

Power and knowledge in nursing practice: the contribution of Foucault

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This paper explores the implications of Michel Foucault's philosophical analyses for understanding nursing practice. Foucault describes power within a given society as unfolding not through large-scale events but rather through a complex 'micro-physics'. Power operates upon the human body. With the increasing use of observation, in understanding both the natural and social world, the body has become the subject of the 'gaze'. The body as object, however, is neither a universal belief nor truth but a product of ways of perceiving and examining it. In relation to nursing, the subjection of the body to the 'gaze' and the practices of the institutional environment of the hospital are important for understanding the knowledge formulated. The power of practice is in the generation of knowledge. The nature and form of knowledge is instrumental in establishing the quality of nurse–patient relationships. This paper explores, through the particular exemplar of the patient in intensive care, the power of present practices to shape knowledge, and thereby dictate and limit the quality of the nurse–patient relationship.

INTRODUCTION

The nature of the knowledge fundamental to health care, and the power it wields during its practice, is of continuing interest to philosophers, social scientists and anthropologists, as well as to those individuals who directly use it in administering health care, namely, doctors, nurses and allied health professionals. The development of sociopolitical critique has centred on the nature of the foundations of knowledge and how this influences our present understanding of the human condition. With the advent of the modern world, there have been continuing controversies about the essential characteristics of rationality. In these debates attempts are made to explain the mechanisms of subtle coercion apparent in our society. These modern approaches focus on the development of knowledge and, concomitantly, power from the 'macro' level. Departing from the traditional approaches to understanding health care, this paper examines the contribution of Foucault, who explains that knowledge is generated through the power intrinsic to 'micro' practices. The

'micro' practices operating within the hospital at the ward level and also, on an individual level, are central to the development of knowledge. The way the body is perceived and examined at this 'micro' level is instrumental to how knowledge is constituted and the creation of meaning. This is discussed in relation to the intensive care patient and the environment in which this patient is nursed. This analysis of intensive care nursing demonstrates the specificity of practices in shaping nursing knowledge and thereby dictating the quality of the nurse–patient relationship.

THE CONTRIBUTION OF FOUCAULT

The work of Foucault provides for insightful analysis of unacknowledged assumptions and metaphors in health care practice. The aim of Foucault is to expose the unity of discourse and practice through articulating the interplay between social practice and social discourse. For Foucault there is 'no unity of history, no unit of subject, no sense of progress, no acceptance of the History of Ideas' (Burrell

1988). His work focuses on power, knowledge and the body, and their inter-relationships (Burrell 1988).

Foucault observed human interactions (events) and recognised them as mechanisms that could be used to discuss, if not finally explain the human condition (Dzurec 1989). This technique provides for the uncovering of the 'positive unconscious of knowledge', the precondition which serves to sustain a particular discourse (Hekman 1986). This description and interpretation of discursive practices departs radically from conventional analysis as the analysis of meaning is not centred on the subject but rather on the process (Hekman 1986). With this approach the power of interactions does not belong to an individual or a group of individuals but rather is a force. The contribution of the force is not merely in repression but, more importantly, to put into circulation apparatuses of knowledge (Smart 1985). The significance of this force, therefore, is in its capacity to determine all that can and will be known. In this respect it is a productive force defining the nature and form of knowledge.

THE 'GAZE'

The significance of the science associated with the development of the modern world is not in its knowledge base but rather in its method, which Foucault describes as a 'penetrative form of observation'. The investigation and discipline of bodies made possible through the 'penetrative gaze', inseparable from scientific study, explains his theses with respect to the development of medical knowledge and the nature of activity within the institution. An understanding of the 'gaze' is necessary in order to appreciate the production of discourse. Acknowledging the power of the 'gaze' permits cognizance of how knowledge is generated by practices within the organization.

Implications of the 'gaze' in understanding the body and its regulation

From an examination of practices, Foucault concluded that the body is of consequence only because of its subjection which allows the production of knowledge (Silverman 1985).

Foucault's approach to disease

For Foucault, the power of medicine is in the 'clinical gaze'; that is, the body is an object of inquiry and the individual is a 'case'. This subjection is important in the progress of medicine where as an object, the body is instrumental in formulating positive knowledge (Smart 1985). The nature of this knowledge is attributable to the 'gaze' which ratifies a 'reading of the body' of the patient.

The consequence of 'reading the body' and the import for the understanding of disease is central to Foucault's argument (Sullivan 1986). In the growing corpus of medi-

cal knowledge, the human body is essentially viewed as a pathological object through which to clarify diagnosis. Sullivan (1986) recalls that it is:

... only after pathological anatomy provided a surface upon which the similarities and differences between diseases could be observed and codified could clinico-pathological correlation become the dominant mode of inquiry into the identity and nature of disease. It allowed the eye of the physician to replace the words of the patient as the measure of similarity and difference between diseases... thus disease begins to be autonomous from patients' experienced sense of disability.

This view of the problematic continues within medical science. It has been proposed that the focus on DNA in medical research is further evidence of 'reading the body', that is (Charlesworth *et al.* 1989).

The new biology transforms the phenomena of life processes into something that can be read. The genetic mechanisms are, precisely a *code*, an information system.

The primacy of the anatomical and biochemical body shapes the nature of clinical interactions. The living body is treated in a cadaverous or machine-like fashion with personal identity stripped away as habitual surroundings and clothes are removed (Leder 1992) and invasive procedures performed. The power of this gaze in medical practice creates interactions of an impersonal form. It establishes the precedent for the quality of clinical interactions which will be discussed in more detail.

Foucault's approach to the organization

Through recognition of the primacy of the body Foucault sees modern power as a form of constraint constituted through social practices rather than through a distortion of beliefs (Fraser 1989). The 'penetrative gaze' characteristic of institutions is an effective instrument for the formation and accumulation of knowledge. The 'gaze' dictates the methods of observation, techniques of registration and procedures for investigation (Silverman 1985). Foucault stresses its significance in the form of the power which emerged through the evolution of disciplinary institutions in the late eighteenth century (Fraser 1989).

This power is the means of control brought about by a series of disciplinary measures inherent in modern institutions; that is; hierarchical observation, normalizing judgement, and the examination (Foucault 1977). Hierarchical observation acknowledges that power is maintained through the surveillance of activities; normalizing judgement is the practice whereby individuals are required to conform, and the examination is these two practices operating in unison. In his discussion of 'docile bodies' Foucault (1977) reasons that the significant element was not merely the control of behaviour or language but, more importantly, the efficiency of movements. This is brought about by the modality, that is, the

uninterrupted, constant coercion, supervising the processes of the activity as opposed to the result.

At an institutional level, the discipline of nursing through its fastidious emphasis on ventilation, noise, food, bedding and cleanliness, parallels the objectification of the subject fundamental to medical practice (Armstrong 1983). With its emphasis on the care of the patient's bodily functions Armstrong recognizes that: 'nursing has started to become a surveillance apparatus which both monitors and evinces the patient's personal identity'. This scenario implies mechanistic type nurse-patient relationships (Armstrong 1983). The problematic as highlighted by Armstrong (1983) is that historically nurses have espoused 'meaningful relationships' with their patients. 'Meaningful' here refers to communication which pertained to a social and/or emotional level. This calls into question the reliability of such accounts of nursing practice. It would appear that the nature of meaningful is subjective to historical events in nursing which have influenced the direction and manner of nursing activities.

CARE OF THE INTENSIVE CARE PATIENT

The explicit consideration of technologies of power and social practices and their complex inter-relationship with forms of knowledge, reveals many possibilities for the revised consideration of nursing activities within the context of the intensive care area.

The 'panopticon', an architectural figure designed by Bentham (1843, cited in Foucault 1977) enabled disciplinary power to be maintained through the normalizing gaze.

Essentially it constituted a programme for the efficient exercise of power through the spatial arrangement of subjects according to a diagram of visibility so as to ensure that at each and every moment any subject might be exposed to 'invisible' observation'.
(Smart 1985)

The panopticon is of particular relevance to nursing activities because of its similarity to the hospital ward, particularly the intensive care unit (Lawler 1991). It is within a panopticon that hospital-based nurses provide health care.

Whilst learning about the theoretical aspect of the panopticon, a group of intensive care nurses collectively considered the implications of this structure on their practice. Accordingly, their focus of analysis was the nature and form of the dynamic interactions within the intensive care area and the accompanying implications, rather than the established forms of authority which ordinarily operate in the bureaucracy of the hospital. The group recognized that the prevailing feature of their work was the subtle, yet powerful requisite to perform tasks which enabled the appropriate documentation of a 24-hour observation sheet (Henderson 1991).

The chart

This 24-hour observation sheet, located near the patient, was the pivotal point on which practice rested. Much thought and discussion was invested by health care professionals in examining this sheet. A close examination provided insight into the established nature of the health care which surrounds it. The flow chart was of interest as it prioritized the information which was deemed to be of most value, through the space and position allocated to it. Inspection showed that the sheet documented heart rate, blood pressure, central venous pressure, respiratory rate and other parameters of respiratory observations, urinary output, wound drainage and other physiological parameters, roughly in that order. All of this information was objective in nature. There was a small amount of space allocated for the recording of subjective data which appeared halfway through the space allocated for the objective physiological parameters. Provision was made in this small space for the recording of the level of consciousness and emotional status. However these observations were quantified on a scale with a limited range of options. These data were not descriptive.

On analysis of the chart it became apparent that observation, and hence consideration, of the emotional status of the patient was not given a high priority. It might have been documented in the medical/nursing notes if it was considered worthy of a mention, but generally received little comment. Cognitive function was not viewed as an emotional component of care but rather used in an objective manner. In the case of the intensive care patient, information as to how the patient felt and their cognitive status was not aimed at discovering an individual's feelings but rather was explicated so as to assess pain levels and the administration of patient sedation. Generally, the nurses felt that the information which had to be recorded on the chart had the power to regulate and dictate the form of their nursing activities. Although this information was often repetitious, it still took priority. The nurses stated that despite, at times, feeling that the patients had a need not related to the information being recorded, they still felt that documentation of the observation sheet took precedence (Henderson 1991). This process inherent in the care of the intensive care patient leads to task-oriented care, a well recognized feature of nursing (Brewer 1983, Melia 1987, Walsh & Ford 1989).

The significance of chart documentation

The significance of this practice is how it leads to the formation of knowledge which contributes to the nature and meaning of subsequent interactions. Through the 'gaze' in the intensive care area the body is objectified. Doctors, nurses and allied health professionals collaborate in order to institute a careful documentation process which separates the body into physical components which can be

measured. This knowledge has not only empowered particular kinds of practice but has also invented a new patient, that is, the 'recorded body'; a body about which little is known at an emotional level but everything at a biochemical and physiological level.

THE RELEVANCE OF CONSTITUTED KNOWLEDGE ON THE PRACTICE OF HEALTH CARE IN THE ORGANIZATION

The concept of the subjection of the body to the 'gaze' is most informative for understanding the present practice of health care and its associated knowledges. The manner in which the individual is examined during hospitalization demonstrates that the body, through scrutiny by doctors, nurses and other allied health care professionals, is the site where different information can be elicited depending on the character of the projected 'gaze'. The organizations of institutional care, that is, hospitals, ensure that these bodies are collectively surveyed thereby reinforcing the continuous presence of the 'gaze'. The power of hospital practice lies in its ability to discern that which is to be known. The conformity and restriction observed in clinical practice contribute to the formation of certain knowledges fundamental to health care.

The practice of recording, a necessary consequence of 'reading' the patient, now shapes health care practice. The process of such investigation and analysis shifts the meaning of a situation or event. Armstrong (1987) noted in relation to the dying patient, that the introduction of a death certificate moved attention from the process of dying to a preoccupation with the dead body. No longer was attention focused on the rituals of grieving but rather on the corpse. Vigilance concerning the appropriate disposal of the corpse and accurate documentation, shifted the focus of practice in relation to the corpse. The new discourse, as described by Foucault, meant that at death the analysable human body was fabricated and the dying was silenced (Armstrong 1987). Similarly, in the intensive care area, the analysable body has led to the formation of knowledges. The knowledges, because of their existence, shape health care practice. In intensive care, practice is focused on eliciting information as to the physiological status of the patient and performing tasks attending to the physical needs of the patient. This form of practice limits the quality of the nurse-patient interaction.

With regard to nursing practice, this trajectory causes us to question the basis of the power/knowledge debate. The power of practice does not necessarily provide for the development of that knowledge which is espoused as central to the domain of professional nursing. The increasing knowledge that the nurse has about the biochemical and physiological status of the patient means that the nurse has power in being able to decipher the chart on which much attention is focused by health care professionals.

The knowledge, however, is not powerful for the development of the 'meaningful' nurse-patient relationship. The 'recorded body' is deficient, in a social and emotional sense. This objective knowledge serves to reduce the power of the nurse in relation to the traditional role of 'caring'. Therein lies the paradox for the intensive care nurse: the constituted knowledge is not powerful in the development of 'meaningful' nurse-patient relationships, but is only powerful in promoting communication which the doctor deems meaningful.

CONCLUSION

This study of the intensive care area reveals the power of practice to determine the knowledge generated within the nurse-patient interaction and hence the quality of the nurse-patient interaction. The subjection of the body to the 'gaze' has implications for how the body is known and how this manifests itself within the work environment. The work of Foucault explains the manner in which information is transformed. There is a need to recognize these unexamined practices within health care institutions to better understand our nursing practice.

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