4 For Whom Does the Alarm Bell Toll? On Nursing Identity and Revolution

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Identity as a Philosophical Concept

In the field of nursing, narratives of professional identity are closely tied to the shape(s) of the discipline. How we conceptualize our nursing-selves, individually and collectively, is intimately related to how nurses perceive themselves and their practices; how we compare, contrast, and relate our discipline to others, and widespread, but imprecise popular culture narratives regarding form and functions of nursing. Reimagining nursing identity/identities is thus essential to radical change for patients, communities, and nurses. Refocusing, or perhaps altogether replacing, the conceptual lenses through which we see ourselves, and through which others see us, reaffirms our role in shaping a nursing identity from complex current, historical, social, and cultural relations. Despite its relatively recent rise to prominence in academia and popular politics, the concept of identity has a long history in the Western philosophical tradition (Appiah, 2010; Lewis, 1966; Ricoeur, 1991; Sayers, 1999).

Identity: Seeking Ontological Boundaries

A traditional philosophical understanding of identity is captured in "Liebnez's Law" or "the identity of indiscernibles" (Feldman, 1970; Hacking, 1975). This maxim states that two things without any differentiating properties are indeed the same; they are identical. If we understand identity as complete correspondence of properties (numerical identity) an entity can only share the relation of identity with itself. Anything else with all the same properties is indistinguishable. It is impossible to imagine, for example, two apples which share every property (location in time and space, physical properties, relations to other objects) without thinking of them as identical. The problem is not that things share every property with other things (violating Liebnez's Law), but that they do *not* share every property even with themselves. When looking at what should be a singular thing, we are confronted with innumerable stubborn points of discernment.

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The Problem of the Many

In *Many, but Almost One*, Lewis and David (1999) consider human inability to determine that a particular thing is a unique entity separate from those with which it shares physical and/or conceptual properties. The authors present readers with the example of a cloud. If one attempts to define the cloud, to distinguish it from surrounding "non-cloud," it is impossible to pin down internal or external borders. It contains innumerable, shifting fields of more and/or less densely associated water molecules. The line between cloud and non-cloud becomes at best an indistinct gradient. Outside some arbitrarily imposed level of density at which "cloudness" occurs, it is impossible to locate the edge. If we set the required density high enough, less of the "cloud" qualifies. If we set it low enough, surrounding wisps and invisible vapors are included. Clearly, the intuitively perceived cloud entity is actually a much more complicated, and ambiguous, ontological situation. Lewis and David identify this as "the problem of the many":

> ... all things are swarms of particles. There are always outlying particles, questionably parts of the thing, not definitely included and not definitely not included. So there are always many aggregates, differing a little bit here and a little bit there, with equal claim to be the thing. We have many things or we have none, but anyway not the one thing we thought we had (1999, pp. 164–165)

We thus tend to interpret the world in terms of static and discrete entities when, upon dissecting our conceptual schema, we find exceptions, border cases, overlappings, and ambiguities. This is especially true when adding temporal properties to analysis. An apple's progress from seed, to tree, to apple, to food, to biochemical energy and metabolic byproducts, to waste, etc ... hardly reinforces a sense that it has a static or discrete identity. More accurately, we function in terms of partial or "almost-identity." Lewis and David observe how the ontological situation of identity is thus more nuanced:

> We have a spectrum of cases. At one end we find the complete identity of a thing with itself: it and itself are identical, not at all distinct. At the opposite end we find two things that are entirely distinct: they have no part in common. In between we find all the cases of partial overlap: things with parts in common and other parts not. The things are not entirely identical, not entirely distinct, but some of each.
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> (Lewis & David, 1999, p. 177)

Nursing's Almost-Identity

If we cannot pin down the identity of a *physical* entity, we must recognize the futility of doing so for social and cultural phenomena. If identity is "a spectrum

of cases," the ontologically complex entities which emerge from human interactions (language, concepts, societies, cultures, etc ...) must fall into partial overlap. "Almost-identity" is thus useful for discussing social phenomena. In the context of a discussion of nursing identity–historical or contemporary–it is important to recognize that what we might call the identity of the field *is* an almost-identity. Ontologically, nursing has a general set of properties not distinct from other entities nor entirely internally consistent. There is no platonic ideal or "big-N" nursing—a social phenomenon, it emerges from interactions among people, material and nonmaterial environments, into an almost-identity of related practices and concepts.

Science and technology studies researcher Annemarie Mol would say that nursing is "more than one, and less than many" (Mol, 2003, p. 84). Nursing does "hang together" or cohere as a thing in this world—but not always a unitary thing. It is conceptually bounded and does not encompass every conceivable property. But those bounds are hazy, porous, dynamic. It may not have unity but has some ontological coherence. In contrast, when we think and talk about something, we typically do so in ways that assume it behaves, at least heuristically, as an individual entity. We speak of "clouds," not variegated banks of suspended water. Why speak in terms of identity, unity, and essence instead of almost-identity, multiplicity, indeterminacy, and complexity?

The predominant answer, from early in Western thought, has been some variation on Platonic idealism. Such essentialist approaches share a belief that the material world is undergirded by primary essences (Lowe, 2008; Oderberg, 2007). Essentialism posits that we encounter entities as immanent objects of perception and, somehow, recognize them as expressions of universal concepts. When we see banks of suspended water droplets, we ostensibly recognize them as cloud-things because they demonstrate essential properties and characteristics of a universal concept.

An alternative explanation denies transcendence of form or meaning from any source external to the world we inhabit and experience. This reverses the direction of the relationship between essence and existence, between the transcendent and the immanent. Messiness, difference, and multiplicity are primordial. *We* impose identity upon a world of inchoate chaos by draping essences and universal concepts over messier extant topology. Concepts, identities, and meanings are our creations, and our tools. There is nothing essential, nothing inevitable, about how we order and understand the world. There is no essential form dictating that we see distinct clouds in indistinct banks of water vapor. Likewise, there is no ideal form of nursing versus which worldly instances are imperfect renditions. Instead, processes, practices, and relations are what give rise to the almost-identities of phenomena such as nursing. Nursing emerges from the contingent specificities of its performance, from what it does in the world, and its relations with other (equally emergent and contingent) entities and concepts.

Almost-Identity

Following this constructivist argument that the almost-identities which populate our experienced reality emerge and are continually transformed (what Deleuze and Guattari (1987) call a process of continual becoming) through actions and interactions of human and non-human entities, we can investigate how nursing, a concept and almost-identity, emerged historically and how it continues to become "more than one but less than many," entangled with multiple social, cultural and economic forces. As explored in the following sections, we make the radical claim that nurses are people(!) and that nursing is a social construction inescapably borne of the thoughts, words, and actions of those people and the structures wherein they labor. Nurses are agentive co-participants in these structures, contributing and subject to the drives and desires inherent therein. The power-relations embodied in systems of governance (state agencies, professional societies, auditing bodies, clinical administration, regimes of technological management and control, finance and resource allocation, etc ...) are inextricably entangled with the emergence of historical, contemporary and future practices and narratives of nursing.

Control over the identity of nursing, the power to define who nurses are and what nurses do, has been a central component of this interplay among power, agency, and governance. Both nurses and non-nurses have attempted to speak strategically of a nursing identity, to shape the profession toward political, moral, and/or economic ends. Nurse scholars have illustrated the roles of religion, gender, class, race, technological change, and the dominance of biomedical epistemological approaches in such dynamics (D'Antonio, 2010; Dingwall et al., 2002; Hawkins, 2010; Reverby, 1987; Sandelowski, 2000). To the extent that such attempts sought to delineate sharp borders and essential qualities for nurses and nursing practices, they portray fictions: unnaturally static, specified, sets of people and practices. Such fictional identities benefit those who would limit the creative power of nurses to *become*: to embrace productive messiness and openness. Thus, instead of striving for one identity, we might speak instead of our almost-identity, not only because it allows us to speak more accurately of those we call nurses and the practices we call nursing, but also because it recognizes our contextualized co-agency in nursing's future. It is time to deny *one* essential nursing identity and fight instead for those almost-identities that embody nurses' desires for ourselves, our patients, and our communities.

The radical analysis that nurses are *people* diverges from the ways in which nurses have been heretofore constructed. Nurse identity (what nurses do, how and when) is constructed by productive value for the institution and dictated by multiple oversights and controls. These systems are so efficiently incorporated into operations that they become a way of life, particularly in productivity and efficiency-based environments such as acute care hospitals. Technology, oversight, and reimbursement models operating under the guise of patient safety influence nursing practice in ways that nurses must assess and

address. In the words of Michel Foucault, these mechanisms manifest as significant yet enigmatic political power that "works to incite, reinforce, control, monitor, optimize, and organize the forces under it" (Foucault, 1978, p. 136). These systems of control work to dehumanize the nurse in both practice and personhood and facilitate mortification of self: the dispossession of role, loss of identity, and devolvement of the autonomy that one holds on the "outside." This was seen clearly during the COVID-19 pandemic when nurses were called "heroes," yet deprived of personal protective equipment, autonomy of work, and generally dehumanized into a commodity rather than a working force.

Technology in Identity

Nurses, and therefore patients, are directed by and managed within a powerful panoptic mechanism of technological control (Jenkins et al., 2021). The electronic health record is an easily auditable (read: surveilled) governing mechanism requiring feeding with data mined by the nurse, surveilled from the patient, then regurgitated as algorithmic tasks for the nurse. Data input by the nurse becomes, "... discrete mineable data points that go on a construct map of the patient experience ... and an audit trail for nurses' behaviors, surveillance in absentia [...] a proxy governing forces that are not necessarily present (Dillard-Wright, 2019, pp. 1–2). Order sets, nursing care plans, clinical guidelines, alarms, triggers, and tasks are programmed into the EHR using a privileged hierarchy of so-called evidence-based practices serving the institution. These "best practices" are power regimes that risk exclusion of knowledge and interventions better suited for the patient and eliminate opportunities for innovation. This institutionalized version of "best," or "truth" is a far cry from theoretical and philosophical visions of nursing knowledge, which assert that knowing comes from multiple domains—rather than a singular, empirically and quantitatively fitted to an algorithm (Carper, 1978).

As reporting measures, technology, and artificial intelligence become increasingly ingrained in health care, it is critical that nurses actively engage in asking who is served by the algorithm/data set/care plan/audit. In a profession which exists for care of human beings, nurses must understand whether technology that dictates practice serves those in our care, or if it serves to improve productivity, billing compliance, close CMS loopholes, etc. We must require clear answers about the ramifications and implementation of such structures and processes, including patient harm, loss of autonomous practice, and implications for surveillance and control. Of significant concern to nursing practice is the economic influence of AI that results in a homogenized (read: omnipotent) decision-making body. Because the creation of AI is so complicated, so expensive, there is ample opportunity for those in power (economic elite) to control not only resources, but to dictate a nursing practice that functions for productivity—not for patients or nurses.

In a healthcare system that already survives on profit margins, and therefore necessarily rationed care, AI mainly increases the efficiency, anonymity, and ambiguity of oppressive and harmful control structures that degrade the profession's ability to care.

Patient Safety Oversight

Nursing practice is heavily dictated by regulatory bodies including departments of public health and The Joint Commission®. The policies of such organizations rely heavily upon a Foucaldian governmentality, embedding a vast panoptic system of self-regulation as a mechanism of control. Such regulatory bodies assess certain patient outcomes with utmost severity, and these outcomes (most of which are considered poor), have been designated as "Nurse Sensitive Indicators" (NSIs) in the National Database of Nurse Quality Indicators. The aim of NSIs is to determine whether a nurse has a quantifiable impact on patients. Despite clear evidence that some of the most significant risks for death and disability to patients and communities are social determinants of health and structural violences, nursing quality indicators focus on patient falls, pressure ulcers, restraint use, and nosocomial infections to indicate the value of nursing (Butkus et al., 2020). Each is heavily audited, and significant investment in technology and surveillance used to prevent them. Self-regulation is culturally integrated and enforced: nurses are frequently injured attempting to prevent or cushion patient falls and are significantly more likely to experience occupational injury than other industries. The frequency of these injuries, coupled with certain underreporting, illustrates the extent to which regulatory oversight and control has shaped not only the operational priorities of the nursing workforce, but its willingness to sacrifice physical bodies to institutional interests. When is enough, enough?

Nurses as Sentinels

The previous sections examined the identification of nurses as both inherently amorphous and as almost entirely conscripted, depending upon whether or not there is a necessary element of humanity within the construction of nursing and its execution in practice, science, or education. This is a crucial question in the context of the present historical moment: the throes of a global pandemic in which nursing faces a depleted workforce. How and why we arrived here must be considered via past, present, and future, particularly insofar as the "doing" of nursing is characterized by what is done and who is doing it. What exactly are the sentinel functions of nursing and nurses?

The most basic definition of sentinel is "one who keeps watch," (Oxford Languages, 2022) with the implication that watch is kept to protect someone or something from threat. Presumably, should the threat materialize, the sentinel alerts others in effort to mount a defense. This is a regular aspect of

nursing practice: bedside nurses call for a code team, emergency department nurses call for stroke response, school nurses call caregivers for ill students. In many ways, the nursing profession and nurses themselves thus serve as sentinels for health care. It is this state of *sentinelity* that causes the nurse to be almost invariably positioned at the front line of both care provision and the risk zone for injury. In simplest terms, it is the nurse who is almost always first to observe a change in patient status, and therefore the nurse who is forced to bear the message about this change to someone who can direct action to address it. This is not unlike how nurses are often the first to see the dangers of an oncoming issue—a pandemic, a workforce shortage, a crisis of cost and payment—but are largely barred from initiating decision-making to halt the onslaught. Despite the myriad social structures that cast nurses as lesser professionals in healthcare science and practice, the need for nurses to engage in sentinelity is undeniable—absent nurses, much of what is considered healthcare is also absent, as are warnings when circumstances become dire. Yet, while an army sentinel can generally expect a responsive show of force, for many nurses the response to an alert is silence—a page not answered, a caregiver does not pick up, the rest of the staff are busy elsewhere. Worse, the response is some form of, "Well there's nothing we can do about it." What then is the nature of sentinelity in the nursing profession; how and for whom is it enacted?

Sentinelity and Advocacy

Nurses are often described as engaging in "advocacy"—advocating for patients, for policy change, for professional dynamism in science, education, and practice. This is interesting insofar as it implies that nurses are asking for something. To advocate is to press one's case for a particular action, usually on behalf of a less empowered person or group. In some cases this specifically entails supplication: a way of signaling need that tends to inspire cooperative responses (Van Kleef et al., 2010). In acts of advocacy, the nurse is often required to seek cooperation from diverse sectors and work to unite, cooperatively, their combined assets. Doing so may thus invoke supplication to or pleading with a gatekeeper, bringing to bear once again the state of sentinelity: calling for attention to something. Supplication, however, does not connote a responding defense of the supplicant—rather, perhaps due to its use in religious practices, it implies some sacrifice for both supplicant and respondent. What then is sacrificed in the act of making a request or acting as an advocate, in supplication?

In the religious sense, supplication is an act through which an innately inferior being (human) seeks a particular, positive relationship with a superior force (divine) (Tekke & Watson, 2017). Here, the former must necessarily admit inferiority in seeking the help of the latter—in effect, sacrificing individual ego for a chance at unity. At the same time, the superior (divine) is believed to sacrifice some of its superiority in deigning to respond. Whether or

not that is a true sacrifice, there is thus an encoded hierarchy wherein the supplicant (advocate, nurse) must prove worthy of the respondent's attention. Determination of this worth is based on how well the supplicant renders themselves appealing, how well they have followed the tenets of the practice—indeed, how "good" they appear. This resonates distinctly with the ethos of the feminine, particularly the divine or angelic feminine, as invoked throughout the history of nursing.

Sentinelity and Gender

The operationalization of the feminine in nursing is neither a novel nor entirely historic occurrence. Of interest here is the parallel development of nursing and feminist social critique, beginning from the moment Florence Nightingale noted that "On women we must depend ... for personal and household hygiene" (1860, p. 79). Historically, this impetus for nursing is also rooted in first-wave feminist ideologies, which foregrounded the presumed "feminine" ideal as a vehicle for tempering society through "incremental and progressive reform" (Brisolara & Seigart, 2012, p. 293). At nearly the same moment, the idealization of the feminine influence as the "angel in the house" seized the public imagination and enshrined acts of caring, sacrifice, and submission as markers of true femininity (Kühl, 2016).

Crucial to this liminality between the angel in the house and Nightingale's "ministering angels" is the consistency of the deified feminine, and how it is fundamentally self-sacrificing. While the angel in the house sacrifices her own agency to sustain the domestic, private household and provide loving, caring supports for husband and children—with attention to the very clear expectations of heteronormativity and motherhood for women—the ministering angel sacrifices her capacity to *be* the angel in the house by going into the public sphere and caring for those in need. The acts of self-sacrifice carried out by both "angels" are thus appropriately noble for female-identified persons. This suggests that regardless of where and in what capacity the feminine is enacted, it has a specific sacrificial and subjugated character.

Appropriate execution of femininity then imputes these qualities to both the female-identified person and the nurse—and requires that nurses engage in performing actualized femininity and sacrifice by the nature of their work (Rivers, 2020). During the COVID-19 pandemic, such sacrifices became almost taken for granted, and nurses were pressured into ever more impossible working conditions in the supposed interest of public health. One organization even sued to prevent nurse employees from leaving positions they had resigned (Heim, 2022). Although it failed, this attempt demonstrates the presumption that a nurse can be reduced from crucial, individual, and agentic professional to "an object existing to serve the establishment" (Jenkins et al., 2021, p. 3). When nurses are thus objectified and othered, sacrifices of their own health and safety become acceptable losses rather than sentinel indicators of system problems.

Silencing the Sentinel

The histories of feminism and nursing continue to be inextricably bound, with the professionalization of nursing standing at the same juncture as the rights of women to be freed from constraining institutions such as coverture and denied suffrage (Burton et al., 2020; Fowler, 2017). Although the first wave is generally construed as ending mid-20th century, this conjugation of nurses' positionality in the professional environment does not. As late as 1967, Stein described how "the nurse is to be bold, have initiative, and be responsible for making significant recommendations, while at the same time she must appear passive. This ... (is) to make her recommendations appear to be initiated by the physician" (1967, p. 699). Notably, the nurse in this passage is specifically female, as Stein describes a remarkable gymnastic of sentinality that both serves to alert the physician to a patient issue while preserving what is obviously a façade of appropriately feminine silence and subservience. Clearly then, nurses must accept and actualize themselves as subjugated, sacrificial, and relatively silent to faithfully (intentional use) execute their professional roles. This is quite at odds with the role of the sentinel, necessarily sentient and aware, holding critical responsibility for assessing and warning of trouble.

Nurses have described the silencing of their sentinality in a variety of contexts, those which affect them as practitioners and scientists as well as those affecting patients, families, and communities. Silencing occurs where nurses' complaints about workplace injury risks are not addressed (Kay et al., 2015), when nurses are forced to ignore ethical qualms about workplace issues (Lamb et al., 2019), and when caring for incarcerated patients (Jenkins et al., 2022), among others. In each case, the nurse's ability to serve as the sentinel, calling attention to an encroaching threat is erased—and conditions remain static or worsen.

When sentinel calls receive no response, there can be a sense of having been rendered helpless in or abandoned by the institution—sensations described as moral distress, moral injury, or organizational betrayal (Brewer et al., 2020; Dean et al., 2019; Wocial, 2020). While evocative of negative experiences, these terms are also connotatively emotional and imply that the reaction of nurses to being silenced is a mere matter of managing feelings—not flagrant subversion of what should be the chain of command. This is particularly evident in the flood of responses to burnout among nurses during the COVID-19 pandemic: much attention was devoted not to bettering institutional supports for the work of pandemic nursing but to fostering "resilience," "mindfulness," and other individually-oriented responses to systems-level problems (Schlak et al., 2022). These impute responsibility for remedying the problem to the nurse—in effect, killing the sentinel messenger. A dead sentinel is by definition silenced, but quite effectively transmits the message that speaking out is dangerous. The losses that spawn betrayal and moral injury or distress among nurses are thus also acceptable

losses–they are, after all, only feelings and a sacrifice the nurse should be willing by "nature" to endure.

Reclaiming Sentinelity

Clearly, there are numerous social forces that impugn the legitimacy, authority, and capacity of nursing science and practice as sentinels in health systems. Common among them is the consignment of the most fundamental elements of nursing—advocacy, caring, preservation of health, and safety for nurses and patients—to a subjugated status. Advocacy involves supplication to an "authority:" physician, executive, or manager. Provision of care is somehow gendered in the feminine, and characterized as something done sacrificially and by instinct rather than as a product of dedicated professional, scientific study and practice (Burton, 2020). Preservation of health and safety is assigned not to the system designated as "healthcare," but to the individual nurse—turning wholly on individual "resilience" or ability to be "mindful." In each case, nursing is made subservient and its sentinelity muted. This critical diminishment of the professional "space" for nursing also reduces disciplinary influence on science, practice, education, and policy. Moreover, the systems and institutions with which nurses must affiliate are often used as levers to further constrain the profession—in effect, putting the angels back in the house. Here again the entanglement of femininity and its expected attributes with constructions of nursing is manifest, and the liminality of nurse and angel evoked. The professionalism and import of nursing are confounded by systems and influences that constrain and disempower, clinically and philosophically.

These influences are re-created throughout nursing, where power structures remain disproportionately hierarchical, and create systems that inculcate and acculturate new personnel—from day one nursing students to newly hired faculty members—into "good" behaviors required for success. Mainly, this ensures that nurses continue to internalize silence and sacrifice as integral to the profession—and that this internalization is borne out and repeated across education, practice, and science. Where silence and sacrifice are prized as characteristics of the good angel/nurse, determination of the value of the nurse's contributions—how "good" they really are—can only be made *down* a power gradient. Those at the top of the gradient evaluate those below, and thereby enforce these norms. This has been called horizontal oppression but is perhaps more realistically identified as exploitation of power imbalances and hegemonic norm enforcement.

Acting with sentinelity, however, can disrupt hegemony. In the case of the nurses who were sued to prevent resignation, some fascinating and even oppositional dynamics arose. Initially, the nurses rejected their working conditions–effectively eschewing continued sacrifice and ceasing to act in supplication to the constraining system. The system sought to reassert control, utilizing the legal system to prevent resignation and re-establish status quo.

Interestingly, however, doing so elevated the nurses from resource objects subject to the control of system management to personnel so central to system function that their departure became a crisis. The case exemplifies exactly how and when sentinelity is acknowledged: the point at which continued sacrifice is rejected, and the nurse ceases to act in supplication. This requires a fundamental shift from self-sacrifice to self-advocacy, and reasserts nurse agency—dispensing with what Stein called "a transactional neurosis" meant to preserve the status quo (1967, p. 703).

Rejecting the subjugation of nurses' sentinelity into hegemonic power structures that value meekness, nonresistance, and silence may thus be the most radically imaginative professional act. The disruption of such power structures may ironically return nursing to its feminist roots: aligning with more modern, intersectional feminist perspectives centering choice, opportunity, and social justice (Burton, 2020). Critically, however, such an alignment must actively preserve and amplify sentinel nurse voices rather than allowing them to be absorbed into other structures. As an example, nursing represents itself as a social-justice oriented field–throughout the American Nurses Association (ANA) *Code of Ethics for Nurses with Interpretive Statements* are sections addressing environmental health, human rights, and health as a universal right (ANA, 2015). In fact, the document concludes with direct attention to social justice—but emphasizes its pursuance within *structures*: professional organizations, accrediting bodies, health systems. These by nature cannot be radically sentinel, as they are largely based on and fueled by the same hegemonies that claim subjugating authority over the profession.

Reclaiming sentinel voices within nursing is thus no mean feat, and the tendency for small groups to be collapsed into larger and ultimately less nimble organizations will always carry silencing capacity. Nonetheless, approaches such as Walter's (2017) emancipatory nursing praxis, Dillard-Wright's (2022) enactment of mutual aid, or the work of Holmes and colleagues (see Evans et al., 2020; Holmes & Gagnon, 2018; Johansson & Holmes, 2021; McIntyre et al., 2020) on poststructuralist analytics in nursing are inherently disruptive to hierarchical systems that demand supplication and silence from "good" nurses. These approaches reaffirm the critical nature of and need for active, intentional sentinelity in nursing, and allow creativity, visibility, and equity to flourish for individual nurses as well as in public perceptions of nursing.

Concluding Remarks: On the Importance of Critique

In light of what is discussed throughout this chapter, it is clear that political awareness is an attribute all nurses must develop. Poststructural analysis is a powerful vehicle for deconstructing the discourses and practices surrounding nurses (Williams, 2005). The productive aspect of this perspective has been highlighted extensively. This said, we are left with a pressing question: where do we go from here? The solution is not simple, but we believe that whatever the theoretical and political tools deployed, nurses must resort to ongoing *critique* of

the discourses and practices that try to shape and domesticate us. We turn again to Foucault, for insights regarding *critique*. For Foucault, critique is both theoretical and practical. In a 1978 talk titled "What is Critique?" given to the French Philosophy Society, Foucault spoke of critique as "voluntary inservitude" ("*inservitude volontaire*") or "informed unruliness" ("*indocilité réfléchie*") (Holmes & Gagnon, 2018). The word "informed" is extremely important. Critique must be informed; it must be anchored in a robust approach and account for continuous interplay between knowledge and power (Holmes & Gagnon, 2018). Such a political approach is clearly akin to resistance. The sentinel approach constitutes a good example of Foucauldian resistance. Foucault famously claimed that "the art of not being governed or better, the art of not being governed like that and at that cost" is the "very first definition of critique."

As mentioned, critique and resistance must go beyond theory to become day-to-day practices. Faced with multiple attempts to govern nurses' discourses and practices, critique ultimately takes aim at the various *apparatuses* ("*dispositifs*") contributing to exclusion and subjugation, exposing the inner workings of power (including violence) to fight them more effectively (Evans et al., 2020; Holmes & Gagnon, 2018; Jenkins et al., 2020; Johansson & Holmes, 2021; McIntyre et al., 2020) Poststructural tools such as deconstruction, genealogy, and archaeology are some amongst many that could be mobilized to subvert the violence that tries to bend nurses to breaking, both professionally and personally (Holmes & Gagnon, 2018).

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