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From discipline to control in nursing practice: A poststructuralist reflection

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Abstract

The everyday expressions of nursing practices are driven by their entanglement in complex flows of social, cultural, political and economic interests. Early expressions of trained nursing practice in the United States and Europe reflect claims of moral, spiritual and clinical exceptionalism. They were both imposed upon—and internalized by—nursing pioneers. These claims were associated with an endogenous narrative of discipline and its physical manifestation in early nursing schools and hospitals, which functioned as "total institutions." By contrast, the external forces—diffuse yet pervasive—impacting upon contemporary nursing more closely align with the power dynamics explored in Gilles Deleuze's concept of the *Society of Control*. The example of sensor technology and telemetric monitoring of nurses' locations in the clinical setting exemplifies the intense presence of surveillance, performance metrics and the "rationalization" of nursing practice. It falls upon nurses to recognize, accept or challenge these dynamics in order to shape the future of nursing practice into a discipline which embodies our values and priorities.

KEYWORDS

agency, arborescence, discipline, foucault, postmodern, rhizome

> A critique does not consist in saying that things aren't good the way they are. It consists in seeing on just what type of assumptions, of familiar notions, of established and unexamined ways of thinking the accepted practices are based…To do criticism is to make harder those acts which are now too easy.
>
> (Michel Foucault, in Rabinow and Rose [Eds], Foucault, 2003, p. 172)

> The administrations in charge never cease announcing supposedly necessary reforms: to reform schools, to reform industries, hospitals, the armed forces, prisons….'Control' is the name Burroughs proposes as a term for the new monster, one that Foucault recognizes as our immediate future…There is no need to ask which is the toughest or most tolerable regime, for it's within each of them that liberating and enslaving forces confront each other.
>
> (Gilles Deleuze, 1992, p. 4)

1 | INTRODUCTION

During the second half of the 20th century, the forces shaping nursing practice transitioned from a regime of strict self-regulation and a finite number of interdisciplinary relationships to a simultaneously dispersed and intensified regime of surveillance and control constituted through exponentially expanded disciplinary entanglements. Our contemporary practice includes uncountable connections of responsibility and interdependency between the nurse and an increasingly expansive professional context: hospital administrators, government auditors, accrediting agencies, private and public

funding groups, professional organizations, academic departments, increasingly informed and involved patients and the economic interests of multiple public and private actors.

There is an essential ambivalence regarding the effect of these entanglements/relationships upon our practice. Researchers have illustrated that the complexities of the contemporary healthcare context offer both opportunities (Hassmiller & Combes, 2012; Prybil, 2013) and challenges (Austin, 2011; Gordon, 2005; Jameton, 2013; Krichbaum et al., 2007) for nurses and our patients. We argue for the recognition—and critical engagement with—the reality of nursing's myriad social, political and economic interdependencies. Intentionally exposing these forces (which are subtle and dispersed yet potent) allows us to understand our practice—its successes and its failures—in a richer context of power relations, knowledge and control.

2 | THE ENDOGENOUS DISCIPLINE OF NURSING PRACTICE FROM THE 17TH TO EARLY 20TH CENTURIES

The diverse set of practices constituting the modern professional field of "nursing" in Western Europe and North America grew from particular contexts of individual and community caregiving throughout the previous two centuries (D'antonio, 1993). Parochial and secular charity organizations were instrumental in the development of organized nursing from the 17th to 19th centuries (Keeling, 2017; Kreutzer & Nolte, 2016; Nutting & Dock, 1907). During these eras, the infirm were largely cared for by their families. Wealthy patients would contract physicians and attendants to care for them within their own homes. Care of the institutionalized (incarcerated, insane, orphaned, etc…) and the destitute fell upon the above-mentioned charitable organizations and their cadres of predominantly young, female and trained (to various extents) caregivers (Hehman, 2017; Kreutzer & Nolte, 2016; Nutting & Dock, 1907).

By mid-18th century, the economic and demographic changes wrought by the industrial revolution and the growth of urban populations increased the need for health care outside of family (Hehman, 2017). Building upon their experiences in institutional caring with religious and secular charitable organizations, trained female caregivers sought to create professional nursing as a new form of labour, a stable and respected occupation for women. The virtually complete replacement of the piecemeal system of untrained hospital attendants by professional nurses in the 21st century illustrates the success of this transition.

In order to achieve this major feat, early nursing leaders aligned gendered notions of caregiving and cleanliness with new healthcare dynamics created by broad economic and demographic shifts. These pioneers, in a sense, claimed motherhood over the dependent and infirm, their self-identified charge analogous to the care of a mother for her family; guarding the moral, spiritual and physical hygiene of her patients. This involved the self-imposition of severe regimes of self-discipline and self-control linked to the religious roots of the discipline. Nursing expected its practitioners to adhere to spiritual, ethical and behavioural norms drawn from the domestic and parochial roots of the profession (D'antonio, 1993; Nutting & Dock, 1907).

From the parochial nursing organizations of the Sisters of Charity and the Deaconess movement's Motherhouses to the early hospital-based training of the late 19th and early 20th century, early nursing functioned largely in terms of what Goffman (1961) termed "total institutions." Total institutions are defined as those in which whole blocks of people are bureaucratically processed, whilst being physically isolated from the normal round of activities, by being required to sleep, work and play within the confines of the same institution. Prisons, hospitals and psychiatric hospitals are Goffman's key examples.

The total character of these institutions is described in Abagail Nutting and Lavinia Dock's observation regarding the similarities between the training of deaconesses in the 19th century and that of professional nurses in the early 20th century:

> It is interesting to see how much of their system and detail our modern training schools have inherited from the Motherhouse—the probationary system… the letters from clergyman and physician as to character and health; the allowance of pocket-money…the grading of pupils from probationer to head nurse…and every principle of discipline…Continuous and systematic instruction was regarded as indispensable
>
> (Nutting & Dock, 1907, pp. 40–41)

Young women predominantly trained, worked and lived within a relatively insular institutional structure. The practice of nursing emphasized self-discipline in the moral and professional realms. Professionally trained nurses, it was argued, should be as moral, caring, temperate, obedient and organized as the nonprofessional caregivers they eventually supplanted were immoral, callous, intemperate, rebellious and slovenly (Goodnow, 1919; Reverby, 1987). This self-discipline encompassed their social relations and professional practice and was thoroughly embodied. A 1919 textbook for first-year hospital nurse trainees asserts that:

> Self-control in all things is one of the finest fruits of a nurse's training…she should have about her an air of positive daintiness; no odor or perspiration should be there, not a suggestion on her breath of disordered digestion or uncared-for teeth…Digestive disturbances are caused by rapid eating, insufficient mastication of food, unwholesome 'off-duty' lunches, thinking too much of one's work while at meals, etc.; a clean mouth, a well-cared-for digestion, a clean skin, tidy hair, smooth hands with nails showing proper attention, and whole, clean clothing are as little as should be expected of a nurse who has self-respect
>
> (Goodnow, 1919, pp. 28-29)

By claiming the moral, behavioural and practical (in terms of the superiority of nursing organization and performance of patient care) high-ground, early nurse leaders adroitly parlayed gendered cultural expectations of cleanliness and caring to create, nearly *ex nihilo*, a professional space created for (and largely by) women in developing industrial economies during the 19th and early 20th centuries (Hehman, 2017).

Although we have emphasized the endogenous construction of nursing's professional identity during its formative centuries, we recognize the field's interdependence with its historical context. Gender expectations, religion and major economic changes during these eras undeniably shaped the early practice of nursing. However, the external forces shaping contemporary nursing (and health care more broadly) are qualitatively much more diffuse, subtle, and diverse. This is largely the result of their relationship with new disciplinary modalities which allow the unrelenting surveillance and control of nursing practice.

3 | CONTEMPORARY NURSING PRACTICE

Nursing's tradition of self-management and self-determination continues today to a certain extent. Nursing typically constitutes a separate and independent department within both training institutions and hospitals. Nurses are trained throughout their careers primarily by other nurses. Our licensure requirements are determined by nurses and, if we violate the norms of our profession, we must answer to a board of our peers. However, the intensity of our internal self-governance has inarguably decreased. Contemporary nursing (at least in Western Europe and North America) does not function within the disciplinary matrix of the past (except, perhaps for nurses in the military during periods of active deployment). Our working lives are governed and disciplined, but our "personal lives," to a much greater extent than nurses in the 18th and 19th centuries, are our own.

The success of early nursing's project to "stake-out" a stable profession for women in health care has, along with broad socioeconomic and cultural changes, contributed to the metamorphosis of early nursing practice and its strict endogenous moral and practical disciplines. Contemporary nurses are more diverse (demographically and professionally) and more economically secure than their predecessors. With this increasing personal independence, however, nurses and nursing are no longer one and the same. The identity of "nurse," once proscribed and clearly directed by the totality of the practice institution, has now shifted to encompass a wide array of practices and professional environs—whilst certainly a positive development, this also means that the specified, self-directed formation of an idealized identity has faded from the collective professional consciousness, and there is no longer a specific touchstone for the "nurse" identity.

In parallel, with the decreased emphasis on self-discipline as a function of nursing work, and its expression through work within total institutions of nursing education and practice, we find increasing exposure to forces of control and management external to our field. Nurses are subject to a diffuse yet pervasive system of surveillance and control driven by shifting economic dynamics, sociocultural expectations and narratives of medical care as well as new technologies of data collection and processing. Consequently, forces external to our discipline are now often the primary influences shaping our practice.

3.1 | Contemporary control: A tangled web of forces and narratives

In recent decades, financial considerations have transformed health care practices. Rising costs associated with demographic changes, chronic diseases and expensive new therapies have "prompted the application of the business model (and its related practices) to medicine, with the goals of improving efficiency, restraining expenses and increasing quality…creating an acute awareness of costs and reimbursement" (Hartzband & Groopman, 2009, p. 101). These dynamics have transformed nursing as well.

In the 1990s, cost-effectiveness efforts by managers of health maintenance organizations and hospitals contributed to the increasing use of lower-paid "nonlicensed personnel" at the bedside, performing many of the traditional "domestic" duties of nurses and prompting fears of a decreasing role for nurses in hospitals (Aiken, Sochalski, & Anderson, 1996). On the other end of the spectrum, advanced practice nurses expanded their clinical footprint by positioning themselves as cost-effective alternatives to medical personnel in specific clinical settings (Sandelowski, 2000, pp. 187–191). Increasing use of ancillary personnel and the movement of a growing portion of the registered nursing workforce to administrative, educational, policy-making, research or advanced clinical roles has fundamentally changed the overall practice of nurses in North America and Europe (and likely in other sociocultural settings).

The increasing presence of financial concerns within nursing practice has affected the practice of those nurses remaining at the bedside. The advent of performance-based pay and the control of funding by powerful public organizations and private insurers significantly increased the exposure of nurses to regimes of auditing and evaluation. Increasing hours are spent collecting and recording data in myriad checklists, audits, evaluations and reports (Gordon, 2005). Austin (2011, p. 160), observes this dynamic as "the replacement of 'humanistic care'…by the fulfillment of streamlined, predictable tasks serving expectant 'customers'". The "customer", however, is not only the patient, but the organization and even the greater regime of data collection and surveillance. In addition to documenting their own activities in an increasing level of granular, real-time detail, nurses are frequently serving as the eyes and ears of the institution's general regime of surveillance and control. Hospitals are financially dependent upon a vast field of nurse-generated data to satisfy the reimbursement requirements of insurers, as well as regulatory bodies. Whilst nursing surveillance and reporting (including monitoring of their own performance or the activities of other

healthcare practitioners, patients or visitors) may be couched in the rhetoric of patient safety or advocacy, we must also ask ourselves to what extent our involvement in these activities of control are mainly serving the organization's goal of fiscal and administrative control. Understanding the multiple implications of how we engage in the provision of care is an inherently political project. As the historian of the American hospital Charles E. Rosenberg writes: "Questions that can be framed as matters of justice and autonomy are at once questions of control and economic gain. Perceptions of right and wrong, of appropriate standards of practice, constitute de facto political realities – variables in negotiating choices among rival policies as well as in particular clinical interactions" (Rosenberg, 1999, p. 35).

The dynamic whereby modern nurses are embedded in a growing web of data collection and practise surveillance is amplified by an increasing sociocultural expectation of standardization and rationalization in health care. A dominant narrative is that the weaknesses of modern medicine/nursing (high costs, unpredictable outcomes and uneven patient satisfaction) are due to production inefficiencies driven by a deficiency of rational behaviour and an excess of administrative and clinical variation (Berg, 1997; Institute of Medicine, 2001; Wachter, 2004). Movements and organizations assert their abilities to correct these deficiencies. For instance, production inefficiencies are the target of proponents of "Lean" organizational processes and methods (Kim, Spahlinger, Kin, & Billi, 2006). Professional societies, researchers and countless public and private organizations publish "best practices," "clinical guidelines" or white papers to raise the twin ideological pillars of "patient-centred care" and "evidence-based practice." Hospital policies (often based on the publication of professional societies and government organizations) are instituted to manage individual variation in behaviour in pursuit of these ideologies as well as the hospital's financial interests. New technologies of data collection, processing and reporting such as telemetric monitoring, electronic medical records, shared national databases and electronic devices designed to monitor and control the professional practice of clinicians (Radio-Frequency Identification badges, pagers, individual telephones, location monitoring devices, etc.) are both the concrete expression of these narrative forces and the means by which their teleology is manifested. In the ideology of modern rationalized and standardized health care, the technologies of data collection and processing (surveillance) shape contemporary nursing practice.

It is important to point out that we do not suggest that these trends in health care are universally or necessarily negative in intention or outcome. Reduction in inefficiencies and irrationalities may allow scare resources to be shared more widely. Greater standardization and rationalization in diagnosis and treatment may lead to better and more predictable outcomes by controlling risks and maximizing potential benefits of care. Concern for the patient experience may make health care more caring and pleasant. These are the benefits, or potential benefits, driving the massive economic, intellectual and administrative investments in the collection and analysis of data. However, as dual subjects and objects of this system, we need to acknowledge the narratives which underlie our practices and recognize that they are historically contingent and heterogeneous in their causes and effects. A critical perspective can protect us from blind faith in these ideologies and help nurses retain agency in their practice as they navigate this web of interests, expectations and philosophies about how health care should be performed. We agree with Gilles Deleuze's (1992) strategy in his prescient postscript on the *Societies of Control*. "There is no need to fear or hope, but only to look for new weapons" (Deleuze, 1992, p. 4). Critical analysis of our nursing practice and an awareness of the pervasive presence and power interplay of power and ideology within which it is embedded is a first step in the development of the weapons we will use to shape nursing care in our chosen fashion.

4 | THEORETICAL INSIGHTS

Poststructuralism was developed primarily by French continental philosophers in the 1960s and 1970s (Williams, 2005). Several of its prominent figures, including Deleuze & Guattari, Derrida, Foucault, Lyotard and Kristeva, are recognized for the development and expansion of this somewhat unorthodox perspective focused on, and critical of, the concepts of truth, discourse, knowledge production and power and, ultimately, the variously flagrant or subtle processes of normalization and their effects on the production of identities/subjectivities.

Poststructuralism is a rigorous critique of all structuralist projects whose goal is to create a rigid understanding of a phenomenon—its truth or essence—despite the fact that this understanding is itself based on norms created and disseminated within and through processes of normalization and naturalization which in turn are contingent instantiations of social, cultural and economic forces—as opposed to essential or transcendent natural facts (Williams, 2005). Poststructuralism challenges the way we perceive the reality in which we live. Our understanding of a phenomenon is therefore a matter of perspective; it is not based on any abstracted or absolute truths. We must also recognize the extent to which norms are not only produced by these apparatuses/ structures. The disciplinary and professional fields of nursing are not exempt from the coercive imposition of norms. Poststructuralist approaches have led to the successful deconstruction of specific regimes of truth. Poststructuralism constitutes a subversive approach that allows us to question that which is considered common sense, our perceptions, and our understanding of what is true or false, good or bad (Williams, 2005).

4.1 | Foucault, power and discipline: Anatomo-politics

In *Discipline and Punish* (1977), Foucault posited that a key element of a disciplinary society was to have individuals internalize social rules and auto-regulate their behaviour. He (1977) referred to this as "discipline" and argued that this anatomo-political form of government of conduct

had replaced previous sovereign structures of overt and often violent and spectacular manifestations of power (e.g. public executions).

Anatomo-politics aims to produce technologies that serve to exert a hold over others' bodies, "not only so that they may do what one wishes, but so that they may operate as one wishes" (Foucault, 1977, p. 138). A multitude of distinct processes are internalized by individuals before being established in institutional structures. According to Foucault, it is these various processes, which make up disciplines. Disciplines may be defined as "methods, which made possible the meticulous control of the operations of the body, which assured the constant subjection of its forces and imposed upon them a relation of docility-utility" (Foucault, 1977, p. 137). They make possible the creation of submissive, yet skilful, docile bodies through concerted actions of multiple disciplinary technologies. Disciplinary technologies seek to manage every aspect of life. The previously cited example of the 1919 nursing textbook's prescriptions on personal bodily control can be interpreted as an example of an anatomo-political regime in the construction of the discipline of nursing.

4.2 | Discipline and surveillance

According to Foucault (1977, p. 157): "disciplines must also be understood as machinery (techniques) for adding up and capitalizing time." Disciplinary power proves to be successful, yet it relies on rather simple technologies. Throughout the 18th century, architecture was developed not to improve its external features but rather to focus on the interior layout of buildings in such a manner as to assure constant, hierarchical observation.

Hierarchical observation is characterized by the fact that the role of supervisors is subdivided in order to ensure a continuous monitoring of everyone. The result is a state similar to Orwell's (1984) Oceania, a perfect society in which power seeps into even the most intimate thoughts. Bentham (1863) envisioned a concrete application in the shape of the *panopticon*, an architectural structure consisting of a tower surrounded by cells, where each cell is under constant surveillance by a watchman in the tower. Thus, individuals are disciplined by the fact that they are potentially under the constant supervision of the watchman. Whether or not the gaze of the jailor is upon them at any particular moment, their constant penetration by the regime of surveillance leads to intensive self-discipline, as they must behave at all times as if they were indeed surveilled. This flawless regulating apparatus would be at its most concrete and appropriate form in prison settings and instils within each and every one a continuous state of exposure in a place where power is omnipresent (McHoul & Grace, 1997). The institutions of schools and hospitals likewise contain some element of this surveillance and self-disciplinary dynamic.

Normalizing judgment complements hierarchical observation by means of micro-penalties, a system of gratification-punishment in which ranking serves as punishment or reward. The establishment of norms dictated by ongoing ideology constitutes one of the building blocks of discipline. These norms serve as standards for discriminating between what is considered desirable or "good" and what is not. The self-disciplinary character of early nursing where norms of professional and personal behaviour (and bodily function) can be read as both a strategic reaction to social and economic forces and as the imposition of a disciplinary regime of surveillance within (anatomo-political) training of nurses.

4.3 | Deleuze and control

For Deleuze (1992), the government of conduct in the contemporary era occurs through total observation (hypervisibility) beyond the confines of finite institutions and modification of the contexts within which people display behaviours. Deleuze (1992) put forth the idea that society moved away from being "disciplinary" and towards "control." Moving away does not mean that the disciplines no longer exist, merely that *control* is now the more pervasive force.

Deleuze (1992) posited that the *society of control* is a pervasive and omnipresent mechanism, which operates so that observations and effects occur without people noticing (intensified and extended panopticon). It is a comprehensive system that tracks all movements and modulations in ways that are "continuous and without limit" (Deleuze, 1992, p. 6). The society of control is decentralized, no longer operating from a single imperial site, but from multiple foci, none of more importance than others (Hardt & Negri, 2000). This system is nonetheless fully socially integrated (capillary) with decentralized components (nodes) working coherently without an overseeing unique structure. Lastly, the society of control is malleable, perpetually changing based on needs, whether these are local, temporal, or based on the person or object being assessed. As its outcome, control does not regulate based on pre-established moulds, but ensures fluctuations fall within certain (normalized) limits; thus, control appears to be more flexible and more encompassing (read total) (Deleuze, 1992). We see these characteristics in the contemporary entanglements of forces contextualizing contemporary nursing practice.

Regarding health care, Deleuze (1992) stated that, "the new medicine 'without doctor or patient' singles out potential sick people and subjects at risk, [and] substitutes for the individual or numerical body the code of a 'dividual' material to be controlled" (p.7). This quote could be applied to nursing staff as well. That is, within the control society, the focus is on predicting outcomes that are deemed unwanted; it is not about a behaviour but contextual parameters. As such, the focus is modulations, contextual parameters and deficiencies that are below the level of the individual (e.g. identified molecular abnormalities). As such, a particular human body is "broken down by being abstracted from its territorial setting…then reassembled in different settings through a series of data flow" (Haggerty & Ericson, 2000, p. 611).

5 | GOVERNING NURSING—A CASE STUDY

The ascendant role of analytics, data collection, metrics and standardization of practice (the process as transcendent subject) in

contemporary nursing reflects our profession's contribution to the cultivation and nourishment of the control society. A particularly illustrative "case study" of this dynamic within nursing is the increasing use of Real-Time Location Tracking technology for the surveillance and management of the nursing workforce.

Real-Time Location Tracking Sytems (RLTS) use technologies such as Radio-Frequency Identification (RFID), Wi-Fi and Global Positioning Systems (GPS) to "tag," detect and track physical (equipment and supplies) human (patients, visitor and staff) resources throughout the hospital (Curtis et al., 2008; Fisher & Monahan, 2011; Jones & Schlegel, 2014; Krohn, Metcalf, Salber, Metcalf, & Salber, 2017; Velez, Rita, Pedro, & Silva, 2016). For instance, nurses' badges may contain a transmitter which "checks-in" with sensors at various locations in their workspace. This creates a real-time and continuous record of the nurses' movement throughout their workday. Depending on the placement of sensors, administrators may have access to a detailed temporal-spatial "map" of time spent in clinical spaces such as ward rooms, individual workstations, supply rooms and medication rooms. Data collection may also extend to nonclinical areas such as breakrooms, restrooms, hallways or any other space covered by the sensor network.

Fisher and Monahan (2011) trace the proliferation of these technologies to post-9/11 funding streams meant to increase the timeliness and efficacy of hospitals' responses to natural or man-made disasters. For instance, RFID transmitters on badges used to unlock hospital doors or parking structures or to "clock-in" or "clock-out" of work can generate a list of personnel who may still be within the structure. More granular data from multiple checkpoints may enable rescue workers to physically locate patients, staff and visitors more rapidly and accurately. Another suggested application is the tracking of patient and staff contacts during communicable disease outbreaks for the identification of potential vectors of pathogen within the institution and community.

Whilst administrators and project-supervisors endorse narratives of security and safety during catastrophic events, the technologies are, in practice, primarily used as management tools and serve to "translate all hospital activities into discrete, measurable units that can be soberly managed from afar" (Fisher & Monahan, 2011, p. 548). Technologies and economic resources originally intended (narratively if not in actuality) to address patient, employee and public safety concerns have been co-opted into the growing arsenal of mechanisms for surveillance, quantification and control of everyday nursing practice. The concept of "surveillant assemblages" in which regimes of surveillance and monitoring "transcend institutional boundaries [and] systems intended to serve one purpose find other uses" (Haggerty & Ericson, 2000, p. 111) illustrates the ways in which the system of surveillance and management reinforces the arborescent and linear hierarchies via rhizomatic connections of people, spaces, time, technology and concepts. Our engagement with these emergent phenomena must be no less rhizomatic.

6 | BECOMING RHIZOMATIC: A PATH TOWARDS RESISTANCE

If we observe that nursing is increasingly susceptible to subtle but pervasive forces of control, how do we use this knowledge? What are the ethical and practical implications of a critical engagement with flows of force, surveillance and control within which we labour? How can we transform striated spaces into smooth ones? Along with Deleuze, Foucault showed us "the arbitrariness of institutions and show which space of freedom we can still enjoy and how many changes can still be made" (Foucault, 1988, p.11).

The first consequence is that we, along with Foucault and Deleuze, must recognize that social phenomena are historical and contingent. They do not rely upon idealized realities. There is, in other words, no ideal "big-N" Nursing against which our current practices can be judged, compared and found wanting. The idealized concept of Nursing (or Medicine, or Health Care, or Caring or Science) is generated through the complex interplay of social forces including, crucially, our daily practices and the stories we tell ourselves about those practices. The Platonic ideal of a Nurse in the Eighteenth and Nineteenth Centuries included associated concepts of self-discipline, ethical, spiritual and sexual cleanliness. This ideal nurse has drifted substantially in the intervening centuries. Today's nurses are instead judged against equally Platonic ideals of rationality, efficiency and standardization of practice. Foucault and Deleuze would see both of these supposed ideals as actualizations or creations of specific social power relations. By historicizing the concepts underlying nursing practice, we affirm that its future is as contingent as its past. We are not dependent upon any "universal necessities" (Foucault, 1988, p.11) in determining the future shape of our field. Instead, we creatively reconstruct the conceptual identity of nursing any time we practise, think about, or talk about our profession. Butler claims an identical reconstruction regarding gender: "there is no gender identity behind the expressions of gender… identity is performatively constituted by the very 'expressions' that are said to be its results" (Butler, 1990, p. 25). In nursing, the very performance of practice—in the context of the latest tools, technologies, and measurements—thus iteratively constructs professional identities.

It is the sum aggregate of our daily practices, our moment-to-moment decisions and thoughts that actualize our experienced reality and give shape to nursing. Nursing's current forms (in all of their variability) are the actualization of a multiplicity of virtual possible forms. It is our inescapable professional prerogative and responsibility to actualize the future forms of nursing. The extent to which nursing practice accepts, rejects or, (more likely) mutates and redefines its relationships with the force-flows of the control society (surveillance, standardization, intellectual automation and the reduction of experience into discrete data points) is not predetermined; it is an ongoing process: a *becoming* of nursing.

Of course, this raises the critical question of what form(s) we should fight for or against as we actualize our discipline and profession. What is the ethics of nursing if there is no transcendent

Platonic ideal of nursing upon which to judge our practices? For Deleuze, life (and associated phenomena) is defined by vitality and creative differentiation, by the constant interplay of deterritorialization (differentiating and resisting movement away from normativity and conformity) and reterritorialization (universalizing movements back to conformation).

> This is how it should be done: lodge yourself on a stratum, experiment with the opportunities it offers, find an advantageous place on it, find potential movements of deterritorialization, possible lines of flight, produce new flow conjunctions here and there, try out continuums of intensities segment by segment, have a small plot of new land at all times
>
> (Deleuze & Guattari, 2004[1987], p. 161)

Intellectual and political creativity, flexibility, resistance and a critical orientation as well are captured in the Deleuzian concept of the rhizome. Rhizomatic thought permits ambivalence, allegory, chaos and diversity because one is not attached to a singular official structure, a rigid pattern, an imposed and straightforward stream of thoughts and practices. In effect, the rhizome is a "counter-thought" that offers new possibilities because it does not follow a logic characterized by dichotomy or binary positions (good versus bad; more efficient versus less efficient) or hierarchical, linear relationships between concepts (the arborescent model). According to Deleuze and Guattari (2004), the rhizome does not rely upon a structure nor does it rely on a particular axis of treelike thinking. For these philosophers, trees and roots are sad expressions of systems of thought relentless in its quest to force work within hierarchical systems and imposed "truths." Ample examples are found in practices (lean processes, "best practices", clinical guidelines, etc.) on full display in clinical settings. Rhizomatic thought would acknowledge, accept and promote debate regarding ways of practising nursing, even if competing narratives clash with one another. The rhizome is a political, a nomadic and perhaps a transgressive object (or subject). It is embodied in a particular type of writing or speech, which challenges the status quo and regimes of truth that are taken for granted, promotes alternative discourses and suggests paths towards "lines of flight" (resistance) (Colebrooke, 2002; Holmes & Gastaldo, 2004).

As discussed above, most nursing work environments obey a strict representation of reality, which is permeated and regulated (if not coerced) by discourses on "truth" and politicized technologies in order to govern individual and collective bodies. Some environments are more flexible and provide opportunities to create, to make connections and allow *multiplicities* to flourish. Often, these environments subvert the order of things and as such can be called *rhizomatic* (until these environments are themselves co-opted and become *arborescent* in their structures). New environments or sites of social interactions (*assemblages*) are created among multiplicities often to escape the constraints of ordinary life. These assemblages between persons and objects should be understood not in terms of internal structures (or fixed meanings); instead, *assemblages* must be accounted for in terms of their endless possibilities and multiple, albeit transitory, connections. As Nixon (2012) notes: "it is not in the excavation of stable structures that things are to be understood, but in the immersion in the endless play on and of surfaces" (p. 140). Of course, in the context our analysis, these surfaces are nurses' bodies, and the practices they perform. These bodies enjoy forming *assemblages* with others, debating new trends and allowing *intensities* to flow and produce new potential *becomings* and, therefore, new subjectivities (Gagnon & Holmes, 2016). Rhizomatic thinking constitutes a marginal space of experimentation outside the normative grid proposed and regulated by institutional discourses.

7 | CONCLUSION

The practical tasks of nursing care provision are myriad and complex, often rendered more so by the advent of technology and tools that appear in the guise of simplifying the nurse's routine. Without attention to the actual assemblages of what comes to constitute nursing work, it is far too easy to allow the apparent simplification of the work to take on a mechanistic character—effectively erasing the creativity, judgement and indeed the very humanity that has necessarily and iteratively shaped the construct of professional nursing. In order to reduce the potential for devolution of professional nursing practice is vital that we sustain our rhizomatic developmental perspectives. Even as we take possession of new technologies and processes within the profession, we must attend to the impetus for creative growth that such possessions can provide—rather than allowing them to limit and stultify the very work that is nursing. Poststructuralist perspectives such as those of Michel Foucault and Deleuze/Guattari provide powerful conceptual tools for a critical rethinking of nursing practice. Identifying, challenging and strategically resisting the flows of control and arborescent structures will, we believe, maintain the dynamism, creativity, social relevance and ethical grounding of our discipline and profession.

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