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Chapter Two: Privileging Practices: Manifesto for “New Nursing Studies”

Introduction

The title of this book could be read as suggesting that theory and research *precede* practice – that research and theory have *implications for practice*. In this chapter we challenge this formulation by privileging practice. Rather than theory and research *informing* practice, we argue that how we conceive of practices, that is, how we *theorize* practices such as those practices recognizable as nursing – has consequences for how and why we theorize nursing and what we expect nursing research to generate. While some may argue that all nursing theories are really theories of practice, we want to differentiate our argument in this chapter from that perspective. It is our contention that the practices constituting nursing have not been taken nearly seriously enough – and this is especially so in explicitly theoretical writings. This chapter is not about theory of and for nursing. Instead, we articulate an approach to nursing as a set of empirical practices that occur in organizational contexts. Practices inform, and are informed by, those organizational contexts. The approach we take here is that, by taking the study of practices seriously, we are able to think deliberately about the practices that constitute nursing, to theorize them in ways that can strengthen those practices and thus, are able to talk about practices on their own terms. By doing so, we endeavour to encourage good practices to travel outside of the very particular circumstances where we find them to make practice better in other locations.

We begin with a brief example that is a description of nursing practice recently published in a local newspaper. The context behind the story is the recent rise in deaths associated with the drug fentanyl, which is a synthetic analgesic approximately 100 times more potent than morphine and 50 times more potent than heroin. Police and health authorities have tracked the increase in accessibility of this drug to illegal imports from Asia to Canada’s west coast. The nurse

¹ Each of the authors contributed equally to the writing of this chapter.

whose practice is described in this story works as a street nurse in Victoria, British Columbia, a mid-sized city on Canada's west coast.

[Sage] Thomas carries a kitbag with nursing supplies ranging from over-the-counter painkillers and antacids to clean syringes and crack-cocaine pipes, along with the opioid-antidote naloxone – the injectable lifesaver for overdoses of painkillers such as fentanyl. “My week was full and intriguing and wonderful,” Thomas said on a recent Friday evening in August, sounding anything but worn out. “Always an adventure. I love my job.”

Some people might wonder how it can be rewarding to seek out unpredictable people affected by severe poverty, mental illness and addictions. “I really get to know people on a very human level and they are all incredible people,” she said. “One hundred percent have had a lot of trauma, but it totally blows me away to see the strength and resiliency they embody.”

The majority of her clients are homeless, while others are at risk of being evicted. *“It’s a matter of keeping an eye on them, learning the places they hang out, their favourite parks and getting to know the people who know them – in case they don’t show up.”* “I’m in touch with people who historically have a very damaged relationship with health care and society, and I put the onus on health care and society [for that],” Thomas said. “And our team is about bundling relationships and trust. We work with folks with no expectation that they will quit [using drugs.] Wherever they’re at, we support them.” (Dedyna, 2015, emphasis added)

What’s going on here in this example of nursing practice? Sage Thomas is engaged in forms of nursing practice that are distinct from the location of the vast majority of nursing work in hospitals. She does not wear a white uniform. She does not monitor her patients with telemetry, nor do her patients seek her assistance by pressing a call bell. In fact, it seems that even that very basic relationship between nurse and patient is reversed in this example: rather than being drawn away from work with patients by a ringing bell from elsewhere on the nursing ward, this nurse spends her day tracking patients down, searching for them in familiar places, and, when they are not found there, drawing on the knowledge of other members of the street community to try to find them.

What is the best way to think about this as an example of nursing practice? Many elements in the preceding example might be considered examples of practice. We could have pointed to her account of her week, that it was “full and intriguing and wonderful.” We could have pointed to her account about the way her team works by “bundling relationships and trust.” Instead, we have highlighted her method for finding patients: “It’s a matter of keeping an eye on them, learning the places they hang out, their favourite parks and getting to know the people who know them – in case they don’t show up.” Why is this section of the story the focus of a chapter that seeks to illustrate an approach to theorizing practice?

The reason is both simple and complex: The statements attributed to the

nurse in the newspaper article and reproduced in the preceding paragraph are accounts of a practice that are thoroughly interpenetrated by theories of work (“full and intriguing and wonderful” – a theory of work that stands in contrast to “drudgery” and therefore does the journalistic work necessary in the article to mark this nurse as heroic), and theories of psychology (“bundling relationships and trust” – this description of practice is so abstract that it effectively conceals any actions taken by the team). By contrast, the italicized section offers examples of actions engaged in by the nurse to accomplish her work in this unique practice setting. Upon first reading this account of nursing, we wondered where this individual learned to nurse in this way and in this place. It is unlikely that she was taught about finding patients in need of healthcare in parks and back alleys in any of her nursing courses. But she will have learned other things about caring for patients – and we read in this example an instance of a nurse adapting that learning to the particular circumstances she works in. There is something underway here that leads her to practice in this particular way in this particular place. It is our contention that it is possible to consider these actions as practices that are useful in this work setting and therefore to theorize the practice of nursing in this setting.

“New Nursing Studies”

We are interested in outlining an approach to the study of nursing and its constitutive practices that privileges a dynamic rendering of *nursing-in-process* – a becoming-nursing. The use of this language, taken from the work of nurse philosopher John Drummond (2002, 2004), underlines an approach to “knowing nursing” that is at once philosophical and empirical. To figure nursing as an open event (Drummond, 2002) entails recognition that its enactments continuously emerge and are yet-to-emerge, that nursing practices are distinguished by contingency rather than determinacy. And yet, at the same time as we work to hold nursing open, as nurses and as researchers we are called to account for specific enactments of nursing, to offer empirically grounded analyses of “what is going on.” To attend to what is going on and at the same time, keep the event of nursing open, clearly requires a view of practice (and practitioners) more fulsome than one which suggests that nursing is (or should be) the rational application of a stock of knowledge to nursing situations (perhaps most familiar to nurses in the articulation of the “nursing process”). Against this static, scripted, and highly individualistic understanding, we draw on a more recursive understanding, taking nursing practice to be an unfolding activity situated in a collective social and material world (Palsson, 1994).

We have placed “new nursing studies” in quotations to try to mark this

approach to studying the dynamism of nursing practice, not necessarily to claim that what we are proposing here is entirely new. Indeed, as is indicated by examples of this sort of work we point to later in the chapter, some scholars have taken similar approaches to the study of nursing practice. Our effort here is to try to gather those approaches together under the name of “new nursing studies” to encourage the rise of an intellectual movement. Thinking nursing in this way is intended to keep the event of nursing open, recognizing its contingencies and differences, resisting the seduction of limits, and ensuring the work of thinking nursing has an open future (Drummond, 2002). Can “new nursing studies” develop knowledge to answer the critical questions how can we do what is best and how can we know if it is best?

Current theories of nursing have tended to profess and claim territory, territory associated with particular knowledge (for example, knowledge derived from nursing theory or from evaluations of practice that generate “evidence” that, it is argued, drives nursing “interventions”) and locations (for example, hospitals, communities, homes, residential care settings) in an effort to form and bolster the profession as an *outcome* of research. This tendency to shift focus away from specific practices over to outcomes has been noted by scholars both inside nursing (see Wainwright, 2000) as well as outside the profession (see Mol, Moser, & Pols, 2010).

Speaking specifically of practices of care, Mol, Moser, and Pols (2010) credited nursing theory with starting a scholarly conversation about care (p. 7). However, tracing the path taken up within conventional nursing studies, they noted, “analysts of nursing care, while exploring how (care) was organized as ‘women’s work,’ argued that, for all that, nursing needed to be understood as a real profession. Rather than a criticism, this was a claim – in pursuit of power” (p. 9). So, instead of engaging in a detailed criticism of how the practices of nurses were being interpreted to inform and advance the profession, it is our contention that a concern for examining practices has been set aside by nursing scholars. Our aim is to re-institute a concern for practice in a way that keeps the practices *and* their effects in our view and available for study on their own terms in order to provide tools for reflecting and improving on them.

A well-known example from nursing history of the distinction we seek to draw out here will illustrate our point. In the nursing literature of the late 1980s and throughout the 1990s, an emphasis on the concept of health promotion emerged in which a position was advanced, perhaps most notably by Nola Pender (1982), that there was a strong alignment between the goals of health promotion and those underlying the educational preparation of nurses. Pender’s position exemplified a claim in pursuit of power. Health promotion was, for Pender and many of her contemporaries, a unifying goal for nursing, and in this way, a powerful claim on territory that could be used to advance nursing’s pro-

fessionalizing efforts. But while the explicit goal was for nursing to occupy and lead the practice of health promotion, associated practices were rarely the subject of research (Purkis, 1997), and subsequent theories of health promotion have been primarily prescriptive rather than descriptive (Whitehead, 2011). In 2009, Wilhelmsson and Lindberg interviewed district nurses working across a range of jurisdictions in Sweden. They sought a purposeful sample of nurses who had experience in what nurses self-identified as “health promotion work” (p. 157). Despite this self-identification as a prerequisite for participation in the research project, these nurses described “indistinctness” as a key barrier in their efforts to prioritize health promotion in their everyday practice. One nurse was reported as stating:

I'd like to know exactly what the [district nurse's] job description is; that's something we've always wondered about and don't think it's clear. How many functions are we supposed to be able to do? *We take care of all of the patients.* You can look in any book you like from the National Board of Health and Welfare, there's no description of our functions. A more detailed description is needed (p. 161, emphasis added).

It is curious to us that a practice, introduced into nursing almost 40 years ago, a practice that some argue is synonymous with nursing, continues to be experienced by these practicing nurses as something they are deeply unclear about. They wonder, when asked by researchers about their health promotion work, if what they do in the name of health promotion is accountable on those terms. The interviewee recorded here seems confident that she and her colleagues “take care of all of the patients.” Yet she is not sure whether the care they provide would be accepted as legitimate by those who ask them to incorporate health promotion into their practice. It is important to note here that the lack of clarity about what health promotion practice is *does not stop these nurses from practicing*. In its preoccupation with the professionalizing agenda for nursing, attention to practices was set aside as though they were not important. As a result, health promotion remains overdetermined and under-theorized and completely unavailable to these nurses to provide an account of their work with the people they care for.

In advancing “new nursing studies,” we wish to return our gaze to the practices of nursing that have always been there, available for study, for debate and for interpretation. “New nursing studies” seeks to create and protect a space where the practices that nurses enact in all their diverse locales can be put into words in order to “help to make the specificities of (nursing) practices travel” (Mol, Moser, & Pols, 2010, p. 10). This articulation of the specificities of practices is not prescriptive but suggestive (Pols, 2015); practices are talked about, shared and examined for their use and effectiveness in other circumstances and in other care locations.

What is it that is done by nurses, and how may their local dealings with particular problems be of use elsewhere? What, for instance, can Sage Thomas's practice learn from other practices – or what can her practice inspire for others? If we think about her practice context, we could imagine that a practice concerned with clean syringes and harm reduction rather than care aimed at curing addiction can learn from, or inspire care for, people with chronic diseases, or suggest good ways to manage practices of reaching out to patients rather than always expecting patients to come to the nurse. Many of the intricacies in nursing practices are these local responses to specific problems.

But what is learned in one place tends not to travel to other practices. For example, in her study of the uses and effects of telecare technologies for people with chronic diseases, one of us (JP) learned that “reaching out” to care for symptoms is not an uncomplicated good (Pols, 2015, p. 83). As in Thomas's practice, some people may value “being connected,” and welcome professional surveillance of potential harms, but there are situations where increased control by professionals does not give people opportunities to develop their own practical knowledge (p. 87). So, while research on effects of telecare devices is piling up, we are still largely in the dark about how nurses put these devices to use, what problems they encounter in doing so, how they work around these problems, and in what terms they evaluate the results and the reshaping of their care practices. It is this type of knowledge we attempt to make transportable in “new nursing studies,” even though it may not be possible to grasp it in statistical generalizations or predictions on probabilities. Our interest is in articulating and creating new sensitivities that are relevant for care practices, and that may create practical and moral suggestions for practices in other locales and under different circumstances.

We argue for an approach to the study of nursing as myriad practices that cannot assume fixed identities or fixed intentions, but rather takes up nursing as comprised of practices influenced and shaped by the forces within which they are enacted, day-by-day, moment-by-moment. Why? Because nursing, practice, and care are all complex and contested activities – we cannot take any of them for granted. Contested practices such as these, left unexamined and unspoken, risk being “squeezed” (Mol, Moser, & Pols, 2010, p. 11) into a straightjacket of methods that cannot articulate care practices on their own terms.

As we advance this work, we work within the challenges posed by a portrayal of nursing as innumerable “instances.” These instances are each unique in their expression on one side, as well as being shaped by the organizing limits of language on the other side. These limits can be imposed with care and sensitivity to “tame” all that uniqueness in order to show how practices in one setting might well learn from or inspire practices within quite different settings. Our aim will be not to point to such alignments as obvious instances of where nursing might

claim territory, but rather to figure nursing as an open event by noticing such patterns, asking questions about what characterizes such patterns and whether they might be theorized as nursing. It is in this way that we seek to undermine and challenge the long-held view that practices emerge unproblematically from abstract theory. “New nursing studies” looks to practice first and foremost in order to theorize nursing.

Nursing: A Polyvalent Profession

As noted above, commonalities among specific enactments of nursing certainly do exist. But these may be at a high level of abstraction (i. e., nurses “care for all the patients”), suggesting that any specific nursing practice gathers together a range of elements, including its material practices, to constitute itself as something we then call nursing. We take the notion of care practice as a loose concept to direct analysts towards actual situations and events where people, together with their artifacts and ways of understanding the world, aim for improving or stabilizing the situation of the people or things cared for. Care practices have a normative orientation towards some kind of good that needs to be specified by such empirical analysis. Nurses evaluate their actions and adapt them if they judge necessary. They *tinker*, as it is called in care studies (Mol, Moser, & Pols, 2010) or are *concerned* about their practices (Latour, 2004; Puig de la Bellacasa, 2011).

Care practices is also a loose notion because it is possible to trace elements to different places with which they have relations. As noted previously, the sociality of practices is given from the outset; to be in a practice means to actively and knowledgeably engage an environment constituted in and by persons, relations, materialities, and discourses (Palsson, 1994). The work of care is dispersed in this collective of people and things (Winance, 2010). This understanding has the practical effect of decentering the nurse, the patient, or even the nurse-patient dyad, shifting attention to the relational networks that comprise everyday life. Struhkamp (2005) described this well in her analysis of what is involved in caring about patients’ autonomy through something as apparently straightforward as food choices. On one level, patients are offered menus through which they make selections. But for this to work, one must also consider the organization of meals in institutional settings – the trays, the food trolleys, the kitchen staff, the unit routines, the convenience of preparing certain food items – a whole set of material practices that make a choice possible. Some decisions depend on capacity, but “things” help make eating well more possible or easier. Decisions by themselves, like individualistic models of practice, are not enough.

The privileging of this understanding of practice in studies of nursing is not

unknown, but it is not a dominant way of proceeding within the academy. Instead, nursing history has been characterized by struggles to define nursing, or to propose one unifying and correct theory for nursing, struggles through which we would argue that scholars have failed to attend to or take care of the multiplicity of ways the event of nursing continuously emerges. We see in this widespread desire to curtail diversities associated with multiple practices a related tendency, which is to treat nursing as a matter of fact. This problem we will explore by drawing again on the work of John Drummond (2002, 2004), and extending his insights through the use of Bruno Latour's (2004, 2005) differentiation of matters of fact from matters of concern. We begin with Drummond's conceptualization of polyvalence as it relates to nursing.

Across many of his essays, Drummond's concern was the same: he was against dogmatic images of thought in nursing and wanted to draw us to the practices of nurses as a matter of concern. In an essay exploring the place of the humanities in nursing, Drummond (2004) reflected on theories of the avant-garde, late nineteenth- and early twentieth-century artists and writers concerned with what they saw as an increasing techno-rationalism in society and the displacement of the arts and humanities from the social world. To be clear, Drummond did not argue that avant-garde theory is a theory for nursing, but rather used the *concerns* of these authors to think through the conditions – political, economic, and cultural – through which the avant-garde emerged. Drummond then linked these to the problem of what appears to be an increasingly disembodied rationality constituting the limits of nursing today. And there is plenty of evidence for Drummond's concern.

For example, Rudge (2013) recently analyzed nurses' enrolment in "quality improvement projects" such as the "Productive Ward," where good care is tied to reducing "wasted time" and sold to nurses as "releasing time to care." What interests Rudge is how nurses have been drawn into this preoccupation with productivity, (cost)effectiveness and efficiency, and more specifically, to accept and work hard for what has come to count as productivity in healthcare settings, a concept lifted from the manufacturing sector. Notable is the ease with which economic discourses and industrial processes are incorporated into care practices, valued by nurses as a means to recapture consistency and reliability in an increasingly turbulent work environment, albeit without the sources of this turbulence – austerity measures and changing workforce characteristics – either named or addressed. But, as Rudge observed, the *appearance* of a smooth running system is all important: "the ward sails like a swan (all surface beauty and serenity) while the tools (those ugly legs) work frantically under the water" (p. 208; see also Rudge, 2011). In this, nursing is an object to be manipulated like any other – limited, determinant and bound tightly to a narrow conception of "good" practice.

It is with a view of this sort of practice context that Drummond (2004) made what he described as “four modest observations,” questions or issues that he suggested nursing will need to return to again and again. Nursing continually returns to these issues not because, or not simply because, they are irresolvable, but because somehow thinking through these observations is essential to scholarship; we return to these questions “with a force of purpose” (p. 528), needing to revisit these concerns each time, in a different way. Drummond’s observation most relevant to this discussion is that “nursing is a polyvalent profession” (p. 528). Polyvalence refers to the combining power of elements, and for Drummond, nursing is polyvalent insofar as its enactments “stretch across a continuum where the discourse practice at one end of the continuum may bear little epistemic relation or resemblance to the discourse practice at the other end” (p. 529). The Swedish nurses asked to account for their practices of health promotion represent an example of such polyvalence.

In most contexts, having the quality of polyvalence is understood as a strength, a capacity to gather together a range of elements to constitute something novel. The same could be said for nursing, with the notion of polyvalence recognizing that any specific instance of practice is new, gathering together a range of elements to constitute itself – nursing, so figured, retains an open future. However, against this useful notion of polyvalence, we have years of effort by managers, administrators, and educators to form the nurse and the practice itself in a uniform way to meet the demands of the day (Ceci, Purkis & Wynn, forthcoming) and, as noted earlier, a near total disregard on the part of researchers to treat practices seriously and to develop research strategies that centre practice.

As is aptly demonstrated by Rudge’s (2013) analysis, Drummond’s (2004) attention to the concern expressed by avant-garde writers as to how to proceed in an uncertain world, one where nurses’ practices have become increasingly instrumental and rationalized, is not misplaced. As he frequently observed, failing to recognize the nature of the practice lends itself to closure in thought, rather than to the (necessary) struggle to get things right. Closure is also the effect of efforts to treat nursing as a “matter of fact.” These efforts are ongoing and forceful, taking up a great deal of nursing energy, and yet have mostly been in vain because, we argue, nursing is not actually a matter of fact; nursing is a “matter of concern.” What is the distinction? Here we draw on Latour (2004) to extend and consolidate Drummond’s reflections on polyvalence.

Most simply, matters of fact are objects that have been disconnected from the web of associations and relations that enable their existence. In Latour’s (2004, 2005) account, the first thing to understand is that the world is not actually made up of matters of fact. Matters of fact come, so to speak, after the fact. And though they represent much work on the part of human beings (or more accurately, on

the part of assemblages of human and non-human actors), they are also, suggested Latour, “a poor proxy of experience and of experimentation ... a confusing bundle of polemics, of epistemology, of modernist politics” (2004, p. 245). Latimer’s (1998) work on the complex translational processes of nursing assessment, which is often treated as if it were a relatively straightforward and objective procedure, provides a good example of this. Latimer suggested that most often assessment is treated primarily as an episodic, cognitive activity; patients’ needs are given and nurses simply read the signs, the “facts.” Instead she found that assessment practices are continuous, situated, and skilled, with patients’ needs organizing and organized by the context, as well as requiring a context in which they can be viewed, all bearing little resemblance to the five-step nursing process that most students are taught, and through which nursing itself and patients’ needs emerge as tight, contained matters of fact.

The idea that there are objects “out there,” in this case, patient needs that are simply waiting to be discovered, reflects an attitude of modernity where the human subject is set over and above the world, retaining for him or herself the principles of agency, action, and will and assuming for all other entities a mere background status. It is this attitude or centring of the human subject that enables a division, creating an “out there” which we then come to “know” through our particular knowledge practices. Matters of fact thus emerge apparently naturally from our knowledge practices, but significantly, they tell us more about *how we can know* than about *what is there*. As Pyyhtinen and Tamminen (2011) observed, if we only try to explain action and events with reference to an intentionality and will located in the human mind, we will not be able to explain very much. We end up muddling the question “What is there?, with the question, How do we know it?” (Latour, 2004, p. 244). It is not, then, that matters of fact are simply made up or that they are not real, but rather that they represent a partial and polemical understanding of experience; reality is not exhausted by matters of fact (Latour, 2004, p. 232). As he wrote, it is not that we should dispense with matters of fact, but rather, he suggested, we need to treat them more carefully by making sure that the diversity of agencies is “not prematurely closed by one hegemonic version of one kind of matter of fact claiming to be what is present in experience” (2005, p. 118).

In Latour’s (2004) analysis, matters of fact are objects whereas matters of concern are things. This distinction is both crucial and liberating for thinking nursing. An object, a word that is derived from the Latin, meaning “to throw,” is only ever a partial rendering of a matter of concern. Things or matters of concern, on the other hand, may be understood as gatherings, the meaning of the word “thing” being rooted in Old English, Norse, and Icelandic languages and referring to a meeting, council, or assembly. For Latour, the difference is clear: “things that gather cannot be thrown at you like an object” (2004, p. 232).

Though it is a problem of modernity that objects have become how we deal with things, with matters of concern the relation remains fluid: objects or matters of fact may become things again, and matters of concern may become objects. And, of course, things that *are* things may be recognized as things again; this way of returning objects to the practices from which they come and in which they figure is our hope for nursing.

Although not from nursing, one startling visual example from Latour (2004) may help to clarify this point. In 2003, at the point of lift off and through its long journey, the space shuttle Columbia existed as a matter of fact. When it disintegrated at the point of its re-entry into the earth's atmosphere, it suddenly and tragically became a matter of concern. It was reconnected to the web of associations that made it possible, violently returned back into the structural conditions of its own production, and it became necessary to examine the assemblages that had made its existence possible (Latour, 2005, p. 175). We were, as Latour observed, "offered a unique window into the number of *things* that have to participate in the gathering of an *object*" (p. 235).

Efforts to turn nursing into a matter of fact, an object, have become so commonplace we hardly ever remark upon them anymore. John Drummond was one who did not let these go but continually brought our attention to the emergence of these objects, the mechanisms of their effect and the implications for nursing as a matter of concern (2001). Quality of care, for example, a matter of concern in which facts, values, politics, actions, people, and institutional routines gather of necessity, is increasingly read primarily as an object with programs of quality improvement, and outcome specifications becoming the sites of production of something called quality of care. The silencing of the event of quality of care, its emergence as "real" only to the extent that we might efficiently track and measure it, loosens its status as a desirable ideal, something that we might tensively strive for and experience in innumerable ways. And it is not that quality of care as a matter of fact, an object, is not real or significant, but that it is a partial and political conflation of the numbers of participants that are gathered in the thing – quality of care – to make it exist.

We see this in our own work, in the response to the gathering of what it is to care for a family member with dementia. For all sorts of reasons, family caregivers, and their health and ability to keep going, are a matter of concern to governments and health systems. Yet from all the beliefs, values, institutions, routines, actors, and material worlds that of necessity gather here, the question of what we can do is too often answered by the production of a new object, in this case, a tool to measure caregiver burden that is capable only of affirming a specific and limited understanding. In this object, caring for a family member with dementia is a burden, one that may be assessed and measured and alleviated with episodic interventions or applications of care. Yet, at the same time, while it

seems obvious that tools that measure care burden are a “poor rendering of what is given in the experience” (Latour, 2005, p. 244), these objects stand as seemingly transparent carriers of the experience, now defined by inputs and outputs disconnected from how they have been made (Purkis & Ceci, 2015).

Our task is not to simply debunk these objects, to demonstrate their inadequacies, but rather *to gather, to show*, as Latour suggested, “*how many participants are gathered in a thing to make it exist and to maintain its existence*” (2004, p. 246, emphasis in original). Our critical task is to reconnect care burden, quality of care, health promotion, the nursing process and the like back to their webs of associations, to allow things to become things again by relating them to the practices in which they are assembled. As Latour (2005) argued, this is the important ethical, scientific, and political point: when we shift our attention to the worlds of matters of concern we challenge the indifference to reality that accompanies treating the world, treating nursing, as a matter of fact.

Articulating “Good” Nursing Practices

“New nursing studies” focuses then on descriptions arising out of close observations of nurses as they engage in their practice and compares such practices across contexts in an effort to articulate the values and concerns of nurses. In raising the notion of “values” here, we want to distinguish our approach in the “new nursing studies” from that of principle-based ethics, commonly used in medical ethics, and the normative stance taken in care ethics literature (e.g. Tronto, 1993). We do not seek to apply a normative definition of “care,” for instance, and show how instances of practice either measure up or fall short. To do so “positions care practices in the world of facts, to which ethics and morality are added from the outside” (Pols, 2015, p. 82). Rather, we advance an approach here that Pols (2015) has described as an “empirical ethics of care” (p. 82) that articulates the forms of the good that participants cherish or attempt to bring into being, to gather, in their practices. An example will illustrate our direction.

Recall the description of nursing practice described at the beginning of this chapter. Nurse Sage Thomas’s practice was described as “*keeping an eye on [her patients], learning the places they hang out, their favourite parks and getting to know the people who know them – in case they don’t show up.*” This description clearly shows that Sage Thomas is not in need of external guidelines, regulations, or normative frameworks, but that her practice has a fine-grained normativity to make her care practice “good.” Now, let’s look at an example of nursing practice described by Davina Allen (2015) in her recent book. In this example, Allen describes the work of nurse Maureen who works on a surgical unit as a ward coordinator.

Maureen has just completed processing a newly admitted patient and inserts the various assessment tools, care plans and record forms into the patient's file. She places the medication chart prominently on the nurses' station and affixes to it a note requesting that the doctor prescribe night sedation which, she has established, the patient usually takes to help her sleep. Maureen removes a sheet of paper from her pocket, unfolds it and scrutinizes the content. It is a list of all patients on the unit; for each a complex set of symbols denotes the current status of their care. Some of these inscriptions are in blue, some in red. The latter is information Maureen has added, having attended the ward round earlier. It is her practice to colour code her entries so she can identify readily new developments to be passed on to the person responsible. Several issues now have been attended to: the junior doctor has prescribed medication for the patients going home tomorrow; the discharge letters for the community nursing service are prepared and the receptionist has been instructed to arrange out-patient appointments. Maureen ticks off these items on her sheet and glances at the clock. There is just enough time to telephone the social worker to check the progress of Mr. White's home care arrangements before she must leave for the morning meeting to discuss the bed state. All today's discharges are going ahead, but she knows the elective admissions are likely to remain on hold as there are patients in the Emergency Unit who require beds. She hopes she will not have to take patients for whom another service is responsible, as the work of organizing care for "outliers" is more difficult, but she accepts that this obligation is sometimes necessary. (Allen, 2015, p. 2)

It would seem that these two descriptions of nursing practice could not be more different from one another: one describes care in the community, the other on a busy, modern surgical ward; one describes the nurse as being in search of people who may require her assistance, the other describes the actions required by a particular nurse whose job it is to get patients in, and then out of hospital again, as quickly and as efficiently as possible. Yet rather than being distracted by the differences between these examples of practice, we could instead examine these practices in a more symmetrical (Latour, 1987) way. While the practices are different, both descriptions of practice point to the matters of concern that organize the work of these nurses.

For nurse Sage, her gaze is characterized by a wide-scale view of the community. Her patients could be anywhere, though she knows that there are particular places in the community where they tend to "hang out." If they are not found there at times of the day that Sage has come to know as their typical pattern, she fans out her concerns to other members of the community to ascertain if those she is worried about – for instance, those she suspects might be active drug users – have been seen recently and if so, where. If she is to intervene before the deadly effects of fentanyl take their course, she needs to be constantly vigilant as to the whereabouts of these individuals. Sage's concern appears to be the protection of her patients from the often unanticipated effects of a drug that is mistaken for other drugs of much lower potency. She cannot know if those

patients actually have fentanyl nor where they might go to take the drug. And so she practices a form of protective vigilance while wandering the streets and parks, meeting people known to her and likely being introduced to people new to the street community.

Nurse Maureen's gaze encompasses the entire surgical unit. At the beginning of the shift, she has recorded specific bits of information about each of the admitted patients on her piece of paper. Having made rounds with other ward personnel earlier in the shift, she has added her own observations or notes about specific actions that will be required of her or others on the team over the course of the day in order to keep patients moving towards discharge. Maureen, too, practices a form of vigilance. Her worries are those that impede patients' progress towards discharge. Maureen's vigilance is directed towards ensuring other members of the team do their work so that all the required pieces of the puzzle are in place when a patient is ready for discharge: prescriptions and letters for the community nursing service are ready, care requirements for each discharged patient have been prepared, and out-patient appointments have been made. Everything is ready for the eventuality that the patient is deemed ready for discharge. Maureen's gaze remains above the details of everyday care for the patients on her ward. Indeed, she orients her gaze beyond the present moment and into the near future when patients currently awaiting admission from the emergency ward will require processing, in a manner we assume would be similar to the processing she has just completed. She wonders whether or not patients who will need to be admitted to her ward are surgical patients. And even here, she does not express concern about what sort of illness the patient is experiencing but rather what different sorts of arrangements might be required by those patients she calls "outliers" in order to organize them towards discharge.

What can such different forms of practice tell us about nursing? How can what is gathered in these instances recognizable as nursing tell us something about the specificities of care practices? And how can those specificities inform each other?

Responding to these questions, we recognize the possibility of valuing nurse Sage's practice over nurse Maureen's practice. Sage's practice seems somehow closer to patients, less bureaucratic, more humane perhaps. But to make such judgments is to remain in matters of fact (e.g. proximity to patients, professional attire, tools used to engage in practice) rather than where matters of concern are privileged. How might "new nursing" take up these very different descriptions of practice and enable us to articulate "good" practice in ways that allow those descriptions to travel to other practice settings and possibly inform "good" practice there?

Aesthetics and Nursing Practices

In order to perform “good” (another loose concept that needs empirical substantiation) nursing studies we need tools and vocabulary that allow us to empirically discover and theoretically discuss more varied types of goodness than “principles” only. With the social sciences leaving normativity either to medical ethics to suggest rules and guidelines, or to translate it into measurements and outcome evidence, there are not many tools to articulate the intricacies of nursing practices. What different types of values and goods are important for nursing? How do these motivate people and practices? What vision of the world do they accompany? How do values organize people by creating particular kinds of generalities, or where do they make differences? When can it be good to look out for people, or even bring them crack-cocaine pipes, and when is care best shaped as having the overview?

We suggest a rehabilitation and reinvention of the notion of “aesthetic values” for this work. Pols (2013) argued that aesthetic values in daily life and care are best understood as social values, referring to “what we appreciate and value in a fundamental way” or to what emerges as good in our social practices of *valuing* (p. 187). Aesthetics provides a vocabulary to talk about values that are not universal, but are also not completely idiosyncratic. “New nursing studies” aims to study these forms of morality, or matters of value or concern, by attending to the everyday practices through which these values emerge. In the eighteenth century and before, aesthetics described values that not only related to art, but also to daily life. Later however, the use of the term aesthetics was limited to descriptions of private matters of taste, to individual matters of virtue and the good life, or for theorizing the fine arts – thus the meaning of aesthetics became quite limited. However, restricting aesthetics to private matters of taste or private idiosyncrasies ignores the social and cultural practices in which such valuing emerges. Clearly relating aesthetics only to the arts is of limited use to nursing practice; however, we suggest that studying how nurses and others engage in the social activity of *valuing* is critical. What are the values that emerge in care practices, and how are they influenced by situations, technologies, and research practices? What values lead to what kinds of care practices? What values do nurses care for? These questions need empirical specifications and theoretical reflections.

We conclude by returning to our critical questions: how can we do what is best? And how can we know if it is best? The answer is that there will never be a final answer, nor a statistical certainty. Nurses will have to keep tinkering, evaluating their actions in ever differing situations where they seek to care. These nursing practices can be cared for in turn by research that is sensitive to what is of value within these practices, hence creating new sensitivities that help

reflect both on connections to other practices, and to see where improvements could be made. This is the aesthetic task we suggest for “new nursing studies.”

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