Subversive Care
An Intersectional Analyses of Nursing as Affective Labor

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Abstract

Nursing and intersectionality is yet an under-explored field of research. This study is a tentative of reflecting about the interconnections between the care process in health settings such as mental health and end-of-life care, body experience and multiple aspects of health, discrimination and hierarchies in the medical setting. This reflection aims at recognizing spaces of autonomy where nursing knowledge could actively contribute to oppose to the medical patriarchal knowledge. By using an intersectional lens, the purpose of this study is to highlight how connections between biopower, assemblages and affective labor may provide useful inputs to the nursing profession and to recognize its potential for subversion.

Number of pages: 66
Table of contents

- Introduction ........................................................................................................................................ 4
- Research questions and structure of the thesis.................................................................................. 9
- Methods, Autoethnography and Ethics............................................................................................ 13
- Background ....................................................................................................................................... 18
- Chapter 1: Intersectionality, Biopower and Affective Labor.............................................................. 21
- Chapter 2: The body in the medical care: nursing and patient’s corporeality.................................... 30
  a) touching the body as a therapeutic act............................................................................................ 34
  b) the virtual body .............................................................................................................................. 36
  c) delegation of the corporeality in healthcare ................................................................................ 37
- Chapter 3: The communication of pain and the limits of medical language
  in caring contexts ................................................................................................................................. 39
- Chapter 4: Nursing in a female psychiatric ward for acute mental conditions.................................. 44
- Chapter 5: Nursing in an End-of-Life setting: dying at home............................................................ 51
- Conclusion.......................................................................................................................................... 57
- Appendix: A collection of gender stereotypes of the nursing profession in Italy............................ 59
- References.......................................................................................................................................... 64
**Introduction**

Perugia, January 2005: my very first week of field experience in a Psychiatric ward, a ward for female patients only. G., short auburn hair and blue eyes, is nervously standing close to the Psychiatrist office door, waiting for her turn to meet the Doctor. She has some very urgent matters to discuss and did not sleep at all last night: the voices are back. Amongst the confusion and the frenetic activities of a typical morning shift in the ward, I cannot help to notice her anxiety in waiting for the Doctor, her arms left dangling on her legs, her open hands slightly shaking. G. refused to take her medicines in the morning, she obsessively repeats that she will take them after seeing the Doctor. It is her turn, she enters the Psychiatrist office… and she leaves after a few minutes: the Doctor has only reinforced the concept that she has to continue with her therapy and the voices will soon disappear. G.’s eyes are wet, she returns to her room after collaboratively taking her tablets, she prefers not to have her breakfast.

I find myself thinking on how her urgency has suddenly become ordinary routine under the Doctor’s eyes, and a feeling of frustration slowly grows in me. A few hours later, when the rhythm of the ward has calmed down, I decide to visit G. in her room: she is sitting on her bed, watching the trees outside the locked window: “Can you see it? Those eyes staring at me, there, in the trees… can you see them?”

I have no right answer, I just stand without speaking. I will never forget my feeling of inadequacy while trying to formulate a “right” answer to her question. All of the theory learned as a nurse student and I was not yet prepared for the field. I kept thinking, how to help, how to therapeutically relate with a person suffering from schizophrenia, hospitalized for re-activation of her symptoms even if under constant treatment for years?

I hear myself asking “whose eyes are those?”

“It’s him. He is back. He knows where I am. He will never leave me alone!” G. starts to become upset, I just made a mess…

Luckily she calms down and slowly goes to bed, asking me why the Doctor did not want to listen to her, and… “What if that was all an agreement between the Doctor and him?” She wants to leave the ward, she does not feel protected. I can see her eyes slowly closing down and her words
becoming blurred: the medicines are working and she is about to sleep. I leave the room but
cannot relieve my feeling of inadequacy: how am I supposed to help? What is my role, as a
Nurse in a Psychiatric ward, apart from giving the prescribed therapy and keeping track of all the
active symptoms for the Doctor to review? Before joining the Unit, fresh from my dissertation in
mental health, all was so clear in my mind, the importance of a multi-disciplinary team and the
process of care and the nursing diagnosis, but now nothing seems to be relevant except my
feeling of frustration for not knowing how to really help.

What I was experiencing, looking back with my current increased awareness and knowledge,
was the impossibility of connecting the individual experience of suffering (e.g. the uniqueness of
G.’s history) to an abstract framework given by interpretative models as structured by the DSM\(^1\),
namely the medical and statistical classification of mental disorders.

Yet, in my studies I have always found very stimulating the discussion about the difficulties of
giving pragmatic meaning to theories, or on the opposite, of how to theorize about tangible and
individual experiences. Maybe for this reason as a student I have been initially attracted by
theoretical philosophy, later by social and medical anthropology, the cultural aspects of the
health and the body, and I finally landed at studying nursing and mental health. Throughout this
journey my being a woman, coming from a place full of contradictions and exposed to post-
colonialism, such as Southern Italy, has shaped my knowledge and gender studies have given
voice to my experience as no other disciplines have done before.

This thesis is a tentative of reflecting about the interconnections between the care process in
health settings such as mental health and end-of-life care, body experience and the irreducibility
of multiple aspects of health/disease to fixed and clear medical diagnosis and objective
categories. This reflection aims at recognizing spaces of autonomy where nursing knowledge
could actively contribute to oppose to the medical patriarchal knowledge. A special emphasis
will be given to the role of the nursing profession to create positive and constructive bridges
between the warm corporeal experience of the patient and the often aseptic and cold medical
approach, which founds its knowledge on the biological quantification of symptoms and signs.

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\(^{1}\) Diagnostic and Statistical Manual of Mental Disorders (DSM), whose fifth edition was published in 2013.
A significant portion of this project will include the reflection about the experience of pain (both in its mental and physical manifestation) and how disruptive this experience can be for the patients, their relatives and the health professionals gravitating around the patient. Coming from a situation where a mental condition has seriously affected the life of a member of my close family and the functionality of my family itself, and having worked in highly demanding contexts such as acute mental health and end-of-life care, my personal experience will be my pivotal orientation throughout this process.

My theoretical background will draw from philosophers who wrote about the irreducibility of the individual experience to any pre-fixed neutral knowledge, such as Nietzsche and Foucault. The centrality of the body and the physical experience will open the ground to connect the theoretical aspects to the pragmatic ones, taking into account that the individual experiences are always embodied: our corporeal processes are mediated by our experience, not by abstract discourses, and many times we cannot even verbalize very meaningful events and relationships in our life. The suggested author for exploring this subject will be Nietzsche, who has used metaphors and poetry, and ultimately the silence, at the very last stage of his work, for the impossibility of giving voice to the deepest and most painful aspects of life.

The deconstruction of the neutral and objective medical discourse will be supported by the theory of sexual difference (Irigaray, Cavarero) that uncovers how the presumed biological and scientific thought is actually a sexualized masculine thought, which has either excluded or marginalized the feminine one. While the affirmation of medical knowledge is typically positive and masculine, on the opposite psychiatric and terminally ill patients are described with female characteristic: passive, not productive any more, failed, unable to cope with the social pressure, in need of support, losers… (the odious word that usually defines a terminally ill person who has "lost" the battle against a chronic disease, a masculine vision of the illness as well). Sexual difference theory clarifies how the medical science reflects a patriarchal system of knowledge and why atypical area of medicine such as psychiatry and end-of-life care are of difficult scientific codification in the medical paradigm.

The reflection about the potential role of nursing in refusing the objective and aseptic medical knowledge is rooted in the specificity of the nursing profession: its physical and relational closeness to the patients intended as a whole, body, mind and emotions. The vision of care as
affective labor, elaborated by Negri and Hardt will highlight the interconnections between biopower and life (Agamben, Foucault, Esposito) and will be supported by intersectionality.

Daily nursing praxis shows how reflecting about the relationship between nurses and the corporeality of the patients is a critical element in the current evolution of the nursing knowledge: however in many western countries the direct management of the body of the patient is delegated to other paramedic figures, such as nurse-aids or technicians (typically for washing the patients or for collecting blood samples).

My thesis would like to highlight that caring does include touching the body of the person and it is nevertheless an act full of potentially therapeutic meaning, which in my opinion has to be performed by trained and highly skilled health professionals. On the contrary, not realizing how the impact of a poorly skilled health worker can have humiliating consequences on the patient is a serious and major issue in the current medical care, as I have witnessed during my years working in the field.

The corporeality, intended as a complex dimension that includes the physical aspect of the body but at the same time involves mental and relational aspects, including gender and how we perceive our body, in my opinion represents a privileged field where nurses perform their profession but at the same time is the place where many nurses experience a deep crisis when they realize that in the medical care the corporeality of the patient is often neglected through strategies that will be explored in the present thesis.

In a closed hospital context, where the institutionalization of the patient is established also with well-defined dynamics of power amongst doctors, nurses and patients, the difficulty of the nurses in understanding the corporeality of the ill person is evident. In this sense the role of the nurses is often described with female characteristics, such as patience, support, ancillary functions. Those functions are seen as naturally present in the women and those assumptions create a subordination to the role of the doctor, seen as the depositary of the objective and scientific medical knowledge, where the nurses are given a more "humanitarian" role.

All those elements lead to define the nurse as the health professional who is constantly dealing with the ambiguity of his mandate, which includes to be close to the body of the patient, when at the same time the hierarchy present in the medical context and its strict means of controlling the
space, the time and the autonomy of the patients (ward routine, not accessible spaces such as the
doctors' rooms, restricted time for receiving the relatives, controlled food and beverages, ...)actually are meant to create an experience of disintegration of the wholeness of the body.

The image of nurses as mediator of the ambiguity, operating in areas whose margins intersect
with health, social space, power relations and therefore may be blurred, being in constant balance
between the aseptic medical knowledge and the bodily experience of pain and suffer of the
patients, will accompany us thought this journey, which as mentioned before is indelibly linked
to my personal and working experiences.
Research questions and structure of the thesis

It is my hope to contribute towards critically reflect about the position of the nursing profession in healthcare and more specifically its social and gendered position, using an intersectional framework.

I approach this research by asking the following three questions:

- are there spaces of autonomy within the nursing profession where a resistance against the neutral and universal, patriarchal knowledge that dominates the medical approach to health and disease, may be present and exercised, and what does happen in those spaces?
- what is the role of intersectionality, biopower and assemblages in nursing knowledge?
- how is body affected by time, space and language manipulations in the health settings, and why does it matter to nursing?

In doing so, I will search for healthcare settings where the medical approach seems to be weak, less structured or in crisis and I will try to identify if and why nursing has more autonomy in those settings, considering that, based on my working experience, where nurses work more independently from the doctors they are more able to creatively find solutions to complex and intersecting health and social, psychological issues thanks to an approach that is flexible, more oriented towards the single person and that includes more actively the corporeal dimension of the person.

The analyses of the role that nursing may play in counteracting the hegemonic medical discourse will be an intersectional one, in the sense that I will try to incorporate reflections about processes of oppression and privilege, social expectations on health and illness, the corporeality dimension of the illness and institutional practices of control of the body, as well as identifying multiple spaces where to implement changes.

The structure of the thesis therefore reflects my search for those spaces of autonomy and I will virtually move between different healthcare scenarios, taking into account my nursing training and work experiences. For this reason I will draw from my biography and I will incorporate memories and reflections of my lived knowledge to support my initial questions.
The purpose is to use my embodied life itinerary to actively produce a critique of the patriarchal system of oppression of diversity, where for diversity I refer in this thesis to how the medical knowledge has identified people suffering from mental health conditions (chapter 4) and terminally ill people (chapter 5).

The structure of this thesis will mirror my biography also in a chronological way. Coming from a theoretical and philosophical background I will depart from authors that have theoretically developed the concept of biopower and I will use this concept for a reflection about how medicine controls and disciplines health institutionalised processes and why nursing may play a critical role in this scenario (chapter 1). I will use the idea of affective labor, as envisioned by Negri and Hardt, even if recognizing that nursing cannot be reduced to its affective dimension, to affirm that nursing may contribute to produce creative healthcare. This is because nursing is a profession that has direct access to the corporeal dimension of the person, and the body is the place where we all incorporate pain, knowledge, culture, social expectations and a multiplicity of life aspects (chapter 2).

When I started working as a nurse I noticed, however, how nurses are increasingly delegating the care of the body of the patient to other healthcare figures, such as nurse-aids, and I will try to reflect in depth about reasons and implications of this current approach.

For this reason the second chapter of the thesis is further divided into three sub-chapters that correspond to a reflection on three major issues that nurses may encounter in their dealing with the body of the patient, the first one being touching the body in a meaningful way, in the subchapter "a) touching the body as a therapeutic act", where I try to focus on how much potentiality for creative care and liberation from the neutral and one-directional medical concept of healthcare is present in the fact that nurses do deal with the corporeal dimension of illness.

The sub-chapter "b) the virtual body" explores the issue of taking care of a body that is sometimes perceived by the patient as a virtual body in the sense that medical diagnostics apparatus make diagnosis and treat the body in medical imaging projections and how this approach often alienates the body of the patient. I will try to reflect on how this issue is relevant to nursing care.
The third sub-chapter "c) delegation of the corporeality in healthcare" is centred on why I think that the delegation of the direct management of the body of the patient by the nurses may negatively affect the quality of the healthcare and I identify this space as a crucial one for actively opposite to the medical hegemony over the ill body.

Moving from the corporeal dimension of the illness to the verbal expression of pain in the third chapter represents a tentative, which again chronologically mirrors my biography of when I started working in the psychiatric context, to reflect about the experience on how medical knowledge is limited in addressing the often non communicability of the pain lived by the patient, both in its physical and emotional, psychological dimensions.

Considering that the experience of pain had affected, at that time, a member of my close family and I had found emotional relief in my love for philosophy and the poetic, metaphorical parabola lived by Nietzsche, in the third chapter I try to focus on how a de-structured language such as a creative and poetic language may be close to the almost incommunicable experience of pain and how this type of language may be used to perform a creative type of nursing care to counteract the negative consequences of the aseptic and structured, masculine medical language.

The fourth and fifth chapters represent my personal working immersion, in chronological order, in two healthcare fields where I believe the medical hegemony shows its limits and opens a space for nursing to affirm all its potentiality for creative and proper intersectional healthcare.

Chapter four focuses on mental care and I tried to highlight how psychiatry represents a sort of frontier space for the affirmative medical knowledge and the recognition that the biomedical approach shows all its limits when dealing with mental conditions, limits that can be turned out in positive implications for nursing and anti hegemonic actions.

Chapter five focuses on end of life care, a field that, at least in my country (Italy) suffers from the almost complete loss of interest of medical intervention and therefore nurses are highly autonomous and may spontaneously provide insights of resistance and very meaningful inputs for a revolution against the mechanicist medical approach to care.

Recognizing that the nursing profession itself suffers from the consequences of the medical and masculine discourse, having nurses been relegated for centuries to an ancillary role in respect to
the doctors role, I have dedicated the final part of the thesis to a collection of stereotypes that
nurses in my country encounter in the workplace and in the social spaces, again taking into
account that professions who are considered being of less value, such as nursing compared to
doctors as occurs in Italy, may actually turn their perceived inferior or weaker condition to a
more creative, flexible and less structured approach.

I believe that this field of nursing knowledge is under-explored, in the sense that currently nurses
are trained to perform as close as possible the rigid and mechanicist medical model of
healthcare, in a tentative to structure the profession as much as possible and following the
concept of evidenced-based care.

I do not deny that, on one hand this empiricist paradigm has indeed provided a reliable basis to
perform safe nursing care, but on the other hand the importance of the individual dimension of
care has been dramatically reduced, as witnessed by the delegation of the corporeal dimension of
care.

My contribute to the field would be to reflect about the huge potentiality for anti-hegemonic
discourse that nursing has, whenever it recognizes its intersectional position both in healthcare
and more broadly in the social dimension as well.
Methods, Autoethnography and Ethics

The choice of autoethnography as methodology for my research comes from the realization that subversion can be exercised only from subjectivation, by positioning ourselves and extracting meaning from lived experiences. This choice is very much connected to feminist intersectional epistemology. Intersectional feminist researchers have hugely contributed to the vision of knowledge as a “situated” one (Haraway 1988), an embodied knowledge, always located in a specific context of production.

By asking the question. “Whose knowledge are we talking about?” we realize that knowledge cannot be separated from an embodied subject, namely from the subject we are talking about. Since situated knowledge equals embodied knowledge, the feminist intersectional epistemology is applied to embodied productions and practices of the subject, who is never a neutral subject.

On the contrary, the subject of the feminist epistemology is a differentiated one, with a body, an age, an ethnicity, a class, a sex, a life in all its intersecting aspects, including unbalanced power, privilege, social position. The question of objectivity in knowledge is a crucial one as well. Recognizing that knowledge is always situated means that who produces knowledge has a partial point of view, not an universal one, and is responsible and accountable of this partial and situated knowledge.

In my opinion, this position is highly liberatory. The lie that knowledge is measurable, objective, universal, essential and evidence-based can be finally uncovered and challenged. Objectivity is a matter of the embodied subject, not a vision that promotes a kind of transcendent approach where who produces knowledge, in the most impartial and scientific way, is somehow not responsible of the production because it does not express their point of view.

Knowledge is produced in a context, it does matter to who produces it, and includes a precise sense of responsibility for the subjects involved. In this sense knowledge is always situated, partial and carries dynamics of power in it.

This is the reason why I chose to use my biography to develop the thesis. At the beginning the philosophical academic background inside me was strongly opposing to use the pronoun “I”, largely avoided in academic contexts where I belonged to, therefore I was initially reluctant to share my experiences and world view, precisely because I feared a lack of impartiality.
However, I acknowledge that studying feminist epistemology has largely contributed to a radical change in the way I currently understand knowledge.

As Lykke explains, “there is no ‘outside,’ no comfortably distant position, from which the world can be analysed. On the contrary, the researcher is involved, in compliance with and co-responsible; and knowledge production will always imply a subjective dimension” (Lykke 2010: 5), and “For some post-modern thinkers this philosophy of science led to relativism and an abandonment of all objectivity criteria. ‘The death of truth’ has been placed on the agenda, stressing that science is nothing but stories, and that no criteria can define why one story is better or worse than another” (ibid)

The idea the Lykke gives of the researcher as a guide has radically changed the way I see academic research, and I fell in love with the concept of the guide: “The guide is not a relativist; on the contrary, she has committed herself to sharing with the traveler her knowledge about the landscape—to show, to give tips, to explain, to point out. But, in contradistinction to the god’s-eye view of the positivist knower, the guide is not an irrefutable authority. In the relationship between the guide and the traveler, ultimately the important factor is always the curiosity of the traveler. At the end of the day, it is the interests, passions and thirst for knowledge of the traveler that determines to what aspects of the guide’s stories about the landscape and its sights she or he will pay attention.” (2010: 6)

I have used biography with the hope to act as a guide and to raise curiosity about the status of nursing knowledge in regards to its connection with feminism and subversion of the patriarchy in the medical field.

Acknowledging my embodied position, I have decided to use the method of autoethnography also for my personal self-consciousness and for trying to extract meaning from my life experiences, in a tentative to reflect about my position and connect my personal story to the social one.

In doing so, I believe it is important to state that my embodied and historical position is that of a 39-year old, white Southern Italian, cis-gendered, able-bodied female, coming from a working middle class and mother of two children. Recognizing that I come from a privileged position as a white and middle class, straight person, I am also someone who has experienced discrimination in at least three major aspects of my life: as a woman, as a person coming from Southern Italy,
and as a nurse. Specifically, as a Southern Italian woman, my life has been clearly shaped by prejudices and post-colonial\(^2\) cultural and socio-economical aspects.

Relevant to this thesis is the fact that I position myself as a person who has been able to recognize direct and factual discrimination in the medical workplace possibly because I have been exposed to different forms of unbalanced power since I was born. The common stereotypes that accompany people coming from Southern Italy, at least in my country, is that we are lazy, slowly-minded, prone to break the law, too extroverted and almost animal-like in our social life.

Added to those prejudices there are those related to being a woman in Southern Italy, typically described by Northern Italians as basically illiterate, not emancipated, passive, catholic, in search of a partner to have a stable income, always prone to have children, apparently chaste but loose women in reality.

Continuing on an autobiographical note, and in a tentative to use situated knowledge, as Sparkes affirms when describing the method of auto-ethnography, “to drawn upon the experience of the author\(\text{'}\)researcher for the purposes of extending sociological understanding” (Sparkes 2000: 21 in Wall: 2008) I realized that my image of a Southern Italy woman had been shaped by others and I had no agency in that.

When I left my home town and moved northern for studying Philosophy, I abruptly realized that I had lived a privileged life since, coming from a middle class family whereas many families in Southern Italy are seriously affected by unemployment and economic issues, and now I had suddenly being reminded of my clearly assigned social position: passive, lazy and loose Southern Italian woman.

And again, years later, when I graduated in Philosophy and enrolled the Nursing program, and especially during my first experiences in the field, a third element of discrimination was suddenly added on myself: being a nurse, a profession of much lower social reputation than the doctor\(\text{'}\)s one, at least in my country.

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\(^2\) Southern Italy is currently undergoing a process of not-recognized post colonialism. Italian institutional history has never acknowledged that Southern Italy has been actually colonized by the North of Italy, both before and after the unity of the country in 1861. However, the socio economic effects of colonialism are still cogent in the South.
I started to reflect that many people had simply categorized me as a Southern Italian female nurse....Summarizing: I was now perceived by others as being:

- lazy
- passive
- loose woman
- of a low social status

Interestingly, before leaving my southern home town I used to see myself as a quite bright person of a middle class status.

My interest for subversion and resistance was born the moment I realized that I had left others decide who I was, and the same moment I decided to direct my work interests in atypical fields of healthcare, perceived as “not worth to work in”, of less value or almost abandoned, like the case of palliative care in Italy.

Feminist intersectional epistemology has provided me with a very important framework where I can finally situate my voice and self-reflex about the responsibility for the knowledge I produce while situating myself as a researcher of subversive spaces in healthcare.

Under an ethics point of view, I do realize that by acknowledging the partiality of my role as a researcher, I cannot speak for others. I can hope to act as a guide and stimulate curiosity, but I cannot skip the dynamics of power, even when talking about subalterns, in this case being nurses perceived as subaltern to doctors. My position of academic researcher is nevertheless a privileged one, and being an European white producer of knowledge I definitely cannot represent, for example, nurses working all over the world at different longitudes and latitudes, with different social and work-related struggles.

The issue of the responsibility in representing minorities is a major one in the white epistemological academic field, since uncovering the position of subalternity of some voices may confirm and crystallize the subalternity itself. An example is that many colleague nurses refuse to accept to see themselves as subaltern to doctors. They simply see their role as being naturally beside the doctor’s one and they receive true personal gratification for being useful and
contributing to the well being of the patient, without asking too many questions about their social status or perceived image. For clarity I wish to specify that I never conducted an organic and structured study, or interviews about the way nurses perceive themselves and their role as care providers, in relation to the patriarchal medical knowledge. I largely drawn from my working experience and personal verbal exchanges with my colleagues in more than ten years of nursing activities. Acting as a sort of “killjoy”3 I tried to confront my opinions about subtle, and sometimes evident, dynamics of unbalanced power in the workfield, and my opinion is that many nurses realize that their mandate is much more complex than what doctor or patient expect, but they need more theoretical and intersectional background, at least in the foundation of the nursing programmes, and eventually in life long learning courses, which are mandatory but tend to focus of practical aspects of the profession rather that providing critically theoretical competencies. Such theoretical background would allow nurses to develop critical thought skills and opportunities for self-reflection.

Other than reinforcing a vision of subalternity, a significant ethic issue is to see the nurses as an homogeneous group and therefore contributing to create an essentialistic vision of the nursing profession. This reflection helps to realize that instead of speaking for subalterm, subalterm (nurses) should be given the possibility to speak for themselves4 and access the privilege that is tightly hold by the power of white Eurocentric academic researchers.

In a tentative to avoid essentialism and reproduction of power as a researcher, and following the suggestion of Lykke (2010) “to focus on small, localized and contextually specific stories, rather than exploring over-arching master narratives that take for granted specific assumptions about society, gendered power differentials, emancipation and particular priorities as regards intersectionalities”, I choose to focus on decentralized, localized places of resistance directly lived and embodied using the method of autoetnography, at the same time trying to support my findings with a theoretical framework and authors who challenged the patriarchal and essentialist relationship between knowledge, subject and science.

3 Reference is made to Sara Ahmed and the image of “Feminist Killjoy” (2010), a figure of troublemaker who disrupts the ease of other people to perform practices that are supposed to make them happy, while this comfort zone is constructed in very limiting ways and is used to control certain groups of people, in this case nurses

4 Reflections about the voice of subalterm in post-colonial studies as analysed by Spivac (1988)
Background

Nursing, care and feminist research seems to be yet an unexplored field in academia. Nursing profession has been gendered from its beginning, and it has been defined a female job given its mandate of care, which has historically been associated to female attitudes.

This seems to have caused feminist scholars to focus on strong examples of women who challenge the gendered stereotype in health and decide to become doctors, therefore opposing to the masculine vision that wanted male doctors and female nurses. As a consequence, more women throughout years have become doctors and actively challenged the medical profession and its gendered male leadership, whereas nursing struggles to affirm its autonomy from its stereotyped gendered public image.

On the other hand, nursing scholars have produced a number of reflections about the "awkward" or "uneasy" relationship between feminism and nursing, in specialized nursing publications (Sullivan 2002, Hoffman 1991) and they often question if feminism has neglected nursing and has not helped to challenge the traditional gendered dynamics of the profession.

Sullivan argues that “nursing has long had an ambivalent relationship with the women's movement. The profession was largely unaffected by the first wave of feminism in the late 1800s to the early 20th century that ultimately granted suffrage to American women. Problems between nursing and feminism emerged with the second wave of the movement in the 1960s, when the battle for access to education, the professions, and freedom from abuse and exploitation occurred. Feminists urged bright, young women interested in health care to eschew nursing in favor of the higher status and more lucrative profession of medicine” (Sullivan 2002: 183)

This vision of nursing, even in feminist research, is caused by the difficulty that nurses have to be recognized by the public opinion as fully autonomous health professionals, due to the narrow biomedical model of care and hierarchical system in medical settings that sees the doctor being in charge of the patient’s health.

“The challenge for feminists (and nurses who are feminists) is to address the differences between protective legislation and equality, rather than trying to turn potential nurses into physicians.” (2002:184)

Nurses are considered, by both doctors and patients, to be assistants of the doctors, unable to formulate independent and critical thinking, unable to use their competencies without having received an order to do so (order given by the “chief”, the doctor). The nurses’ role as fully
competent health professionals is therefore neglected and ignored by public opinion, and by other actors in the medical care and academic knowledge as well.

“Complicating the awkward relationship between nursing and feminism is the portrayal of nursing in the media. Popular characterizations of the nurse as a sexpot or as hard-nosed and uncaring, such as Nurse Ratchet, the appropriately named character in ‘One Flew over the Cuckoo’s Nest.’” (2002:183)

Nursing has also suffered from the consequences of the stereotype of being a “natural” choice for women, much less for men, since it evolves around the process of caring, an aspect of life that is considered to be a “natural” predisposition of women.

“Nursing frequently had been touted as a family-friendly occupation. (Note that this precluded nursing being perceived of as a profession.) A woman (seldom a man) who became a nurse was told that she could work in any city where her husband might find a job, that she could enter and leave as her child care obligations required, and, most importantly, she could schedule days and hours around her family’s needs.” (ibid.)

Previous researches show that nursing knowledge has also tried to incorporate feminist theory in the practice (Wall 2007) and has dealt with biopower and care (Georges 2008), in a tentative to shift from the dominant medical vision of health care and producing meaningful and autonomous innovations in nursing knowledge.

Wall recognizes that “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.” (Wall 2007: 39).

Interestingly, Wall notices that the difficulty for nurses to open to feminist theory is caused by their aspiration towards biomedical science:” Notions of professionalism, and the corresponding need to practice 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” (2007: 40).

And again “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” (ibid.)
On the contrary, the field of women and care has been widely studied by feminist scholars, who have uncovered how notions of caring reveal the traditional gendered differentiation of male and female roles in our society. Those researches, however, never seem to focus on the nursing profession, but on the ethics of care in a broader sense.

An example, for the Italian scenario, is represented by the work of Elena Pulcini, who is developing an ethics of care aimed at understanding which emotions and feelings are at the basis of a caring attitude, therefore enabling care to be freed from the risk of a gendered, altruistic and sentimentalist vision (Pulcini 2009). The ethics of care may bring interesting outputs to the nursing knowledge, in its research of developing a true autonomous epistemology, which in my opinion needs to differentiate from the medical, biomechanistic one.

In conclusion, I believe that reflecting about how nursing, in all its uniqueness and professional dignity, may subvert the patriarchal knowledge in the medical field is at the moment an unexplored topic and I would like to contribute on the field with both my theoretical background and reflections drawn by my work experience.
Chapter 1: Intersectionality, Biopower and Affective labor

Years ago, when I enrolled the nursing program I was still very fresh of my philosophy studies and therefore, in many and variegate occasions I had been academically exposed to the concept of biopower as elaborated by Michael Foucault (Foucault 1978). However, over those past years I was more focused on the anthropological aspects of the concept of care, especially when applied in psychiatric settings, since along the way of my philosophy program I become enamoured of the beautiful discipline of medical anthropology and I was directing all my energies to the project of working in the field of ex- (and restructured) psychiatric facilities with the purpose of uncovering clusters of inequalities even after the closure of “locked asylums” occurred in Italy under the effect of the revolutionary “Basaglia Law”, the Italian Mental Health Act of 1978 that reformed the way mental care is addressed in Italy⁵.

It was during my nursing scholarship and later, while actually working as a nurse that I entered the complex world of power relations between doctor and nursing knowledge, and I started to reflect more broadly about how marked divergences in different fields of knowledge (the medical and the nursing ones), who are supposed to be oriented toward the same aim, can seriously affect the process of care and the expectations of the patients in primis.

Nevertheless only when I enrolled the Gender Studies program I fully realized the interconnections between those different fields, largely thanks to the concept of intersectionality, a framework thanks to which I was able to reflect about how multiple aspects of life interconnect, while they are usually seen as separated.

I was also able to realize that signs of discrimination based on gender, social position, power relations and cultural background clearly appear on the life and the skin of the people. As for my personal experience, after incorporating the concept of intersectionality, I had the opportunity to realize that, situating myself as a nurse with a philosophical background, and working with patients with multiple instances, I was placing myself in the space in which the boundaries between health, clusters of discrimination in the care process, power and privilege issues on the field, the corporeality of the patient ans many other aspects are blurred and exclusively seen and tackled, when recognised, as isolated aspects by the current medical knowledge.

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⁵ Italian law: [legge italiana numero 180 del 13 maggio 1978, "Accertamenti e trattamenti sanitari volontari e obbligatori"] (this law act was a revolutionary one since declared the mental institutions to be outlaw in Italy)
The theory of intersectionality argues that identities are not monolithic and linear, but lived and embodied, and therefore always changing and mutable, experienced through multiple and transversal relations. This approach helps to identify and conceptualize how different systems of oppression and discrimination can simultaneously affect identities and how and why individuals are placed in such diverse social hierarchies of power.

As suggested by Jasbir K. Puar, intersectionality may be considered “the dominant paradigm through which feminist theory has analysed difference” and probably the most important contribution to women’s studies in conjunction with other fields (Puar 2012:49). At the same time, Puar argues that “intersectionality as an intellectual rubric and a tool for political intervention must be supplemented-if not complicated and re conceptualized -by a notion of assemblage”(2012: 50). The notion of assemblage is initially formulated by Deleuze and Guattari (1987) and aims to focus not on the content but on the connections, on the relations between things.

In this sense, while intersectionality may be seen as a framework or a standardized method of inquiry about discriminations, used to theorize about concepts, assemblage describes how concepts connect with other concepts. Using Puar’s words, we should approach this concept asking “not necessarily what assemblages are, but rather what assemblages do” (2012: 57).

Assemblages are relevant to health and illness because they allow to see the body in its constant re-shaping of itself thanks to a variety of relations that are not only biologically located inside the body (such as organic relations between cells and tissues, neurons etc.), but also cultural, social, psychological, physical when physically interacting with other bodies.

My vision of the body has been influenced by the deleuzian vision, that body is a creative entity, able to affect and be affected, able to perform and influence political and social activities: it is not just an organic organized agglomerate of highly specialized cells and organs meant to sustain our material life (this aspect is necessary, but not exclusive).

What does the body do, under an assemblage point of view? First of all, focusing on what the body does, instead of what the body is, allows us to understand that we all are embodied subjects who project our actions and expectations.
Following this suggestion of focusing about the *doing* rather than the *being*, I would like to draw a connection between *intersectionality-assemblage-multitude*, the latter being a concept envisioned by Antonio Negri and Michael Hardt (2004). To better understand this connection and to realize why it is relevant to the nursing knowledge, I will use the concept of biopower as the connecting thread of the discourse.

Puar had already suggested (2012: 62) that the discourse about intersectionality and assemblage was related to the debate on social forms of control and discipline, following the work of Foucault and Deleuze. She argues that “while discipline works at the level of identity, control works at the level of intensity”, and again “Foucault distinguishes between disciplinary mechanisms and security apparatus, what Deleuze would later come to call “control societies”.

On the disciplinary organization of multiplicity, Foucault writes: "Discipline is a mode of individualization of multiplicities rather than something that constructs an edifice of multiple elements on the basis of individuals who are worked on, first of all, individuals” (Foucault 2007: 12). Therefore, Puar suggests not to dismiss assemblages, since “assemblages encompass not only ongoing attempts to destabilize identities and grids, but also the forces that continue to mandate and enforce them” (2012: 63).

Michael Foucault has argued that power is situated and exercised at the level of life, intended both as the human body and the political life (Foucault 1978). Living creatures perform several life activities during their existence: they are born, inhabit a body that is subject to time and space limitation, they mature, may sicken and eventually die. This life cycle may be also applied to whole populations, multitudes composed of such living beings, and that human vitality (and mortality) is subject to several forms of discipline and control. Power over life is defined with the word *biopower*, a set of factors and mechanisms thanks to which life elements become the object of a strategy of power.

It means that this type of power is applied directly over the *bios*, over life also in its very physical and tangible form: the body. Power over the body includes different forms of discipline, mutilation, physical restrictions, objectification of the body, control of the body and and its functions in the health settings as well.
Being, amongst many other characteristics, an assemblage of sensory organs, our body conveys inputs of pleasure and pain as well, and it modulates them. Those bodily experiences are subject to a strong form of control in the medical environment, and the nurses are the ones delegated to deal with it in the healthcare setting. In fact, nurses have constant access to the body of the patient, in its \textit{bare} form, in its raw form, while performing care activities: collection of blood samples, washing intimate part of the body, use of probes and catheters that enter the skin and the organs of the patients.

The concept of \textit{bare bios}, raw life, has been introduced by the Italian philosopher Giorgio Agamben (1995) and I find it to be very relevant to the nursing knowledge and to the topic of biopower. Moreover, the terms "biopower" and "biopolitics" have been used by Antonio Negri and Michael Hardt in \textit{Empire} (2003) and they have made those concepts relevant to their vision of the present society, together with the concept of immaterial and \textit{affective labor}, which has been linked by them to caring jobs, such as nursing. Finally, the exponent of the so-called "Italian thought", the Italian philosopher Roberto Esposito has tried to expand the Foucauldian analysis on biopower, articulating the concept of \textit{immunity} as the "power to preserve life" (Esposito 2004), providing ideas that can be used to support the intersectional approach of nursing knowledge as well.

I will consider using the thought of Agamben, Negri-Hardt and Esposito to support the idea that nursing represents an enormous potential for the valorisation of the singularities and possibly liberation from the patriarchal order.

Even if the current dominant vision of nursing science, at least as I have witnessed during my nursing studies, has a strong focus on biomechanicism, evidence-based rational and technical aspects\textsuperscript{6}, I believe that nursing knowledge has its core in the intersectional position that it occupies and the social value that it may provide: nursing is shaped by and deals with power relations in all of the life aspects, gender, socioeconomic status, age, ethnicity. Illness is a reality for all of us, and if it is true that many illnesses are social and economic-related, many conditions can affect people coming from privileged social positions as well and many people experience

\textsuperscript{6} Nursing science is currently oriented to specialize in very advanced and technical aspects of the process of care, in a tentative to get closer to the medical empiricist and biologist knowledge. In Italy this is confirmed by the fact that nurse-aids are replacing nurses in a variety of daily routines such as washing the patients and assisting them while eating, if they are not physically or mentally autonomous.
hospitalization or need medical/care support at some point in their lives. Nursing manage the
transition from public life to hospital life of the patient and deal with both the corporeality and
the social aspects of illness.

Considering that illness may affect life, and life expectations can change after being diagnosed
with an illness, especially with some types of illnesses like a psychiatric condition or a terminal
condition, nurses are asked to work not only with the body of the patients, but also to be aware
and recognize the social implications and life changes that illness may bring to those people.
Early recognition of social needs after the hospitalization, for example, can help people without
family support to receive prompt assistance by the state in the form of home care.

In my opinion, this is the core of the nursing profession and a truly intersectional knowledge is
vital for the profession to develop and make a change in the healthcare.

An initial step may be the recognition, by nurses, that a self-critical approach, and an awareness
about how to avoid replicating oppressive power relations, are needed in order to construct
positive care processes. Nurses have an ethical mandate to care about people, without making
assumptions about who does or does not deserve medical care, and being self-critical about it
represent a real progress in the nursing profession.

During my years of nursing practice in Italy I heard several times harsh judgements and
assumptions about some patients who did not deserve healthcare, and those comments were
sometimes done by other nurses. Typically included in the category of "not deserving help" were
the patients dealing with substance abuse, or people who underwent a compulsory psychiatric
hospitalization after having mentally decompensating, or people whose weight was strictly
linked to their conditions (a patient who is overweight and also suffering from a cardiac disease,
for example, or a patient who suffers from anorexia and the nurse is struggling to find a vein for
infusion of fluids during the hospitalization).

Treating other people as if they not deserve to be cared of, or as if nobody would care if they die
is based on the assumptions that some lives "deserve" living more than others.

Agamben has made clear that this discrimination is based on the dichotomy zoê/bios: a heritage
of classical Eurocentric culture and strictly related to the concept of biopower and "sovereignty"
(Agamben 1995), a social construction that includes the power, exercised by the ruler, over the life and death of those being ruled.

In *Homo sacer* (1995:3), Agamben underlines how in ancient Greek two words were used when referring to *life*: *bios* and *zoê*, where *bios* is the properly "human" life that deserves to live, whereas *zoê* is the raw life, the *bare*, simple and biological life, that all alive beings have in common but that is not properly "human", is not differentiated. Agamben goes on explaining that, in the classical age, deciding whose life could be considered as bare life was the role of the sovereign who would declare that those who had only bare life could be excluded by the social community and even killed by anyone without fearing legal retribution.

This was the life of *homo sacer*, a figure of archaic Roman law, whose life whose bare life and might be killed and yet not be sacrificed to the gods since his life (*zoê*) was not worth a sacrifice. Power over life has, from the very beginning, involved the body and the management of illness and health, and Agamben underlines that in the biopolitical structure of modernity and the decision on the value or non value of someone's life, "the concept of life "unworthy of being lived" applies first of all to individuals who must be considered as "incurably lost" (....) or "incurable idiots" (1993:81). Therefore terminally ill people or people suffering from acute mental conditions escape the possibility for reintegration in society and following the ideology of sovereignty over life and death, they do not deserve to live.

It is very sad that, having worked in both healthcare settings, the end of life care and the mental health care, I have witnessed that those medical fields are almost abandoned by the current medical knowledge, because either doctors cannot rely on the biologist approach to illness, like in psychiatry, or because the illness cannot be treated anymore, like in end of life care.

This happens because medical sciences and biology are focused on treating the biomedical body, while the body, as envisioned by Deleuze and Guattari (1984), is not only the medicalised *body with organs*, but more a *body without organs*, an organic/non organic confluence of biology, culture and environment (Deleuze and Guattari 1984:9). What emerges from this perspective on the body is the confluence of relation and the potential for creativity and multiform combinations of physical, cultural, gender and social relations, and the relations contribute to what Deleuze and Guattari call *assemblages.*
Assemblages represent the myriad of relations and interactions that develop in an unpredictable way and reassemble and shape our identity, including our body. This means that the dynamics of power and knowledge, including biopower and sovereignty over death and life are never eternal or immutable, on the contrary can be challenged. And it is in those spaces where the power structure is weaker, such as medical frontier zones like mental care and end of life care, that a revolution against forms of control can start, and between those intersections, in my opinion, nursing can emerge as the profession who that can operate the change, at least implementing a self-critical approach of recognizing and not replicating oppressive power relations.

Nursing may focus on recognizing restricted or mutate capacities of the person affected by an illness and can help the person to redefine its capacities to build relations, without necessary pushing them into what society perceives as 'normality'.

This approach enables the creative potential of nursing care to fully express itself, and working on the person capacities and abilities in an inclusive way, taking into account the body biological functions but also its emotional and psychological well being and the cultural and social needs.

The embodied health is always a process, an assemblage in becoming, always creative and never repetitive, as opposed to the medical vision of the biomechanistic body, where health is defined as the absence of a disease, therefore using a negation and a reduction to affirm a reality. Biopower works towards the negation of diversity of deviance, and control over life, negating the validity of individual and bodily knowledge. In this sense health, illness and healthcare are intrinsically political, since for all of us health is also a territory of social control and resistance of our individuality to the sovereign power.

The subject, biopower and biopolitics are central in the vision of the Italian philosopher Tony Negri: he believes that life, in its assemblage meaning, therefore intended not only as biological life but also the political life, constantly exceeds the structures and the apparatus of power (Negri 2003). Negri recognizes the importance of assemblages as a way to talk about singularities, and wonders how minorities ans singularities may become powerful and start an insurrection against the capitalist society and its forms of control. Negri works with Michael Hardt on the project and together they create the concept of multitude (Negri and Hardt 2003), intended as the multiple and differentiated singularities such as precarious workers, migrants, women, manual workers,
indigent people who move to free themselves from the capitalist subordination and looking for spaces of freedom. This is a process in becoming, never linear or static, but similarly to the assemblages it is constantly arranging and rearranging itself, that cuts across multiplicities and the bodies, the desires of the singularities that decide to free themselves, "the multitude is biopolitical self-organization" (Negri-Hardt 2003: 411).

Negri and Hardt depart from the idea that processes of exploitations of people are social (2003: 13) and capitalist productivity is no longer a material one: Michael Hardt explains that the migration from industry to service jobs means tat in our post-modern society "the term service covers a large range of activities, from health care, education, and finance, to transportation, entertainment, and advertising. The jobs, for the most part, are highly mobile and involve flexible skills. Most importantly, they are characterized in general by the central by the central role played by knowledge, information, communication, and affect" (Hardt 2003: 91).

Hardt goes on explaining that the passage towards informational economy involves the development of new production processes, that are now centred on affect, information, and knowledge services, therefore the type of labor involved in this production is immaterial labor, that is, "labor that produces an immaterial good" (2003: 94). Immaterial labor includes affective labor, namely the form of labor based on human contact and interaction, and "health services rely centrally on caring and affective labor (2003: 95). This labor is immaterial, even if it is corporeal and affective, in the sense that its products are intangible: a feeling of ease, well-being, satisfaction. (.....) Caring labor is certainly entirely immersed in the corporeal, the somatic, but the affects it produces are nonetheless immaterial. What affective labor produces are social networks, forms of community, biopower. "(2003: 96) where, for biopower, Hardt refers to the potential of affective labor, the power to manage life, not the activities of procreation but the creation of life "precisely in the production and reproduction of affects"(2003: 99). However, Hardt recognizes that the dangers behind the potential of affective labor as a form of biopower from below may include the sexualization and the gendered division of labor, risking to reinforce the patriarchal constructions of reproduction and the relegation of women as naturally disposed towards affective labor.
Recognizing those risks, however, suggests Hardt, must not deny the potential of affective labor for liberation: ”on one hand, affective labor, the production and reproduction of life, has become firmly embedded as a necessary foundation for capitalist accumulation and patriarchal order. On the other hand, however, the production of affect, subjectivities, and forms of life present an enormous potential for autonomous circuits of valorization, and perhaps for liberation." (2003: 100)

This potential for liberation is fully expressed by the position that nursing has as a profession that produces affective labor and may organize its knowledge towards the recognition of health as an assemblage, creative process and working within the quest for freedom lived by the multitude.
Chapter 2: The body in the medical care: nursing and patient’s corporeality

Our body represents our personal space and it is built through social interactions, similarly our identity is strongly influenced by our actions and how others perceive them, and most of the times our body is the most visible mean to express ourself and to vehicle our actions in the world. Often, through our body and our visible appearance other people collect information about who we are and what position we have in the society. Differences and social identities often reflect the bodily differences, such as difference of age, gender, ability/disability, ethnic differences.

For this reason the body seems to appear a sort of "frame" (Cozzi and Nigris: 2003) of our identity, and it mediates our relationship with the world. The way medical knowledge perceives the bodily identity of the patient is in continuous evolution, as witnessed by all of us with a direct confrontation with older generations: I have always been interested in cultural aspects of health and I remember asking my grandmother about her habits when she was sick and what role doctors had in the society at the beginning of the century (my grandmother recently died at the age of 100 and she has always been a generous direct source of historical information).

Based on such oral narrative, and considering the geographical location of a small town in southern Italy in 1900, it appears is that a few decades ago the body was more likely to be seen as a whole and the medical knowledge was not divided in sections and specialization, therefore when a disease occurred the ill person was treated at home, by a single doctor with a global approach on the person and the physical contact (physical examination) constituted the main source for collecting information about the health status of the patient.

As a consequence, the corporeality of the patient was not only accepted, but it was given a great consideration. When my grandmother and her siblings were infected with typhoid fever at the beginning of 1900 they were not hospitalized but treated at home, they were not seen by the physician specialized in infectious disease, but by their family doctor; they were not treated with expensive anti-viral medication but their mother was recommended to prepare vegetable broth for eliminating the infection. Bodily fluids and waste were part of the loved ones and there was no shame to manage them.
Similarly, pregnancy and maternity were not seen as a matter to be treated by the maternal health specialist, on the contrary they were managed by women with direct experience of helping other women in delivering their babies. Close contact with the body of the mother and child was taken for granted and a great respect was given to what we nowadays call obstetrics.

Throughout the decades, and in consequence to the affirmation of rational and objective-scientific knowledge, the individuals have gone from direct care to very abstract and complicated systems of de-corporatization, where the body of the ill person has been dissected into multiple medical disciplines. Therefore if I currently suffer, for example, from ear pain, I will be referred by my family doctor to the ENT specialist, and similarly for all other body parts; headache: to the Neurologist; stomach pain: to the Gastroenterologist; breast issues: to the Senologist/Breast specialist, and so on. In the current medical framework I easily do not perceive myself as a whole: I feel as my single organs and body part can be assessed like if they have an autonomous life, independently from my being a unique person.

My intent here is not to judge the eloquent medical progress in the medical filed, especially with regards to sensible matters such as transplant of organs or the creation of prosthetic limbs: my reflection is about the distance created between the world of the patient, which is necessary dominated by the perception of the body seen as unite, single element (when we suffer from a pain, it actually affects ourselves deeply both in the body and in the mind, we really cannot isolate the organ suffering form that pain from ourselves), and the way physician deal with the patient creates an increased distance and negation from the body of the ill person.

It is not infrequent, when talking about the ill body and about how to touch the body of an ill person, to hear comments about the potential impurity of the person, and ideas of contamination are often used in today’s society. An example is given by how migrants are accused to potentially spread exotic diseases when reaching developed countries, where many infectious diseases have been eradicated, a vision that is constantly confuted even by scientists.

The concept of impurity of the body of a person suffering from any type of disease is very much confirmed in hospital settings, where the use of physical barriers (gloves, used for performing all variety of actions, including the ones not at risk of infection) and a very strict organization of
time and space, is put in place, together with a rigid hierarchical structure amongst doctor, nurses, patients and a variety of figures gravitating in the hospitals.

I remember, entering for the first time in a hospital as a nurse, my silent reflection about the use of uniforms and their different colors used for remarking the roles and levels of power: surgeons wearing the green gown are more powerful than the white-gown physicians, because they deal directly with life-saving actions in the theatre room, whereas nurses all dress with simple, white nursing overall uniforms. This color hierarchy does have a visual impact on patients; they recognize the authority of doctors and nurses at the expense of their identity. Individuals become patients in the hospital, though a process that we can define as a reduction of their identity.

I remember the terminology used by medical staff while in the psychiatric ward: Ms. G. is the schizophrenic one, Mrs. L. is the bipolar one. I witnessed the same language in other specialist wards: Mr. X is the "hernia" one, Ms. X is the "cancer" one. In truth, every and each of us is much more than a patient, and no one of us perceive ourselves as a "broken leg" or a sick person at all. When we suffer from a condition, we continue to think of ourselves as individuals who temporary have to deal with a medical issue and if we develop a chronic illness we still do not lose our identity.

I would like to depart from the vision of Margrit Shildrick regarding the biomedical body for explaining why nursing is in a position of creating positive change in the way healthcare deals with corporeality of the patients and the way patients deal with illness.

Margrit Shildrick affirms that, contrary to what the medical model presents, the "assumption that the body is some kind of stable and unchanging given, differentiated simply by its variable manifestations of the signs and symptoms of health and disease" (Shildrick 1994: 11) has been unproblematised, whereas "perception and knowledge are always mediated, and bodies themselves are discursive formations" (ibid.).

And again, "at its most schematic, the medical model favours a professional scientific approach in which a reductionist concentration on the pathology of the body serves to dehumanise the "patient" and reduce her to the status of a malfunctioning machine" (ibid.).
The nursing profession affirms its specificity the physical and relational closeness to the patient and its body, in a way that encloses also its social dimension. This is because the concept of care itself goes beyond the objectivity of the reductionist medical paradigm of cure, the care instead being centred to the single person, individually cared by the nurse.

However, often the relation with the corporeal dimension of the patient is the critical point of nursing care, which in my opinion is trying to detach itself form activities connected with the body, such as washing and cleaning the body of the person, or providing assistance to basic daily needs, such as eating or positioning the person correctly in the bed. This happens, in my opinion, because the closeness to the body of the patient is seen as a "less complex" duty in the healthcare, and nursing is trying to affirm itself as an intellectual profession with its proper scientific background, nursing diagnosis and evidence-based practice.

This approach is confirmed by the fact that the care of the body in the hospital institution is now performed by nurse-aids, while nurses are more involved, a part from the administration of the medical therapy, in the planning of the nurse care plans that, in my opinion, are modelled upon the medical paradigm of scientific objectivity.

I argue that this shifting from the corporeal assistance, namely from touching the body of the patient in a therapeutic way, towards the development of a scientific nursing knowledge, may bring negative consequences to the healthcare, since it distances the nurse form the dimension of the body and contributes to the dehumanisation of the patient.

It is true that the difficulty of dealing with the complex dimension of the corporeality in the nursing profession is particularly demanding in the hospital context, where the negation of the identity of the person and the hierarchical structure between doctors, nurses, technician, patients, is evident, and necessary for the hospital to preserve its role of total institution. Therefore, being the corporeality the direct field of activity of the nursing care, it is in dealing with the body that a crisis may occurs in the nursing profession. This crisis, in my opinion, is the fertile terrain where to start working in a creative way and deconstructing the biomedical paradigm.
Another note of ambiguity in nursing is connected to the sexualization of the profession\(^7\), since the care of the body and the assistance to the sick people has been historically attributed to women in the archaic patriarchal society, where the division between paid male work and unpaid female work has seen the activities related to the nurturing of the family members are *naturally* to be performed by women. As a consequence, nursing has been culturally linked by the patriarchal order to feminine aspects like *patience, obedience, sacrifice, subalternity*, and the medical hierarchy in the context of the hospital care has reflected this assumptions, placing the nursing profession in an ancillary position to the medical one.

Nursing is therefore the field of multiple ambiguities and for this reason I believe that it may easily take position against the rigidity and the omniscience of the biomedical model, itself expression of the masculine hegemony. I like to think about the nurse as the person who is positioned in the realm of ambiguity and contradiction between what it is required by their mandate, namely the physical and relational closeness to the patient, and the negation of this closeness and individual care as imposed by the aseptic medical knowledge, dominated by a model of cure based on the observation of objective symptoms and the reduction of the complexity of the person to the sick organ of part of the body.

On a very positive note, my personal work experience in "weak" and less structured field of medicine, such as mental health care and end of life care, encourages me to think that nurses working in marginal areas of assistance are already experimenting the power of being creative in care and producing significant changes. The dehumanization of the person that happens in the hospital context is significantly more contained in home care settings, where patients can be cared of at home and the nurse can develop an increased therapeutic relation with the corporeal dimension of the person, because the manipulation of time and space in home care is mostly absent.

**a) touching the body as a therapeutic act**

Touching the body, in the nursing practice, should be an highly valued competence. However, I have noticed during my working experience, that only the nurses of older generations are competent in this practice. Many young nurses, on the contrary, refuse the closeness to the skin,

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\(^7\) As analysed by the nursing academic scholar and obstetric Nadia Urli (1999)
the smell and the warmth of the person by delegating many basic caring activities to the nurse-aids. In my opinion, the reason for that issue is mainly a socio cultural one: touching the body is in direct contrast with the aseptic model of the medical care. I also suspect that medical schools for doctors teach the aspiring physician to maintain a social distance to the patients, in order to affirm their social role.

On the contrary, nursing schools teach, amongst other competencies, how to perform a correct hygiene to the patient, how to mobilize a patient affected, for example, by cerebral ictus for avoiding pressure skin wounds, how to correctly and respectfully deal with bodily fluids and other corporeal aspects in a not denigrating way. A correct managements of those aspects is necessary done by the nurse touch, and it is vital for the patient. Touching the body is therapeutic in the sense that it conveys a message of well being, when performed with competency, especially in all those cases when verbal communication is not sufficient.

The refuse by the nurse to touch the body of the patient and the delegation of this act to other healthcare actors probably is caused by the assumption that all activities performed in direct contact with the body are not enough complex, too simple and also include a full and direct contact with the most intimate bodily areas, including smells and skin transpiration.

Maybe only a few health professional would like to perform such activities, socially considered to be on a lower scale of importance compared to more aseptic and intellectual duties. However, touching the body of the other is probably the most meaningful way of communication, since touching the person represents entering in a very intimate relation, with stronger implications than, for example, the verbal communication.

Nadia Urli makes a very meaningful distinction between two different modalities of touching for the nurses (1999:49): touching can be *instrumental*, when the physical touch is done for making easier the performing of a following activity, for example disinfecting the skin for cleaning a lesion.

Touching can also be *expressive*, when it is done is a creative and spontaneous way to establish an affective contact.
It may be reasonable that most of the touching modalities in healthcare are instrumental, however also those acts create a contact that has an affective meaning, both for the patient and the care giver, therefore if touching is performed in a non competent way and conveys a message of disrespect, this contributes to the dehumanization of the person in healthcare.

Touching with the gloves when not necessary, namely when there are not risks of infection, may also be perceived in a negative way by the patient. The message is intended as not wanting to get in touch with the skin of the other, considering that the experience of illness is always embodied.

b) the virtual body

I believe that sometimes we perceive our body as something external from us when we undergo some diagnostic procedure. This is what I experienced when I had my first mammogram, my breast uncomfortably squeezed by that cold x-ray machine, and every single projection of my breast from the inside, searching from some abnormal sign.

The introduction of technology in the medical field, in my opinion, has escalated the perception that our body is divided into infinite particles and divided into multiple organs, and whenever one of those particles or organ or body district gets sick, it is not the whole person who is affected, but just those part, which has to be cured or removed in order to be functional again to that machine that we call body. This mechanicist vision of the body expresses the presumption of the medical knowledge that cures the organ, fights the disease, but does not take care of the person as a unique subject.

The current medical technology allows to enter data relative to our body and transform it in information, statistical data, virtual representation, interconnection with medical databases, bypassing the culture, the needs, the fears, the expectations of the person.

The body of the ill person undergoes an information process that leads to a new identity, it is not just a "biological body" anymore, it is a digital identity now connected to computers and visualized by doctors to better planning the therapeutic plan.

Digital health and virtual health communities, auto diagnosis may have a potential for liberation from hegemonic forms of body control, and actually our bodies are already a fusion between
biological and technological elements (as famously anticipated by Donna Haraway), however I cannot deny that for a significant portion of the population, represented by the elderly, the perception that their body is gradually intersecting with technological elements may be extremely distressing.

Many patients in geriatric care, for example, cannot comply with external prosthesis and they prefer not to be treated, since they cannot accept or understand this new version of their body.

While medical technology works toward linearity and order, in a tentative to overcome the limitation of the human body, and also thanks to measurable digital data, many people feel excluded and perceive their body as being external from themselves. In this sense and for those people the virtual body is opposed to the lived body, still perceived as an unity. I believe that nurses have a role in recognizing and addressing both the needs of the virtual body and the lived body as well, again moving across intersecting directions of care and providing individualized assistance.

c) delegation of the corporeality in healthcare

As already analysed, the current biomedical model does not seem to work towards the development any meaningful space to the direct bodily contact between patient and doctor, and similarly does not focus on the importance for the patient to be therapeutically touched by the caregiver.

The relation with the lived body of the ill person may generate a feeling of discomfort and emotionally challenge, and for this reason many health professionals prefer to put a distance and "freeze the emotions", instead of opening to the other and giving affective care. The doctors have tailored for their profession the role of creating a diagnosis and providing a therapy for treating the disease, while the nurse has been delegated to deal with the corporeality, the lived body and the social dimension or family support of the patient.

When a person is hospitalized, it is the nurse who has to introduce them to the hospital routine, and to forms of time and space control, such as the time for the visits by the family and friends, and all of the norms regarding food or what can enter the hospital space.
This delegation made by the doctor to the nurse has defined the role and the function of the latter, and has placed the nurse in the field of the direct assistance, the most intimate and total and complex of the healthcare. This dimension, in my opinion, is also the place where a revolution in the care can happen, towards the humanization of the medical assistance and knowledge.

The limits of the nursing position, and the reason why the profession is currently unable to make the cultural and social jump of affirming its intersectional and creative mandate, is the fact that nursing has developed itself in a subordinate position and yet following the path of the medical paradigm, dominated by the organicist model of body, which does not provide the necessary skills for opening to the other and understanding the pain and the sufferance.

The experience of pain is strongly individual and subjective, nevertheless it is not rare to hear doctors complaining about a patient who "has been exaggerating about their pain", while on the contrary the patient continues to feel not understood and often look for alternative or more holistic forms of medicine, such as traditional medicine, bioenergy medicine and similar.

My impression, as witnessed on the field, is that sometimes the doctors consider the narrative of symptoms of the patient not reliable, and maybe this approach is caused by their medical education, where they learn by reduction and exclusion, not inclusion of the emotional aspects of the illness. It is not rare that patients express to the nurse their frustration for not being understood, or not understanding the doctor, and they ask for support to the nurse also to better understand their medical condition and what it is going to happen to them. In my opinion, only recuperating the corporeal dimension of the person as a whole, with their individual, cultural and social history, the pain and the illness as a fully human experience can be understandable and therefore properly addressed by healthcare.
Chapter 3: The communication of pain and the limits of medical language in caring contexts

The physical, emotional or mental pain has a very unique place in our life, since its object is ourselves, while all other senses are projected toward external objects, like hearing a sound, or desiring, fearing something or touching an object. All those actions are placed outside our body and create relations with the external world, are measurable. On the contrary, pain cannot go beyond the boundaries of ourselves, it can be expressed but not proved or lived by others, it is not objectively measurable. Our friends and loved one of course can empathise with us, however the pain that we experience remains a subjective experience.

Considering that the pain is always embodied and lived through the body, we must not forget that the body is an assemblage and therefore immersed in a myriad of relations with the world and the people, and for that reason the need of communicating the pain is central in our experience.

Nevertheless, intense and total pain is often not communicable, and since the person who is suffering cannot easily express how they feel, the language used for talking about pain is often codified by those who speak for the person: this is the case of the medical language.

Doctors and nurses should be able to interpret and express the pain that the patient cannot communicate, in order to produce quality healthcare. However, often the patient is considered not to be a reliable narrator of their sufferance, and this happens, in my opinion, because the medical approach is so focused on its biologist research for objective evidence that, being the pain not measurable by laboratory results or diagnostic tests, is often neglected.

The negation of the reality of the pain, for the patient, escalates the pain itself and de-humanize the person and neglect their right to be understood and treated, cured and be cared of.

The limits of the medical language to properly address the experience of pain are easily recognizable in the context of the hospital care that, being a total institution, creates mechanisms of control of the subjectivity of the patient, negating or reducing their identity. This includes the dimension of pain.
In Italy, in the hospital context it is very common to witness, for example, a sort of infantilization of the person who is suffering, who sometimes receives half information about their medical condition, or advice and recommendations meant to falsely calm them and their anxiety. Another example is the complexity of the medical terminology, so technical and impersonal that creates a barrier between the patient-doctor communication.

Typical of the failure of nursing communication with the patient is, for example, the habit of changing the bed linen of a person who is in pain without looking at them and talking with the nurse colleague about meaningless questions.

Why is the medical scientific language so unable to recognize the depth of the experience of pain?

I would like to refer to the experience of failure of logical and rational thought expressed by Friedrich Nietzsche and his use of poetry and metaphoric language to express the human condition, and I would like to suggest nursing knowledge to build upon those consideration for opening to a creative and maybe poetic language when dealing with patients in pain.

In *Dionysos-Dithyramben*\(^8\), Nietzsche affirms that the poetic language is able to create and move across infinite worlds, it proves that there is not a world that is the same for all of us, and that pain and existence are united in the poetic language. When the objective and measurable qualities exceed the subjective experience of pain, the person has the perception of the non-communicability of the experience and therefore the failure of the logical and rational language.

For Nietzsche, the poetic language is a way of communicating that is not static, but colourful and able to express and capture the variety of reality, a reality that encloses infinite ways of expressions, including the poetic language and the silence.

The use of the poetic language in the last period of Nietzschean theoretical production represents the last tentative of using a language that is free from the over-conceptualization of the scientific language (Galimberti 2000). The modern science, Nietzsche argues, and the philosophy itself, in the research for universal and irrefutable evidence and knowledge, has lost the ability to communicate in a passionate, fully lived and embodied way. The scientific language has become

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\(^8\) Italian edition cured by Colli and Montinari (1997)
aseptic, crystallized, measurable, without colour, whereas life in all its expression, including pain and sufferance is full of colours and imagines, emotions.

Another element of the rational language is the fact that objective knowledge cannot contradict itself: something cannot be and not be at the same time. Life contradicts this principle, since often apparently contradictory thoughts or feeling can be present simultaneously and this make life even more colourful and joyfully chaotic.

Poetry language is not crystallized yet, Nietzsche argues, because it is still connected to the lived images and feelings and can express pain, as well as joy, using images and metaphors. Therefore the acknowledgement of the multiplicity of reality and the limits of the dry technicism of objective knowledge where the basis of the experimental use of poetry in the last period of Nietzsche, until he reached what is beyond language, the silence, the impossibility to communicate to others our own experience. Rationality is a lie, and life is dominated by chaos and undifferentiated multiplicity. This thematic is often referred as the vision of Apollonian and Dionysian dichotomy, where the two Greek gods represent the linearity of life, which is a lie (Apollo) and the reality of life which is chaos and irrationality (Dionysus).

Being the scientific language a product of the masculine hegemonic thought, and as uncovered by the philosopher of sexual difference Luce Irigaray (Irigaray 1989), I would like to think of the use of poetic language as a tentative to subvert the power structures that see both the subject and the object of science, including the medical science, a male. The central actor of medical science, and therefore the health care, has been a male from the very beginning: the unique, linear subject.

On the contrary, fragmentation, multiplicity, difference represent a deviance that is negated by the medical science because it violates the principle of non contradiction, basis of the mechanistic thought. Mental health and end of life care, in my opinion, can be seen as two examples of this "deviance" from the self-confident science and therefore represent a crisis for the patriarchal medical knowledge.

The failure of the medical language to communicate with the patient opens the ground, I believe, to very interesting consequences for nursing knowledge and practice. Before analysing the connection between subversion, language and artistic production, I would like to focus on the
importance of choosing the correct words in the interaction with the patients. The language is a part of the therapeutic process and the words used in the dialogue with the patient can have a strong influence on the care itself, and the poetic language with its metaphors and rich images can facilitate the elaboration of the patient’s condition, improving the well-being.

What does it mean, for nurses, to use a poetic language in the care process?

It means developing a type of care that revolves around the single person, that uses images to explain needs and emotions connected to the illness, and that allows to communicate with critically ill people, like in the case of acute psychotic patients and terminally ill people.

A beautiful aspect of the nursing profession is the closeness to the person as a whole: the body, the mind, the emotions, the sociality, the relatives and friends (considering that nurses also deal with practical sides of the assistance, like for example clothes, personal objects, image and care of the body), and this closeness to the person gives access to the life of people at their most vulnerable time, when they are ill, chronically ill, acutely ill or when they are about to die.

This allows nurses to witness human histories that probably even the most creative writer could not image, therefore why not use a creative language when dealing with people, instead of the over-rational and neutral language imposed by the medical approach? The poetic language is powerful because it draws from life images and deconstruct the lie of the objectivity, for this reason I think that, when patients ask for the reason of an illness: “Why is this happening to me? What did I do wrong? Am I to be punished for the pain I caused to others?” the use of images can produce a meaningful change in how to deal with the condition.

As a palliative care nurse, I have witnessed how the pain of the oncological patient at the end of the life is a total pain, in the sense that the pain is experienced at all levels: physical, psychological, social, emotional. Being that a subjective experience, there is not an objective way to deal with it, under a therapeutic point of view, and the relational aspect is a crucial one. In my opinion, the objectivity of the medical language cannot provide adequate answers to the sense of anxiety and the pain of the patient and the relatives close to them. The powerlessness of the scientific language in accompanying a person to death is tragically evident in the use of empty words of encouragement, words of embarrassed and false hope that the pain will disappear and the day after everything will be better...
Being the nursing care performed on the single person, on the single subject, I believe there is space for resistance and subversion in the use of a creative language that may be able to relate with the person and help to communicate even the experience of total pain. Following the suggestion of Negri and Hardt that nursing is immaterial affective labor, therefore a creative form of production of an immaterial product (well being), nursing can disrupt the power by creatively producing a new form of care, a subjective and embodied care, free from the assumption of the neutral and evidence-based care.

The power flows through life, through the life of the subjects and the subjectivity is the place where subversion can take place.
Chapter 4: Nursing in a Female Psychiatric ward for acute mental conditions

My very first work experience as a nurse was in a protected facility, in Perugia, central Italy, a long-term medical facility that hosted people dealing with multiple chronic conditions AIDS-related, all of the patients had no income or family support and therefore were admitted under recommendation of state social workers. It was a residential setting, where every person actually lived there, their rooms were personalized and from the outside it just looked like a villa in the beautiful countryside.

Being on long-term treatment, all the guests knew each other very well, including the members of the multi disciplinary team who worked there: doctors, nurses, psychologists and social workers. The arrival of a new face was always a huge challenge for the guests, since it implied revealing their medical and life conditions to a complete stranger, who was supposed to be introduced to their social and health background for continuity-of-care purposes.

I must admit that I really value, now, the fact that I entered the medical field in a very uncommon working environment, where the interior of the facility was modelled by the patients' personality and personal taste, and I had to access their space asking for permission. I was the intruder who was basically having access to their kitchen, their bedrooms, their life without being invited.

My role was very simple on paper: administering the medications, being sure that the patients were actually taking them, considering that each guest was suffering from multiple conditions and therefore the number and type of medications to be taken was really high.

One of the patients was J., a very young lady, in her twenties, with a confirmed diagnosis of AIDS after having being raped while she was working as a sex worker. She also had been diagnosed with bipolar syndrome and periodically has issues in complying with the retro viral and anti psychotic therapy, she was often very explicit about how she felt her life being useless and she periodically was highly oppositive to any type of medical support.

I was told by my colleagues that she was used to leave the facility without informing the personnel, for several days a month and then showing up when she needed solace, and when she
was back she was utterly devastated both physically and mentally. She was a very secluded person and I must admit that I was completely clueless on how to even just relate to her.

My experience in that facility was very short, because after a few weeks I was notified of a new job offer and I quit them: I was about to start my experience in the public hospital, always in Perugia, and more specifically in the female psychiatric ward.

With my astonishment, one of the first patients I met in the ward was J., who had just been hospitalized in psychiatry after having tried to commit suicide, and when discovered had tried to harm some of the people who were staying in the protected facility I had just left. I could witness first hand the huge difference of care provided in the hospital ward and how it affected her, compared to how care was delivered in the protected facility: doctors and nurses do strictly manage the time and the space in the hospital, the rooms and the corridors are aseptic, the body of the patient is constantly manipulated.

In a psychiatric ward this may even become coercive: the hospitalization of J. was done against her will, therefore she was determined to use all the means to fight and escape the ward. She was crying, and kicking and trying to bite doctors and nurses in a desperate tentative to escape. At the end she was immobilized on the ground and she was administered an injection of strong relaxant and anti psychotic treatment. Afterwards, she slept for one day and entered the routine of the ward, trying her best to modulate her mood with the purpose of being discharged as soon as possible.

During her stay at the ward she never gave a sign that we had already known each other. She left the ward when her conditions had stabilized, and she returned to the protected facility. We never met again.

In the ward, I was assigned to a very experienced nurse for our shifts, she was about to reach the retirement age and, to me, she acted as a live historical memory of all the changes in mental health care in Italy, which she had witnessed throughout her career. During our nightly shift conversations, I eagerly asked for her memories and considerations about how the Basaglia Law changed in praxis the nursing role in the psychiatric setting, and my colleague was very much happy to remember the old times.
The Law no. 180 was published in Italy on 13 May 1978 and it is often referred as the most revolutionary Italian Law. It was elaborated by the Italian psychiatrist Franco Basaglia, who in his studies was influenced by Sartre, Merleau-Ponty, Heidegger\(^9\) and it represented the end of the mental total institutions in Italy. Until then, people suffering from mental conditions were institutionalised, the majority of them on a very long term, or forever. Many of them were admitted when they were just children and never returned home alive, they spent all their lives locked in the *manicomio* (asylum) because they were judged, by the dominant medical knowledge, not fit to be part or to be re-introduced in the society.

The Basaglia Law, as a matter of fact, unlocked the psychiatric institutions and all the patients, now dignified people again, were directed either to their families, which were meant to be supported by several projects of care delegated to the local mental authorities, or, for patients without family support, they were assigned to semi-residential facilities and proper houses were provided by the state. It was a huge change and many territorial realities were not ready to deal with the integration of the so-called *matti* (mad people), now suddenly and easily visible in every day life.

What was left of the psychiatric ward that by law could now admit no more than fifteen patients, was meant to deal with acute conditions, when people affected by a mental condition were showing signs of not compensating and they needed to be assessed and treated in a protected environment, namely the psychiatric unit. However, the Basaglia Law stated that the duration of the hospitalization had to be limited in time, less than one month for major cases and only with the consent of the state authorities for coercitive hospitalization. This happened when the conditions of the person could result in harming themselves or people around them.

Going back to my nightly conversations with my colleague in the psychiatric ward, I already mentioned that I eagerly wanted to know how it was like before the Basaglia Law, my interest being at the time an anthropological one, oriented to understand the dynamics between patients and society. I did not yet have an intersectional approach and I was focusing on the concepts of health and illness under a social point of view, without considering intersecting aspects such as

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\(^9\) For a biography of the psychiatrist Franco Basaglia, see Parmegiani and Zanetti (2007)
corporeality, mental disability or gender (I was in female ward, with a privileged position to reflect about the feminine response to that environment).

With an increased awareness, I realize now that nurses working in mental health deal with multiplicity and instability in the sense that psychiatry care leaves a door open to creativity, as opposed to other healthcare settings such as for example surgery or critical care, where nurses undergo a highly specialized and technical training and in a few months is safely able to deal with medical emergencies and the technical activities become a routine.

A nurse working in mental health is placed in a different scenario: the pain and the needs that have to be addressed are often unspeakable, so intimate that there are no routine techniques that can be used to ease it. Most of the times the patient in a psychiatric ward denies help from the nurse, does not want to be touched or refuses the treatment, especially if they are dealing with persecutory thoughts. This can create frustration and anger in nurses, who cannot see how this crisis does open the road to real change: using the silence, or respecting the patient who does not want to be touched or washed, creating meaningful care relations is something that can actually be done in this unstable context.

But why is mental health care different from, for example, critical care or internal medicine or surgical care? Why would be easier, for nurses, to work with an intersectional and creative approach even if the psychiatric field is so complex that cannot be codified with linear evidence-based guidelines?

My opinion is that mental illness, as opposed to the majority of other medical branches, shows all the limits of the linear patriarchal medical knowledge, based on the methodology of cause-effects.

Mental illness demonstrates that health does not concern only the biological body, but also the relational social, affective and creative one. Being healthy or sick, being strong or weak is not incontestable, is not constant: identities are transitory, not linear. Mental conditions are now described as syndromes, not as fixed, immutable diagnoses. That happens because the medical science has recognized that, for example, a person whose onset of mental condition shows the
symptomatology and the signs of an obsessive-compulsive disorder, within a few years can evolve in bipolar condition, who may later evolve in a psychotic condition such as schizophrenia. The transience of identities and mental states is something that we experience throughout our whole life and recognizing it helps us to enlarge the boundaries of the so-called "normality": the person suffering from an acute mental condition shows their pain going beyond the limit of what we identify as "normal" or socially acceptable.

The Italian feminist psychiatrist Assunta Signorelli\textsuperscript{10} explains that in order to accept and understand the person who is suffering from a mental condition we have to widen the boundaries of what is considered "normal", not pushing them into the perceived normality (Signorelli 2015). She suggests that we should admit our inability to medically interpret the mental distress, and suspend our judgement on the person, we just need to value the others for how they are, subjects like ourselves, and respect them (2015:74). In my opinion, this approach is very relevant to the nursing practice, since it suggests what are the key points in the mental care process and helps healthcare providers to build up positive therapeutic relations with the patients.

As a young nurse, I was wondering: "How to therapeutically relate with a person suffering from schizophrenia, and I think that being available to embrace the other, challenging our knowledge and assumptions and suspending the judgement on other’s diversity may be the answer.

In healthcare I often hear references to the importance of "creating a distance", being neutral when dealing with the pain of the patients, in order not to be overwhelmed and to continue functioning and providing high-quality assistance, but I have witnessed that this approach in the medical care does not contribute to the health of the patients, and its limits become very visible in mental care, where the biological approach to the illness is very limited and not at all predominant.

Opposed to the culture of the distance, there is the culture of the openness and closeness: being open to the patient who suffers from a mental condition means being creative and opening our space to embrace the other, allowing them to feel not alone any more. Embracing the other may be challenging for the nurse but it is the moment when the solitude and the isolation of the other really breaks down and meaningful relations can be built.

\textsuperscript{10} Assunta Signorelli was a close colleague and collaborator to the psychiatrist Franco Basaglia, she studies the gender and psychiatry question in Italy (2015)
Being accepted is already an answer for the patient in a psychiatric ward: I remember when a woman was admitted in the ward with the diagnosis of severe catatonic depression. She was completely speechless and motionless, she could not eat or drink, her bright eyes open but fixed and clouded.

Unfortunately, even if doctors and colleagues knew that she was an human being who was dealing with unbearable mental and emotional sufferance, she was treated by some of them like an exhibit animal: they used to talk about her, in front of her often in a disrespectful way because she could not collaborate with the daily body cleansing and the treatment. She had built a wall inside her for protecting from her pain, and my colleagues were additionally building a wall to distantiate themselves from what they could not understand and accept.

After days of massive anti-depressant therapy she slowly relieved her mental distress, but that was not supported by creative and meaningful relational care. Even after several diagnostic tests (MRI, EEG, etc.) and during a number of medical interviews conducted by the psychiatrist and between her and her relatives it was not clear what had pushed this woman to fall into such a severe catatonic depression. The wall she had build in herself and between others was still in place and that was a missed opportunity for the whole equipe to positively make a difference in her life.

What does it mean to nurses to be creative in mental healthcare?

I am not referring to art-therapy laboratories for people suffering from a mental condition, on the contrary I believe that they should attend art courses not specifically targeted to them, regular art courses. For creativity I mean focusing of the doing, for a moment leaving ourselves and who we are and opening to the other, take on an attitude of moving towards the other, widen the boundaries of our judgements and starting to listen to what the other is saying, or not saying.

Amanda Signorelli affirms that sometimes she has the feeling that psychiatry is not properly a science, in its empiricist sense (2015:75), but it is closer to philosophy: psychiatry approaches and schools go along philosophy streams, and follow or precede social movements. She poetically affirms that psychiatry, at the end, is a tentative to understand the modalities of how to live, how to stay in the world. For this reason psychiatry should not try to affirm its medical
power by using force against the body, in the tentative to "fix" the mind, like what happens with coercive treatment, on the contrary should open to its social and philosophical soul.

Once again I believe that nursing is the health profession that is intrinsically projected toward the social and cultural aspects of health and illness, therefore in a discipline like psychiatry, where the biologist paradigm is weak, there is space for producing quality healthcare, centred on the relation with the person and finally shifting the focus from the illness to the patient.
Chapter 5: Nursing in an End-of-Life setting: dying at home

Death really is intersectional: it arrives for everybody, no matters of ethnicity, gender, age, socioeconomical status. While some specific types of illness can affect some groups of population and they are sometimes triggered by socio-economical factors, death equally affects human beings by definition. What is not equal is the way we die, how we die: some people have the privilege to die surrounded by the love of friends and relatives, at home, while for others death occurs in isolation, fear, violence.

The Italian songwriter and singer Fabrizio De Andre’ has written a beautiful song about death, describing how dealing with death is subjective and it may depend by our social position:

[The Death]

La morte verrà all'improvviso
avrà le tue labbra e i tuoi occhi
ti coprirà di un velo bianco
addormentandosi al tuo fianco
nell'ozio, nel sonno, in battaglia
verrà senza darti avvisaglia
la morte va a colpo sicuro
non suona il corno né il tamburo.

Madonna che in limpida fonte
ristori le membra stupende
la morte non ti vedrà in faccia
avrà il tuo seno e le tue braccia.
Prelati, notabili e conti
sull’uscio piangeste ben forte
chi ben condusse sua vita
male sopporterà sua morte.

Straccioni che senza vergogna
portaste il cilicio o la gogna
partirvene non fu fatica
perché la morte vi fu amica.

Guerrieri che in punto di lancia
dal suolo d’Oriente alla Francia
di strage menaste gran vanto
e fra i nemici il lutto e il pianto

davanti all’estrema nemica
non serve coraggio o fatica
non serve colpirla nel cuore
perché la morte mai non muore\(^{11}\)

\(^{11}\) My translation: “Death will suddenly arrive, will have your lips and your eyes, will cover you with a white veil and will sleep beside you. While resting, sleeping or fighting, death will arrive without announcing, without hesitation, without clamour. Woman, you wash your beautiful body in fresh waters, death will not look at your face but will have your breasts and your arms. Bishops, nobles and counts, you cried very loud at your door, who lived in privilege cannot bear the idea of death. Poor people who humbly suffered in life, death was a friend to you and departing was light. Warriors who fought everywhere from East to France and caused grief and sorrow to your
Continuing on an autobiographical note, after working for several years in the psychiatric ward, I moved to the territorial service of end-of-life care, the palliative care unit. I remember one of my nurse colleague asking me: "Why do you want to work with people who are going to die for sure, what is the purpose of giving assistance to someone who cannot be cured? You will not learn anything under a technical point of view, for me this job has to be done by nurses who are going to retire and are not motivated anymore".

I was quite shocked and frustrated to learn how death is seen, by the medical paradigm, as the defeat of the medicine, and when I started my training in palliative care I also learnt how difficult is in Italy for terminally-ill patients to receive a dignity in end of life: Italian doctors, especially in Southern Italy, where the catholic influence is strong, are resistant to prescribe palliative treatment, such as morphine, and they justify their position by affirming that opioid drugs create dependence. In my opinion, and based on what I have witnessed, most of the doctors believe that pain has to be experienced and not removed.

The issue of opioid dependence for terminally ill people, of course, is a non-sense. Putting dependence against unbearable pain on the scale of risks-benefits (an image often used by doctors to convince patients about the validity of the proposed treatment), surely the vantages of not feeling devastating oncology pain outnumbers the risks of developing a drug dependence during the last weeks of life.

Why is this relevant to nursing and what can nurses do to create quality end of life care?
Similarly to what happens in mental health care, where the diagnosis are not biologically made or laboratory-evidence defined and the openness/creativity of the nurses makes a difference in the care process, end of life care is, under a medical point of view, the realm of the medical defeat.

The linearity and the presumption of the medical knowledge, that illness is an enemy that has to be eradicated from the hosting body, suddenly crush against the reality on the "incurable" disease and the focus seems to switch from the enemy, the disease, to the patient, the person who has lost enemies, in front of the latest enemy courage and efforts are vain, you cannot hit it at the heart because death cannot die."
the battle against it. Typically people suffering from a mental condition and terminally ill people are associated and described with feminine attributes and personality traits patriarchally assigned: sensitive, weak, fragile, losers. I personally very much oppose to the concept that terminally ill people have lost their battle against any sort of disease, it gives me the impression that, whenever a person successful heals against an illness, the credit goes to the medical equipe, while for incurable conditions the focus shifts on the inability of the person to keep on living.

And I have witnessed this medical approach first hand during my work in palliative care: I was assigned to an home care unit, and I was stunned when I realized how much autonomy nurses have in this very peculiar field of healthcare, like if doctors rarely want to be involved in it.

In Italy, palliative care is performed either in the facilities called hospice or directly at the home of the patient. Usually the hospice is the facility that supports the families who carry the burden of dealing with all the distress coming with a diagnosis of terminal disease, namely the end of life of their loved ones. Every time that the pain and the direct management of the person is becoming too much for the family, the hospice accepts the patient and a net of social and healthcare workers provide support to the affected person and the family as well.

Whenever the family decides that the loved one may be taken care of at home, the palliative nurses provide daily assistance and end of life care. I was one of those nurses, entering the private space of the person and their family with my nursing bag and trying to do my best to alleviate pain and guarantee a good quality of life weeks before dying.

Whoever has been close to a terminally ill person knows very well how the body of the person changes, and how many signs of medical support are present on their body: gastric tubes, central vein accesses, catheters, ostomy bags, deep wound dressing bandages, artery lines, semi-permanent subcutaneous lines for the opioid treatment.... And above all, the person and the body that suffers the oncology pain, their room, the pictures, the clothes and the relatives/friends who eagerly await for the daily visit of the nurse to change that dressing, and to check on the quantity of the morphine, because sometimes they still feel pain, and “what if something is going wrong with the treatment?”
Accompanying a person to die at home, with dignity, is a complete humbling and distressing, yet enriching experience, where the nurse is alone, without the superstructure of the hospital and the presumption and the omniscience of the medical paradigm. I am not denying that all nurses, in the hospital wards, do deal with death: in emergency, critical area, surgical rooms, geriatric units and many other care settings. However, providing home assistance to a person who is slowly leaving this world is different, nurses are much more exposed to their life and less "protected" from emotional breakdown.

We must not forget that each of us has a personal idea about death, maybe some of us fear it, some of us think that is part of the normal life cycle, others may have a religious view about it. Nurses do not make exceptions.

We cannot make experience of our own death and telling it to others, but we encounter death when we witness the death of a person close to us, a loved one. From that point we start formulating our own perception about death, and sometimes we may forget or deny that we will make experience of death. This is very true for the biologist medicine, that finds the limit of its omniscience in the unavoidability of death. My personal opinion about the relation that the medicine currently has with death is that medicine is ignoring it, pretending that death is an aspect of life that does not need attention. The consequences of the negation of death in healthcare is that patients close to death are abandoned, not treated with dignity, hidden and isolated like if they give scandal, or sometimes pretending that they can still be cured, and therefore are exposed to indescribable therapeutic persistence, with painful and invasive medical procedures whose discomfort outnumbers the expected benefits.

Following the short essay written by the palliative care physician Giovanni Zaninetta (2001), who wonders id death can be cured (Zaninetta 2001: 273), I would answer that death can be avoided, and this is the aim of medicine, but interesting for nursing knowledge is that unavoidable death cannot be cured but, shifting focus from death to the person, end of life can and must be taken care of.

The approach of medicine on death is that of a war against it, and this may be justified when death can be avoided, but when death cannot be avoided, like in the final phase of a chronic and degenerative condition like cancer, people have still the right to be cared. The issue is that
medical knowledge, in its delusion of being omniscient, is not interested in a "lost battle", and distances itself from this phase of the life, putting the patient at the margins of life, in a zone that is not yet death but at the same time not "real life" anymore. This crisis opens the door for a deep reflection, for all health personnel, to finally develop a creative and meaningful relation with the patient.

I think this is the reason why nurses are autonomous in end of life care, because it is the one medical field that shows the defeat of the triumphant medicine, the medicine that pledges to find a cure for all diseases, and that when it fails, the cause if of the person who has lost the battle. Opposed to the concept of medical cure, there is the concept of nursing care, a care that has to be guaranteed to every person and that is managed by the nurse who often experiences the isolation, in common with the patient.

At the nurse is requested to take care of the terminally ill person in all of their aspects: the dying body, the emotions, the palliative treatment, the distress of the family, the last minutes before dying, and all of those components have to be cared of by guaranteeing an high quality of life. Focusing on the doing, creating positive relations by taking into account the uniqueness of the person really makes a difference, touching the body of the person in a respectful way, avoiding unnecessary additional pain while administering the palliative treatment is an highly valuable skill, which means a lot for the person and the relatives close to them.

Ultimately, dying at home must not be a privilege, on the contrary receiving high quality end of life care has to be guaranteed by the healthcare systems, as a form of respect towards all the individuals and thanks to nurses skilled in treating with dignity the terminally ill person.
Conclusion

In this thesis I have tried to show that the potential of the nursing profession in actively contributing to the subversion of medical patriarchal, masculine knowledge is a huge one. In my opinion, this potential has not been adequately recognized yet, neither in feminist academic field nor by nursing scholars. My initial research questions were focused on the importance of uncovering spaces of autonomy for nursing and using an intersectional framework to support a the awareness of the complexity of the mandate of nursing profession, a profession that itself suffers from gendered stereotypes and, in my opinion, needs to integrate feminist theory inputs.

In order to address the research question *Are there spaces of autonomy within the nursing profession where a resistance against the neutral and universal, patriarchal knowledge that dominates the medical approach to health and disease, may be present and exercised, and what does happen in those spaces?*, I have used an autoethnographical method of research that has allowed me to incorporate my personal and working experience in two healthcare settings, the psychiatry ward for acute mental conditions, and the home assistance to terminally ill people, where the power relations between doctors, nurses and patient are atypical and may be fertile places for starting a resistance against established medical power, and promoting meaningful change in healthcare.

For addressing the research question *What is the role of intersectionality, biopower and assemblages in nursing knowledge?* I have used an intersectional lens to highlight how connections between biopower, assemblages and affective labor may provide useful inputs to nursing knowledge to recognize its potential for subversion. Negri’s concept of *multitude* has been used to recognizes the importance of singularities, and to wonder how minorities and singularities may become powerful and start an insurrection against the patriarchal society and its forms of control, in this case the medical power.

In answering the question *How is body affected by time, space and language manipulations in the health settings, and why does it matter to nursing?* I tried to underline that is critical for nursing to recognize the importance of touching the body, using creative language and respecting the individual perception of illness of the patient, mainly focusing on the importance of not
delegating the dimension of corporeality in the process of care, delegation that may augment the dehumanization of the patient.

In summary, I believe that linking feminism to nursing could bring useful changes in the profession and could provide a background for reflecting about the gendered aspects of nursing and hierarchies in the medical setting. In this sense, feminist intersectional theories present a rich opportunity to consider the relations amongst language, body, power, gendered labour and how those aspects influence the current health systems and the way healthcare is provided. Those reflections would have a major positive impact both in the way healthcare is provided, recognizing the uniqueness of every person and their right to have their own vision of health and expectations about well-being, and a impact also on the need for independence of the nursing knowledge from the mechanicistic vision of the current medical one.

A concrete example for developing new theoretical scenarios in nursing could be the integration of feminist theories in nursing degrees. This would allow nursing to critically reflect that there is no need to aspire to a standardization of knowledge, as proposed in medical degrees, to create effective and evidence-based knowledge. On the contrary, nurses need to be encouraged to deal with intersectionality in order to creatively fulfil a mandate, the one of providing nursing care, which is complex and touches so many aspects of the life of the patients that cannot be reduced to a subaltern role.
Appendix: A collection of gender stereotypes of the nursing profession in Italy

The nursing profession in Italy has undergone a restructuring only in late 1990, when it was affirmed by law that nursing courses had to be established at a university level, and after the completion of a three-year degree and the passing of a state exam, which allowed to become health professionals.

Around the same period, the nursing deontology code was created and it affirmed the autonomy and responsibility of the profession\textsuperscript{12}.

Before this restructuring, aspiring nurses had to attend a two-year professional course that focused mainly on the technical aspects of the job, and their role was ancillary to the doctor's. The doctors prescribed the \textit{cure}, the nurses had to provide the \textit{care}.

Many of the most experienced colleagues I worked with were extremely technically skilled but could not risk taking responsibility and providing a more relationally-creative care, they were perfectly functioning within the medical paradigm that wanted nurses as mere executors of their orders. Considering that unbalanced power relation, and that in Italy the medical profession is mainly composed by men while the nursing profession by women, gender stereotype have found a very fertile terrain to grow and disseminate.

I would say that currently in Italy, and in particular within the hierarchical sovrastructure that the hospital represents, there are two dominant stereotypes:

- the doctor is a man, powerful, competent and rich, he is the one who takes decisions
- the nurse is a woman, economically less well-off, less competent, she complies with the doctor's instructions, cannot take decisions

This image reflects the social image of a woman who is not economically autonomous, but passive and complementary to the man. In addition, the image of the nurse is denigrated and sexualixed. In popular culture, nurses always try to have sexual relations with doctors, dress with sexy lineries under the uniform and wear an heavy make-up. Erotic and porn movies may be centred around the sexual performance of a female nurse, but never of a female doctor. The "sexy nurse" is even included in the catalogues of carnival dresses.

\textsuperscript{12} As elaborated by D.M. 739/94, Legge n.42/99, Legge 251/2000, Legge 43/2006, Codice Deontologico
Male nurses, on the contrary, are associated with higher level of competence and promptness, many of them are visible in emergency care and are seen as more trustworthy and strong. I personally recall of a medical director in critical care who openly requested for male nurses in the unit he directed, because they were more resilient and quicker, he thought.

What are the reasons behind those gender stereotypes in nursing?

Donatella Cozzi affirms that the connection between nursing and femininity is essential to understand the evolution of the nursing profession and its image (Cozzi 2003:375): nursing has its roots in the division of labor and in patriarchal societies caring was considered a natural duty of the woman, such as taking care of the children, the sick and the elderly. The home and the family were the places where women performed, under the form of unpaid work, nursing and assistance activities, while the men where in charge of the economical family income and performed their paid working activities outside the home.

One of the major consequences of this separation between unpaid female work and paid male work was that power was not equally distributed within the family: the man took charge of his professional life and realized himself in the social and public community, the woman was assigned to subordinated positions, which required submission, execution of orders and less exposure to social life. She was assigned to taking care of the well-being of the family members and the house space, such as domestic duties. It was seen as a form of spontaneous caring for the others, a role naturally assigned to the women by the patriarchate.

The Italian feminist of sexual difference Adriana Cavarero explains that in the patriarchal order the woman is oppressed in her own feminine psychology (Cavarero 2002: 159), because the reason of the social division of power lies in the biological sexual difference that has been used by the patriarchal order to generate unbalanced gender relations in the society.

I agree with Cozzi that the nursing profession and its gender stereotypes reflect the sexual division present in male sexist societies. In Italy the access to nursing courses for male students was made possible only in 1974, thanks to a law\textsuperscript{13} that recognised the need for the profession to be regulated and innovated.

\textsuperscript{13} The Italian law Legge n.124 del 25/02/1971
The history of Italian nursing\(^{14}\) shows that, after the Second World War, the nursing scenario in Italy was problematic: nurses were not enough qualified and performed their duties on a voluntary basis, following the principle of Christian charity and therefore providing assistance to people who were at the margin of society like if it was a sort of "mission", being close to ill people, their contaminated bodies without any protection. The number of infectious and communicable diseases was very high, compared to the chronic conditions that are prevalent in nowadays society, and the use of barriers such as disposable gloves and facial masks had not been implemented yet.

Therefore the nurse was a figure situated in a blurred position (Cozzi, 2003:376), fluctuating between the high sphere of morality and Christian charity towards the ill people, and the lowest of material duties, such as cleaning the infective body of the ill people and therefore being exposed to contamination. For this reason many nurses in the post-war Italy were coming from the poorest social classes, some of them were prostitutes or women with alcohol issues who, providing assistance to the ill people in the hospital, were also seeking moral and social acknowledgement.

It was only after the foundation of the first nursing schools (not yet at university level), that the social role of nursing shifted from a charity duty, "naturally performed by women given their natural inclination towards caring for the other", to a real profession, even if not yet autonomous from the doctors. However, the sexualized origin of the profession has contributed to relegate it in a role of subordination within the medical context.

It is also important to underline that the nursing courses in Italy have been and are still taught by physicians, not by nurses, except for very specific classes such as technical aspects of the nursing care. When I attended my nursing course degree I witnessed how most of the subjects were taught under a medical doctor point of view, and it seemed as if the content, for example, of anatomy class or pharmacology class, had been shortened by the teacher-doctor compared to the same subject proposed to the students of medicine. Same teacher, different content, I would say selected content for nurses, whose focus was "what a nurse should basically know in order to fully support the doctor".

\(^{14}\) For a detailed history of the nursing profession in Italy, see: Sironi 2012.
The main objective of the nursing courses has been, for years, how to prepare technically-competent personnel whose job is to execute the orders given by the doctors.

Therefore in popular culture, in Italy, the nursing profession is still seen not as a "proper profession"; I sometime realize how the patients, and people in general, refer to nursing as a charity mission, I would say a social form of altruism and personal sacrifice, for which is not necessary to develop any specific skill, a part from having "a big heart".

The sexualized image of nurse is dominant in the Italian mass-media culture, and advertisement, movies and television series often propose the stereotype of the "sexy nurse", female nurse of course.

I have tried to collect a number of stereotypes, both expressed by sentences and comments that I or my nurses colleagues have shared throughout the years, and also how nurses have been portrayed in mass media culture.

Nurses are often referred as:

- beautiful and sexy
- sexually available to have intercourses with doctors
- not real health professionals
- paramedics
- did not study too much, nursing studies are easy
- chose nursing studies because not good enough to become doctors
- work only for the monthly salary
- do not really care about patients
- deal with the most shameful body materials
- do not have many responsibilities, the doctors take responsibility for their mistakes
- are very well paid, considering that their job is easy and have not studied too much
A collection of movies that portray the nurse profession in a sexist way or a denigratory way:

- *Si spogli..... Infermiera*, directed by R. Asher (1963)
- *L’infermiera nella corsia dei militari*, directed by M. Laurenti (1979)
- *L’infermiera*, directed by N. Rossati (1975)
- *L’infermiera di notte*, directed by M. Laurenti (1979)
- *Gli infermieri della mutua*, directed by G. Orlandi (1969)
- *Un sacco bello*, directed by C. Verdone (1980)
- *Le comiche 2*, directed by N. Parenti (1991)

Several Italian actresses have portrayed the role of the sexy nurse, such as Gloria Guidi and Edwige Fenech, in sexy-comedies of the ‘70s.

A special mention goes to the animated series that in Italy was transmitted on television with the title "Candy Candy", whose protagonist was an orphan girl who found social redemption discovering that her mission was becoming a nurse: with her white skin, long blond hair and blue eyes she became a symbol of altruism and dedication to the "others", influencing generations of young girls in Italy. I could never forget that, when introducing ourselves to each others the first day of the nursing degree, a good number of aspiring nurses admitted that they choose to become nurses after watching their favourite animated series: "Candy Candy"!
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