necessary to problematize the major binary categories defining the body-inside/outside, subject/object, active/passive, fantasy/reality, and surface/depth” (p. 33). For my purposes Grosz assists me to think about the bodies of nurses as both subjected to power, inscribed by and productive of discourses and also as a lived, felt, experienced, fleshy materiality that has a specific interiority.

Foucault writes that:

The body is the inscribed surface of events (traced by language and dissolved by ideas), the locus of a dissociated self (adopting the illusion of a substantial unity), and a volume in perpetual disintegration. (1984a, p. 83)

Foucault's body is a body of surfaces, inscribed by social practices, an instrument and target of power (Grosz, 1994). His body is able to be revealed in its totality and thus can be fully ‘known’. Genealogy Foucault says dispels “…the chimeras of the origin” (1984a, p. 80), and it is thus that Foucault argues against the phenomenological body. For Foucault there are no hidden ‘truths’ of the body, no essences waiting to be uncovered, no depths to be interpreted (Fielding, 1999). An individual does not come to know themselves, or recognise themselves through their body (Foucault, 1984a). The body is instead produced by power relations which take hold of the body and:

...invest it, mark it, train it, torture it, force it to carry out tasks, to perform ceremonies, to emit signs...it is largely as a force of production that the body is invested with relations of power and domination...the body becomes a useful force only if it is both a productive body and a subjected body. (Foucault, 1977, pp. 26-27)

To me this appears to make Foucault's body a passive body, and while he always stresses that power is relational and acts upon actions, it is also true that Foucault's useful bodies are political tools, tools of capitalism that are subjected to power, docile bodies, able to be rendered visible. However while I propose that Foucault's body is passive, what his conception of the body does do is provide a framework for being able to visualise the body as a site of political struggle, as having the ability to resist, providing the subject has knowledge of the self.

Merleau-Ponty’s conception of the phenomenological body is substantially different to that of Foucault. His bodies are primordial and prediscursive,
“...subject and object...existence and essence” (Merleau-Ponty, 1968, p. 130). His subjects know their bodies, not just because they can see and feel them, but because they are their bodies, Merleau-Ponty’s subjectivity is embodied. It is his phenomenology of being. His body has surfaces, but it also has depths, which are never totally known to the subject, that seems to be part of the ongoing mystery or project of life. Fielding notes that in Merleau-Ponty’s work “...depth is for the body a sustaining and interior possibility that is rendered in its phenomenological being through our interactions with the world” (1999, p. 78).

When Foucault dismisses the body with depths and says that there is nothing to see except what is on the surfaces, he condemns body-subjects to a passive existence within discursive relations. He also delivers unto us a ‘truth’ of the body, Foucault's truth, which is the truth of the body of man, because it is about men that he writes. He shuts off the body to women, and for my purposes nurses. I find it more productive when thinking about nurses and how they work with their bodies to reflect on the ambiguities of embodiment, the partialities, the art and aesthetics of becoming, as women. A nurse’s body is the pre-eminent tool of her practice. The nurse’s body is inscribed by sociocultural practices, but she has, as well, psychic and phenomenological depths that she gathers together and brings forth, to bring herself to her practice, body and soul. The body of the nurse would seem to be necessary for production of a nurse’s knowledge. Not everything in life has to be rendered visible, that is a particularly empirical and masculine construct. There are millions of people around the world who believe in the existence of the Judaeo-Christian God, yet none of them I suspect have been able to render him up as visible, although many have tried. It does not appear to cause them to falter in their beliefs. While I find Foucault’s analyses useful, I do not allow myself to be constrained by his belief that there are not essences and depths that I can explore and think about.

Cultural practices are instilled and inscribed on nurses’ bodies. These practices first came in the form of uniforms which restricted movement and covered the materiality of her excessive female body, and which originally resembled those of nuns (Wand, 2004). Veils and caps projected angelic images and also defined hierarchical rank, belted waists were to emphasise femininity. The movement of
the nurse’s body needed to be quick and efficient thus directing their forces and energies. Epaulettes and badges denoted rank and hierarchical structures served to enforce rules and regulations and reinforced that “…nurses knew their place” (Papps, 2001, p. 6). Papps notes that these cultural practices were part and parcel of the prescribed representation of the nurse and were associated with “…notions of passivity, docility, servitude, obedience and subservience to the medical profession” (p. 7) and to the patriarchal institutions of health.

I believe the body of the nurse is regarded in Platonic terms as being ‘appetitive’ as opposed to ‘rational’ and therefore needing to be controlled (Bashford, 1998; Garmanikow, 1978). Shildrick and Price note that “…the body seems to have been regarded always with suspicion as the site of unruly passions and appetites that might disrupt the pursuit of truth and knowledge” (1999a, p. 2). Thus my note in the previous paragraph about nurses’ uniforms being necessary to cover up her ‘excessive’ body. Throughout history nurses have been represented by a variety of dichotomies from virgin/whore to angel/temptress, they are predominantly sexualised/eroticised representations. Porter (1992) suggests that the sexual stereotyping of nurses is related to the intimate body work nurses do. Nurses are perceived of as intruding into very personal, sometimes messy and unpleasant aspects of patients’ bodies, and this is “…countered by the demeaning of nurse’s own bodies” (Porter, 1992, p. 522). The body of the nurse can be seen as a site of political struggle and feminist theories help to provide an understanding of this struggle (Hyde, 2000). Because nursing is a feminine profession the specific roles and identities that are expected of women in society have contributed to the shaping of nurses’ bodies and their selves. To paraphrase Csordas (1994a) I am writing not just about the body of the nurse, but ‘from the body’, I am reclaiming the territory of her lived body.

The embodied self of caring nursing practice

Within this section I am concentrating on an area of neglect in nursing scholarship, that of the embodied self of the nurse in her practice. The use of the word ‘neglect’ immediately makes me think of what happens sometimes to patients who have experienced a cerebro-vascular accident (stroke), how they
sometimes neglect the affected side of their body, almost as if they have forgotten it is there. I would argue that something similar happens in nursing, and the neglect is significant for nursing because it is persistent. Nurses' absent bodies are like spectres on a stage, shadow puppets of the proscenium, visible and yet invisible. If nurses had more awareness of the living sense of themselves within their nursing practice, then their bodies in turn would have increased consciousness which may lead to greater awareness of self, what Frank (1991) calls 'embodied consciousness'. Awareness may as well have the effect of assisting nurses to clarify and articulate what they do within their practice worlds.

As Benner noted two decades ago “[n]urses must change the way they describe what they do in actual practice” (1984, p. 205). The publication of Benner's *From Novice to Expert* was an enlightening moment for many registered nurses. Here was a nurse scholar writing about nursing practice using the vehicle of exemplars, stories from nursing practice to bring practice alive. For some nurses her work has become akin to doctrine (Padgett, 2000); it is also true that her research has assisted many nurses to explore their practice through an interpretive lens (Thompson, 2000). In addition Benner's work had within it potential stepping-stones to enable nurses to examine their practice worlds through lenses of poststructuralist and feminist critiques. That this failed to occur as part of her research project reinforces for some nursing scholars (Padgett, 2000; Thompson, 2000; Walker, 2003b) the inherent political conservatism of nursing, and in this instance the particular conservatism of Benner herself (Padgett, 2000; Thompson, 2000).

The corporeal reality of nurses' bodies in their practice demands more adequate representation than it has had to date, which as I noted earlier in the chapter are shadowy glimpses. I perceive of this as being an ongoing process of consciousness raising amongst nurses with much potential for the future. The taken for grantedness of embodied, embedded, enfleshed, ensouled and enselved practice has been historically a knowledge vacuum for nurses. Nurses need to be able to recognise this and make it visible for themselves. Matter matters. Humans are material beings. The body is a cultural construction and an effect of discourses, but it is so much more than that.
Williams and Bendelow in the following passage describe the body as:

...a fleshy organic entity and a natural symbol of society; the primordial basis of our being-in-the-world and the discursive product of disciplinary technologies of power/knowledge; an ongoing structure of lived experience and the foundational basis of rational consciousness; the wellspring of human emotionality and the site of numerous 'cyborg' couplings; a physical vehicle for personhood and identity and the basis from which social institutions, organisations and structures are forged. The body, in short, is all these things and much more besides. (1998, p. 2)

Williams and Bendelow's evocative description of 'the' body encompassing both the phenomenal body as well as the discursive body removes uncertainties I might have had about physical presence being something to be reckoned with. The body is not merely something there courtesy of nature, our bodies are channels for what happens in our lives and all that we do. The primordial body for Merleau-Ponty has existed since the beginning of time and it is only because we are embodied that we can experience the world with the openness that is needed and come to an understanding of it. For Merleau-Ponty the capacity for openness is intrinsic, and thus pre-discursive (Fielding, 1999), the embodied subject can move in and out of situations that it fundamentally precedes.

In nursing practice nurses' bodies are for all intents and purposes the fundamental cornerstones of their practice. Scholars of nursing (e.g. Boughton, 1997; Brown & Seddon, 1996; Lawler, 1991 & 1997; Routasalo, 1999; Savage, 1997; Street & Kissane, 2001; van der Riet, 1997; Wilde, 1999) write about the bodies of patients and the intimate access that this entails for nurses. However, within this scholarship nurses have not recognised nor included their own bodies. Frank proposes that "...the body is a problem for itself" (1991, p. 47) more than it is for society. Those few words capture the spirit of my work. In my opinion it is as if by simply being there, the use of the body of the nurse in her everyday practice is tacit. Because nurses take their physical selves for granted they can be thought of as disemboding themselves and reinforcing dualism in their everyday lives (Williams & Bendelow, 1998). There is a further dualism in that nurses sometimes privilege doing over thinking (Walker, 1997a). Perhaps what nurses are privileging is their ability to do their work efficiently, as purposeful directed
bodies. Walker (1997a) suggests there is a level of anti-intellectualism within nursing that he claims is well-entrenched, a view that is shared by Traynor (1999). I have an alternative sanguine perspective, in that for me nurses are sometimes inarticulate and there is an absence of a philosophical culture that would enable nurses to have a feminine embodied identity of their own. Nurses, as I have discussed previously in Chapter Seven, would benefit from a language/langage and writing of their own (Irigaray, 1985b), a public (as in recognised, acknowledged) discourse that is of their own creation about the corporeality of their practice. It may be beneficial for nurses to inhabit the langage of their own in practice so that the talk they talk informs the walk they walk.

To subvert Descartes’ maxim, for nursing it appears to me as if what happens in practice is ‘I do therefore I am’, or perhaps ‘I care therefore I am’. I prefer Merleau-Ponty’s eloquent subversion of Descartes where “I think, I am” are placed on an equal footing, and where “I think” is “…re-integrated into the transcending process of the ‘I am’, and consciousness into existence” (Merleau-Ponty, 1962/2004, p. 446). Grosz (1994) uses the Mobius strip to illustrate this, a concept derived from Lacan. The Mobius strip is a three-dimensional figure eight that twists, contorts and rotates on itself and on this surface exterior surfaces and interior depths are indeterminate, one side can become another (Grosz, 1994 & 1995). The body is thus a ‘hinge’, and an “…articulation of the world” (Vasseleu, 1998, p. 27). Thinking about bodies in such a way provides space for rethinking what has been traditionally known. That which has been inscribed on women’s bodies by their being seen as a lack, can be subjected to a careful reinscription, through a reconfigured speculum, offering something that is represented on different terms, not simply more of the ‘other’ of the same.

In order to articulate embodied practice, nurses could talk about it more, to find ways of expressing those tacit inarticulables, and holding onto them by writing them down. Benner (1994a) writes:

Social meanings and their embodied social postures, stances, habits, skills and practices are relevant for recovery, rehabilitation, for nursing practice, and for skillful ethical deportment in caring for the ill...[Nurses] have focused more on the mind than on the body and have not developed adequate language for the experience of skilled,
responsive psychosocial bodies because of our “representational” Cartesian bias. (1994a, p. xvii)

Using phenomenology helps nurses to explore a different understanding of their practice, outside of instrumental reasoning and a received understanding of their bodies as being a ‘tool’ fit for the purpose. As Benner notes phenomenology holds promise for “...making practical knowledge visible” (1994b, p. 124). Aristotle’s concept of practical wisdom combines thinking activity which is practical and concerned with ‘human good’ (Lauder, 1994). The practical knowledge and wisdom of nurses combines doing and thinking as a whole and should not be separated into discrete elements, each informs the other. Being a practical body should not mean diminishment of status. The practical body of the nurse is thoughtful, knowing, and brings embodied knowledge to her practice, she is incarnated as a perceiving subject.

After Foucault’s re-working of the body (1977 & 1978), it could be argued that the body of the nurse is the location of the production of knowledge of nursing (Shildrick & Price, 1999b). Not only are nurses’ bodies produced as disciplined and regulated tools of discursive practice, but they are also generative of new discourses. The more experienced a nurse becomes the more skilful her work, the more the ‘forces’ of her body increase (Foucault, 1977). For Foucault the body is subjected to power in order to change and improve it, the body becomes ‘docile’. While it is possible to describe what occurs with nurses’ bodies discursively, I do not agree that nurses’ bodies can be reduced to the discursive. Each nurse brings to her practice a cultural, historical and embodied history that is unique to her. I enjoy Benner’s description of a person as ‘skillfully embodied’ (1994a, p. xix) and consider the term an apt description of nursing practice.

Morphology is emphasised by Irigaray and enables her to explore an alternate vision of women as embodied subject-selves. She offers a complex vision of fluids and fluidity, of the feminine sex as being multiple, of women being bonded to other women, of women’s desire as being owned by them. Vasseleu describes morphology as “… a discursive reality which is irreducible to either material or cultural determination…the form of a body as it is valued and represented, as it is interpreted and lived culturally” (1998, p. 9). The feminine morphology of nurses
includes that they are sexed bodies, practical, creative and thoughtful. How nurses use their bodies and how they know with their bodies is part and parcel of how they come to know their practice world.

Initially for student nurses the use of their physical self in practice is a difficult role to learn, as they negotiate bodily boundaries and what is appropriate/not appropriate physical touch. It is a challenge to describe this to students as they move through the differing spaces of nursing practice, learning to recognise a variety of landmarks. How to describe what ‘is ok’ and ‘not ok’, how to know when a certain touch and perhaps a certain look taken together mean more than a professional relationship is intended to constitute (Savage, 1995). Part of the becoming of a nurse is learning about non-erotic bodily contact in a healing context where the resources, strength and care/ministration by one body (that of the nurse) makes the illness experience bearable and aids the self-healing work of the other (the patient). This learning is part of the nurse beginning to integrate her-self within her practice. It is important it is done carefully and thoughtfully with an eye to the consequences for both the nurse and the patient. The availability of the physical self of the nurse is an ongoing dilemma in nursing practice because physical contact is a part of the everyday practice of most nurses (McQueen, 2000). Much nursing work is about providing ‘bodily comfort’ (May & Purkis, 1995) whether that be washing a patient who is in bed, helping a patient walk to the bathroom, or comforting distressed relatives. The materiality of the nurse-patient relationship reinforces that nursing is “...an intensely grounded activity that takes place between bodies” (May & Purkis, 1995, p. 289).

Vasseleu asserts that there is “...no discourse in existence of a feminine investment in light... it would appear that light plays no part in the ethos of women” (1998, p. 16). I consider ‘light’, or as Vasseleu means, vision, has played and continues to play an important role within nursing. In nursing mythology there is the iconic vision of the ‘lady-with-the-lamp’, Florence Nightingale in the Crimea, wending her way amongst the soldiers at night, guided by both the light of her lamp and by her vision. Light is important to nursing because light guides both vision and touch, light is part of the ethos of nursing. The lamp of night time is warm and caressing as opposed to the cold light of day. When a patient calls for
a nurse in the night, s/he waits for the 'light' to appear, bringing with it the nurse who will most likely speak softly and attend to their needs. The regardful-caress of the nurse is visual/physical and it is embodied. It also contains the scopic gaze of assessment, nurses are part of that economy as well.

Nurses learn a lot by looking at a patient, and also from observing their eyes, locking onto the eyes of another, it is a component of coming to know the patient as more than an object on whom a set of practices are performed. The visual scan or 'clinical gaze' is an important part of nursing assessment and practice. However I believe the 'clinical gaze' of nurses is qualitatively different to what Foucault describes because he is primarily referring to the clinical gaze of medicine and the power of doctors to diagnose and intervene (Foucault, 1973). The clinical gaze attempts to make the invisible totally visible by using "...codes of knowledge" (Foucault, 1973, p. 90) to identify the signifier (signs and symptoms), this is the empirical, reductive gaze. Within this gaze Foucault argues that the 'essence' or the 'heart of the disease' the signified disappears (p. 91).

However, for patients and for nurses the 'heart of the disease' matters. There is more to ill health than a collection of objective, visible signs. Getting down to the heart of the heart of things matters, because illness manifests itself in a variety of ways. There is not always objective clinical data to be gathered. It is possible to be unwell and have no specific signs. The lived experience of illness for the patient is integral to nursing practice. What the patient feels like is important. The nurse shares these experiences with the patient and her practice has to be embodied to do this effectively (Maeve, 1998). Perhaps as Lawler (1991) suggests there is a 'nursing gaze'. The nursing gaze I suggest is qualitatively different to that which Foucault (1973) describes. The nursing gaze cares for its focus or topic of regard, the signified remains in place. For May (1992a & 1992b) there are potential problems inherent in the gaze because it is his belief the patient is subjected to a set of surveilling, normative practices when the nurse talks about 'getting to know' the patient and 'sharing the experience' with the patient. On the other hand I consider it is important to remember that patients do have agency, they do not have to share or tell everything, there is choice. Individuals choose what to tell in life, most adults are reasonably adept at sifting the contents of their
conversations. When it comes to power I become concerned at Foucaultian interpretations such as those of May (1992a & 1992b) which assume power to be pervasive and invasive, a hovering dark cloud. Power is relational and a strategy, resistance is always an option, for patients, and for nurses.

Benner (1984) writes about the ‘intuitive practice’ of expert registered nurses. Intuitive practice involves the use of ‘looking’ as much as anything else. So what is it the nurse sees when she looks? She is looking for non-verbal cues from the patient’s eye contact or gestures. Nurses are skilled at this kind of ‘reading’ of the patient (Morse, 2001). She sees the usual objective signs such as skin colour, facial expression, and physical movement. What else does she ‘see’ that alerts her to the fact that perhaps all is not well? And importantly, how does she communicate these subjective ‘feelings’ to others involved in the care of that patient. With other nurses it is easy, because they understand a nursing colleague who says to them that a patient does not ‘look’ right, and to keep an ‘eye’ on them. With non-nurses this can be more of a challenge, and these ‘feelings’ are often not recorded in the public record about the patient, the patient’s notes. However, they are passed on between nurses in the private domain, at the verbal ‘handover’ between shifts. An example is a new graduate commenting that the most ‘important’ information about patients for her practice is not what is written in the notes. It is what is told verbally to her by the nurse that has been looking after that patient. I interpreted this as a perceptive comment of a new practitioner and it made me smile.

Savage undertook a study of nurses’ work with patients, using the concept of ‘closeness’ which is a “...form of rapport which allows self-disclosure or ‘openness” (1995, p. 3). Self-disclosure is seen by Savage to be not only verbal, but also occurring through the body using strategies such as posture and touch. Touch is integral to nursing practice. Irigaray writes that “[n]o nourishment can compensate for the grace or work of touching” (1993a, p. 187). Within nursing practice touch is work, and where there is time it is carried out with grace and concernfulness for the other. In caring for patients nurses bring themselves to their practice. Touching, stroking, caressing; these gestures are evanescent, but they leave behind them invisible tracings of the nurse’s self. Invisible markers that she
has been there and made a difference for that patient. Whether it is the lightness of a hand on a shoulder or assisting with a wash in bed, she has been there, and has carried out acts of caring.

Merleau-Ponty’s concept of ‘flesh’ is described by O’Loughlin as “...a basic term describing the phenomenon of perceiving and of being the object of perception, of reciprocal tactile contact; that is, of mutual mingling” (1997, p. 25). ‘Mutual mingling’ is significant for nursing, it is the concept of the seer and the seen, the toucher and the touched, the Visible (sensible) and the Invisible (intelligible). Following on from this Vasseleu states that:

...[t]he body is a term within flesh—it participates in so far as it becomes perceivable only through its structuration as perceiving/perceived. The body never perceives itself independently of the language of perception, as a thing itself. (1998, pp. 26-27)

The body is flesh because it perceives and is perceived. For Merleau-Ponty perception is a form of creative receptivity, meaning that the embodied self of the nurse is receptive to the embodied patient. Within flesh Merleau-Ponty’s concept of vision is incarnate, vision dwells within a space which is tactile as well as visual and Merleau-Ponty states that “...vision comes to complete the aesthesiological body” (1968, p. 155). Irigaray (1993a) is critical of this claim in her assertion that Merleau-Ponty privileges vision. She asks why he wants the body to be completed and why it has to be completed by vision. For Irigaray ‘movement’ seems to be preferable for developing an aesthesiological body. Note that she does not want the body completed, not for women. And I can see her point for women, and for nurses. If I conceptualise nursing practice as akin to a dance of healing, then movement would seem to offer many possibilities. Via movement my body, my being, is in connection with the world as I move through my practice world. Through movement I am also revealing and knowing the world of the patient. Within the private spaces of nursing practice I am able to move around unrestrictedly, claiming these spaces as my own, as my ‘dwelling’ (Irigaray, 1993a).

‘Just listening’ (Frank, 1998b), is something nurses do a lot of within the course of their practice and there is a taken for grantedness about this being ‘just’ part of
the job, part of the ‘doing’ of practice. When patients thank nurses for listening and being there, the nurse will often reply that it is part of her role, which it is, but it is a significant and valuable component of her work. Implicit within listening is hearing, it is part of the healing process and requires not making judgements when patients are trying to make sense of their own experiences (Casey & Long, 2003). Listening requires of the nurse being there, being real, being present, giving of self, listening with every pore of her embodied self and soul. Listening comes from the heart. Listening and conversing are crucial to every day working relationships. Listening is prior to understanding, which is something that has to be arrived at within the complexities of conversation. And because when we listen it changes us, we can never come to a full understanding of what the other is saying. Understanding remains partial, which is why we are engaged in never ending dialogue with each other, and the world we inhabit. When listening to patients nurses are cueing in to meanings about what the patient is saying (Sakalys, 2003). They are listening to the patient’s story of their health-illness experience and between the nurse and the patient can be constructed what Gadow (1996 & 1999) terms a ‘relational narrative’ that demonstrates unity between nurse and patient. Listening is about ‘bearing witness’ (Arrigo & Cody, 2004; Perlesz, 1999) to the other at a time when integrity and identity are often threatened.

Embodied actions keep nurses in touch with the realities of their working environment and enable them to function skillfully in that environment. They are tuned-in, in an embodied manner. Nurses use all their senses to make sense of that world. They look and they see, they listen and they hear, they touch and they feel, they communicate with their bodies. It is not all phenomenological, the cognitive domain inserts itself, at these times she is using a scopic, assessing gaze. She is looking for signs, touching skin to feel heat and moisture, listening to hear breath sounds, anxiety in voices. This is the scopic gaze, and then her body ‘knows’ because of its storehouse of memories what should happen next. Her body knows if her patient is in danger because her heart rate increases, her gaze becomes focused, the speed of her movement quickens. She is quickly processing information using both knowledge and experience to make an informed decision about what to do next. She knows something is wrong because something is
missing from the mix, something does not add-up, and she often knows from
‘looking’ at the patient that all is not well with them. These are the ‘tacit
inarticulables’ nurses sometimes have difficulty communicating to medical staff,
because it is these ‘essences’, these intuits, which do not fit within the sanctioned
language of the public discourse.

When a patient is acutely unwell, whether they are suicidal or whether they have
had major surgery, the healing relationship established with them is intended to
make a difference otherwise there is no point in the nurse being there. Nurses
asserts Morse “…are the caretakers of suffering” (2001, p. 47) and as such are
responsible for understanding suffering and the responses needed to alleviate it. I
like to believe that when I have worked with a patient I leave a tracing of myself
behind, that I have left an invisible inscription on that patient’s body. I may have
assisted someone with a shower, washed their hair and massaged their scalp for
them. I may have settled someone into bed for the evening, made sure they are
warm and comfortable and turned off the light. I may have been with someone
who is depressed and distressed and encouraged them to eat and drink a little. I
am with this patient, with my skill-full body, with my knowledge and expertise
about relating to patients, with my skills of making another body clean and
comfortable, with my responsibility for alleviating suffering, with the essences of
embodied caring and knowing. Via my body I develop a sense of self and who
and what I am in the world, I experience the world of nursing practice through my
body. To be a nurse is inscribed on me, both my surfaces as social markings and
also on my psychic depths, that which is not wholly known to me.

_Caring as a trope?_

What is this thing called caring, which as some scholars have stated is difficult to
define (Kuhse, 1995; Paley, 2001; Savage, 1995). Many nurse scholars have
written about caring. (e.g. Benner, 1984; Benner & Wrubel, 1989; Bruni, 1991;
Jackson, 2000; Leininger, 1988; Morse, Solberg, Neander, Bottorff, & Johnson,
1990; Speedy, 2000; Watson, 1979 & 1988; Winman & Wikblad, 2004). Despite
this extensive body of writing, caring remains nebulous and elusive. In addition
many scholars who write about caring acknowledge that it is hard to define
(McCance, McKenna, & Boore, 1997; Morse et al, 1990) The scope of caring literature is broad and indeed causes confusion for nurses (Heslop & Oates, 1995) and others. Kuhse finds nursing literature deficient when trying to come to an understanding of care. Nurses she says, “...use the term ‘care’ in many different and potentially contradictory ways” (1995, p. 450). The reason I have called this section ‘Caring as a trope?’ is because a concern of mine is that much of the writing about caring has reduced the term to that of a metaphor, covering generally what it is that nurses think they do in their practice. I want to be clear that I am not aiming to provide a definitive definition of care, or indeed any form of definition, if there could be such a thing. I am addressing care, albeit briefly, because it appears to me that it is something that nurses are forever trying to define. I have grown tired over the years of reading lists across a variety of texts that purport to render visible caring attributes or caring concepts, they remind me of word salads, and as such have little meaning for me. I am aware this is a seditious thing to write and I may be struck down, but I am bored with caring as it is currently written.

Caring is a dominant discourse of nursing which has altered over time to accommodate changes in social contexts and also significant changes in healthcare practices. Caring has been conceptualised as an ethical practice by Noddings (1984), the grounds for which Kuhse (1995) believes are insufficient for an ethical model. Kuhse contends that while care is important ethics requires “…justice as well as care” (1995, p. 447). Van Hooft (1999) does not share Kuhse’s view of ethics. He puts the case that Kuhse’s utilitarian approach means that her ethics requires “…objectivity, consistency, clarity of thought, impartiality, and universality” (Van Hooft, 1999, p. 112). When it comes to human relationships and making decisions about care (where possible always in relationship with the patient), it is not always possible to be objective, subjective perceptions do get involved. For nurses as agents who are involved in a relational narrative with patients, standing on the outside of the situation and looking on impartially would seem to me to be neither possible or desired. An ethic of caring is about having an ethics that relates to people as opposed to a cluster of detached behaviours couched within a theory of justice.
Nightingale reinforced a type of care that centred on environment, sanitation, nutrition and a type of holism (Garmanikow, 1978; Selanders, 1993). Care in the late 20th and 21st Century while continuing to have as its basis the importance of the nurse-patient relationship, also involves much more in the way of technological interventions. The burgeoning wave of technology has the potential to create barriers in human-to-human care (Sefer, 2004). Allen (1995) suggests that when nursing tries to position itself within the broad spectrum of science nurses lose sight of the fact that they earn a living from illness and suffering. Nurses work within systems that do not ‘care’ about individuals and which increasingly within an economics of health, exclude suffering individuals from access to care. Clarke (2004) and Holzemer (1997) echo Allen’s perspective. Clarke also notes that when patients get well this is generally attributed to the skill of the medical staff as opposed to the care of the nurses. Clarke comments that “...nursing perennially runs the risk of being defined by its absence” (2004, p. 67), a view that I share.

Paley comments that:

...nurses’ knowledge of caring is, almost exclusively, knowledge of what is said about caring. The vast majority of empirical studies report the views and perceptions of nurses...and make no attempt to describe what nurses actually do... Knowledge of caring is a knowledge of things said, and the ‘things said’ are catalogued, indiscriminately, as experience, perceptions, concepts, meanings and so on. (2001, p. 190)

Ouch, more sedition. There is a possible link between knowledge of caring and what I described in Chapter Seven in relation to nurses’ language, speaking and writing. Nurses do not often write about what they actually do in their practice, the day to day specifics of their work. This is demonstrated in both the public record of the patient’s notes, and in published literature. What I ‘think’ I do, may be vastly different to what I ‘actually’ do when someone is observing me. If caring is a tenet of knowledge production in nursing it would seem to be important to be able to describe it clearly before diving off into a blur of abstraction, obfuscating the specular lens.
When students enter nursing programmes one of the things they often say is that they want to ‘care about people’, which is admirable and I would never say that more caring is not required in the world, it is. However, what I am less clear about is whether their education enables them to clarify what is meant by the word itself. Nurses are expected to care, it is an altruistic image of nurses portrayed across media. Colliere expressed this succinctly when she wrote “…care itself was never taken into account as a specific activity…it is the definition of what a nurse is to be” (1986, p. 102). I do not know if nursing literature has moved much further than this. Nursing as a profession could benefit from discussing whether caring is an activity, a set of attributes, a mix of the two, or perhaps neither.

The all-enveloping ‘caring’ role can bring an excess of baggage with it. Sometimes I just want to do my job and I do not always want to be expected to care about people. I am happy to care for them, but there is a subtle difference in the terms. I care for people in that I provide skill-full care that is based on knowledge and research, includes sharing information and acting as an advocate. I am as well clear about the philosophy that underpins my nursing practice. I believe much of the scholarly writing about caring is an attempt by nurses to define their own contribution to patient care and to articulate points of difference from medicine. Part of the problem for nurses surfaces in their being able to justify what is done in the terms dictated by the legitimated clinical discourse. When nurses try to define caring they are trying to define a role for themselves, and a space of their own. This is within healthcare structures where, as Reverby (1987) notes, nurses are ‘ordered to care’. The word care itself is dissonant and fractured. Nurses do not ‘own’ caring, and in splitting caring off from curing or healing, nurses may have done themselves a disservice. Care in its most general sense occurs largely within the private domain of practice, a practice (if it is a practice) that happens as part of the relationship between the patient and the nurse. As discussed in Chapter Seven, the private domain of practice is a substantial and unrecognised part of nursing work. It is unrecognised partly because it is kept secret, out of sight out of mind. It is also unrecognised Kuhse (1995) points out because that which is seen as being ‘women’s work’ has often been ignored throughout history, as opposed to men’s work which is understood to occur largely in the public domain. Care is integral to the history of the lives of women.
A gender aside

It is suggested by scholars of nursing that gender is a problem for nursing (e.g. Ceci, 2004; Cheek & Rudge, 1995; Doering, 1992; Garmanikow, 1978; Kane & Thomas, 2000; Porter, 1992; Sandelowskiki, 1997; Speedy, 2000; Witz, 1994). Thus Witz writes that “...the problem for nursing has been and continues to be the problem of gender” (1994, p. 23) and Porter comments that “[t]he most striking difference in the composition of medicine and nursing is gender” (1992, p. 511). The themes related to gender in nursing scholarship centre around beliefs that nursing is oppressed by medicine and that the work of nurses (i.e. caring), is devalued because it is gendered and reflects the division of labour in healthcare.

There is within feminist theory a vein of thought that is wary of the sex/gender distinction. Much contemporary Anglo/American feminist theory from the 1980’s onwards asserts that gender is a social phenomenon and shies away from ‘sex’ as a biological or essentialist concept (Grosz, 1994). Gender ‘studies’ are perceived of as being political studies. On the other hand Irigaray’s (1985a & 1985b) work argues for knowledge development that is related to sexual difference, because she suggests it is sexual difference that has resulted in women’s invisibility in language and discourse, and it is language that structures culture. When there is a focus only on the social and political as occurs with the notion of gender, women are further disenfranchised because they still lack representation within the symbolic and semiotics (Braidotti, 1994a). Without their own representation in the symbolic women cannot be subjects, they remain confined to immanence. A positive analysis of women, which Irigaray’s is (although as discussed in Chapter Two not all gender theorists would concur), takes into account both language and materiality.

Gender is a reality of the everyday working life and existence of registered nurses, as is sexual difference. I suggest both are important within any analysis of nursing. Nursing is coded as feminine and medicine as masculine, this has effects on nursing both symbolically and politically. Symbolically the ‘masculine’ perspective is always presented as being the ‘human’ perspective, thus relegating the ‘feminine’ to the position of other. I share Porter’s (1992) view that nursing is
a 'weaker occupation' thus it is hard for nurses to try and structure an equitable partnership with medicine. Nurses are not powerless but need to work strategically to use the power that they do have more effectively (Cheek & Porter, 1997; Doering, 1992). I am unsure if nurses want or need more power, but they do want greater recognition for what they do (Wicks, 1995 & 1999; Witz, 1994).

When nurses write that gender is the problem for nursing, they are continuing the process of denial of themselves as embodied beings-in-the-world, they remain invisible. Medicine does not have to be concerned about this problem, because the masculine body is considered as the norm, even as it is disembodied. Phallocentrism confirms the masculine body as the referent for the 'others', as the dynamic symbol of intelligibility and transcendence propelling him heavenwards, in the Name of the Father. Amen and may he rest in peace.

Technology of self-caring-for-others

I have been thinking about the ethical, and epistemological status of nursing, and whether I am able to imagine a difference being brought about in these domains of nursing. I maintain the status of nurses is debatable in both areas, however I propose that through thinking the unthinkable, speaking the unspeakable, imagining the unimaginable and looking for the "...blanks in discourse" (Irigaray, 1985b, p. 142), change could be effected.

Foucault (1988) describes 'technologies of the self' whereby individuals "...experience, understand, judge and conduct themselves" (Rose, 1996, p. 29). Taking care of one's self can be understood as an ethical practice. Coming to know one's self while at the same time improving one's self can be seen as an epistemological practice. Foucault notes that care of the self is "...also the knowledge of a certain number of rules of conduct or of principles which are at the same time truths and regulations. To care for self is to fit one's self out with these truths" (1998b, p. 5).

Papps maintains that "[n]urses... construct themselves through technologies of the self, by engaging in regimes of conduct, which produce particular regimes of truth. It is how nurses choose to create themselves that is important" (2001, p. 10).
In addition to ‘knowing one’s self’ and ‘taking care of one’s self’ I propose to extend Foucault’s technology of the self by proposing a ‘technology of self-caring-for others’. In line with Foucault, I would describe this as ethical practice, a technology of the self in that this is how nurses go about their daily work, and come to know themselves epistemologically as ‘nurse’. It is part of the ethics of the development of self in nursing, how nurses take care of themselves, and it is perhaps how nurses come to the ‘truths’ of themselves as nurses. The nursing subject is an ethical subject position that touches the core of being-for-others as part of a connected, healing relationship.

What does it mean for nurses to take care of themselves? It means a measure of coming to know who and what they are as nurses epistemologically and ontologically and being able to articulate this position. It is also important for nurses to come to terms with the personal and professional self (Doane, Pauly, Brown & McPherson, 2004). As Hacking (1986) notes we use ‘self-knowledge’ to accompany us through life. For nurses it is about understanding their roles and responsibilities and whom they are responsible for and to. It is crucial when faced with situations of caring for patients who are critically ill and or dying (Wakefield, 2000). It is about having an understanding of the socio-political structures within which they work. It is acknowledging they practise a feminine profession and recognising the validity of this. For nurses to take care of themselves in this manner could lead to a transforming of themselves and greater awareness of power and authority, both in their relationship with themselves and with others. The ability to transform the self is an example of power being ‘productive’, which Foucault frequently said. Foucault (1998b) considers that when one is properly able to take care of the self then one is better equipped to take care of others. Olsen brings to mind something similar as he writes about ‘empathetic maturity’, which he suggests is having a “…sense of caring for another person” (2001, p. 37).

Smart (1998) is critical of Foucault’s work about care of the self and queries that if an individual is able to spend so much time working on themselves that this might cause them to become selfish and lacking in concern, caring and responsibility for others. I am unsure if Foucault meant it to be like that, the idea that working on
the self was a lifelong project as it was for the wealthy Greeks and Romans of antiquity. I suspect he was more pragmatic, and there is little doubt that as he was coming to the end of his own life, the need for him to care for him-self became pressing (Veyne, 1997b).

Care for self implies relationships with others. Self-caring-for-others is nurses recognising the need patients have to be cared for in the broadest sense of the term. It is an ethical relationship within which nurses are aware of the need of the patient to be cared for and included in this is having respect for human dignity (Jacobs, 2001), which I suggest should be reciprocal. Frank flags a caution as he writes that “[c]are is too often conceptualized as the unilateral obligation of a moral subject, the caregiver, to a passive object, the ill person” (1998a, p. 313). It is a cautionary tale and one that often goes unheeded when nurses write unproblematically about ‘empowering patients’.

An aspect of self-caring-for-others is ‘presence’ or being ‘present’ with patients (Smith, 2001). Benner (1984) describes presence as one of the competencies to be demonstrated by nurses within the ‘helping role’. It requires care of the self because in order to be present wisely and care-fully the nurse has to know and understand herself (Arrigo & Cody, 2004). For a nurse to be present to another Doona, Haggerty and Chase express presence as “...a state in which the nurse is in the same place, near or in front of a patient, and in the same moment, holding out to the patient the gift of care” (1997, p. 6). Presence is thus the making of a human to human connection, where the nurse takes her ensouled and embodied self for a purposeful act of being-with the patient, looking for cues both verbal and non-verbal. It is part of the healing dance of practice that involves movement and symmetry, the sinuosity of a skill-full body.

The gift of care is perhaps a phenomenological essence of women, because as Cixous writes, “...she’s a giver” (1981, p. 259). She is generous and is “...capable of losing a part of herself without losing her integrity” (p. 259) her desire is based on generosity, as opposed to his possessive desire that wants to take and possess everything. The ‘gift’ is feminine desire and is based on generosity. It is also based on a genuine solicitude for the body being cared for, a love of that body and
a desire to see its wholeness respected and restored. The ‘gift’ is a useful analogy for nursing practice, based on the nurse trying to give of her-self and within this her body-work to her practice. She is a giver. However in nursing ‘giving’ should always be tempered with a modicum of caution, giving of one’s self as part of a duty of care is part of a moral discourse of nursing (Gilbert, 2001). Self-less altruism constructs the nurse as having to care, as being an object of caring, when it should be a choice. Merleau-Ponty clarifies this when he writes:

The central phenomenon, at the root of both my subjectivity and my transcendence towards others, consists in my being given to myself. I am given, that is, I find myself already situated and involved in a physical and social world-I am given to myself, which means that this situation is never hidden from me... (1962/2004, p. 419)

That I am given means I am a subject and I cannot be reduced to what I do. That I am given to myself means my body cannot be understood as an object of knowledge. The nurse’s embodied self in the art of self-caring-for-others remains hers, it is not something that is given lightly. It is however something which is given extraordinarily cheaply in terms of monetary recompense. However, that is another story, and this is not the space to address it.

Taylor comments that being human is characterised by having at its heart ‘dialogical’ characteristics, we all communicate with one another through the richness of language. It is through this expression he says that we come to define ourselves through the “... ‘languages’ of art, of gesture, of love” (1991, p. 33). These dialogues continue even when the people with whom we originally had them, move on from our lives.

We are embodied agents, living in dialogical conditions, inhabiting time in a specifically human way, that is, making sense of our lives as a story that connects the past from which we have come to our future projects. That means...that if we are properly to treat a human being, we have to respect this embodied, dialogical, temporal nature. (Taylor, 1991, p. 106)

An elegant and eloquent quote which serves to emphasise that communication is important within the embodied practice of nursing. Dialogue can be both verbal and non-verbal, it can involve a look, or sometimes a gesture. Relational narrative
is described by Gadow (1996 & 1999) in similar terms as those expressed by Taylor, a mutual making sense of an experience through construction of a story for a specific time and place. Self-caring-for-other and allowing and making space for the patient to take-care-of-themself. This is the mutuality that makes practice bearable.

Irigaray’s totems and nursing

It is clear that our societies assume that the mother should feed her child for free, before and after the birth, and that she should remain the nurse of man and of society. She is the totem before any totem is designated, identified, represented. This state of affairs must be understood if we are to learn how a woman, or women, can find a place without remaining shadowy nurses. (Irigaray, 1993c, p. 83)

This is an interesting passage that requires careful reflection. I think first of all that what Irigaray means by ‘totem’ is that women’s role is emblematic, because she is a woman society deems her role is thus. A totem protects nurtures and provides a meaning to live by, in that sense it can be sustaining. There are expectations of women that are related to their reproductive role. Women are the spiritual nourisher and protectors of society. It is clear to me Irigaray is not claiming this to be a negative, the problem for her is that women do not have any choice in the matter. They are disenfranchised and disempowered. She asks women to think about their role as nourisher and protector and challenges structures that have imposed this, particularly phallocentrism.

Irigaray contends that because women have no self of their own this leads to their being at war with other women, and in particular their daughter(s). Women are not permitted within the symbolic order to have a positive relationship, instead they are forced into a relationship of strife (Irigaray, 1993c). A woman is defined by her social roles as to whether she is married, to whom she is married and if she has any children. Within this structure women are forced into competition with one another. This is an example of how women are represented as ‘other’ within patriarchy, that conceptually strange and irrational system whereby women are relegated by the logos to a symbolic and material role defined for them, they are effaced.
Where are the systems of exchange among women Irigaray (1993c) asks? Women have for centuries been a commodity of exchange amongst men and within society and Irigaray asks where are the structures for women to have their own currency, their own gods/goddesses amongst women? For nurses these are important questions. Nurses care for others, they enfold them and provide them with sustenance, and this could be seen as an extrapolation of their reproductive role as mothers. Within the oedipal triangle of the structures of health, the doctor is father, the nurse mother and the patient is the child. Dalmiya and Alcoff (1993) ask whether ‘old wives’ tales’ are justified and argue that because these ‘tales’ are seen as unscientific they are relegated to the edges of epistemological respectability. However, we should not forget the totem-related role of wise women who carry many of the spiritual resources of society, especially to do with the health of the body and its healing. Fecundity can be both a blessing and a curse.

Irigaray however is very clear when she points out that “[w]e don’t have to give up being women to be mothers” (1993c, p. 18), and she is so right. Equally nurses do not have to give up being women to be nurses, they aren’t constituted by the role. There is though a tightly woven matrix whereby a large part of the physicality of nursing practice is related to how the body of the nurse is constituted by power relations, perhaps a sacrificial body. Nurses can unconsciously become sacrificial bodies, they put their bodies on the line (Deans, 2004) physically and emotionally. Nursing can be back-breaking and at times heart-breaking toil, nurses carry at times emotional burdens (Wiltshire & Parker, 1996; Young & Oliver, 1997) and it is important that nurses recognise this in order to carry out tolerant and compassionate care. Displaying support and compassion for one another is also important, if nurses are not able to do this it would follow they will have difficulty demonstrating compassion ‘honestly’ for the patients in their care (von Dietze & Orb, 2000).

Do nurses sacrifice them-selves to become that totemic emblem of obedience, servility, docility, speechlessness and thoughtlessness, perhaps at times they do. The image of the winged angel floating about in her demure frock, bearing the lamp which is a signified for nursing practice, a powerful totem. Totems in a
spiritual sense ward off evil. It is as well to remember that the wise women of history were feared for their mysterious wisdom and power, they were sometimes deemed as witches. Angels or witches, who would you rather have looking after you?

**Re-visioning with speculum**

Cody (2000) suggests theory provides a lens through which to view both practice and oneself. Irigaray would say that nurses have always been viewed through a particular speculum within masculinist discourse. Nurses have only been able to see themselves able to see themselves as a reflection, an apparition within the medical speculum that valorises the dominant discourse and suppresses others through structures of power and knowledge. A possible task for nurses is to get hold of the speculum and look inside it differently, with new eyes.

"The mirror freezes our becoming breath, our becoming space" (Irigaray, 1993c, p. 65). When Irigaray discusses the 'tain' of the mirror, she is writing about the components of the mirror, and she is critiquing Lacan's mirror stage. Lacan's mirror is flat, women, especially in relation to their sexuality can not be seen/represented in it. Thus what is needed is a different kind of mirror, a speculum, which can reflect angles and difference. Nurses can use speculum to explore her-self, the inside of the other. Nursing is caught in the 'gaze' of the medical eye/ I, seen in the flat plane of the mirror as the other of medicine with a disembodied knowledge eviscerated for the world to see, the skeletal reductionism of nursing knowledge. Isomorphism enables medicine to continue its domination of nursing. Only when nurses are able to situate themselves in their own space will they be able to claim the authority of their knowledge and recognise that much of their knowledge comes from their practice as embodied selves. Nurses could choose to insert the speculum of accountability into their practice to invoke a thoughtful sedition and move away from the all-consuming gaze of medicine.

Irigaray is encouraging women to use the concept of 'speculum' in a creative way to reconceptualise them-selves into a new way of becoming-woman, and seeing them-selves as other than the other, and other to what the mimetic structures of
patriarchy impose on them. There is symmetry in this conception for nursing. I am using Irigaray’s theory of speculum to re-vision the becoming-nurse so that what the self of the nurse becomes is what she wants it to be instead of what has been imposed on her. The specular body of the nurse has been created as an image that makes her unknowable to herself, unrecognisable.

Braidotti suggests that “...through the strategy of mimetic repossession of the feminine by feminist women, a political process is set up that aims at bringing the ‘other of the other’ into representation” (2002a, p. 24). Mimesis can be subversive. The feminine lacks positive representation in the symbolic order (Irigaray, 1985a). If women lay claim to their own imaginary they will be empowered to create a symbolic order, replete with their representations, instead of being cast as the shadowy other, which for nursing means the other of medicine. Irigaray moves away from hegemonic constructions of the subject in seeing each sex as being separate, rather than the ‘other’ being derived from the ‘one’. She articulates a symbolic which is not according to the Name of the Father and therefore phallocentric. Within a re-visioned structure nurses would be identified as subjects in their own right, they would learn to acknowledge the role of their traditions and icons, they would recognise themselves.

Summary

In this chapter I have explored how to conceive of a nurse and to achieve this I have discussed the embodied self of the nurse within her practice. It is my contention that the actual physical body of the nurse is invisible, and this is perhaps because it is perceived to be tacit. The body of the nurse is sometimes inferred but seldom discussed. In addition I have argued that the body of nursing practice is also invisible, partly because of how it is understood by nurses to be inarticulable. Much nursing practice is carried out within the private discourse between the nurse and the patient, silently and secretly and thus remains invisible to those on the outside. If nursing practice is invisible it can have the effect of helping to keep nursing knowledge invisible and obstruct the pathway to nursing knowledge being sanctioned as legitimate. Nursing knowledge is embedded in embodied practice. Sanctioned knowledge in healthcare remains grounded in
Empiricism. Empiricism is a powerful discourse both controlling knowledge development and importantly obstructing knowledge development that is not seen as fitting within reductionist principles.

Conceiving of a nurse does not mean that one is a born nurse, or that one is born to nurse. How do nurses define themselves? I am unsure as to whether nurses are able to clearly enunciate themselves. By ‘enunciate’, I am using Irigaray’s meaning where she is referring to the position of the person who is the speaking subject in discourse (Whitford, 1991b). I am drawn to Irigaray’s (1985b) re-reading of Through the Looking Glass, where Alice shatters the mirror, to get through to the other side. She does this in order to escape other’s representations of her-self, to the point where she no longer knows who she is, and learns to recognise herself. It is perhaps timely for nurses to shatter the reflection in the speculum and create the possibilities for their own practice. Marshall states that “[i]t is precisely because it is so difficult to name our bodies and what they do that corporeal feminist theory needs to pay more attention to naïve accounts of experiences” (1999, p. 73). Naïve for my purposes meaning registered nurses who are intelligent and skill-full practitioners but lacking experience in writing about themselves and their embodied work, as opposed to lacking wisdom. Most nurses in my experience are wise.

Nursing is a vessel for the specular lens of medicine, which can have the effect of reducing nursing to a series of ordered tasks. How to conceive of a nurse is a challenge for nurses, if as Irigaray (1993a) suggests, conception remains the premise of the active male who designates perception, which is passive, to women. Conception is a double-edged sword, because it also refers to reproduction, and Irigaray’s claims that for man, woman is the receptacle for the phallus and also the ‘envelope for man until he is born. Inherent to this might be an expectation that she deserves equitable treatment but instead she “...finds herself encircled by a language, by places that she cannot conceive of, and from which she cannot escape” (Irigaray, 1993a, p. 94). She is locked into his conceptions of how she will be. He is trapped as well in his conceptions of how he wants her to be, forever drawn back to the specular matrix in order to try to both
find and lose himself. He wants to be her but the nearest he is able to get is to control her within his own conception.

The conception of medicine is clear and has a primary emphasis on the body and an understanding of its mechanics. The conception of nursing is I believe less overt. Good and DelVecchio Good comment that medicine is a “... very peculiar healing system” (1993, p. 85), with the body as the object of medical knowledge and the focus of the medical gaze. Nursing knowledge has an emphasis on the individual patient as being part of a wider socio-political context. The clinical gaze of the nurse is subjectively different to that of medicine, it could be said to be less scopic with a focus on healing.

There is a contrast in foci between the professions from the beginning of their respective education. “Science is the point of entry into medicine... medical education begins by entry into the body” (Good & DelVecchio Good, 1993, pp. 90-91). Nurses learn a substantial amount of science during their undergraduate education, but it is part of the whole, as opposed to the whole point. I share Dzurec’s (2003) view that the separation of the professions in education, research and practice can be divisive. There is limited opportunity for practitioners to discuss or question healthcare assumptions and to come to an understanding and respect of each other’s epistemological differences. This has the effect of causing practitioners to act in accordance with the dominant paradigm and its empiricist norms. It also has the effect of reinforcing binaries such as care/cure. If the two professions were to work together complementarily, this could have the effect of their being able to sit between the binaries, in territory which is seen to be uncontested.

Nurses are seen by doctors to be carrying out the care that is prescribed by the medical practitioner, they are often practising under direction (Chiarella, 2000). Except that is a myth. In my experience, that is not what always occurs. Nurses often do what they believe is the right thing to do, what their practice knowledge and experience leads them to do, because this is the stuff of nursing. Nurses do the dirty work no one else wants to do, or refuses to do. As Lawler notes nursing is an “…inherently untidy discipline” (1997, p. 47) and nurses work involves a wide
variety of demands. A significant part of the role of nurses is ‘totemic’, and is systemic throughout primary, secondary and tertiary care settings where nurses do the bulk of the physical work, they are the ones who are there, twenty four hours a day, seven days a week. The totemic role can also be seen as a spiritual role. It could be said that nurses are sacrificed or allow their selves to be sacrificed because of their totemic role.

My conception of a nurse is of an individual who through the technology of the self knows herself in order to enable her to care for herself and others in a knowledgeable, regardful way, through the gift of presence. This I have described as a technology of self-caring-for-others. She recognises her practice as being embodied and that her body has both surfaces and depths, the perceiving body of phenomenology, necessary for being-in-the-world.

Within the next chapter I will explore possibilities for nurses to move towards what I describe as thoughtful practice. This will involve a drawing together of themes relating to language and embodiment that I have addressed from Chapter Three onwards.
Chapter Nine

Towards Thoughtful Nursing Practice

...certain fields of experience are not susceptible to demonstrative reason or scientific method, and require instead another type of understanding that can only be described as mythical. (Vattimo, 1992, p. 37)

Introduction

Nurses put their bodies on the line (Deans, 2004; Hinsby & Baker, 2004). Nursing is back breaking work in more ways than one (Shakespeare, 2003). Frequently nursing practice is hard heavy slog when working in secondary and tertiary care settings. In other areas such as mental health, community health and emergency departments nurse are increasingly susceptible to verbal and physical assault, it seems to be a sign of the times. Nurses put their bodies on the line because theirs are working bodies. It is an integral part of their practice, in the ongoing dance of care, that they develop an intuit of how to keep themselves safe, this comes about as a matter of experience and is not something they learn in class. Nurses develop a sense of knowing by looking, feeling, smelling when things are going or going to go pear-shaped. This is embodied thoughtful knowledge, it is nurse-sense, and can only come about by being engaged in their work and listening to their bodies and the bodies of those around them. Bodies change when individuals become anxious, agitated, angry, dying. After some years an expert nursing practitioner by assessing what is happening now and comparing it to her memory banks of experiences, her embodied knowledge, will intuit that ‘something is not right’, and hopefully she will act on this knowledge.

Many facets of nursing practice are a challenge to explain and do not respond to reductionism. Some nursing practice for nurses, clients and colleagues has approached mythical status. The familiar image of Florence Nightingale haunts
nursing practice, however Nightingale is not nursing today (Buchanan, 1999). An aim within my thesis has been to use the metaphor of ‘speculum’ creatively to explore nursing myths, and rather than demythologise them to incorporate them within the genealogies I have been describing. Myths serve a purpose, they are culturally inscribed within language and custom and as such are inherently part of nursing practice and knowledge. Myths within nursing are linked to the stories nurses tell and how nurses go about doing what they do. Myths are as well part of a feminine understanding of psychoanalysis (Vattimo, 1992), they are evident in the work of Irigaray. The unconscious self has its reasons for being as it is. The use of the self within nursing practice should be seen as a portal as opposed to the self being seen as the source of practice. This is I believe congruent with a poststructuralist and phenomenological reading of nursing. Within this chapter I will explore several themes which may help to illuminate how nurses may have and hold thoughtful embodied practice.

Autonomy in nursing practice

Part of my interest in the development of self in nurses, stems from the fact that for much of my adult working life I have been exposed to neo-liberal political ideology. This ideology emphasises individualism, and in nursing has come to mean usage of terms such as autonomy, accountability, and reflection on practice (Rose, 1996). These are individual pursuits, closely linked to the cult like status of working on oneself, the personal here is very political. In addition there is the latest professional ‘tool’ of individuals having professional supervision of their practice, not far removed from Foucault's (1999a) notion of the ritual of the confessional. Individuals are encouraged to confess their sins, weaknesses and have penance in the form of ‘knowing’ they are doing something positive for themselves, and especially for the organisation that employs them (Gilbert, 2001). Supervision is purported to empower practitioners in that they come to know themselves and through this become autonomous practitioners. The autonomous practitioner is more useful to the organisation that employs them as they are self-managing and have effectively been moulded into a ‘docile’ body (Gilbert, 2001). The idea of self-surveillance may seem far-fetched but nurses are becoming
accomplished at this, they scarcely need their governing bodies to do it for them anymore, an interesting turn in the spiral of power-knowledge.

I am not sure whether this is food for concern or thought. Clinical supervision is couched in terms of professional practice, and also about nurses holding autonomy as practitioners. The derivation of the word autonomy is interesting. ‘Autos’ comes from Greek for self and ‘nomos’ is Greek for law. There is a perception that autonomy is about individuals being independent and accountable. I am beginning to see autonomy more as a process of self-governance, self-surveillance, and the gaze at one’s reflection in the mirror, a certain desired ethos of practice. What I ask is, is autonomy a figment of the collective imagination or an attribute nurses have been led to believe they must have.

Walby et al state that “Nursing does not have the autonomy that is associated with the traditional form of a profession” (1994, p. 155) and this is partly because while nurses are responsible for their individual practice they do not bear overall responsibility for the patients with whom they work. Walby et al also believe that although registered nurses as a group are highly skilled, they are rule bound within their practice which contributes to a degree of regimentation. Nursing claims to control the terrain of ‘care’, this has been a strategy for nursing to differentiate nursing practice from that of medicine, to legitimate nursing practice as a separate and authoritative body of knowledge. This has been partially successful but presents nursing with dilemmas. Surely if one is ‘caring’, one is also treating or healing, I have always had some difficulty in regarding the two domains as separate. If in the process of caring, nurses are not treating, then what is it that they believe they are doing?

Irigaray reminds me that I come from a genealogy of women that is unique and women need to hold onto this, it bears significance for nursing as well:

Let us try to situate ourselves within that female genealogy so that we can win and hold on to our identity. Let us not forget, moreover, that we already have a history, that certain women, despite all the cultural obstacles, have made their mark upon history and all too often have been forgotten by us. (Irigaray, 1993c, p. 19)
The genealogy of nursing is primarily women. As a registered nurse I emerge from a long line of practitioners who trace their nursing genealogy back to the ‘wise women’, and more contemporarily to Florence Nightingale who is the ‘mother’ of modern nursing as it is known today. Nurses have a history, it has an impact, and history re-creates nurses in the image of what went before. Sacrifice is assumed like a sacred mantle in a profession where the protagonists are said to be non-subjects, but it is a mantle with thorns. Martin holds the view that for women, accountability would be preferable to sacrifice. Martin asks whether “...rituals of sacrifice silence the speaking that is required in communities of accountable relations? Sacrificial rituals of expulsion allow for punitive systems of extradition” (1997, p. 70). Registered Nurses are held to be accountable for their practice by the Nursing Council of New Zealand, but it is a peculiar kind of accountability. It is alienated accountability in which nurses’ practice on their own terms is not affirmed but judged according to its adequacy in relation to someone else’s conception of what it is about. It is perhaps not really accountability but about being an inquisitve where the terms of the inquisition are dictated by a normative set of ruling powers in the domain of the Name of the Father. Some of the normative powers are couched within terms such as risk management. Risk management causes the practice of many health professionals to become increasingly rule bound and inflexible, removing autonomy, individuality and the capacity to practice intuitively (Lupton, 1999). Instead there is evidence-based practice which disembodies health professionals and removes choice from patients. This is an example of health professionals being subjected to Foucault's (1988a) technology of power and domination. As Patton notes “...states of domination will always constitute limits to the autonomy of those subject to them” (1998, p. 73). As long as nurses have the capacity, the will to act, domination always has the potential to be resisted, this is what constitutes human freedom.

When nurses write about being autonomous practitioners or nursing as an autonomous profession perhaps what they are addressing tangentially are the characteristics of professionalism (Traynor, 1999) which Turkoski (1995) and Walker (1995a) claim is defined by male occupations and is a masculine construct. It is the self-same subject man, the active autonomous agent that has
created history, which women being passive objects were denied access to. Code argues that the concept of autonomy assumes humans are "...self-sufficient, independent, and self-reliant" (1991, p. 77), which ignores the fact that humans depend on one another to create their world and have to work co-operatively to succeed. Autonomy as it is posited alienates humans from one another and reinforces notions of unified atomistic man forging his way through the world, on his own recognisance, an 'iconic figure' (Code, 2000), an Enlightenment-liberal masculine myth. Autonomy is not morally, politically or sexually neutral, yet the term itself is used casually as if it is. The rhetorical ideals of autonomy pervade the discourse of professionalism. Code considers that this holds us to a "...regulative autonomy ideal that, paradoxically, underpins patterns of oppression and subjection" (2000, p. 181).

I have difficulty envisioning nurses as being fully autonomous practitioners when they are not legally sanctioned to make treatment decisions. In addition to this, doctors do not have to abide by or agree with the clinical decisions registered nurses make. Nurses' knowledge is not considered to be authoritative, it is subject to mediation and corroboration by medicine (Code, 1991). Autonomy as it stands now is not intended for everyone. Rather, some individuals are less 'perfectly' autonomous than others and are positioned as 'other' (Code, 2000). So what is it that nurses are looking for when they write about autonomy? They are expressing their skill and knowledge and that they are able to take part in decision making in healthcare alongside their medical colleagues (Chiarella, 2000). Nurses do not want to be doctors, the professions are different. However, their knowledges are complementary to one another and should be able to be synthesised in a style of decision making where the patient benefits and all parties, not just the doctors, get credit for this. Acknowledgement of input, knowledge and expertise. Not much to ask for one might naively think, however, it is never that simple. As Code (1991) points out, in healthcare doctors have the status of credible, authoritative knowers and this status remains denied to nurses.

Medicine takes up nursing space, has symbolically denied nurses space and time. Irigaray writes of women:
...we have to construct a space for ourselves in the air for the rest of our time on earth-air in which we can breathe and sing freely, in which we can perform and move at will...to construct our airy space is essential. It is the space of bodily autonomy, of free breath, free speech and song, of performing on the stage of life (1993c, p. 66).

One way for nurses to carve a path through their spatial poverty is by recognising the materiality and autonomy of their bodies in their relationships with patients and medical staff. Having an effective relationship with a patient offers nurses much more than an opportunity to use their knowledge and skills. As May notes “[i]t also sets out a semantic space in which the meaning of nursing work can be located, and in which ideological notions of what nurses do can be fully enacted” (1992a, p. 482). This is perhaps a much more ‘airy space’ for nurses than the illusion of autonomy.

Historically, control of space has run alongside control of knowledge and it is only a couple of decades ago that nursing knowledge was, if not controlled, then certainly heavily influenced and prescribed by medicine. I have clear memories of sitting in class being lectured by different medical practitioners on how they expected their patients to be cared for after specific surgeries. Sometimes different surgeons required different care for the same surgical procedures. This remains characteristic of medical practice of establishing and asserting ownership of the ‘body’ of the patient, and also indirectly controlling the body of the nurse as she is directed how to care, because she is perceived as an ‘unreliable knower’ (Code, 2000). Medicine certainly shaped how care was delivered and in essence controlled the ward spaces and time by constraining how nurses were to practise. The doctor knows best. This from my observations has changed a little, in public hospitals at least. However the physical geography of nursing space continues to have an impact on their perceived status (Dendas, 2004). Space is generally allocated for doctors and nurses tend to get the leftovers. Nurses need suitable environmental space to conduct their daily work. There is little negotiation about who gets to use space and within this nursing is expected to defer to the higher authority and quite possibly the higher value accorded to the labour of medicine. Parker (1997) asserts that nursing space continues to be colonised by science and technology as well as competing temporal demands of patients, doctors and an
economically driven model of health that places endless demands on how nurse’s work is to be accomplished. As well, the construct of nurses that some doctors continue to hold limits nurses’ practice and shapes how they are to act, spatially and temporally. For many nurses their conduct remains disciplined because of long established hierarchies of power. Nurses inhabit uneasy space in the 21st Century.

Wicks (1995) offers a different perspective on nursing autonomy by examining three areas of nursing practice; pain relief, wound healing and care of the dying patient. She explores how in these areas of practice nurses practise a particular discourse of healing and that it is autonomous. Wicks notes that the nurses in these clinical areas have negotiated this space to extend their practice. The key word for me is ‘negotiated’. The nurses have often negotiated the extension of their practice with their medical colleagues, and sometimes put it to them as a fait accompli. This is significant and is important for the future of nursing. No person is an island. Patients deserve the best possible care, which should be negotiated amongst health professionals. Negotiated care happens in many clinical areas but Wicks (1995) notes it is often marginalised, unacknowledged by doctors and to an extent ‘secret’ amongst the nurses.

Nurses’ relationships with their medical colleagues are not, never have been and never will be straightforward. However, if nursing is to move forwards, her relationship with medicine will have to alter, and nursing is going to have to initiate the changes, because as it stands, nursing has the most to lose. Solidarity is necessary for nurses as a ‘body’ to bring about change. Having a sense of solidarity may enable nurses to get a sense of themselves as being enmeshed within a body politics, as having in a sense been forged within sociopolitical structures of power. Maintenance of integrity may be more appropriate than current conceptions of autonomy. Integrity includes community and commitment (Code, 2000) and the importance of social relationships and experience (Merleau-Ponty, 1962/2004) as opposed to the perverted from of autonomy which continues the subjection of nurses and limits their capacity to act. A collective integrity would emphasise all parties working together, depending on each other, for the collective good of the patient.
None of this is easy. When I think about ‘problems’ and ‘dilemmas’ in nursing and possible solutions to them, and then start unravelling the myriad of problems in the solutions, it gets confusing, hard to find a path out of the labyrinth. I go back to a passage Foucault wrote and which I find reassuring:

My point is not that everything is bad, but that everything is dangerous, which is not exactly the same as bad. If everything is dangerous then we always have something to do. (1983b, pp. 231-232)

In other words, take nothing for granted. Be deeply suspicious of that which appears straightforward and common-sense, it often masks a different reality.

*Female, feminine, feminist nursing practice*

Part of the quest of this thesis has been about nurses’ search for identity and an exploration of what grounds their identity and sense of being-in-the-world. The creation of identity and the self for nurses takes place as part of an ongoing dialogue and struggle with structures that have sought to position nurses as ‘other’ and ‘less’. The self of the nurse dwells in the materiality of the body, matter that is gifted with memory, coded by unconscious processes and brought in to the light via language (Braidotti, 1994a). The construction of self and identity for nurses is a challenge I suspect, in part, because of the particular knowledge paradigms nurses have aligned themselves with in order to have their knowledge and practice legitimated. Allen writes of nursing, “[t]he practice world understands itself within a pervasive foundational metaphysic. The adherence to foundationalism is intimately tied to our relationship with science because the appeal to science legitimizes our professional power” (1995, p. 174).

Science, nurses have been led to believe, is what counts for being acknowledged, being listened to, and nursing has been searching for an ‘ideal listener’ (Kaplan, 1996), for some time. This has not however been successful. Nurses in a sense remain alienated from their practice, believing rightly or wrongly that they and their work are not valued (Jackson, 2000) or listened to. Mulligan argues that nurses want “…recognition for caring and nurturing equal to that given for curing
and repairing” (1992, p. 173). Perhaps the ideal listener will not appear on the horizon until nurses get conversations going amongst themselves across a range of contexts, keep the conversations going, keep nourishing them, and be supportive of each other even if they are not always in agreement. Disagreement can be productive, it does not have to be divisive. However, speaking with a common voice, may help nurses to affirm their identity, and initially it is probably important to do this amongst themselves.

Cixous’ (1981) *Laugh of the Medusa* is about women’s conversations as is Luce Irigaray’s (1985b) *This Sex Which Is Not One*. They celebrate and affirm women’s voice, whether in text or conversation and encourage women to be heard. The myth of Medusa is well known, she was a Gorgon, a woman with a sinuous mass of snakes for hair and the ability to look at men and turn them to stone, which she did until beheaded by the frightened Perseus. Men were mimetically drawn to her, both fascinated by her beauty and terrified of the consequences of this fascination. Stop listening to what men said about her says Cixous, they were terrified of her, look at her, “...she’s beautiful and she’s laughing” (1981, p. 255). Irigaray and Cixous encourage women to find/reclaim the female voice, “…the equivoice that affects you, fills your breast with an urge to come to language and launches your force; the rhythm that laughs you” (Cixous, 1981, p. 254). I encourage nurses who choose to, to claim their female, feminine, feminist voices and to have some fun doing so. Having fun in the form of humour encourages a sense of rebellion similar to that required by writing, humour can assist us to express ourselves gleefully. For nurses to claim their own voice could mean that they learn to speak their own language, which may help make their practice articulate, and visible. I have become increasingly aware of the importance for me to reflect on how I am spoken through by language. Through having their own voice nurses could as well learn to communicate with greater clarity and collegiality so that others are more aware of what it is that they are saying.

Braidotti describes a female feminist as “…someone who longs for, tends toward, is driven to feminism” (1994a, p. 167). She likens it not simply to political beliefs but as being motivated and enriched by ‘desires’. These desires according to
Braidotti invigorate women to search for “...freedom, lightness, justice and self-accomplishment” (p. 167). Lightness Braidotti believes is important, alongside humour. It is easy to get bogged down by doctrine, for example some feminisms and postmodernisms. Laughter raises the spirits and is food for the soul, the often earthy humour of nurses comes to mind here. Plus, laughter can be deliciously and wickedly subversive.

How does the feminine as the ‘dark side’ of Western theoretical discourse relate to the speech, the intelligence and the discurvity of real-life women? (Braidotti, 1991, p. 106)

The ‘dark side’ is about women’s relationship to light which has since the time of Plato been linked to sight and visibility (Vasseleu, 1998). Visible light, natural light, is linked with perception and invisible light, with thought and ideas. Women we can quickly deduce are associated with ‘natural light’. In Cartesian thinking “[t]he light we see is not what interests the mind of reason. Our eyes are merely instruments of a mind which ‘sees’ a light which commands our vision from without” (Vasseleu, 1998, p.43). Sensory qualities of light are not wanted, because they obfuscate judgement, visibility is restricted to “...black and white” (Foucault, 1970, p. 133). I am beginning to see the light and it is akin to having re-glazed some windows. Merleau-Ponty rehabilitates this perspective about light by insisting that the two forms of light are woven in and on each other and are grounded in corporeality. The texture of light, its phenomenological tactility is important for how we experience spatial and temporal relationships. When Braidotti writes about women inhabiting the dark side she means that women have been rendered invisible, not transcendental but absent, left standing on the outside not able to obtain an objective view of themselves and their being. If women do not know themselves as an object, it makes it impossible for them to know themselves as a subject (Vasseleu, 1998). I have an image of nurses in here, pushing against the texture of darkness and coming into a light of their own.

When I think about writing as a woman, writing in the feminine as a feminist I have in mind Irigaray’s project of which Vasseleu writes:

While Irigaray is negotiating a place for the feminine within the representation of sexual difference, she is not trying to negotiate
that place by resorting to the inverse of a masculine paradigm and embracing the absence of light, invisibility, and a distaste for looking as essentially feminine. (1998, p. 16)

In writing about nursing I have tried not to write about that which is opposite to the dominant masculine discourses. I would like for nurses to be in the ‘light’ to be ill-lumen-ated and to be visible. I do not want the identity of nurses as women, as feminine, to be tropes for hidden meanings, as caring has become.

Braidotti asks, “...what is the theoretical significance of women’s political struggles in terms of the development of our thinking in the feminine?” (1991, p. 11). Drawing a map of feminist ideas as opposed to a definitive lexicon, Braidotti is writing about feminist thought and the importance of same. She notes that women’s thought for so long was denigrated and dismissed as irrelevant thus leaving a substantial gap in the quantity of “…feminine theoretical and intellectual genealogy” (Braidotti, 1991, p. 147). This gap can be applied to nursing, and it is not a negative, it is simply the way that it has been, for decades. The gap opened up a conduit for medicine to colonise the thinking, the practice the body and the ‘voice’ of nursing.

Nursing has been rendered invisible, cloistered under the guise of protection, the paternal metaphor of psychoanalytic theory, the Name of the Father. Made invisible to the point where many nurses believe the rhetoric of what is said and written about them (Colliere, 1986; Mulligan, 1992; Sandelowski, 1997). Medicine attempts to control the body of nursing by claiming themselves as being the master discourse. Irigaray would possibly comment that medicine is terrified of the corporeality of nursing practice. In attempting to control, medicine tries to eviscerate nurses’ practice by claiming their knowledge is limited (Littlewood, 2002). Of course, nurses are reassured that their contribution as ‘hand maiden’ is important in the overall schema, just not too important.

The ‘good’ of the patient must retain primacy at all times, however nurses must retain primacy over their practice, their knowledge and themselves. It is important that both professions have a clear understanding of what the other does, and in order to do this they may benefit from communicating with each other more effectively, as discussed in Chapter 6, instead of appearing at times to talk past
each other. Co-operative conversations between the two groups about whom is responsible for what would be useful and may help to engender the professions acknowledging their practices as complementary to one another. Enhancement of nurses’ roles should be negotiated in partnership between the professions, instead of their roles being extended when medicine deems it necessary (Witz, 1994). At times the ‘good’ of the patient is forgotten in the battle for territorial protection. As Paterson and Phelan note “…doctors are quick to hold off nurses who aspire to do more, and are well equipped to do so” (2003, p. 55).

Nurses’ ‘voices’ appear in a variety of texts such as the largely private discourse of nursing practice and the stories that are told in the verbal end of shift handover. Wiltshire and Parker (1996) consider that the verbal handover is an important tool for nurses to release the burden of what they feel is abject about their work with patients, that which they are not able to discuss with others. The halting attempts by students to explain what their practice means to them and their early recognition that aside from their nursing peers few others appear to understand what they are talking about are further examples of nurses’ stories of the abjection of their practice. I have had it said to me, ‘I do not know how you could do a job like that’, many people have little idea of what ‘a job like that’ entails. Except that it seems private, personal and often about ‘things’ which are not discussed in polite conversation, those ‘things’ that are often to do with patients’ bodily boundaries that have been transgressed by illness. For example patients for whom mobility is impaired, who can’t sleep, who are suicidal, who are in pain, whose breathing is compromised, when ingestion of nourishment/liquids and excretion of waste is a problem, those who are suffering. The things that mean patients need nurses to work with them in a healing relationship. The ‘things’ of nursing are akin to the ‘things’ of women’s lives, women’s business, “ …taken for granted…storied…grounded in experiential knowing…silenced” (Lawler, 1997, p. 49). Nurses’ business, not quite good enough, not quite scientific enough, not quite knowledgeable enough, not quite this, not quite that. Just not quite right. Nurses could make a conscious choice to write their feminine practice and cut through the discursive devices that hold them bound to scientific discourses. In collaborating in story telling and being thoughtful interlocutors with one another nurses can be subversive and create something of their own, from their bodies.
‘Ecriture feminine’ is a form of writing about embodied female subjectivity that is clearly demonstrated in the work of Cixous and Irigaray. They seek to affirm female subjectivity by engaging in polemic with psychoanalytic theory that has positioned women as lacking and being other. In making a case for ecriture feminine Braidotti is careful to remind that it is not a biological body to which she is referring, rather it is the body as “...a cultural artifact that carries a whole history, a memory of coding and conditioning” (1991, p. 243). There is meaning here for both the text and the unconscious of nursing and nurses, and it is about language. Texts are language, bodies are text; language is inscribed by culture and to creatively explore the possibilities it is important to retrieve the repressed female body from where it has been exiled.

As Irigaray writes “[s]he is constituted from outside in relation to a social function, instead of to a female identity and autonomy” (1993c, p. 72). It is important for women to be seen as separate from their biological functions and societal roles, otherwise they will continue to have difficulty ‘becoming’ themselves both as individuals and members of the community. Nurses are defined in relation to the functions they perform. The traditional way of ‘looking’ at nursing through the speculum undermines nursing and sends back distorted images which are not of nurses’ making, they are exteriorised and flattened. Nurses may benefit from looking at themselves in a mirror of their own creation, to contemplate themselves as individuals and “...repossess [their] gestures and garments” (Irigaray, 1993c, p. 65).

How nurses think and how nurses have been disallowed from thinking has been a protracted act of political domination, torn asunder by forces from within the profession as well as forces from without. Feminisms have had little impact on nursing practice (Webb, 2002) and education (Anderson, 2000) for amorphous reasons. Despite the fact that these knowledges would be invaluable for nurses to analyse their practice within the confines of patriarchal institutions (Chinn & Wheeler, 1985; Doran & Cameron, 1998; Glass & Davis, 1998; Gray, 1995; Hezekiah, 1993) and the socio-political forces that are at work within a gendered profession (Ceci, 2004). Feminisms as politics and philosophy are sometimes misunderstood and misrepresented within nursing, or simply ignored. I have had it
said to me that nursing students should not learn about feminisms because some students are male. Speedy comments that perhaps nurses “...do not believe that the feminisms offer anything better than they currently have” (1997, p. 217). A scan of textbooks used in undergraduate education demonstrates that feminist scholarship has a minimum of influence on nursing education (Emden, 1995; Kane & Thomas, 2000; Mulligan, 1992).

Nursing education in New Zealand has had a brief exposure within polytechnics and universities, and has been careful not to rock the boat. There have, to nursing’s discredit, been rifts between education and service. Service want a certain ‘type’ of end product and that is not necessarily a graduate with the ability to think critically, philosophically and politically. Of greater importance to service is the graduate as a source of competent labour, a technically skilled commodity to fuel the furnace of the work force. Off the new graduate goes to be consumed by the grinding of the machinery of health, and at times, shamefully, by their nursing colleagues.

Chanter makes a valid point when she notes that:

It has become difficult, ... to invoke the female body, sexual difference, or women’s experiences without alerting suspicions that one harbours essentialist tendencies. It is almost as if women’s sexual specificity is an unfortunate fact that feminism has done its best to forget since the discovery of gender. (1995, p. 26)

The ‘discovery’ of gender, primarily by Anglo-American feminist theorists has been of great value in advancing the political cause of women, particularly in the arena of equal rights (Chanter, 1995). The writing of theory of sexual difference is more established within the circles of continental philosophy, especially the work of Irigaray, Kristeva and Cixous, and more recently Braidotti. Sometimes there has been a modicum of inflexibility amongst the two groups. In the 1980’s concerns were expressed about the work of Irigaray, Cixous and Kristeva as being a return to essentialism, and the risks to women associated with this positioning (Young, 1985).
As previously discussed in Chapters Four and Seven, I believe that for the purposes of my work, writing about nursing as a profession that is sexed as feminine, as different to being ‘gendered’ is more constructive for my purposes. I acknowledge that nursing is a gendered profession, and by this I mean that nurses work within patriarchal healthcare structures. However, nursing is also a female, feminine profession, undertaken primarily by women (Cheek & Rudge, 1995; Miller, 1991; Parker & McFarlane, 1991; Yaros, 1991), sometimes seen as being too female for some feminists, and largely ignored by feminist scholars (Buchanan, 1997; Mulligan, 1992), or denigrated by them. Buchanan points out that some feminists have used imagery/mythology about nurses to make the assumption that this is what ‘real’ nurses are like. That within mythology there is a kind of inherent ‘nurse-ness’ and whatever it is, it’s not very good, not very feminist. Nursing is not a valued occupation for a woman because nurses are somehow seen to be complicit with patriarchy in obstructing the advances of feminism (Buchanan, 1997).

There has been a long history of what Sandelowski (1997) notes as the ‘mutual disdain’ that nurses and feminists have had for one another. The feminine qualities that nursing is said to embody are also qualities associated with women in the domestic sphere of the home (Lupton, 1994). Nursing as a ‘feminine’ profession is devalued and perceived as inferior by both feminists and some nurses themselves (Colliere, 1986; Sandelowski, 1997). Nurses, notes Code (1991) are not perceived as credible, authoritative knowers. To be a credible knower means being able to reflect traits of being “...dispassionate, neutral, objective...calm, cool, collected” (Ceci, 2004, p. 79). These are not traits coded as being feminine. They are aligned with masculinity. The construction of masculinity Falk Rafael (1996) contends prepares men to ‘dominate’, while femininity prepares women to be ‘dominated’. This in turn makes power the realm of men and caring the realm of women, a negative construct that devalues the potentiality of both sexes. Falk Rafael asserts that it “...stifle[s] the potential of half the human race” (1996, p. 5). It is my contention that it stifles the potential of men as well as women. When nurses are perceived as being ‘emotional’ and that is placed alongside essentialism it can be read as meaning that nurses do not have to be taken seriously. I take issue with this and believe it is important to
correct such a faulty notion. If the ‘man of science’ is as objective as he claims, how can he allow such emotive nonsense to cloud his disembodied thinking.

History, notes Oakley, has “...defined a good nurse as a good woman, and this can be counted as both the weakness and strength of nursing as a profession” (1986, p. 183). Nursing is perceived of as being women’s work and something that is ‘natural’ to their natures. Nursing has experienced having its knowledge marginalized to the borders of care, functioning quietly and efficiently within the private domains of care (Wicks, 1995). If one accepts Irigaray’s (1985a) premise that woman is not a subject, equally it could be postulated that nurses are not able to see themselves as knowing subjects who are able to direct the course of their practice (Chanter, 1995). I would like for nursing work to be re-visioned as being an engaged, thoughtful and positive use of the attributes which are derided as being women’s work; re-visioning the feminine in nursing through an Irigarayan influenced speculum, and introducing new textures, a different tactility, a degree of radicality. I believe that what is important is that the re-visioning is done through the speculum of a woman, not as other, but as one, instead of a mimetic representation within patriarchy which women have historically had little control over.

Nurses, I believe, make a conscious choice to use their embodied selves in their practice, because it is one of the crucial elements that makes a difference to their practice. Yes, nurses have learned these attributes via socialisation, but they are important and valuable in an increasingly disconnected society. Human to human relationships are necessary, humans need other humans to touch them, to relate to them in order to survive, in order to be alive. The feminine role is a positive one. Being nurturing, supportive, compassionate, empathetic, emotionally connected are valuable and valued by patients. They are part of the reason why patients enjoy nurses. Even as nurses ‘become’ more knowing subjects, recognising and embracing the embodiedness of their practice, it will still be a challenge for them to write their feminine practice within a language from which they are excluded (Chanter, 1995; Yaros, 1991). The social realities of nursing are real, there is real work to be done by nurses.
Articulating difference/s

Parker (1995), writing about the work of nursing theorist Patricia Benner, notes that:

Benner’s work epitomises the feminist aim of rediscovering and revaluing the experiences of women. She has opened up a world of embodied practices, of expertise embodied in these practices and wisdom contained in the narratives of ethical practice. She posits a corporealised relational self and describes engaged care as a moral source of wisdom. (1995, p. 342)

While having respect for the work of Benner, I am less convinced that she has ‘opened up a world of embodied practices’. She has opened the door a fraction and discussed embodied practice, but writes little about the physical self of the nurse in taking herself to her practice, and her work bears minimal tracings of feminist theories or postmodernism for analyses of power relations. According to Thompson (2000) Benner’s work is conservative. In addition I consider that what she achieves with her lists of competencies for nurses is a recipe for creation of the ideal Benner-eyed nurse. I fail to see that her work helps nurses to articulate points of difference in their practice from medicine.

For me a significant issue confronting nursing is that of articulating a point or points of difference from medicine, nurses dancing as they do in that liminal space between patient and doctor. Gender is not the only problem confronting nurses. If nurses continue to write this, they will remain enslaved by it both in language and practice. Nurses’ history of using language is part of their genealogy. The language nurses use to think about themselves comes out of their history, but there are no specific indicators to say when the language appears. As Allen, Allman, and Powers (1991) point out, language can enslave as well as liberate. It would be preferable to be able to look back upon the nurses as an embodied subject who is “...the eloquent relic of an existence” (Merleau-Ponty, 1962/2004, p. 406), rather than the subject who is positioned as the speechless other within the symbolic structures of the Name-of-the-Father. To be an ‘eloquent relic’ means that bodies are not machines attached to the conscious self, but instead are the vehicle for being-in-the-world, the key to expression of thoughts, feelings and intentionality. Wiltshire and Parker capture the essence of this perfectly when they...
comment that "to nurse… is… to supplement the body of one by the body of the other" (1996, p. 23).

Nursing epistemology could be based on social justice, health in the broadest context with the community and the world as an ally, which would be a point of difference. Access to health care should be a basic human right, yet across the globe many individuals are marginalised within healthcare structures, disempowered, vulnerable and silenced (Hall, Stevens, & Meleis, 1994; J. Hall, 1999). That health has become a commodity and healthcare a politicised state industry should be of concern to nurses. That the population seems to be not getting any ‘healthier’ should have nurses and other health professionals sitting up very straight in their chairs, taking notice, and doing something, getting involved, being proactive. The political could become very personal.

In a thought provoking paper addressing her own experiences of having cancer Beverly Hall, a nursing academic, asserts that “[we] have lost our concept of primary prevention” (2003, p. 61). Hall’s ‘we’ is addressed to all health professionals. She considers that some of the funding which is targeted towards early detection would be more usefully spent on ‘…preventative and health oriented research’ (p. 61). In addition Hall believes the totalising power of medicine is burgeoning which causes patients to become ‘medicalised’ and disempowered because medicine owns the diseased body, owns the knowledge of treatment and considers itself best placed to make decisions. Medicine is able to enforce compliance by threatening not to help if patients deviate from prescribed norms. Nursing is closely aligned with medical practice and Hall suggests nurses are lacking in awareness about medicalisation.

Brown and Seddon conducted research which resulted in their contending that “…nursing’s focus appears to be inward, upon defining what nurses do, with articles such as those which examine the performance of differently educated nurses or the journal reading habits of registered nurses” (1996, p. 34). Jacobs comments that nurses have been trying for a long time to define what they do, she describes the process as the “…triage [of] certain words” (2001, p. 18) and that nurses remain “…lost-at-sea” (p. 19). Brown and Seddon concur this type of
writing has validity, it however does little to provide a vision for nursing as having articulated a point of difference in the provision of healthcare. According to Brown and Seddon (1996) nursing has to be able to challenge medicine by forwarding a clear, philosophically argued alternative to the scientific model. Nurses carry out their work in many different environments and thus are acutely aware of the issues in society that affect health. From this it is reasonable to be hopeful that nurses could challenge the dominance of the biomedical model of care and offer a valid alternative, a different style of knowing. Dendas comments that nursing needs “...space for theoretical development” (2004, p. 18) within work environments which often add to the stress of the job. To expand on Jacobs’ (2001) seafaring metaphor I would add that nurses might be required to start rowing, sweat blood, and be prepared for a long and challenging journey.

What nurses could focus on is primary health care and an ‘enhanced’ (Witz, 1994) role, something nurses are well positioned to do. Witz describes an enhanced role as one where nurses are ‘upskilled’ and the nurse-patient relationship becomes an alternative to the doctor-patient relationship. According to Witz an enhanced role alters the traditional balance of power. This would introduce a different philosophy of patient centred practice and offer choice for patients, something they generally do not have now. I am not advocating that nurses would own patients, on the contrary I believe patients own themselves. Nurses generally forge good relationships with users of healthcare services, they like nurses and trust in them to do the right thing. Within primary health an alliance between nurses and communities could lead to improvements in services and ultimately health. Primary healthcare creates the conditions where communities learn to look after themselves, with knowledgeable support and guidance.

A contemporary example that principles of primary health apply to is that in Western democracies there is an increasing incidence of overweight in the population. This has ramifications for health in the future with an expected increase in the incidence of Type II diabetes. In turn increasing ill health across the body will result, with the requirement for secondary care intervention. Hall’s (2003) paper reminds me that whatever nurses do within healthcare services it is essential to remember that the body of the patient always belongs to the patient,
not the nurse and that if they do not want to participate or tell or share, that is their right and this must be respected and supported. Nursing practice should support patients’ dignity and rights to make their own choices (Gadow, 1996 & 1999).

Nightingale was the first to describe nursing as an art, indeed as the ‘finest art’ (Mitchell & Cody, 2002). Nursing as an art and a science is more of a challenge to conceptualise. I cannot help but think that the ‘science’ is an attempt to author-ise the knowledge of nursing, the received wisdom being that scientific ways of knowing are more valid. Nursing practice is founded on the notion of the lived-body of the patients that nurses care for. The meaning of the experience for the patient is what both drives nursing practice and serves as a basis for nursing knowledge (Hezekiah, 1993). These are concepts that separate nursing from medicine, they are also concepts that are potentially undermined by notions of ‘best practice’ and the contemporary euphemism of evidence based practice. Evidence is replacing experience and intuition and is becoming the new ‘truth’ of healthcare, possibly it has already achieved this status. Practice that is based on evidence will, the advocates and proselytisers tell us, lead to best practice. Phenomenology says that there are no truths, and that life is an ongoing project of uncertainty as individuals ‘extract essences’ from experiences with their community and the world (Jacobs, 2001).

Evidence based medicine (EBM) first appeared in health care a decade or so ago (Walker, 2003a). It is based around the idea that practices in health should be based on researched evidence as opposed to belief (Traynor, 2000). It is strongly promoted within healthcare organisations and indeed functions as a moralising discourse because those who are seen to not take it on board run the risk of being intellectually discredited (Traynor, 2000). Thus as Walker comments it has a “...deeply ideological function” (2003a, p. 146) and serves particular interests about the ‘truths’ of scientific knowledge (Clarke, 1999; Cody, 2003). Traynor notes that there is scepticism amongst nurses about evidence based care because it is at odds with much that is fundamental to nursing about relationships and work environments that are ‘highly contextual’ (1999). There is little room for phenomenology or expert clinical judgement in this ‘regime of truth’, and more insidious is the amount of further control that will be able to be exerted on nurses.
by the economic managers of health. Evidence based practice (henceforth EBP) may lead to alternative practices used in nursing becoming more marginalised than they are now, because nurses have not adequately researched their own practices and they do not name what they do (Walker, 2003a).

Zeitz and McCutcheon (2003) ask whether EBP can and should become a reality for nursing. They make the case that “...basic nursing practices remain unquestioned, are based on tradition instead of evidence, are regulated, do not require clinician decision-making” (Zeitz & McCutcheon, 2003, p. 272). Zeitz and McCutcheon use the routine of vital sign taking for temperature, pulse, respiration and blood pressure as an illustrative example and contend there is little evidence to support this practice. Rather than the wholehearted embrace of EBP they make the case that it would be preferable to change the contexts within which nurses work. This would include nursing research to provide evidence for practices used and the wide dissemination of this knowledge in order to bring about change in some of the regulated and routinised practices of nursing which tend to control nursing practice. I partially agree with the authors, in that it I consider it would be of benefit for nursing to loosen controls that bind nursing practice. However I am sceptical about EBP as it is configured. I would be concerned that EBP would reinforce a powerful dualism of so called objective scientific evidence on one hand versus clinical judgement, tradition, clinical expertise and clinical intuition. Traynor suggests it is possible to envisage research as “…a successful outcome of social control, an effectively internalised discipline and a new assault upon ‘professional autonomy’ by the state” (1999, p. 193).

I am concerned that ‘evidence based practice’ will take nursing back to Leder’s (1992a) reductionist ‘Cartesian corpse’, which ignores the fact that much ill health can not be ascribed to single factor origin. Our bodies are connected to the world and while the endpoint of that connection may be a certain biological disease, disease does not arise purely from mechanical or chemical dysfunction. Ill health is multi factorial, treatment should be as well and ‘levels of evidence’ do not take this into account. The sucking of bodies into the vortex of science and technology is both seductive and misguided and EBP will lock nursing into a scientific frame from which it may not be able to extricate itself. Not enough attention is paid as to
why a condition of ill health may have arisen. The reach of the medical gaze is that of a panopticon and the new discourse of ‘evidence’ aligns with political ideology and the economics of health, particularly rationing of access to healthcare (Traynor, 1999).

Walker (2003a) asks a pertinent and timely question, where is the evidence that EBP works and makes a difference to patient outcomes? Further to this I would add that if EBP is claimed to be a ‘better’ way of implementing healthcare, I would like to see the evidence that patients are ‘better off’ than they were previously. Nursing has enthusiastically embraced the idea of EBP (Clarke, 1999; Walker, 2003a) despite having a long history of using a variety of ‘evidence’ from science, interpretivism and experience (Cody, 2003). Using a wide range of evidence is important for the ‘good’ of the patient and also for nurses to be able to articulate points of difference about their practice. Kerr, Woodruff and Kelly note that there “...remains reluctance [amongst nurses] to incorporate research activity into practice” (2004, p. 17). It is important that nursing contributes by researching their own practice and actively disseminating their knowledge to healthcare colleagues (Clarke, 1999; Kerr et al, 2004; Zeitz & McCutcheon, 2003). Research is both a professional responsibility and necessary for generation of new nursing knowledge. However, there is more than one way to conduct research and present the results of that research. Traynor suggests that resisting the “...power of the technology of evidence” (1999, p. 195) is an important tool for professional integrity, and perhaps I would add also survival. I believe it is crucial that nurses shape how they will use the technology of evidence, rather than allowing their practice to be further shaped and controlled. Critical scholarship is required to challenge the claimed authority of EBP and to keep cognisant of the fact that we are working with human beings, who are embodied, enselved and ensouled, not Descartes’ machines. Nurses’ practice and research should be congruent with the values they claim are important to them, that of caring and human to human connection. Nurses’ practice knowledge is visceral and comes from the heart as well as text books. EBP has the potential to eviscerate this knowledge and act as a ‘flesh-eating’ disease, leaving little but the skeletal disembodied remains. Nurses do not have to follow in the footsteps of the master, once again. Nurses could allow their practice to dance and not be shackled to the ‘other’.
Nomad practice

Deleuze and Guattari’s (1987) concept of the ‘nomad’ is described by Massumi:

“Nomad thought” does not lodge itself in the edifice of an ordered interiority; it moves freely in an element of exteriority. It does not repose on identity; it rides difference. It does not respect the artificial division between the three domains of representation, subject, concept, and being; it replaces restrictive analogy with a conductivity that knows no bounds...The space of nomad thought is qualitatively different from State space. Air against earth. State space is “striated” or gridded...Nomad space is “smooth”, or open-ended. (1987, pp. xii-xiii)

Feminist writers such as Irigaray, Cixous and Braidotti use nomadic forms of thinking and writing to critique the phallocentric ‘State’ model of thinking that has always permeated Western discourse (Massumi, 1987). State space is striated in order to ‘vanquish nomadism’ and control exteriority (Deleuze & Guattari, 1987). When space is striated it is confined and demarcated within inner boundaries, effectively pigeon-holing knowledge. Control is in the form of restricting movement in public space, keeping individuals under State control. The nomad is a wanderer who takes her own paths and enjoys the autonomy of knowledge she has in free, open-ended space. Her space is not controlled by someone or something else. It sounds complex, and indeed Deleuze and Guattari’s *A Thousand Plateaus* is not the easiest read, literally. However it can be absorbed by a process of what I call ‘dip and delve’ to grasp some of its essences.

Braidotti has used the concept of the nomad for what she calls her ‘nomadic political project’ which for her incorporates a need to have “…real-life women in positions of discursive subjectivity. The key terms here are embodiment and the bodily roots of subjectivity and the desire to reconnect theory to practice” (1994a, p. 158). These are themes that inform my work about nursing. Central to Braidotti’s analysis is a critique of the universal notion of the subject as being masculine, self directing, rational, body denying and transcendent. Women are not represented in this model, they are unrepresentable as the ‘other’. Braidotti’s feminist subject is nomadic because she is embodied and multiple and takes
account of the history she has travelled through to come to where she is now, as a becoming woman. She is open-ended, not teleologically-ordained.

A nomadic project for nursing means re-looking at nurses’ historical images, totemic practices and representations within health, their genealogies. These were discussed in Chapters Six through to Eight. It is important that nurses identify the power locations they inhabit and which have been formative in the development of self in nurses. The spaces nurses inhabit are so familiar to them that nurses do perhaps not think about them on a conscious level. Nurses are ‘embodied and embedded’ in the locations of their practice, sometimes unaware of the politics which help to keep them there (Braidotti, 2002a). Nomad practice for nursing means taking icons and traditions to a new place where they take on a new form and creating alternative discourses within a new location. The new discourses would chart their own space and would have their own time. Being a nomad means to accept the disjunctions between/among different layers of one’s subject positions, as well as the harmonious elements. Nomadic subjects don’t always have to be nice girls, disjunctions are theoretically and ethically acceptable. As nomads nurses would no longer be reliant upon the ‘one’ (of medicine) saying what the ‘other’ (of nursing) was allowed to do. Nurses would be ‘one’, while at the same time having multiple identities. This could potentially lead to a form of freedom for nurses, freedom from being a subjugated discourse, because this is probably the type of freedom nurses would gain the most benefit from.

Nurses as nomads are skilled in their relationships with patients and using the art of ‘becoming’ to gesturally gather in patients to the folds of embodied practice, to both the surfaces and the depths where spatiality and temporality are intertwined, the phenomenologically open body. As Merleau-Ponty states “[t]o be a body, is to be tied to a certain world,...our body is not primarily in space: it is of it” (1962/2004, p. 171). Re-figurations of totemic practices will happen when nurses engage in a collective process of disputing and challenging faulty premises about themselves. And this includes the premises that nurses hold about themselves, not only those that are held by others. This is about practice as well as process, the talking has to stop sometime and be replaced by political action, activity. Foucault (1998b, pp. 2-3) is wary of the concept of liberty or freedom. He asserts that it is
important to emphasise practices rather than processes. The idea is to decide what practices need to be initiated to bring about change. Relationships of power involve domination as well as liberty. They are interdependent.

Freedom for Merleau-Ponty is a little different. As with Foucault, he rejects the Enlightenment liberal construction of the individual. However, his conception of freedom is about the ability of the lived body "...to structure its world and to realise the potentialities informed by its social history" (Diprose, 1994, p. 107). Freedom for Merleau-Ponty is about being in the world in the ambiguous and ever-changing situation we find ourselves in. We can never have total freedom because it is contingent upon us being part of a 'inextricable tangle' (Merleau-Ponty, 1962/2004). Merleau-Ponty seems to say as well that our experience of freedom can alter in proportion to what our bodies can deal with. In contrast to Foucault he writes that "[n]othing determines me from outside, not because nothing acts upon me, but, on the contrary, because I am from the start outside myself and open to the world" (1962/2004, p. 530). This is Merleau-Ponty's primordial and prediscursive subject.

Nurses are embodied subjects who conduct and construct embodied practice. The body of the nurse marks her status as embodied subject, and is a site of discourses of the body, as well "...the body still remains the site of the transcendence of the subject, and as such it is the condition of possibility for all knowledge" (Braidotti, 1994a, p. 59). Nurses' bodies are living 'texts', inscribed with symbolism, they can be seen, and they can be known. Nurses' bodies are tactile, they touch, and they can be touched (Merleau-Ponty, 1962/2004). To slightly warp the words/intent of Braidotti I would add that the nurse:

... is the basic stratum on which the multilayered institution of phallogcentric medical subjectivity is erected. She is the primary matter of the hospital/clinic and the foundational stone, whose silent presence installs the master/doctor in his monologic/scientific mode. (Braidotti, 1994a, p. 119. Words in italics added)

The nurse is a foundational force in her own right and if she recognises and reclaims her bodily self she will be enabled as a nomadic subject to "...break constraints and open new vistas" (Massumi, 1987, p. xiii). She will be able to
knock down the striated walls which have pigeonholed her and wander and wonder in the landscape that opens up to be explored, that airy space of endless possibilities.

In Plato’s *Phaedo*, Socrates who is about to be put to death is discussing death and the soul and he says:

Surely we think of [death] as separation of the soul from the body? – and of being dead as the independent state of the body in separation from the soul, and the independent state of the soul in separation from the body? Surely death can hardly be anything else? (Plato, 1986, p. 23)

The ancient philosophers, of whom Plato was one, valorised the soul at the expense of the body. For them the body was the mortal receptacle for the soul, which was believed to be immortal. The soul needed to be free from the body, but this analysis which has riddled philosophy for thousands of years is faulty. The body needs to find a soul to dwell there in order to present a unified image of the ‘one’ to the world. The body is not an appendage to the self and soul, it is the material constitution. Looking for a soul is like waiting for Godot, or searching desperately to try and catch a glimpse of your eyes to peer into the depths. The glimpses are evanescent.

As a ‘vocation’ nursing is claimed to be good for the soul. I would ask whose soul is it anyway, and how is this nebulous soul defined in relation to nursing? Foucault’s soul is the sum of the discourses inscribed upon the body and what it can do. For Foucault “...the soul is the prison of the body” (1977, p. 30). For me the soul is present, alive and embodied. The soul of the nurse comes into being as her body comes into contact with the patient, thus for me it is immanent. When nurses own and affirm the subjectivity and productivity of their bodies in their dealings with or caring interactions with other bodies, this mutually incarnates souls. Awareness of the embodied self perhaps brings greater understanding of the soul. The soul within this story needs to be immanent, present. Of little value is having some invisible transcendent flitting about, nurses have been invisible for long enough. Merleau-Ponty’s body is located within the soul, but I do not see it
as being imprisoned there. The soul is integral with subjective space and because it has spatial qualities Merleau-Ponty proposes that:

I distribute through my body perceptions which really belong to my soul, and put perception into the thing perceived. But that is merely the spatial and temporal furrow left by the acts of consciousness. If I consider them from the inside, I find one single, unlocalized knowledge, one single indivisible soul, and there is no such difference between thinking and perceiving as there is between seeing and hearing. (1962/2004, p. 247)

What Merleau-Ponty means here is that perception is always embodied and does not exist as a thing in itself outside the body. That I perceive does not mean the same as I think, all consciousness is perceptual and is as a result of how I inhabit the world.

Irigaray’s divine in nursing

An aim of this thesis has been to explore how nurses could potentially go about finding them-selves and becoming subjects. Martin states “[I] anguage, maternal genealogy, representation of women in the symbolic, feminine divinity, feminine bodies, are all inseparable expressions of women-becoming subjects” (1997, p. 64). These are themes that course through Irigaray’s work and inform the theoretical perspective of her ethics of sexual difference. It is through ongoing exploration and going back to these themes that she hammers her ideas into your consciousness, so when you read her these are the things that you are looking for, her method is effective. I have become enculturated with her way of thinking, and I believe this is something she sets out to do with her readers.

Rosi Braidotti, who along with Margaret Whitford provides perhaps the most illuminating understandings of Irigaray’s work, writes the following:

Her methodological stance seems to me to pose a crucial question: how can we nourish and develop what is most innovative and subversive in women’s thought, while avoiding the classic traps awaiting the feminine: mimetism, dependency, denegation, hysteria, aporia? How can we speak, think and create, within structures that are misogynist and seem to feed off the exclusion and appropriation
of the feminine? ... How can women repossess and recover the positivity of the feminine? (Braidotti, 1991 p. 249)

How Irigaray does this work for women is skilfully. She is as well as an accomplished theoretician, a crafting, perhaps even crafty writer, who weaves her own careful matrix. Via a series of recurring themes and images she unravels the masculinity of discourse, while running parallel to this she creates a new female subject who is both subversive and radical. Irigaray avoids the usual pitfalls that accompany some writers of the feminine who in attempting escape often compromise themselves and the feminine on the way to the altar of high theory. Irigaray remains Luce-id throughout. Reclaiming what is positive in the feminine self and making these aspects inclusive to embodied nursing practice has been a theme of my thesis. I believe this is an important aspect of nurses reclaiming agency in their practice.

Air, water, fire and earth, the four constituent elements of our universe, that of which we are made and within which we live, elements which have been written about since the beginning of philosophy. They are as Irigaray points out understood little within a Western culture which does not often dwell on the “...material conditions of existence” (1993c, p. 57). There are tracing lines for these elements throughout the embodied material reality of nursing practice. We have to have air to breathe, water to stay alive, a form of fire to keep us warm and the earth to both feed us and keep us grounded, they are gifts of life. ‘Sticky metaphors’ (Cixous, 1991) for these are limitless. The elements come to mind for me as I contemplate the alchemy of ‘wonder’ and the relationship this has to nurses’ being-in-the-world.

Irigaray writes, while she is engaged in a ‘conversation’ with Descartes about wonder being ‘the first of all the passions’, it ‘has no opposite’, “[w]onder being an action that is both active and passive” (1993a, p. 73), there is no anti-thesis, no anti-wonder. Wonder is the anti-thesis of regimentation and restriction. For me, to wonder is to contemplate and illuminate that space for nursing between body and soul, it is a desire to know and understand and it is appetitive and nourishing. The four elements are part of what I think about as being the sacred in nursing, and I wonder whether nurses have misplaced the sense of their practice as being sacred,
as being connected to the environment and each other, humanistic care versus technology and evidence. A dreaming of wonder about nursing practice might help to pinpoint a new space for nurses to inhabit as their own, a space that is open and limitless and important because nurses have created it themselves. A new space could offer endless and new or non-restricted possibilities, so that there are as many different ways of caring as there are carers. A sense of the sacred that is inherent in material practice would help nurses to transplant the icons and traditions of their practice to a new place, in order to inscribe them as their own discursive practices. This would have the effect of making them strong and resilient to attack, thus conserving them for a different way of being-in-the-world, resistant to the dominant phallic discourse of medicine (Irigaray, 1993a).

Irigaray suggests that women lack a female god of their own to share, because and here she cites Feuerbach, “God is the mirror of man” (Irigaray, 1993c, p. 67). I do not believe she is meaning a worshipful entity, more a representation that offers women the hope of becoming, infinitely, which she believes is not offered to women with the Christian god. What Irigaray is looking for is the creation of an ethical order both for and amongst women, a genealogy of women, which must within it have a relationship with the divine. Muraro (1994) speculates that Irigaray could be incorrect in saying there is no female god. It is Muraro’s belief that because women have freedom, this means a female god has already arrived. For me having a relationship with the divine, rather than being about gods male or female, is closely linked with wonder. It suggests a strategic rethinking of symbolic space and time and the materiality of the four elements. What we feel about the world and the mystery of ourselves in amongst it all, our own divinity. We should always want to wonder because the world then becomes for us full of endless possibilities, we can dream of creating futures.

Summary

Looking out over the vistas towards thoughtful embodied practice is a significant goal for nursing. It involves both imagining and activity. It asks of nurses both to speak to and listen to one another, and the others with whom they work. Being asked to listen should not need to be seen of as creating divisiveness, it means
having respect for one another. The ideals of autonomy as prescribed within a
gendered discourse leave little space for connection, mutual dependence and the
gratefulness we have to one another as individuals and as social groups. Our space
is replete with the elements of life and it is these that help us to be connected to
one another. Nursing is a feminine profession, it is a great deal more than
‘women’s work’, and recognising and embracing this may help nurses to
appreciate themselves more than they do. Conceptualising nurses as nomads
recognises their potential for “...mobility, changeability and transitory nature”
(Braidotti, 2002a, p. 70), which to me is more positive than being stuck at a
crossroads, not knowing which way to go. There are endless possibilities that
require commitment to be enacted, being set loose as Braidotti (2002a) suggests
with the passion and force of Dionysus. I will raise a glass to that.
Chapter Ten

Loosely Tying Ends

Cixous' poetic prose is affirming for nurses as she writes:

Write yourself. Your body must be heard... A woman without a body, dumb, blind, can't possibly be a good fighter...It is by writing, from and toward women, and by taking up the challenge of speech...that women will confirm women in a place other than that which is reserved in and by the symbolic, that is, in a place other than silence. (Cixous, 1981, pp. 250-251)

When nurses write they think and this helps them to identify potentials for resistance. Political awareness is a powerful tool. From a few gifted thinkers revolutions are enacted. I think about the impact of Freud, Marx and Foucault and reflect on their skills as writers. I reflect on the potential of revolutionary possibilities from nursing thinkers. Nurses could make it a reality for themselves, by taking up a pen and writing for their lives. When nurses write their practice they leave a tracing of where they have been, and they leave a legacy for the nurses that come after them, providing they do not shoehorn themselves into writing according to pre-formed texts adapted to other purposes. Writing helps nurses to explore the self and careful reflection assists nurses to recognise themselves and be them-selves (Penney & Warelow, 1999), reflection through an ever evolving specular lens which can be liberating. I write for the ideas yet to come from my pen, and I will write until I write myself clear, into the light.

What I set out to accomplish in this thesis was to make visible the embodied self of the nurse within her practice. On the journey I have travelled over mountainous terrain and worked with the philosophical oeuvre of a diverse range of thinkers in order to try and envision something new and positive for nurses and nursing practice. I believe the work of Luce Irigaray has a great deal within it that is valuable for nursing practice because she challenges the supposed logic of phallocentrism and encourages women to learn to speak with their own voices.
Being enabled to speak with their own voice is important for nursing which has a protracted history of having a voice that is both quiet, silenced and marginalised. Irigaray’s conception of a sexual difference that does not collapse into essentialism and further entrap women has been enabling for my work and encouraged me to assert the positivity of the feminine in nursing practice and to value this positivity as integral to holding thoughtful practice. I have found Irigaray’s work to be affirming and challenging, encouraging of critical thought and positive resistance and I encourage nurses who choose to, to engage with her work.

My exploration of the phenomenal body of Merleau-Ponty and Foucault’s genealogical body that is produced through effects of discourses has been an interesting journey. I tend to agree with Grosz (1995) that the two approaches are not strictly compatible. However, what I assert is that for nursing, the ability to explore the embodied self and soul, as a meaningful whole is crucial. As is the additional task of thinking about how social practices are inscribed on bodies so that they become a certain ‘type’ of disciplined body. Phenomenal and inscribed are not the same but present aspects of the same living and changing entity that is always becoming something other than what it is, partly as a result of the words with which it clothes and informs itself and whose traces are etched into it by thought. It has gradually become clear to me that as long as the philosophical integrity of the positions is maintained, anything is possible. I hope I have made this clear throughout the ‘body’ of my thesis.

Walker believes there is an ontological crisis in nursing, “...a crisis of faith in what it means to be a nurse” (1997a, p. 5). There is a long and complex history for this crisis and it will not change quickly or without considerable resolve by nurses themselves. The dye was set for nursing early in the twentieth century with the advent of penicillin and medicine becoming from that point forward, increasingly able to align itself within a bio-mechanical model of cure (Pryce, 2001). Prior to this point the sides were reasonably matched when it came to patient care. Both professions cared for patients to the best of their abilities, relative to the contexts of knowledge of that era. Thanks to Florence Nightingale nursing practices were at least ‘clean’, as was the environment of the ward. Medicine was an imprecise
profession, diagnostic tests did not exist. Patients were much more relied upon for being able to provide accurate symptoms of their illness processes, the treatments suggested often had more to do with mystical quackery than effective 'cures'. Application of leeches and bloodletting spring to mind, as does the use of mercury for treating syphilis.

With the advent of an increasing pharmacy at their hands, doctors were able to write prescriptions for medications that 'cured' disease. In doing so, for many, they effectively disembodied their practice. Diagnosis and cure became paramount directives for the doctor-patient relationship. Nurses increasingly came to be seen as handmaidens, following directives for care, they were effectively 'ordered to care' (Reverby, 1987) and they were expected to unquestioningly defer to medicine (Doering, 1992). Doctors assumed the sole right to diagnosis based on medicine's belief that they have a greater understanding of the body and of disease processes. As Brown and Seddon point out:

Society values the knowledge of the processes of the body far more than the ability to care for the diseased body; hence not only is medicine given more authority; it is also far more highly valued than is nursing. (1996, p. 31)

Having knowledge of the processes of the body is reductive and mechanistic and has a facade of precision that passes as accuracy. Nurses would benefit from exploring what it is that they do within their practice lives and what they have to offer that is both complementary to and also different from medicine (Witz, 1994). If nurses believe they are doing it now, it is not working because no one out there appears to be listening. Woolliness about 'caring' does not cut it in the 21st Century and as well perpetuates a myth of selfless altruism (Francis, 1999), in itself a powerful constituting discourse within nursing.

As Paley (2001) notes the caring literature makes much of what nurses say about what they do in their practice, but there is little attempt to describe what nurses actually do. Paley writes that “[a]uthors do not generally discriminate between ‘perceptions’ of caring, the ‘concept’ of caring, the ‘experience’ of caring, and caring itself” (2001, p. 190). The elision makes for repetitive reading, there have been many attempts to define caring with the authors not seeming to consider the
parameters of what they are trying to write about. The body of writing on caring requires thoughtful and embodied development. There is much written about caring not being ‘valued’ by society (e.g. Jackson, 2000; Reverby, 1987; Speedy, 2000; Witz, 1994). However, patients value caring, so what might that tell me. It tells me that nurses overemphasise what is written about caring being a gendered construct. It also tells me nurses could value caring more themselves and ally themselves with their patients. It tells me as well that research could be undertaken about caring from the perspective of the patients, for patients to be able to give voice to their experiences of being cared for. This is often related anecdotally and written into stories and exemplars. It could as well be written/presented through a variety of different research practices.

What is the specific knowledge of nursing that differentiates nursing practice from that of medical practice? Nurses have to write this in such a manner as to persuade medical colleagues, and the general public that the relationship between the two professions is interdependent and complementary. In secondary and tertiary care the two professions cannot manage without one another, they rely on each other’s knowledge, skill and expertise. Wiltshire and Parker point out that “[n]urses work with people who have fragile boundaries” (1996, p. 24), patients who for whatever reason are experiencing themselves differently, and who need to be ‘touched’ by the body of the nurse in order to facilitate the work of healing. Walby et al comment that “…it is unlikely that the nurses’ body of professional knowledge will be respected until it is seen to be significant in influencing recovery or promoting health” (1994, p. 78), because as Clarke (2004) notes positive outcomes for patients are generally ascribed to medicine. Caring promotes healing whereas treatment attacks pathological assailants, I consider that to be significant. It would be wise for nurses at this point in time to move away from a fetishistic relationship with the ‘other’, which is medicine (Walker, 1995b). It would be wise to put a stop to the practices which have nurses seeking to be ‘like’ the other, to have and to hold whatever it is that nurses see in the other and which they are desirous of having, perhaps status. It is the pointless exercise of a negating and destructive desire, it has been of little benefit to nursing thus far.
The status medicine holds derives from longstanding social, political and economic privilege. The history of medicine has been very different to the history of nursing. This does not mean that it always has to be like this, discourses do change over time and get replaced. King and Norsen suggest that “…we are all moving into a more fluid model of health care” (1994, p. 89), whatever that is supposed to mean. Watery metaphors, I hope we do not drown in them. I would ask nurses to learn to speak their own desires, they are in the end those which will serve them best. The ‘desires’ are those which express themselves in the movements and lively forces of nurses’ bodies, which may include a desire to witness and nurture healing or a desire to bring solace and affirmation. The element of fire can be used to express a desire to fan the flame that warms the body touched by the frost of disease, disease carrying as it does the cold stillness of death. Nurses can be less constrained by the Name of the Father and the ubiquitous logos, learning to speak with a feminine voice which is true to their practice, true to themselves as skill-ful embodied practitioners. Dare to be creative and speak in a different voice.

Nursing education in New Zealand is relatively new to the corridors of tertiary education and is paradigmatically challenged. There are divisions in nursing education within which medical-surgical nursing remains a powerful structuring discourse. It continues to be represented as ‘real’ nursing, representative as it is of the reductive knowledges nurses are phototropically drawn towards, blinded by the light. It is unwritten, and unspoken, but the development of technological skills has a significant moulding influence in nursing education. If nursing education does not want to acknowledge or address this, the status quo will prevail. The confusion lies with two competing forms of knowledge, empirical knowledge on one hand and interpretive knowing about care within nursing practice on the other (Walker, 1997a).

The hospital remains the point of reference for nursing education, which reinforces the knowledge of a specific form of caring, particular to looking after sick patients in beds. Hospitals are an important part of nursing practice, however it is not all that nursing involves and ‘other’ nursing knowledges and areas of clinical practice run the risk of being stigmatised and seen as not legitimate
(Halter, 2002). Perhaps there is a paradox here, especially when nursing considers itself to be subjugated to medicine. There are subjugations within subjugations. There is a ‘crisis’ in New Zealand of a shortage of registered nurses in all areas of nursing, including mental health nursing and nurses to work in primary health care. There is little chance of this changing unless nursing programmes take a long hard look at their curricula, philosophies and reflect on what they are doing.

Many nursing scholars and others assert that gender remains a primary ‘problem’ for nursing (e.g. Ceci, 2004; Garmanikow, 1978; Papps, 2001; Powers, 1996; Reverby, 1987; Speedy, 2000; Turner, 1986; Witz, 1994). As discussed in Chapter Seven being a gendered profession is part of the problem, but it is not the whole problem. Nursing is held and holds herself a prisoner to history, and that I believe is a greater problem. Nursing perpetuates the construct of gender partly because of how students are prepared for the so-called realities of practice within a secondary care medical-surgical environment, and as well the powerlessness and subordination they are led to believe they will encounter on entrance to that environment. Nursing education reinforces gender stereotypes and reinforces occupational powerlessness. There is an emphasis on process and the ubiquitous Habermasian ‘emancipation’ as opposed to concrete practices. Despite having had a ‘curriculum revolution’ in the 1980’s (Bevis, 1988), nursing has not changed significantly. Nursing may no longer have an apprenticeship model of education, in that nursing now controls education instead of service providers, but that education is increasingly under governance and surveillance by the governing bodies of nursing and the government of the land.

Walker believes nurses need to “…make central the business of critique and intellectual work” (1997a, p. 14). As well as appraising theory it is important to trace its connections in thought and construction through the domain of the Name of the Father, to raise a flag to the assumptions on which it is based, those familiar things which are often taken as a given and not contested. Intellectual work involves nurses coming to know their practice, inverting the speculum and reflecting back to others that what they do is valid, is real and makes a difference in the lives of the communities with whom they work. Nurses put themselves at risk when they encourage students to critique their practice environments and then
negate this by talking about the ‘real world’ of practice (Walker, 1997a). Nurses cannot expect to be integrated selves and thoughtful practitioners if students are invested with negative dichotomies, they are set up and expected to fail, and then someone else can be blamed, the ‘institution’ (Clare, 1993b), something nebulous out there in the firmaments. Nurses make the realities of their clinical working environments because they are there, present. One of the tasks for nurses is to tell others what it is they are doing. It is difficult for researchers to measure nurses’ contributions to patient care when as Clarke notes “...there is little trace of much of the work of nurses in the patient record” (2004, p. 70), nurses have to shoulder the responsibility for this absence.

Nurses should become more knowing of how they are discursively constituted within the critical nexus of power-knowledge. They must be critically aware and prepared to appraise the theory that informs their practice. It is not enough to regard practice as something that is done. Nurses could learn to be more aware of the terrain they occupy and the various actors within it, particularly their nursing colleagues. Professional solidarity is crucial to a lively dynamic profession which is otherwise at risk of fading away because it is open to being fractured and eviscerated by other competing discourses.

Nursing has to be able to legitimate what it does within a world where the hold of science as an epistemic truth is reflected by seductive discourses such as evidence-based-medicine (EBM). EBM reflects the managerialism and economics of health (Walker, 2003a), and needs to be strenuously resisted as it is approaching mythical proportions. Patients within EBM are disempowered and disembodied. This new ‘truth’ of cure is based on measurable cures which have little to do with the other actors in the game, especially the patients but also those actors who are subjugated to this very persuasive model of health care. I am unsure as to whether it can be resisted, but it can and should be challenged. There is an ethics of practice within this, an ethics of performance in practice. If nurses are advocates for their patients they should be able to philosophically argue that there is more to health than the absence or suppression of disease, a purely reductive approach to certain defective or deficient body parts, the ‘broken body’ (Schenk, 1986). As Clarke notes “...health care is essentially about human
interactions” (2004, p. 92), health professionals have to listen to their patients not simply to the results of randomised controlled trials. New spaces for nurses are created when moving outside of reductive paradigms (King, 1995), possibilities for a new voice speaking a different language.

The nurse as ‘nomad’ (Braidotti, 1994a) may be able to bring about change, to change the ‘line of flight’ (Deleuze & Guattari, 1987) and move the terrain to a different place for patients and them selves. There are other knowledges that exist besides science, alternative discourses of healing, which nurses use but tend not to discuss with medicine, thus keeping them marginalised and secret (Wicks, 1995). The nurse who straddles the borders between medicine and the patient, a position of liminality, has potential to push at the thresholds. This is the ‘technology-of-self-caring-for-others’, an ethical stance that I discussed in Chapter Seven. For nursing it can be argued through a speculum of aesthetics; aesthetics are significant to a phenomenological way of being-in-the-world (Merleau-Ponty 1962/2004). The phenomenological self of the nurse is embodied and incarnate and interacts with her community and the world as an ongoing process of knowing and growing herself. Aesthetics are important for self and health and involve the implication of history in the present, aesthetics as an ethics encourages us to reflect on our place as beings-in-the-world.

It is crucial for nurses to know what they do and be able to articulate this in a wise and philosophical manner (Emden, 1995). Thinking about the power of language and how it speaks through nursing (Braidotti, 1994a; Parker, 1999) and using a speculum creatively to give voice to nursing’s intrinsic worth, will ensure nurses are better equipped to know them-selves and their practice. They will also be in an enhanced position to appreciate the value of the femininity of their practice. Shakespeare (2003) encourages nurses to reflect on the importance of their embodied selves to their practice, it is nurses’ greatest, most underrated and unwritten ally. The soul of the nurse is currently trapped within the discursively constituted prison of the unknown and unknowing body (Foucault, 1977), both the body incarnate and the body of nursing knowledge. I agree with Mitchell (2001) who reminds us that nursing has a unique knowledge base and that the best theory for nurses is that written by nurses themselves, not sociologists or others who do
not know nursing practice. Specific nursing theory helps to distinguish nursing as nursing. I do assert however that nursing would benefit from enhanced and resonant philosophical understanding, to encourage a plurality of voices. Engaging with philosophies helps us understand how we are formed and therefore what our predispositions are.

I ask nurses to like themselves and respect their colleagues. I encourage nurses to write themselves and their practice, to stop being silent, as it does them no good. It is important to wrestle philosophically with the ‘truths’ of nursing practice (Manias & Street, 2000). Knowing the truths, as Foucault (1980a) says, will not liberate, however knowing the truths and engaging in debate about them will equip nurses to be agents of change and resistance at a global level, rather than purely local. The struggles of nurses within Western democracies are similar and could be addressed globally, collectively. Witz (1994), pointed out that rapid changes in structures of health made it increasingly likely that the combined power of doctors and hospital managers would have a great impact in the future on the possibilities of change in nursing and indeed in the past decade this has become a reality. I am clear that Walker’s (1997a) ‘crisis’ of faith in what it means to be a nurse is a crisis for nursing, and not medicine. It is nursing that has been at the ‘crossroads’ (Ashley, 1980) of a crisis for nigh on a century, and it is nursing that has to initiate change.

Emden (1995) describes nursing as being ‘capacious’ and willing to cross borders of knowledge. Thinking on this and finding capacious ‘ensheathing’ and retreating to Plato’s cave, I prefer to think of nurses as being capricious. Nurses capricing as nomads, being unpredictable as opposed to being quiet. Caprice could be liberating, as it would be destabilising, and it is possibly frivolous but nurses should be able to have some fun with their daily work. Nurses could become accustomed to expecting the unexpected within their profession, it would be lively, it would be different, and it would be a position of resistance. I agree with Walker when he states that nursing is “…inherently conservative and reactionary” (Walker, 2003b, p. 21). Nurses have a tendency to make their working lives much harder for themselves than it needs to be. While there has been endless change in health, and some of it has been change for the sake of
change, it is preferable to be proactive about change and be involved in it, rather than sitting back and letting it happen to the profession. And then complaining about imposed changes with discussions about how ‘powerless’ nursing is. If nursing wants to be seen as a strong and mature profession, it has to be active, in its own interests. Aroskar, Moldow and Good (2004) argue that nurses should be involved in health policy decisions and they should ask to be involved instead of sitting back waiting to be noticed. As Walker succinctly notes “…it is absolutely time we moved on and carved new conceptual material shape from those histories of relative despair and subjection” (2003b, p. 21). Hallelujah, I couldn’t agree more.

Capriciousness is evident in structures of health care today, there is seemingly little rhyme or reason for what happens, except that it is generally related to economics rather than people, Healthcare has become a misnomer. Nurses could use similar tactics for destabilising the status quo. Being capricious would free nurses to explore and dance with a variety of philosophies, dance their way out of the Name of the Father, out of the ties that bind them and into that liminal space which is aching with potential. The boundaries nurses have both set for themselves, and which have also been set for them by others have historically been rigid. However within this rigidity “[t]he culture of nursing is fraught with inconsistency and contradiction” (Walker, 1997b, p. 11). The ‘dance of caprice’, offers nurses an opportunity to create new ‘maps’ of the terrain, to get a bit lost and not be so concerned about roads traversed previously (Walker, 1997b). I would like to see nurses confound the critics and run off from the Name of the Father with the Body without Organs, as Nomads, with their own voice, on a new Flight Path, claim the terrain of the re-situated camping spot, bang in the tent pegs and laugh. A different representation, a new symbolism for nurses. Freedom perhaps, freedom in the form of being able to speak with their own voices. The embodied knowledge of nursing is nascent, there are a multitude of interwoven landscapes to explore on the journey. Radicality is required, indeed essential in the form of inspired exegeses of embodied practice.

What I have tried to do within my work is to offer an illumination of the invisible bodies of nursing. The actual physical body of the nurse, the body of nursing
practice, and the body of knowledge which is embedded in that practice. Florence Nightingale’s lamp might be a historical symbol, but to me it is an important icon. The imagery of the light of the lamp is warm, caressing and connected, and to me it helps to illuminate that which is not always seen, it helps me to see in a different light. It has helped me to illuminate the invisible bodies of nursing.

Endnote

This thesis is akin to an inner dance and as I have written about bodies, selves and souls I have found myself increasingly drawn into the matrix of what it means for me. The self is expressed within the movements of the body, thus the dance of practice. I will use the four elements to explicate this. I am connected to the land, it earths me and provides contexts for my embodied living. The air that I breathe is not empty space but life giving and full of possibilities for movement and temporal change. Water is life sustaining and as well provides feminine metaphors for flowing, sinuous movement. Fire keeps me warm, can be regenerative as well as destructive and is indicative of fertile Dionysian forces. I am embodied, enselved and ensouled. My own primordial, prediscursive body has been sucked into this and is morphing, there are ‘depths’, ‘surfaces’ and ‘foldings’ which I had not previously contemplated. I have been considering how I do what I do, not simply in nursing education but in life, and find that I am inscribed as a ‘nurse’. This ‘docile’ but fully engaged body has been moulded and shaped by my experiences of ‘being’ a nurse. I have over time ‘become’ a nurse, a member of this feminine profession. I speak through and with my body, my body connects me to my environment, and I have come to see that it will always be this way, which is not such a bad thing.

My body is Merleau-Ponty’s ‘eloquent relic of an existence’. It is a communicative body with a metaphorical monkey sitting on my shoulder, happily chewing nuts and urging me on. I have eaten slept and breathed this work. Interaction with others has become minimal in this year of reflective thinking and writing. I have become distractible, forgetful and edgy. My body has changed over this time; my face lined from lack of sleep, my guts shortles because of a low level of anxiety. My appetite has temporarily withered, meaning my body shape
has altered and my thoughts have altered as well, my embodied self has changed. My life remains an example of Merleau-Ponty’s ongoing project, a thing of mystery and ambiguity. Some authors’ work which I once found engaging I now find less useful, which leaves me hoist on a petard of my own creation. Do I change what I have written, and then change all the associated links to it, I think not. I think it is better to see this work as a beginning as opposed to an end, pragmatism rules this soul and this work. I am cheerfully in thesis derangement.

This work is part of my lived experience, it is me. There is for me no standing on the outside of the text impartially looking in, although perhaps for me, impatiently at times. I am involved in the intricacies and minutiae of what I have been writing, of what I have now brought into being. The work has at times been angst ridden and reflectively melancholic, which has occasionally made it a challenge to breathe life and soul into it. As I write this we are halfway through winter. The garden is silent awaiting the clamour of spring and the dawn chorus. The days remain short but are perceptibly lengthening, the coming of the light, the light of new ideas.

I referred to Irigaray’s angels in Chapter One and I close with angels as well. I ask myself whether I have gone where angels fear to tread. Czeslaw Milosz’ evocative poem On Angels from which I cite a few lines, brings this work to a close.

All was taken away from you; white dresses, wings, even existence. Yet I believe you, messengers.

There, where the world is turned inside out, a heavy fabric embroidered with stars and beasts, you stroll, inspecting the trustworthy seams...

day draws near
another one
do what you can.

(Milosz, 1988, pp. 248-249)
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