Nurses' Engagement with Feminist/Poststructuralist Theory: (Im)Possibility, Fear, and Hope

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The difficulty of engaging with theory should not go unappreciated. Its language, assumptions, and very existence can be hard to grasp. Yet, theories offer meaningful ways of understanding and connecting to the world and describe possibilities for changing and influencing the world. Feminist/poststructuralist theories have a particular relevance for women and other marginalized groups. Why then do these theories seem to be excluded from the set of discourses available to and engaged by some of these groups, such as nurses? My own attempts to challenge my previous disciplinary perspectives and come to terms with feminist/poststructuralist theory may be a starting point to explore the fit between nursing and feminism. To support this exploration, I will draw upon feminist/poststructuralist conceptualizations of discourse, knowledge, subjectivity, and power as presented by key authors such as Chris Weedon, Bronwyn Davies, Joan Scott, and Jacqueline Zita. I will also interweave vignettes from my personal experience into the discussion to illustrate my thoughts on the place of theory in nursing. I wish to appeal to nurses who are thinking about the issues of nursing training and practice and inspire feminist scholars to turn their attention to nursing. My purpose is to consider the question of nurses' engagement with feminist theories and to examine how these theories might contribute both impossibilities and hopefulness in nurses' understandings of the opportunities for change.

> *Reflective aside*: Certainly, I cannot claim to represent all nurses, as though they are a homogenous, unified, fixed group, any more than feminism can claim to represent an essential woman. The group called 'women' is heterogeneous, broadly categorized according to race, class, and sexual orientation, among other categories. Nurses, most of whom are women, are also heterogeneous: they participate in the health care world as hospital nurses (as medical nurses, surgical nurses, critical-care nurses, maternal-child nurses, etc.), community nurses, managers, academics, and philosophers. Nevertheless, I might suggest that my experience as a hospital nurse, administrator, and academic nurse has been so broad that I have encountered many representations of the nursing subject and many examples of the extent to which theory is embraced in nursing. I cannot claim any privileged access to truth based on my experience, but I may, perhaps, be able to reflect back my unique interpretation of the various discourses that have created my experience (Weedon 8; Scott 26).

Seeing a Problem in the First Place

In her book *Feminist Practice and Poststructuralist Theory*, Chris Weedon shares with her readers a picture that illustrates an issue of importance to nurses. The picture shows a happy nuclear family (husband, wife, daughter, and son) in front of their Christmas tree. To Weedon, the image seductively "signifies warmth, happiness and emotional and material security" at the same time that it subtly conveys traditional gender roles – nurturing mother; protective, controlling father; delicate daughter; confident son (Weedon 15-16).

> *Reaction*: My initial reaction to Weedon's feminist interpretation of this photograph was shock and outrage. This picture resembles those taken of my family, and I don't live in a patriarchal household. How could Weedon suggest that this picture represented a feminist problem? I thought about pictures that would be better representations of patriarchy: a battered woman, a woman in a burkha, a prostitute. Then I came to appreciate Weedon's point: Patriarchy can be subtle and difficult to recognize.

Weedon also points out that, despite the potential for patriarchal control within the nuclear family, many women uncritically hold marriage and family as significant life goals (16). The subtlety of patriarchal power can obscure the experience of it. Perhaps this explains why nurses are surprisingly uncritical and unreflective about their social position and why they scarcely give any thought to the influence of gender in the formation of their selves. Nursing has had an uneasy relationship with feminism (Sullivan 183), and nurses may possess an inaccurate understanding of feminist concepts. Exposure to social theory of any type can be limited during nursing education. Although a handful of nursing philosophers have seen the potential in linking feminism and nursing, most nurses do not believe that feminist thinking offers much to nursing because they view feminism as silly, man-hating, and anti-family (Speedy 217). When feminism is recommended to nurses, it is done with the care of female patients in mind and an explicitly stated reluctance to recommend research that focuses on nurses rather than their patients (Webb 558). Nurses also clearly participate in a gender-based hierarchy that bears striking similarities to interpersonal relationships in the family – physician: father, and nurse: mother (Coburn 445). To extend this problematic metaphor further, perhaps patients can be likened to children, meaning that nurses, like 'good mothers,' are continually expected to put the needs of their patients ahead of their own. The appearance of this hierarchy as natural and appropriate gives it a taken-for-granted quality that is very seldom questioned.

Why Feminist/Poststructuralist Theory Will Never Work for Nurses

If I was told anything that was a theory, I would say, No, no! That does not interest me.

-- Ludwig Wittgenstein

Practice has a logic which is not that of logic.

-- Pierre Bourdieu

Patriarchal social relations take many forms, including the sexual division of labour, the male-biased production of knowledge, and the internalized norms of feminine behaviour that are prominent in our society (Weedon 2, 13). Feminist theories offer various, related, ways to view social relations and critique the assumption of a natural order based on gender. Combined with poststructuralism, these theories present an opportunity to consider the relationships among language, subjectivity, social organization, and power in order "to understand why women tolerate social relations [that] subordinate their interests to those of men" (Weedon 12). "Nursing is *par excellence* an example of the subordination of women to patriarchy"; women as nurses are exploited under ideologies that equate nursing with mothering and view the hospital ward as simply an extension of the domestic sphere of labour (Turner 146, emphasis in original). In health care, there is a stark sexual division of labour (physician/nurse) based on the Victorian model of the family and the skills/caring, male/female dichotomy (Porter 510, 512). Because nursing is seen as women's work, nurses are expected to "mediate the concrete particulars for the managers and professionals who have superior positions" in the health care hierarchy (Campbell 187) and subsume their caring work into the "superior [masculine] world of rationality, objectivity, and impersonality" (Campbell 187). Thus, to think about nurses/nursing under feminism's theoretical umbrellas makes excellent sense. However, convincing nurses to think about themselves using these theories may be impossible or, at least, extremely difficult.

Althusser "uses the term *obviousness* to capture this taken-for-granted […] [way] of being a 'subject,'" which is so evident in nurses' social relations (qtd. in Davies 22). Davies explains that people "learn the ways of seeing made possible by the various discursive practices of the social groups of which they are members […] Each person in a social group both shares a set of obviousnesses and is positioned in relation to them" (22-23). Competent membership in a social group involves being able to read situations correctly so that what is obvious (apparent, recognized, understood) to everyone else is also obvious to oneself (Davies 22).

Illustration of 'obviousness' in the discursive practices of nursing: One day, in my work as a

> nurse in the operating room, I was the circulating nurse in a surgical theatre (not part of but present to provide support to the sterile operative team). The (male) surgeon threw a very bloody sponge across the room in a showy attempt to hit the sponge bucket (the receptacle for disposing of used sponges). He missed, creating a biohazardous mess on the floor and on the furniture next to me. At about the same time, he finished his part in the procedure and stepped away from the operating table as he removed his gown and gloves. He could have, at that point, corrected the damage done by his poor aim by picking up the sponge and wiping the floor. Instead, he laughed off his bad shot and headed for the door. I said, "Don't worry. I'll have some woman pick that up for you." He looked at me like I was speaking an unknown language, and then he laughed again and said, "Cute." Afterward, the charge nurse took me aside and told me not to fight with the surgeon because we were there to create an atmosphere of support for him so he could do his stressful and important work. His masculine bravado and my natural role in supporting his work could not be disrupted by my introduction of gender discourse and feminine resistance to power.

Nurses are spoken into existence by powerful discourses that they, in turn, believe. In the contemporary health care system, nurses accept (at their peril) such discourses as medical superiority, evidence-based practice, the nursing shortage, professionalism, and cost-consciousness (Caldow et al. 22; Wall para. 3; Ceci and McIntyre 122; Rutty 243; Ceci 5; Rossides 171). These discourses obscure nursing knowledge, subordinate nurses to medical and administrative control over patient-care processes, make management needs (e.g., staff retention) appear more important than nurses' experiences of their work, and perpetuate a desire among nurses to be defined according to patriarchal ideas of professionalism. Notions of professionalism, and the corresponding need to practise from a scientific base, have been relatively useless to nurses, but they have revealed the ambivalence that nurses, as an occupational group, experience: nurses simultaneously strive to be similar to, yet distinct from, physicians (Liaschenko and Peter 490). Rather than abandon oppressive discourses to understand their work on their own terms, nurses access dominant discourses (even in speaking of themselves) because they have "no alternative practices with which to resist their speaking" (Davies 25). That which is obvious is equated with truth, and 'truth' is hard to refute.

Most nurses have a well-developed aversion to, or disconnection from, theory, no matter how potentially helpful it may be.[1]

> *Remembering*: In 2003, at the beginning of my PhD program in nursing (I eventually transferred to sociology in 2006), my first course was on nursing theory and philosophy. That course was my first encounter with theory, and I

> became immediately and irretrievably overwhelmed by the new language and ideas. I was hostile to the content and became angry that I should have to learn it at all. My first posting to the online discussion forum was a lengthy diatribe on the irrelevance of theory to nursing that expressed my doubts regarding the appropriateness of my studying in nursing, given its esoteric and impractical theories. My professor was patient and reassuring, but I could not move beyond my initial reaction. I withdrew from the course and, shortly thereafter, from the program. I could not see myself ever devoting time and energy to such a meaningless pursuit. Later, when I tried the course again, a classmate posted a similar rant during the first few weeks of class.

Just as some feminists are averse to theory (Weedon 6), nurses react negatively to theory because of its disassociation from experience. Ironically, nursing theory emerged as nurses felt compelled to demonstrate nursing's intellectual and disciplinary equality with more established and theoretical disciplines. This development may have been a reaction to the modernist discourse that associated masculinity with the 'mind' (intellectualism and rationality) and femaleness with nothing more than the 'body' (sexuality and reproduction) (Leonard 66). Ultimately, however, theory in nursing has taken such an abstract form that it is not accessible from within the set of discourses available to practising nurses (Rutty 245). Each of the four major nursing theorists – Rogers, Newman, Watson, and Parse – draw on abstract philosophies, including Eastern philosophies, to develop theories of health and nursing that describe human beings as "unique pattern[s] of consciousness within a field of absolute consciousness" (Sarter 308) and health as a process of evolving consciousness through self-transcendence (Sarter 313). Nurses function in a concrete world of bodies; for them, making the leap to disembodied abstractions such as these must seem particularly difficult, if not impossible. Jacqueline Zita, in a provocative essay, explores the relationship between immanence and transcendence, between the lived-in body and abstract theory. She acknowledges that "the body is most concrete and present to us in our lived daily experience which is, in some sense, antithetical to the labor of abstraction in theory-making" (205). There is no perceived role for theory in the nurse's lived daily experience. The organic relationship between theory and daily life observed by Zita is foreign to many practising nurses.

Thus, there is a strong anti-academic bias in nursing, and this attitude dichotomizes practising and academic nurses (Rutty 248). As is the case within the field of education, of which Roger Simon speaks, "Most discourse that stands for theory about […] practice has been produced within a division of labor between those who construct theory and those for whom it might have some pragmatic value" (85). Simon attributes this theory-practice gap to the construction of theory within universities that function under a set of epistemological

assumptions about knowledge and truth; these assumptions, in turn, (mis)shape the task of understanding practice (85). Epistemological assumptions in academia that favour knowledge creation through rigorous research do not fit easily with the ways of knowing of the practising nurse at the bedside, including practical, intuitive, experiential, and interactive knowledge development (Carper 13; Estabrooks et al. 463). Nurses view theoretical discourse as "something that is being done to them rather than a resource for their own practice" (Simon 85). As such, it is a "form of symbolic violence" (Simon 85), and it elicits strong resistance.

Certainly, nurses recognize that their professional lives could be different. However, nurses are likely to shy away from theory that is political. While nurses can be resourceful, and even manipulative, advocates for themselves within their local circumstances, they have been broadly characterized as politically apathetic (Boswell et al. 5). Feminism is inherently political because it is "directed at changing existing power relations between women and men in society" (Weedon 1). Yet, for nurses to embrace feminist critical theory they would have to risk giving up the "knowledges and commitments […] [that] constitute important resources for coping with everyday life" (Simon 86-87). It can be easier to continue with tried-and-true coping mechanisms than to engage with theoretical possibilities that require "the disruption of professional identities" (Simon 86), which then necessitate a political response (Simon 92).

It can be difficult to come to terms with the concept of 'agency' in poststructuralist theory, and this is problematic for nurses. Poststructuralist deconstruction of the humanist subject emphasizes the 'unfixity' of the subject and the continual discursive construction of the self; it eliminates the ability to theorize about agency and the power that might flow from the self (Clegg 313-14). Judith Butler acknowledges the paradox, ambivalence, and circularity inherent in understanding the self as formed by the power on which it is dependent, and she concedes that "such a formulation can hardly be the basis for an optimistic view of the subject or of a subject-centered politics" (2, 10-11, 29). In many ways, nurses work in a concrete world where assessment and measurement drive plans of care that lead to observable outcomes. Nurses know the impact they have in the process of care and are accustomed to taking results-oriented action. Theoretically speaking, nurses would most likely align with a liberal humanist conception of the self in which individuals make rational choices, accept responsibility for their actions, and maintain a personal commitment to the morality of their choices (Davies 56). The desire among nurses to find significance in the health care system is motivated by a liberal humanist desire to be recognized and celebrated for their unique impact(s) on their world(s). Thus the poststructuralist concept of subjectivity as fragmented, contradictory, discontinuous, and discursively constructed (Davies 57) would not fit easily into a nurse's world view. Experience, which is fundamental to a nurse's professional identity and sense of self, has no inherent essential meaning in poststructuralism (Weedon 33; Scott 37). To the nurse, poststructuralism

would most likely be understood (although not in these terms) as "linguistic determinism" (Scott 34), in which "agency is fundamentally illusory" (Davies 60).

Finally, theoretical language disrupts the sense of "adequacy of one's taken-for-granted ways of communicating about daily realities" (Simon 84). Word-concepts that roll off the tongue of the social theorist, like 'discourse,' 'subjectivity,' 'agency,' 'embodied,' 'desire,' and 'humanist' can seem unintelligible and irrelevant to nurses grounded in biomedical, scientific discourses. It seems reasonable that nurses might want to avoid the potential humiliation of misusing theoretical language (Simon 83). The disconnection between theoretical language and daily reality is beautifully, although unintentionally as it applies to my purposes, illustrated by Sharon Marcus. In an article about rape, she rejects another author's (Hawkesworth's) claim that rape is real (fixed, determinate, and transparent to understanding) (385-6). She asserts that rape exists because language, interpretations, representations, and fantasies that support the rape script (in which players act out prescribed social roles) shape how we experience and use our bodies (400). To a pragmatic non-theorist, such as a nurse, the words 'interpretation,' 'script,' and 'fantasies' do not belong in a discussion about rape; they sound almost ridiculous and seem to completely minimize the horror of such a violent act. Nurses see the real, harmful physical and emotional effects of rape on the patient and her body. Marcus's language seems remote, dehumanizing, and inapplicable to lived experience. Nurses, as non-theoretical practitioners, reject abstract theoretical vocabularies and look instead to language that (to them) best describes their experiences and perceptions. Nurses have increasingly become disenchanted with theory as its adherents have tried to force its use in contexts where it barely fits (Levine 11).

> *Taking stock*: There are a lot of reasons why nurses (and I, as a trained nurse) should avoid an encounter with feminist/poststructuralist theories. These theories do not mesh well with the mindset of a nurse. Nurses can clearly see the injustice of the pronounced inequality between nurses and more powerful groups in health care, such as physicians and administrators. Nurses are distressed about their situations, but they, ironically, accept and continue to access the dominant discourses that construct their experiences. It makes me angry that all we seem to do is stew over it. It is not enough. I am frustrated by nurses' "passion for ignorance" (Lacan, qtd. in Simon 95), by their lack of political will, by their active refusal of information that excludes from consciousness whatever it does not want to know (Simon 95). We need to look for a new way of apprehending our world that is "aimed at the creation of new conditions, within which recovery of the knowledge needed to assess a new discourse is made possible" (Simon 95).

Why Feminist/Poststructuralist Theories are Important for Nurses

There is nothing so practical as a good theory.

-- Attributed to Kurt Lewin

In an article about possibilities in writing, Laurel Richardson asks a question about the consequences of adhering to dominant traditions in research: "Should the medieval vision triumph, what real live people are likely to be excluded?" (938). This question has tremendous applicability to the situation of nurses. Scientific, empirical, realist discourses dominate the professional lives of nurses. Critical, theoretical questions about the roles of gender and knowledge seldom enter the conversations of nurses, although they 'know' deep inside that things are not as they should be. If nurses fail to seek and engage with theoretical perspectives that can open up possibilities, they will be perpetually marginalized.

Nurses need not fear and loathe theory. Another look at Zita's poetic description of theory assures us that theory is on the ground with us, it lives with/in us. It need not be distant, transcendent, and disembodied. Theories are made by an inclusive 'us' in the day-to-day. They are "word-tools for navigating history, directing movements, defining enemies, predicting the future, getting specific, exploring connections, and moving through the hard places" (208). With this description, nurses can feel connected to theory. Theory is *useful* in the living of life.

As well, the language of theory need not be an insurmountable obstacle. To be sure, theoretical vocabularies are highly developed and can be exclusionary. However, "When a new theoretical language is introduced […] what is on offer is access to a discourse and, through this discourse, the possibility of engaging the social world differently" (Simon 91). Zita suggests that theoretical language can be actively created and elaborated upon by the theorist/theory user, opening up the potential for a new theoretical language to be created directly from the imagination of the one to whom it is ultimately most useful. Marcus shows the practical side of abstract theoretical thinking about rape when she suggests the use of forceful verbal and physical resistance techniques that go beyond self-defence to strike at the heart of rape culture (400). These examples offer a direct response to the issue of the academic/practice language divide in nursing. Ultimately, learning a new language enhances our skills, permits us to enter into a new culture, and deepens our understanding of our first language and how it constructs our world view (Richardson 936). For nurses, fluency in both the language of practice and the language of feminist/poststructuralist theory can only bring hope to their struggle for equality. The incorporation of feminist theory into nursing discourses would constitute a radical departure from the status quo. It has been suggested that feminist theory be introduced to nurses during their undergraduate education, transforming nursing education into a political

education that would illuminate the power relations within the health care system, equip nurses with a more critical perspective, and improve the possibility for change (Hagell 231-2).

Contrary to how it might first appear to nurses, agency *is* present in feminist/ poststructuralist theories, which offer a productive way of thinking about making a difference. Bronwyn Davies acknowledges that "agency is never freedom from discursive constitution of self," but she also maintains that it is "the capacity to recognize that constitution and to resist, subvert, and change the discourses themselves through which one is being constituted" (67). She explains that poststructuralist theory can open up a new kind of agency in which a subject "can move within and between discourses, can see precisely how they subject her, can use the terms of one discourse to counteract, modify, refuse, or go beyond the other" (60). This statement reveals the value of discourse theory in its contribution to the understanding of power (Mills 78) and to the creation of a concept of agency that allows for a response to power. Understanding power is a fundamental concern for nurses because it is an important step toward the possibility of enacting feminist strategies of resistance and subversion.

Jane Flax is critical of those who appeal to external, objective truth as evidence of a right to equality and justice. She believes that notions of truth "release us as discrete persons from full responsibility for our acts" and leave us waiting for higher authorities to save us (459-60). Nurses actively attempt to establish external proof of their value and could benefit from a new perspective on agency. In feminist/poststructuralist theory, individual subjectivities and experiences, not 'truth,' become the starting point for political action (Weedon 5). Everyday life is the site of the discursive redefinition of patriarchal meanings and values, and of resistance to them (Weedon 5). There is the possibility of freedom and hope when one understands theory as useful, practical, and intimate. When we understand that effective political actions are personal and local, "there is no longer the illusion of some massive inertia to overcome. Change is constant once we shift our perspective from the aerial to 'ground level.' [Nurses'] tasks become […] more local and manageable" (Finke 166). Every nurse has the opportunity to participate in the creative, political act of imagining that what *is* does not necessarily *have to be* (Hall 130, my emphasis).

> *Seeing hope for change*: I have been pulled this way and that by my encounter with feminist/poststructuralist theory, seeing at times nothing that I can hold on to and, at other times, the very answer to the emancipation of the marginalized. In coming to terms with this new (for me) theoretical offering, I have been caught in a "smooth space" - an uncoded mental space in which movement is aimless, free, and without arrival or departure (Deleuze and Guattari, qtd. in St. Pierre 263-64), going back and forth between the "it will never work for nurses/me" perspective and the "why it has to work" viewpoint. For me,

feminist/poststructuralist theory has opened my eyes to new ways of seeing many aspects of my daily life that, in keeping with my atheoretical disciplinary heritage, were previously invisible to me. Rather than impose lofty and disembodied language on me, theory has given me the language to articulate the questions that have always been inside of me, questions that have grown out of my everyday experience - local, personal, and meaningful theoretical questions about nursing. I see now that questions I have had since I was a new nurse - Why do nurses push the professionalization agenda so hard? Why do they accept the verbal abuse of doctors without standing up for themselves? - are actually theoretical questions that are intimately tied to my immediate work experience. Learning to work with feminist/poststructuralist theories has been painful at times because it has put me at odds with the discourses circulating in my social settings, but, in the end, it has made it possible for me to enact a new kind of agency out of the intersection of the old and the new discourses merging in my life. Having been socialized as a nurse, I believe my intellectual journey reveals something of how nurses' minds work. I know it will take time and a concerted effort to show nurses how this theoretical perspective might release them to influence change in their worlds, but I have seen the power and possibilities inherent in this theoretical perspective. I want to see nurses freed from traditional gender dynamics that render their work invisible and invaluable. I want to see them value their own uniqueness and learn to articulate and defend it, in their own terms, so that others will also value it. I want to see health care defined so much more broadly than medical care and economic control, and I believe that nurses are the key to opening up new ideas about health. It may be that feminist/poststructuralist theories are just the tools nurses need to renew their hopes for change and to usher an alternative work experience into existence. I will do my part to recommend this, and time will tell of its success.

Notes

[1] The phrase "theory-practice gap" is well known in nursing and is the topic of many published works within the discipline, see, for example, Allmark (18), Stevenson (196), and Rolfe (173). back

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