Power and knowledge in nursing: A feminist poststructuralist view

This article explores the concepts of power and knowledge from two philosophical perspectives, the feminist and the poststructuralist, and examines their application to nursing knowledge and nursing science. Principles of poststructuralist and feminist philosophies are presented. The role of the nursing–medicine power relation in the development of nursing knowledge and the interaction of gender issues in that relation are reviewed in the context of nursing history. Both past and current mechanisms that contribute to the maintenance of the nursing–medicine power relation are discussed.

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NURSING SCIENCE reflects the historical, social, and political relations in which it has developed. The prevailing framework for scientific study in the 20th century has been the empiricist or logical positivist philosophy, which aims to predict and control nature. Social forces associated with the logical positivist philosophy have influenced the development of nursing research. These forces include the education of nurse scientists in more developed, empiricist-dominated disciplines and the preference of granting agencies for controlled studies framed in hypothesis testing. In response to these and other social and political forces, nursing theorists have developed frameworks to mold scientific inquiry in nursing in the positivist tradition. For example, during the 1960s and 1970s, Dickoff and James[1] and Diers[2] included hypothesis testing, a key element of the empiricist method, as an essential foundation for nursing knowledge.

Recently, nurse scientists and nurse theorists have questioned the adequacy of the

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empiricist method for nursing. Some nursing leaders argue that the empiricist viewpoint may not allow nurses to see problems important to our discipline because those problems are not conceptualized as valid in the empiricist domain. They cite Kuhn, who cautioned that "a paradigm can insulate the community from those socially important problems that are not reducible to the puzzle form because they cannot be stated in terms of the conceptual and instrumental tools the paradigm supplies."[3(p37)] Other philosophies have emerged that offer opportunities for nursing to identify problems more comprehensively and thereby to redefine its knowledge. Two philosophies, feminism and poststructuralism, are particularly relevant to nursing because they incorporate the concepts of the female experience and of power. These concepts reflect the historical, social, and political dynamics in which the discipline of nursing operates. They encompass a theme central to nursing, that of powerlessness, characterized by oppression, submission, and male domination. The purpose of this paper is to present the concepts of power and knowledge from a feminist poststructuralist viewpoint and to examine their application to nursing knowledge and science.

PRINCIPLES OF POSTSTRUCTURALIST PHILOSOPHY

Poststructuralists assert that there is no one single correct approach to knowledge development. Structure itself is seen as a necessary, but limiting boundary of thought.[4] Michel Foucault, a French social philosopher, describes the mechanisms of social power and knowledge. According to Foucault, power represents a strategic situation in a given society and power relations in society have a specific purpose to maintain social hierarchy through the day-to-day activities of individuals in the society.[5] However, power and knowledge are intertwined. Power limits what is acceptable to be known, and knowledge develops in response to and sometimes in resistance to the limits set by the power relations. In this way, power has a productive element, as well as a repressive element. Finally, power and knowledge are mutually generative and are always exercised in relation to a resistance.[6] It is this presence of resistive elements, even though they may not be of equal force, that creates the possibility of change.

In addition to power, Dickson discusses two other principles of poststructuralism—language and subjectivity. In poststructuralism, language is the common element in the analysis of social organization, social meanings, power, and individual consciousness.[7] Language allows us to give meaning to the world around us; it is imbued with social power. In part through language, the human body becomes the location at which social practices and the organizations of power meet. Rather than being primarily a biologic system, the human body is invested with relations of power and domination.[8]

Subjectivity refers to the concept that individual thoughts and actions are shaped by and reflect social power relations. According to Foucault, there is no immutable individuality. Rather, subjectivity is a process of self-formation in which individuals internalize social power relations.[9] Subjectivity, then, is an individual's sense of self and understanding of the world. However, since

subjectivity is based on power relations, it is not fixed and is capable of change.

PRINCIPLES OF FEMINIST PHILOSOPHY

Feminism has been defined as a world view that values women and that confronts systematic injustices based on gender.[10] Feminist viewpoints cover a broad spectrum of beliefs, but have been categorized into several general perspectives—liberal, cultural, and radical. Liberal feminism is characterized by faith in rationality, belief in the ontological similarity of women and men, belief in the ability of education to transform society, and a view of the individual as isolated and rationally independent.[11] Liberal feminists believe that equality for women can be achieved within the systems of the existing social structure.[12]

Cultural feminism differs from liberal feminism in its contention that there is a basic difference between genders. Cultural feminists believe that women's values, judgments, and ways of thinking are inherently different from those of men and that these distinctive ways of seeing and being should be recognized and respected.[12] Nonviolent and nurturing characteristics are seen as feminist in orientation, if not exclusively female. Wars, terrorism, and environmental disregard are seen as metaphors for male domination, and feminist power is identified as a means for the transformation of destructive social behavior.[12]

Radical feminists insist that the oppression of women is fundamental and exists in all types of socioeconomic structures.[13] Women's oppression is seen as the most basic form of social oppression and the root of racial and class oppression. Their views reflect an intense valuation of women and a deep grief and rage over their oppression.[12] For radical feminists, only fundamental changes in our view of reality and in the existing social structures will result in elimination of female oppression.

ASSUMPTIONS OF A FEMINIST POSTSTRUCTURALIST VIEWPOINT

The convergent elements of the radical feminist and poststructuralist philosophies focus on the concept of power and the social implications of power. Oppression of women results from the existence of male-dominated power relations. These power relations mold subjectivities that subtly support male dominance and reinforce female submissiveness. Knowledge develops as a primarily masculine entity and as a form of social control. Female knowledge exists in resistance to male knowledge and power, although historically there has been an inequality of these forces. The presence of resistance, along with the productive operations of knowledge, represents the possibility for change. The following set of assumptions summarizes this combined viewpoint:

1. There is a subjectivity formed by gender that is socially, historically, and politically based.
2. Power generates and is served by knowledge, and knowledge reinforces and supports existing power relations.
3. Knowledge is developed in an historical, social and political context.
4. Power is always exercised in relation to resistance.
5. Change is possible, because the balance between power and resistance is not fixed.

6. Knowledge is fallible and changeable.[6(p24)]

THE NURSING/MEDICINE POWER RELATION IN THE DEVELOPMENT OF NURSING KNOWLEDGE

The assumptions of the feminist poststructuralist viewpoint can be applied to the historical development of nursing knowledge. As a primarily female discipline, nursing has developed in relation to the primarily male discipline of medicine. The development and maintenance of the power relation between nursing and medicine can be readily linked to the control of scientific knowledge relevant to both disciplines.

Historical development of the nursing–medicine power relation

Historically, the status of nursing education in the United States provides a prime example of the role of (male) medical power in the development of (female) nursing knowledge. American nursing historians have cited the role of physicians and hospital administrators (both predominantly male) in the development of nursing education. Although American nursing leaders adopted the Nightingale model in establishing training schools, they lacked the financial and administrative independence of the English schools. Because they lacked endowment, US schools exchanged student labor for financial support.[12] A system of exploitative apprenticeship in which the unpaid labor of nursing students was sold by hospital administrators grew rapidly and continued well into the 1960s. In contrast, medical schools were not connected to hospitals; they began as commercial ventures and students paid to attend them.[14–16]

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In 1910 the Flexner Report revealed the existence of substandard schools of medicine and resulted in the closing of inferior schools. At that time, nursing leaders proposed a similar study of nursing schools. However, hospitals were dependent on the unpaid labor of nursing students and closing inferior nursing schools would have meant closing hospitals. As a result, the Goldmark Report (1926–1934) on nursing education never achieved the "cleansing" effect that the Flexner Report had on medical education.[16]

In the first half of the 20th century, medical education moved rapidly into the university setting. Nursing education remained solidly linked to hospital administration through the labor of nursing students. In fact, the medical community vigorously protested the education of nursing in the university setting. The influential Dr Charles Mayo of the famous clinic was of the opinion that nurses spent too much time being educated and not enough time alleviating the pain and suffering of humankind.[17] In 1906, the New York Academy of Medicine attacked the overeducation of nurses and even persuaded some 3-year schools to decrease their training to 2 years.[18] In 1908, Dr W. Gilman Thompson summarized the attitude of most physicians when he stated:

> Nursing is not, strictly speaking, a profession. A profession implies . . . attainments in special

knowledge as distinguished from mere skill . . . (nursing) is not primarily designed to contribute to the sum of human knowledge or the advancement of science. The great and principal duty of a nurse is to make a patient comfortable in bed, something not always attained by the most bookish of nurses. Any intelligent, not necessarily educated woman can in a short time acquire the skill to carry out with implicit obedience the physician's directions.[19(p846)]

This prevailing view that nursing did not have a claim to scientific knowledge limited the degree to which nursing adopted the knowledge of other disciplines as its own. In contrast, medicine, which controlled social and economic power in relation to nursing, freely incorporated principles of physiology, microbiology, chemistry, bacteriology, immunology, and even psychology into the domain of medical knowledge. At the same time, the medical profession used its influence to expressly exclude this broad array of what was considered to be legitimate scientific knowledge from the accepted realm of knowledge for nursing. From early in its history, then, American nursing saw its domain of nursing knowledge defined and circumscribed by the medical hierarchy to include only that knowledge which pertained to the comfort, and perhaps the cleanliness, of the patient. Finally, since nursing was not seen as a true profession, any knowledge pertinent to it could not be, by definition, scientific or special knowledge.

In summary, modern nursing developed at a time when women had virtually no accepted social role outside the nurturing, maternal duties of the home. Nursing was seen as an extension of the maternal role. As such, it had no legitimate claim to scientific knowledge, which was the exclusive realm of men, and in particular, of physicians. In fact, the power relation between (male) physicians and (female) nurses was epitomized in the notion that nurses were to be "trained" while physicians were to be educated.

Maintenance of the nursing–medicine power relation

Foucault described three ways in which power and knowledge are used to maintain the status quo: examination, normalizing judgment, and hierarchical observation.[20] There is evidence to support the presence of these forces in maintaining the dominance of medical knowledge over nursing knowledge.

Examinations

Examination is used not only to measure levels of knowledge or skill, but also to impose labels such as "competent," "sane," even "knowledgeable" or "scientific." By examination, the characteristics of one individual are compared with those of a known group.[4] Traditionally, formal examination in nursing has been used to ensure that the characteristics of individual student nurses match what are considered to be nursing characteristics. It is through the process of examination that desired characteristics are rewarded and reinforced. Often, examinations in nursing schools have emphasized testing mastery of the rationale for nursing tasks, rather than mastery of analytical or conceptual abilities. This kind of emphasis in evaluation has reinforced a limited, dependent focus for nursing knowledge.

Normalizing judgment

Normalizing judgment involves the maintenance of acceptable standards and

the reinforcement of conformity. If a person fails to meet expected norms of behavior, "little punishments" intended to make an example of the individual's failures are meted out. Power is camouflaged, while compliance is reinforced.[4] An example of normalizing judgment in nursing is the traditional performance of tasks according to a strict set of rules. At early nurses' training schools, a prescribed method of performing a given task, for example bedmaking, was established and any deviation from that method was not tolerated. In 1909, one student complained in her diary, "We are shown one certain way of performing each duty and woe betide her who fails to adhere to the accepted method."[21(p156)] Attempts to experiment and find another, perhaps more efficient way of doing any task were discouraged. Rigid attention to trifling details was expected in all duties.

The tendency to routinize tasks in great detail without regard to the importance of those details to the desired outcome has persisted in nursing. In relation to the development of nursing knowledge, this custom has had a stifling effect. It not only penalizes initiative and creativity, it reinforces dependency and elevates tasks to a form of inviolate religious rite. If a task becomes more important than the outcome it seeks to effect, then greater value is placed on the limited knowledge of how to perform the details of the task than is placed on any broader knowledge of which the task is only one small part. Unfortunately, this practice continues today. For example, many institutions still find it necessary to detail common nursing procedures in official manuals from step one of "wash your hands" to the last step of "document the patient's response to the procedure."

Hierarchical observation

Within society there is a pervasive observational network that allows those at the top of the power structure to view activities in all directions. Observation promotes and maintains the general visibility of the individual, thus supporting the power structure.[4] Historically, the concept of the (male) physician as the head of a health care team composed primarily of (female) nurses has provided the medical profession both with patriarchal authority and with an ideal vantage point from which to perform the sort of hierarchical observation that Foucault describes. A current example of hierarchical observation of nursing by medicine is the role of the Joint Commission for the Accreditation of Healthcare Organizations (Joint Commission) in the monitoring of nursing care. The primary service that most hospitals provide is nursing care, and nursing services account for the largest number of hospital personnel. Accordingly, the Joint Commission review focuses heavily on the way in which nursing care is provided and documented. Although nurses employed by the Joint Commission perform the reviews, no professional nursing organization is represented among the member organizations that comprise it. Although accreditation is ostensibly voluntary, all federal funds are linked to accreditation. Therefore, economic necessity makes review mandatory, not voluntary.

The present notion of quality assurance also contains elements of hierarchical observation. In quality assurance, compliance to established standards is measured, plans

to overcome deficiencies are designed and carried out, and repeat reviews are conducted. Commonly, other hospital departments, such as dietary and pharmacy, may perform "quality assurance" studies that measure the compliance of nurses to prescribed behaviors. Results may be reported through multidisciplinary hospital committees, which are usually headed by a medical representative, so that medicine is ultimately reviewing all nursing practices.

The effect of hierarchical observation on the development of nursing knowledge has been to limit autonomy through the continuous imposition of new rules. Regulations that structure nursing practice are imposed from outside nursing itself. The need to constantly respond to ever-changing external demands siphons vital energy that might otherwise be channeled into more productive avenues. The development and application of nursing knowledge becomes secondary to the need to meet external expectations, and the gap between knowledge development and practice is widened.

Other factors in maintaining existing power relations

Aside from Foucault's three instruments for discipline, other factors operate to maintain the existing power relations between nursing and medicine. The class difference between nurses and physicians is seen by many nurse historians as creating the motivation and basis for the subjugation of nurses.[12] As a group, nurses typically come from a lower socioeconomic class than physicians and their incomes tend to keep them lower. In recent years, the economic gap between nurses and physicians has widened, so that the likelihood that the two groups will share socialization patterns and interests has decreased.[22] As a result, societal expectations that members of a higher socioeconomic class may exercise dominance and expect deferent behavior from individuals of a lower class operates to maintain the power relation between nurses and physicians.

The disparity in the levels of education between nurses and physicians also tends to maintain the power relation between them. The social value and recognition accorded to educational level contributes significantly to the status of physicians. The identification of nursing as nurturing and "woman's work" corresponds with the notion that nurses do not require education and that nursing knowledge is rightly confined to the hospital setting and not worthy of a truly scholarly environment.

Finally, the characteristics that society associates with a "good nurse" and a "good doctor" support the power relation between the two disciplines. Physicians are expected to exercise male characteristics of independence, self-reliance, and individualism. Nurses, on the other hand, are expected to reflect female qualities of deference, submissiveness, and conformity.[22]

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In summary, the nursing–medicine power relation has been developed and maintained by a series of social instruments that tend to limit the recognition, scope, and expansion of nursing knowledge. Educational and

practice traditions in nursing have supported this tendency.

WAYS OF KNOWING

In nursing and medicine, the values ascribed to scientific knowledge reflect the power relation between the two disciplines. Until recently, the logical positivist or empiricist concept of science was viewed as the only possible one. The values of logical positivism, then, were the values of medicine. By virtue of the power relation between nursing and medicine, they were also the values of nursing. In the logical positivist/empiricist view, the world is dichotomous. It is divided into objective and subjective; there is a clear separation between the knower and the thing to be known. There is only one truth, and the aim of science is to come closer and closer to knowledge of that single, absolute truth.

Finally, in the positivist/empiricist view, the male model is assumed to be the human model. Scientific knowledge has reflected male social domination, so that theories based on men's experiences are accepted as truth. Women are viewed as the "other," deviant from the male norm or prototype. Inherent in the historical development of the positivist philosophy is the assumption of a natural role of gender.[23]

Since power is always exercised in relation to a resistance and since the nursing–medicine power relation has dictated the values of logical positivism, other philosophical views regarding knowledge can be identified in nursing and have developed in resistance to traditional scientific or medical knowledge. Ways of knowing that are not based on a male world view have been described in the nursing literature. Intuitive knowing, for example, consists of cognitive inference, gestalt intuition, and precognitive function.[24] Intuition relies on nonquantifiable elements in the nurse–patient relationship that are not based on environmental cues. Both experience and imagination contribute to intuitive knowing. The value of intuitive knowing for nursing lies in the ability to predict behavior based on inadequate or ambiguous data and the ability to identify implications not directly deducible from explicit data.[24]

Contextual, phenomena-centered knowledge has also emerged in nursing. This type of knowledge values and focuses on personal experience. It relies on methods in which the "humanness" of a relationship between two beings is not diminished or lost.[25] In contrast to positivist knowledge, this type of knowledge assumes an intimate link between the knower and the thing to be known. The concepts of objectivity and of dichotomy between humans and between humanity and its environment is antithetical to knowledge based on the phenomena of human-to-human caring.[26] In this view, nursing knowledge seeks to disclose and elucidate the lived world of human health–illness experience. Some nurse philosophers argue that nursing knowledge arises from the context of human care transactions, acknowledges values, and focuses on personal experience.[26] Nursing knowledge, therefore, derives from the concept of caring, which cannot be measured, only experienced. Nursing knowledge is scientific, insofar as it furthers the scientific aim of understanding and describing natural phenomena.

In summary, the logical positivist concept of scientific knowledge as dichotomous, absolute, exemplified by the ideal of the male

model as synonymous with the human model, and reflected by quantitative methods has been and remains the predominant view of science. This view of science is fundamental to modern medical science. The power relation between nursing and medicine has acted to impose and reinforce these philosophical views in nursing. However, in resistance to the power relation, other philosophical views of nursing knowledge and science have emerged and continue to gain influence among nursing scholars. These philosophies value the interrelatedness of natural, particularly human, phenomena, the intuitive and holistic elements of knowing, and the quality of the individual experience.

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The feminist poststructuralist framework provides a theoretical means of unmasking the conflicts and contradictions between the experiences of nurses as women and as professionals and the socially institutionalized definitions of women's and nurses' nature and their social and professional roles.[6] Poststructuralism, together with the feminist perspective, places questions about the development of nursing knowledge and science in a social and institutional context. The author has reviewed how "science" and "truth" have been used to limit and control women in general and nurses in particular through the propagation of a power/knowledge structure. The power/knowledge structure, as described by Foucault, is sustained by a set of disciplines which take the form of examinations, normalizing judgments, and hierarchical observations. Operating in resistance to these disciplines, however, are alternate forms of knowledge that may be valuable to nursing as it strives to mediate human care transactions.

Power relations are not fixed. Therefore, the development of ways of knowing more meaningful to the discipline of nursing may alter the balance of the nursing–medicine power relation. The feminist poststructuralist framework offers hope for nurses in that it points the way toward change in the nursing–medicine power relation. As Dickson states, the feminist poststructuralist framework "assures women that they need not take for granted the established knowledge [and] power . . . they are humanly produced and therefore bear the potential to be humanly altered."[6(p30)]

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