

Abstract

Nursing knowledge is diversely represented and contested, among academics and clinicians within and outside of nursing. This paper explores several Foucauldian concepts in relation to subjugated, local, naïve and situated forms of knowledge. We argue that these concepts relate closely to the mundane world of nursing and are useful for thinking about, teaching and researching everyday nursing practice. The discussion is tied back to data and analysis from a postmodern ethnography of nurses' assessment practice in an Australian acute psychiatric setting. We show how Foucauldian analysis of nurses' knowledge can usefully foreground taken-for-granted aspects of skillful practice.

Key Words discourse, everyday, Foucault, nursing knowledge, place, time

Foucault's Concept of "Local Knowledges" for Researching Nursing Practice

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Introduction

Nursing knowledge has been a contested site for as long as there have been nursing scholars. We are interested in nursing knowledge as it is expressed in everyday nursing actions, and de-coupled from idealised frameworks for nursing identity, such as: the expert intuitive nurse;^[1] the evidence-based nurse;^[2] or the popular ideal of the caring nurse.^[3] Some scholars have emphasised the need for nurses to explicitly learn and rely on theoretical models of nursing^[4] (such as Carper)^[5] to inform their practice and

others still have promoted the notion of praxis, whereby nurses are encouraged to rely on reflection and action. We suggest that all of these recommendations place a somewhat cumbersome burden on nurses, dividing those exemplars whose practices fit with the respective privileged frameworks, from others who practice nursing in the mundane, messy world of everyday work. This paper teases out several Foucauldian concepts in relation to knowledge. We argue that these concepts relate closely to the mundane world of nursing and are therefore useful for thinking about, teaching and researching everyday nursing practice. We aim to illustrate how the concept of situated knowledge can usefully foreground taken-for-granted aspects of skillful practice.

In wishing to critique the notion of (some) nurses' exemplary use of knowledge, our thinking is aligned to that of Purkis and Bjornsdottir.^[6] The primary criticism of ideal models of knowledge is the way such models exclude or undervalue ordinary practice and knowledge. Pointing to faults in similar conceptualizations of the relationship between

nursing knowledge and practice, they present nurses as intelligent practitioners whose knowledge is "activated" in specific contexts.[6 p248] They rely on Latour's[7] notion of knowledge as transformed in the work with a patient in a particular context. While their argument foregrounds and weaves together what they consider to be scientific knowledge of nursing and knowledge of each patient in context, we still perceive in their argument a lack of engagement with the effaced knowledge of the organizing demands in nursing, or in other words with what it is possible to know and do in a particular clinical context.

In this paper, whatever it is that nurses might know, about patients and about clinical practice, is viewed as emerging from forms of knowledge or discourses that are considered true, however wide or narrow their remit. Conversely, we suggest that nurses may either bypass or tenaciously hold onto forms of knowledge that are all but disqualified and silenced, not having achieved the status of truth. Such forms of knowledge are referred to as local and subjugated.[8]

The Foucauldian concepts of local, naïve and subjugated forms of knowledge are presented here as useful tools to enable elaborating and investigating of the resistant and productive character of nursing knowledge, in everyday practice. These ideas were developed for use in the doctoral study by the first author (BH), involving a postmodern ethnography of nurses' assessment practices in acute psychiatry settings. The study was approved through an institutional (hospital) ethics review, according to the requirements of the national body overseeing ethical conduct of research in Australia.[9] Eleven nurse participants gave their informed consent and names included in field data are pseudonyms. The research methods used in this study are published elsewhere.[10] This paper is primarily theoretical, but fieldwork and analysis from this postmodern ethnography are used to illustrate the potential of this Foucauldian perspective.

Foucault's ideas regarding truth and discourses are first outlined here, to provide context for an exploration of the ideas of subjugated local and naïve knowledges in nursing.

Foucault on knowledge, discourses and social practices

Knowledge and its claims to truth are the starting point for this theorising of nursing knowledge. For Foucault, discourses were the scaffolding for knowledge construction in the social world. Discourses determined what could be considered, known and upheld as truth. Throughout his entire corpus, Foucault frequently directed attention to the place and activity

of knowledge and discourses of truth in Western society. In a lecture entitled "Technologies of the Self", Foucault said:

My objective for more than twenty-five years has been to sketch out a history of the different ways in our culture that humans develop knowledge about themselves: economics, biology, psychiatry, medicine and penology. The main point is not to accept this knowledge at face value but to analyse these so-called sciences as very specific 'truth games' related to specific techniques human beings use to understand themselves.[11 p224]

Here we see a clear link between truth and self-definition, in the light of his later work on subjectivity. Earlier, his focus was on the link between knowledge and power in the development of the dominant forms of knowledge and truths of the human sciences.[12-15]

Academics such as Saussure[16] and his critic, Derrida[17] were interested in discourse principally in a linguistic sense, closely investigating and theorising language in use.[18 p109] However, as Rabinow noted, Foucault "never intended to isolate discourse from the social practices that surround it".[19 p10] Where nurses have often struggled with a perceived distance or a 'theory-practice gap' between knowing and doing in nursing,[2] knowledge for Foucault is intrinsically caught up in local power relations, in the site and activity of knowledge production and use.

Rather than laboring a definition of discourse per se, Foucault focused on the activity of discourses and offered many illustrations of discursive practices from the human sciences. For example, it is through the detailed examination of the way prisoners are housed and observed by prison guards that Foucault[15] built his analysis of modern power. Knowledge and discourses are similarly dealt with here as "systems of thought that are contingent upon as well as informing material practices, not only linguistically but also practically".[20 p49]

Since Foucault considered that discourses were actively produced in discursive practices, discrete discourses could not be sustained in isolation, but were alive in temporal and local contexts of practice. It follows that discourses are far from stable entities, rather they are constantly reproduced, contested and incrementally altered, as they are practiced.[21] Discourses link and refer to other discourses, such as when biomedical discourses are adopted by clinical researchers and power is drawn from certain discursive practices of scientific experimental methods and of measurement, within the broad discourses of natural sciences.

Competing and shifting discourses

The existence of competing discourses is evident for example in Foucault's extensive analysis of the competing discourses of unreason and madness in the early development of the discipline of psychiatry.[13] The power of dominant discourses over marginal discourses is explored in the work of poststructural feminist scholars. Weedon[22] argues that dominant discourses appear natural in society, resting on an established and institutional power base, and serving to main the status quo. This feminist view of dominance calls for a response of concerted resistance by the oppressed to overthrow or shift discourse and practice. However, Foucault himself rejected the notion of the absolute or totalising power of any discourses:

...we must not imagine a world of discourse divided between accepted discourse and excluded discourse, or between the dominant discourse and the dominated one; but as a multiplicity of discursive elements that can come into play in various strategies.[23 p100]

If discourses are bound up in networks of power relations, it follows that the existence of discourses (such as biomedicine) necessarily gave rise to counter-discourses (such as holism, or alternative therapies). Ways of acting and explaining action are viewed as arising out of power exchanges and the use of available language and knowledge. In turn, these exchanges promote further and constantly changing actions, knowledge and language use, or discourses.[23]

Though he rejected the idea of any discourse as all-powerful, Foucault did recognise the persistence of some discourses that others would call hegemonic. In particular, he was scathing in his analysis of the domination of scientific discourses in the game of truth in Western society:

In societies like ours, the 'political economy' of truth is characterised by five important traits. Truth is centred on the form of scientific discourse and the institutions which produce it; it is subject to constant economic and political incitement...; it is the object, under diverse forms of immense diffusion and consumption (circulating through apparatuses of education and information whose extent is relatively broad in the social body,...); it is produced and transmitted under the control, dominant if not exclusive, of a few great political and economic apparatuses (university, arour, writing, media); lastly it is the issue of a whole political debate and social confrontation ('ideological struggles').[24 p131-2]

Even so, Foucault saw instability and contestation as inherent within discourses. In his own research, he displayed a preference for exploring resistances and anomalies associated with dominant discourses. He drew attention to resistances in his analyses of many kinds of disciplinary systems: the

army, the hospital, the prison, the monastery, the school, the family. His work elaborated forms of knowledge that were subjugated within dominant discourses.

Subjugated forms of knowledge

Foucault[8] identified two connected and subjugated forms of knowledge: erudite historical knowledge and disqualified local knowledge. The first was dear to him, as a meticulous student of classical philosophy and historical practices. The second kind of knowledge, disqualified local knowledge, demands particular attention for its substantial relevance to nurses' knowledge. Foucault[8] defined subjugated forms of knowledge as follows:

... I believe by subjugated knowledges one should understand something else, something which in a sense is altogether different, namely a whole set of knowledges that have been disqualified as inadequate to their task or insufficiently elaborated; naïve knowledges, located low down on the hierarchy, beneath the required level of cognition or scientificity. I also believe that it is through the re-emergence of these low-ranking knowledges, these unqualified, even directly disqualified knowledges (such as that of the psychiatric patient, of the ill person, of the nurse, of the doctor – parallel and marginal as they are to the knowledge of medicine - that of the delinquent etc.) and which involved what I would call a popular knowledge (le savoir des gens) though it is far from being a general commonsense knowledge, but is on the contrary a particular, local, regional knowledge, a differential knowledge, incapable of unanimity and which owes its force only to the harshness with which it is opposed by everything surrounding it – that is through the reappearance of this knowledge, of these local popular knowledges, these disqualified knowledges, that criticism performs its work.[p82]

A modest body of research articulates elements of nurses' knowledge that are local and naïve; yet, are identified as essential to nursing work.[25-29] In our view, the knowledge identified in such studies accords with Foucault's[8] definition of subjugated forms of knowledge. Through a close range study of psychiatric nurses' knowledge produced in everyday assessment practice, the first author articulated several subjugated and disqualified elements of nurses' knowledge.[30]

Illustrating subjugated nursing knowledge

The box below contains field notes and subsequent analysis from this empirical research of nursing assessment practices in an acute psychiatric unit.[30] See page 10 for Box 1: Field notes and analysis of subjugated practice and knowledge.

Box 1: Field notes and analysis of subjugated practice and knowledge

After handover, and once the nursing shift leader had allocated all patients to the care of individual nurses for the shift, the nurses' first activity in relation to those patients was commonly to find and see them in the ward. On one afternoon shift I followed Nurse Ewan, as he sought out his allocated patients, in preparation for the afternoon's work.

After handover, Nurse Ewan looked at the whiteboard and jotted down on the back of his handover sheet the names of patients allocated to him. He commented that he didn't know any of these patients well, although he had worked with one patient the previous day and another early in his admission. Nurse Ewan did not pick up patient files, rather he picked up the obs[ervations] folder^a and walked through the ward. He exchanged a greeting with one patient on his list and a couple of sentences with another, returning to the office once he had seen all five allocated patients. He stood at the reception desk and, unbidden, he ran through his impressions of the five allocated patients and the approach he might take with each.

Field Ewan #2

Nurse Ewan began his work with patients by circulating through the ward and briefly observing all of them. Two other nurses, the Clinical Specialist, Nurse Beth and the Group Program nurse, Nurse Carl, had no patients allocated directly to their care, yet they also made a point of circulating through the ward soon after handover, looking into the High Dependency unit^b and seeing the patients for themselves, as one practice which informed their day's work. At this point I wish to emphasise the precedence and ubiquity of nurses' use of observation within the ward.

These nurses favoured observing the patients first-hand, apparently relying on their own senses and the immediate and 'live' information thus produced, over other static and written information available to them in the patient file. An aspect of this live information was their observation of the patient in an immediate social context, including the patient's interaction with the physical environment, with other patients and with staff. Thus, seeing the patient for themselves produced a situated, beginning knowledge of the patient.

Also, when nurses cared for unfamiliar or particularly unwell patients, the nurse often established and maintained a line of sight from themselves to one or more patients, as a taken-for-granted nursing activity. On a morning shift, Nurse Greg adjusted his position in the room as he spoke briefly with me, so that he could also see two patients at a glance:

Continuing our conversation, we both sat down in the High Dependency (HD) unit chairs. But within a moment Nurse Greg was up from his chair, leaning towards a bank of windows and glass door leading out into the HD courtyard. Nurse Greg said "I always look," indicating he wanted to see the patients who were in the courtyard. I leaned forward also, seeing that two patients were standing and smoking out of Nurse Greg's line of vision when he sat in the chair. Nurse Greg then remained standing, within line of sight of the patients and frequently glanced away from me in the patient's direction, while we spoke for a few minutes.

Field Greg #1

Nurse Greg's comment "I always look" indicated that he was conscious of his watchfulness at that moment. This comment was both striking and helpful to me, because there were many occasions during participant observation when I [observer] noticed nurses shifting their position in the room to maintain watch over patients as they spoke with me [observer], but no other nurses made such comments. Indeed, when I interviewed nurses about their inclination to see patients, or to keep an eye on patients, nurses invariably re-framed such work as 'meeting patients'. Nurses' common silence and about their obvious watchfulness suggested to me that the subject position of watching nurse was both taken-for-granted and subjugated by nurses in their daily work. Only in the precise moment of looking did Nurse Greg freely concede that he 'always looked'. Nurses' taken-for-granted privileging of the immediate knowledge they gained through observation in the time and space of the ward is highlighted through this analysis.

^a The 'obs folder' contained a single page for each patient currently on the unit, noting their bedroom number and their location in the unit at pre-set time intervals. Detailed analysis of the routine assessments practices associated with this folder is provided elsewhere.[31]

^b The open-door Acute Psychiatric Unit consisted of two 22-bed acute wards; each of these contained a locked, three-bed High Dependency area or 'HD unit'

Using the analysis in Box 1 as an example, we suggest there is a dynamic association between everyday nurses' practice and disqualified forms of knowledge, in nurses' situated assessments of patients. Nurses both exercised knowledge and gleaned valuable knowledge through circulating and briefly observing patients, and by maintaining a line of sight between themselves and particular patients. Yet, the extensive practice knowledge enacted in skilful observation was subjugated by the nurses themselves, who instead spoke of 'meeting patients'.

Also, the situated knowledge gained about patients and about what nurses needed to do was formed, enacted and frequently over-written in the course of a shift. What the nurses knew by seeing and what nurses did in the moment had little prominence in handovers, ward rounds or patient files. This knowledge was often and implicitly useful for work in the moment but rarely explicitly acknowledged. Indeed, what nurses knew was not articulated or privileged in the clinical setting, either as knowledge to be foregrounded in clinical team negotiations or to be preserved in written documents. In this second sense then, nurses' knowledge was subjugated, amid the work of the unit.

We wish to define two additional terms, to support our investigation of subjugated forms of knowledge in nursing. The concept of "locatedness", as developed by Malpas[32], a theorist in social geography and the concept of "situated knowledges", as developed by critical feminist, Haraway[33], both extend the theoretical work of Foucault, in regard to subjugated forms of knowledge. The concepts of locatedness and situated knowledges are examined in terms of how they intersect with Foucault's work. We then return to the extracts and analysis of field data to enrich the discussion of locatedness and situated knowledges in nursing.

Local, situated knowledge and place

Local knowledge for Foucault refers to knowledge that is specific to a situation and to human actors, and which is recognised as such by the actors, in contrast to knowledge that makes grander truth claims.[8] Increasingly, programs of health geography[34] have attended to intersections between place, clinical practice and knowledge. A strand of social geography that is useful to our argument is the work of Malpas[32,35] on the "locatedness" of knowledge.[32 p189]

For Malpas[32], knowledge is inseparable from location or place of its production, a proposition that is overlooked in modern presentations of universal facts and truths, which are plucked from their place of production and widely dis-

seminated. He described how any location encompasses space and place and differentiates space from place. Space is a concept aligned to scientific enterprises; areas of space can be measured producing knowledge such as a map reference, whereas place refers to an experience of place, is embodied, requires a knower and relies on subjective meaning-making.[32] Malpas[35] noted that modern research, which analysed the role of location in a particular form of knowledge, tended to privilege the objective domain of space over the subjective phenomenon of place. He recognised a "tendency, across a wide range of domains, for space to assert itself in a way that not only obscures and conceals place...".[35 p2348] However, Malpas insisted that these were two interdependent elements of local knowledge.

By exposing the power relations within locatedness, Malpas[35] made clear how science and objectivity distance themselves from subjective experience and thereby gain power to make totalising truth claims. Thus, it is part of the activity of the discourses of science to obscure the locatedness and politics of knowledge. Once biomedical evidence or an evidence-based practice is defined, it is understood to apply in many contexts, far removed from the site and agents of its production. A feminist view of situated knowledge adds another element to this discussion of subjugated knowledge relevant to nursing.

Haraway[33] provided a distinctive feminist critique of scientific knowledge in her theorising of situated knowledge. Like Malpas[32,35], she was critical of claims of objectivity in scientific knowledge, whereby the knowing subject holds the elevated status of one who speaks absolute truth from nowhere, in the sense that objective knowledge is set apart from the context of time, space and experience.[33] The local knowledge produced through ethnography is also in this sense subjugated knowledge, in contrast with objective scientific methods of inquiry that emphasise generalisability. Haraway elevated a particular reflective form of situated knowledge, as knowledge which declares its situation and the partiality of its power relations. Although Foucault did not himself prescribe reflexivity, in his view of the intrinsic place of any knowledge we see sympathy with Haraway's call to reflexivity. To ethically account for the power relations in the research process and in the knowledge produced, reflexivity is an important component of ethnographic research.

Nursing knowledge located in place

Nurses have researched the situatedness of their knowledge and valued a sense of place.[36,37] In a study of an Italian intensive care unit, Goopy[36] built a picture of nursing

practice as a local, cultural activity. By studying local practice and knowledge in detail, she aimed to counter the dominant Anglo-American ideas and assumptions of universal standards of nursing practice in intensive care settings. In the ICU unit that was the focus of her ethnography, Goopy found that far more doctors were employed than nurses, and they shared tasks in ways that are distinctive from "the model that has been taken as a universal given".[36 p148], which defines the roles of doctors as intermittently present and providing clinical direction while nurses are continuously present and providing the volume of prescribed care. Instead, in this unit nurses were legally prohibited to, for example, suction patients and many doctors were on hand to do such work. Nurses worked in pairs to provide routinised aspects of care and deferred all aspects of the relationship with patients and families to doctors. Such forces as the industrial, organizational and legal frameworks, the immediate social relations between nurses in this cultural context, all shaped nursing practices at odds with Western professional norms.

Likewise, Malone[37] attended to the meaning of the place of emergency departments. Reviewing arguments and ethnographic data from earlier research, Malone described how nursing culture is diversely produced, as a result of changes to both the place and time of nursing care. Where organizations institute efficient pathways, short lengths of stay and rapid home care, then nursing practices become more "distal", disengaged from patient experience, with dangerous potential to undermine nurses' everyday clinical and moral decisions. The work of these researchers and Malpas'[35] insistence on tying knowledge to location supported our interest in investigating the locatedness of psychiatric nursing assessment practice. The tabled extract from the ethnographic research illustrates how nursing practice of assessment was closely linked to the space of the ward (Box 1).

In the field notes and analysis provided, nurses' work was intimately tied to considerations of place and space. Nurses could draw on medical knowledge of mental status examination and theoretical nursing knowledge of engagement, which are both predicated on verbal interactions of particular types and are not explicitly tied to physical spaces or places. Yet, nurses in this ethnography relied first and prominently on observation of the patient in the immediate space of the ward, to know something of the patient that was vital to beginning and doing nursing work. Elsewhere we have explicated the knowledge of patients that was produced and used by nurses through observations.[10,31] Here, we emphasise the locatedness/situatedness of nursing knowledge, providing tangible instances for a later discussion of subjugated

nursing knowledge.

The theorising of Foucault[8], Malpas[35] and Haraway[33] all serve to problematise the elements of medical and nursing knowledge that are aligned to biomedical discourses, disrupting their dominance. Time is another aspect of situatedness that is important to an analysis of nurses' knowledge and prominent in the same field data.

Local knowledge and time

In modernity, time is "quantified, linear and historicised"[38 p14] so that social events can be placed in time, using stable means such as external markers including the date on the calendar, or the time on the clock. A modern linear concept of time is also future-oriented and privileges progress, which is typified in nurses' documenting plans at the point of admission and working towards goals. In order to have status within the biomedical setting of a hospital, nursing knowledge of events and patients must be cast in linear time.[39] Such a concept does not legitimise immediate experience and perceptions in time, referred to by Parker[38] as a patient's or nurse's "inner time".[p14]

The dissonance for nurses working both in linear time and with a patient's inner time creates considerable tension and practical dilemmas.[39] Parker[38] described nursing as existing between competing temporalities: patient time, medical time and managerial time. These different temporal positions are associated with different and often incommensurate demands, for relief of suffering, for cure and for efficient throughput. They are also allied to different modes of assessment practice. Nurses are required to attend to patients' immediate experience and fluid perceptions, while also appraising patients' clinical progress and rationing their own time and attention, according to an institutional regimen.

In contemporary healthcare settings the tension for nurses may be intensified, where nurses' and patients' embodied experience of time[39] are at increasing odds with the pace of activity in linear time.[40] Both Parker[38] and Newton [40] pointed out how time is accelerated or compressed in late modernity, through contemporary developments such as advanced communication technologies and economic rationalism. This discussion of tensions in nursing temporality highlights the fleeting and potentially vexed nature of everyday nursing knowledge. In this way, temporality is tied to a critique of the ways nurses communicate assessments and the low status of some forms of nursing knowledge.

Nursing knowledge situated in time

Nursing is often described as an oral culture, whereby nurses' knowledge is transmitted and kept alive through the acts of telling and retelling.[41] The formulations of such knowledge may not be erudite, being shaped for brevity and efficiency or for conveying imprecise details of impressions or affect.[42] Many such details of knowledge are important to accomplish nursing work through a shift; yet, they are not recorded in written form and are not retained beyond their last telling, in contrast to those details that are noted in the patient file and remain for posterity.

As the fieldnotes and analysis (in Box 1) suggested, nurses commonly conducted assessments whilst circulating in the ward and when maintaining a line of sight. These assessments were intensely practical and foremostly pitched at the immediate circumstances of individual patients, often in relation to and in comparison with the circumstances of other patients within the ward. This comparison was important to shift-working nurses, both for providing timely care and for organising nurses' own workloads. But in order to be of interest beyond nursing and in the setting of a weekly ward round discussion, such 'mundane' nursing knowledge would have to be compared with the patient's conduct over a longer time frame, so it could be worked into a discussion of patient progress. Nurses' mundane knowledge of patients in the ward space and in small increments of time was of little or no interest outside of the shift-working nursing audience, precisely when it did not provide an account of progress.

These concepts of knowledge as located, situated and fleeting accord with the postmodern interest in the diversity of truths, tied to context in time, place and language. The recognition that there is a standpoint from which any particular truth comes, connects with the concept that human identities or subjectivities (of nurses, patients) are situated and unstable, rather than fixed.[43]

We have argued that knowledge related to nurses' assessments of patients can be viewed in many respects as situated, rather than as absolute and enduring. The concept of situated knowledge can usefully foreground taken-for-granted aspects of skillful practice. Further, this kind of analysis can give substance to a discussion of the power and status of nurses' knowledge. The contest between dominant and subjugated forms of knowledge can be investigated, by probing the status of specific knowledge upon which nurses rely in their daily work.[8] The discussion of situatedness as a characteristic of subjugated nurses' knowledge is supplemented next by a discussion of the subjugation or disqualification of ordinary

or naïve nursing knowledge.

Naïve forms of knowledge

Naive knowledge is commonly contrasted with scientific and medical knowledge; this contrast is productively theorised by Foucault, who asserted the value of naïve forms of knowledge. Sociologist Carl May[44] showed how Foucault has been used in medical sociology to problematise the dominant medical knowledge of patients and thus to reformulate the question of power in medical settings.

The definition of patients as bodies and as pathology has been problematised through analyses of medicine's construction of patients (instead/also) as social cases, thus drawing attention to "discourses of the social" in medicine.[44 p472] May adopted this approach to usefully construe nurses' biomedical knowledge of patients' objectified bodies, symptoms and diagnoses as "foreground" knowledge and nurses' social knowledge of the patients' idiosyncratic and private subjectivity as "background" knowledge, also essential to nurses' work.[44 p472]

Naïve nursing knowledge

Nurses' everyday knowledge is often theorised by nurses and other researchers as social, ordinary or informal knowledge, reflected in nurses' use of the ordinary spoken lexicon,[44,45,46] or as "practical commonsense" knowing.[47 p57] Overtly gendered and potentially sexist portrayals of nurses' informal knowledge draw a parallel between nurses' intimate knowledge of patient's bodies and mothers tending to infants.[47,48] Such gendered accounts are then associated with nurses' mother-like emotional attachments to patients. Nurse-patient attachments can be devalued as expressions of unprofessional partiality towards patients, which might cloud nurses rational/clinical judgment, so that on occasions nurses' knowledge of patients can be disregarded.[48] Even though the psychiatric nursing workforce is equally male and female,[49] the gendering of nurses' knowledge persists in images of the intimate character of psychiatric nursing work.[47]

In several ways the naivety and ordinariness of nurses' knowledge can be used in power contests to dismiss nurses' knowledge as not authoritative, being merely tied to the nurses' subordinate place, and as natural and unskilled.[48] The tenuous status of nurses' naïve knowledge echoes Foucault's description of disqualified knowledge, as both "insufficiently elaborated" and "located low down on the hierarchy, beneath the required level of cognition or scientificity".[8 p82]

We include here (see Box 2) a second extract from the ethnographic research analysis,[29] of a journal extract from the first author's own practice, as an illustration of the use and subjugation of naïve knowledge in everyday nursing.

This example again shows how nurses' assessments were intensely practical and pitched at the immediate circumstances of individual patients, in comparison with the circumstances of other patients within the ward. Clearly this knowledge was not, of itself, compelling to non-nurses. The lack of interest of non-nurses in the plain knowledge of patient conduct in the here-and-now can be seen in this extract and analysis.

Within nursing scholarship there is considerable interest in theorising ordinary nursing knowledge as productive for patients' sense of being cared for and understood.[50,51] Likewise, some nursing research articulates the tacit nature of nurses' knowledge as essential to nursing work.[28] Nurses' use of ordinary knowledge and lay understandings is also upheld by Allen,[52] where this knowledge is recast as vital to nurses' role in mediating between patients, administrators and other clinical staff. Though mundane nursing knowledge may be increasingly theorised and eruditely discussed, the feminist interest in women's intimate and embodied know-

ing will continue to intersect with Foucault's notion of naïve forms of knowledge, because it aligns the nurse with the patient, whose knowledge is considered lay or ordinary. This work in the academic arena serves to partly offset the unease expressed, both in academia and among nurses themselves, regarding nurses' informal or lay knowing of patients.

Foucault had a particular purpose for reviving disqualified forms of knowledge, beyond defining them as a class of knowledge: he found them vital to the studies he called genealogies. Foucault defined his genealogy as a "union" (rather than an opposition) of scholarly historical knowledge and naïve, local specific knowledge [8] (p.83). Through this union, he showed how particular historical events and contests of power produced certain forms of knowledge, discourses, and subjects. Such a critique can be potent in redressing or resisting the disqualification of forms of knowledge nurses rely on each day.

Foucault's principle of tying theoretical concepts to very specific, detailed and situated practices, in order to more fully critique regimes of truth, power relations and subjectivities, is a great strength in his analysis. This principle prompted us to explicitly tie particularities of practice and context in a project of ethnographic research. In doing so, we brought

Box 2: Journal data and analysis of subjugation of naïve knowledge

The minutiae of a patient's capacity to conform to a daily routine, in concert with twenty others patients in the unit, was important knowledge for our everyday nursing. It was prominent in the knowledge nurses readily called forth, as is evident in this journal extract:

At 8.50a.m. the shift leader told me [researcher] I would be attending the weekly ward round (9.00a.m. – 10.15a.m.), where two of my five allocated patients would be discussed. I had never worked with these two men before this day and had introduced myself to them very briefly at the breakfast table. But in the absence of the primary nurse I was to contribute a nursing view at ward round. I glanced around the ward office and saw that the patient files were gone, so I could not read the file, to embellish what I knew. I moved on to attend to another patient. At 9.15a.m. I was called away by the shift leader to join the meeting, in a room off the main corridor.

I glanced at my handover sheet and skipped through name, age, diagnosis of depression, length of admission. I then said: "His mood seems not to be very low, he slept better last night than the one before, had a light breakfast and is still in his pyjamas. Maybe I'll encourage him to the gardening group ..." I faltered. I had nothing more to say. The nurse unit manager, the consultant and the registrar looked at me blankly. We were all silent for a few seconds. The nurse unit manager coloured slightly. I felt embarrassed to have nothing but this mundane information to offer the review meeting. The consultant led a brief discussion about the patient's response to medication and concluded that he might need to remain on the unit for a week, following a change in dose.

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Working only part time as a nurse on the wards, my knowledge of patients was perhaps dominated by such here-and-now appraisals of conduct and mundane knowledge. But my experience was not unique, as the wards were typically staffed by some nurses who were casually employed, alongside those who worked fulltime. The details I had at hand were certainly of value to me, to determine that this reportedly depressed man was eating adequately, moving about and perhaps requiring some prompting to dress and join in potentially satisfying activity. I needed to know that his depression was not impeding these abilities, to understand how I must assist him meet his fundamental daily needs. Nothing I'd noted from handover or my own brief appraisal signaled urgency, in comparison with other patients in my care.

forward subjugated forms of knowledge, aiming to ensure the relevance of the study beyond the lifetime of the local context.

This conceptualizing and researching of the productivity of everyday knowledge has implications and utility for nursing education, clinical supervision and the formation of more nuanced professional nursing subjectivity. If nursing academics, clinical nurse educators and senior practicing nurses take up such ideas, they are equipped to move beyond standardized notions of assessment practice, which include reliance on talk over observation, on formal, structured approaches to interviewing and on silencing of the nurses' knowledge in medically-dominated clinical team discussions. Such ideas have dominated in the education of nurses, undermining an articulation of the skillful nurses' everyday contribution to clinical team activity and to the movement of patients through hospital settings, including acute psychiatry.

Conclusion

Foucault's concepts of competing discourses, associated discursive practices and forms of knowledge, encompassing naïve and local knowledges which are often subjugated or disqualified, together provide ample scope to explore the value of diverse knowledge in nurses' mundane practice. Having considered directly some important concepts and their application, in regard to truth and knowledge in psychiatric nursing assessments, we conclude this paper by returning to Foucault's overarching view of knowledge.

Increasingly through Foucault's works, knowledge was intimately tied to the practices and effects of power, to the extent that he coined the term power/knowledge to represent their interdependence. "The important thing here, I believe, is that truth isn't outside power or lacking in power".[24 p131] The nursing academy has an investment in the erudite knowledge of nursing, whilst clinical nurses pragmatically take up temporally and spatially situated forms of knowledge and lay understandings of patients, in their everyday work. As nurses and academics seek to gain territory for nursing knowledge as it is diversely portrayed, sometimes in competition with non-nursing clinical colleagues, it is likely that nursing knowledge will continue to be a site of contestation.

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