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Éditorial/Editorial

As I embark on a new journey as a university professor, I am once again confronted to the issue of workplace violence and aggression. Once a faceless taboo, there is now a plethora of articles written on the problem which is so pervasive in health care, and especially in nursing. It is said that health care professionals are 16 times more likely to experience violence at work compared to other workers; and that nurses are the second highest profession for risk of violence and aggression, right next to police officers who are first. This reality is in stark contrast with the caring aspect of nursing which is the reason why many decided to join the profession.

Perpetrators of workplace violence in health care are numerous and include patients and their relatives, managers and supervisors, colleagues and other health care professionals. Aggression can take many forms, from overt physical violence to the more subtle psychological aggression and the often elusive incivility. Instances of aggression are often not reported because the victim is either afraid of retaliation (mostly in instances of intra/inter professional aggression) or perceive an ethical dilemma with reporting someone they are hired to deliver care to (in case of a patient or relative).

Some have argued that acts of aggression must be intentional to qualify as such. However, I have witnessed and been told stories about instances where perpetrators did not realize they were in fact perceived as being abusive. The current workforce diversity where several cultures and generations are now working together can contribute to the perception of aggression. In effect, it is easy to attribute ill intentions to people we do not know or do not understand. Compounded by a shortage of nurses, heavy workloads and increased patient acuity, the work environment of nurses working in hospitals is extremely demanding. There is no time for breaks, meals, to get to know your colleagues, to develop friendships. Instead of being encouraged to do so, nurses who choose to take a break are often perceived as “not busy”, as “having time on their hands”, as “not dedicated to their patients” or even as “lazy”. One can be ostracized just for needing to take a break away from the demands of a busy day.

As an occupational health nurse working in a hospital setting for many years, I was always taken aback by the prevalence of cases of aggression. Talking with employees who were dissatisfied at work, suffering from burnout, contemplating leaving the organization or even nursing

altogether, I was shocked to realize how often these feelings where the results of workplace conflicts or aggression. In my new position as a university professor, I am now confronted with the reality that violence and aggression are both well and alive in the academic world where students and faculty play an integral part in "the dance of incivility". The academic world is a very demanding one for students and faculty alike. It is a highly competitive environment where students need high grades to access programs and funding, and where faculty require extensive curriculum vitae to access promotions and funding. The need to perform "at all cost" can lead to stressful situations which are fertile grounds for conflicts and aggression to thrive.

I am often asked if I think violence and aggression are more prevalent in today's world. On the one hand, I believe that we see an increase in reported cases of violence and aggression because more people are aware of the issue and encouraged to report it thus leading to an increase in "reported" cases but not necessarily "new" cases per say (as some cases might have happened before but we were not aware of them). On the other hand, I would argue that today's society appear to be more violent than it was even just a couple of generations ago. Whether we think of bullying in the school yards of elementary schools or hallways of high schools; of soccer or hockey coaches and referees being attacked by parents; of bus drivers being cursed, spat on or punched; of taxi drivers being robbed and beaten; of road rage; of the multiple law suits against institutions, neighbours, colleagues, family members… Yes, I do believe that as a society, we have become a lot less tolerant and civil towards one another. I recently went shopping at a local grocery store and next to the cashier was a sign "do not spit on cashier". When I asked the cashier about the prevalence of this behaviour she replied "more often than you would think". This reminded me that we all have a role to play if we are to address violence in the workplace and in society in general.

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Abstract
Survivorship suggests a temporal relation. It speaks to the endurance of past trauma and looks forward to a future that it wills into being through the overcoming of adversity. This article traces the warped temporalities of cancer survivorship, exploring its queer dimensions by combining theoretical discussions with readings of two lesbian interventions that address normative visions and narrations of healthy/diseased bodies. Cancer survivorship in each case becomes a poetic narration of desire and disease through the queering of temporality. The authors argue that the extent to which cancer's time warp here belongs to queer temporality depends on whether the queerness refers only to the odd, the uncanny, the indeterminate and the undecidable. Or if, instead, cancer's time warp is queer in the sense that sexuality is already present in cancer's disturbance to temporality. In so far as queer carries with it the traces of sexualities deemed undesirable and perverse, then such connections move beyond an analogous and into an ontological register.

Key words bioethics and illness narratives, cancer health disparities, discourse analysis and cancer knowledge, feminist biopolitics, genealogical-phenomenological discourse analysis, gender and health equity

Queering the Temporality of Cancer Survivorship

JACKIE STACEY & MARY BRYSON

> Critical illness not only presents you with issues of finitude, but more importantly, it threatens the very foundation of time structuring by removing you from life's comforting rhythms. It becomes a struggle not to *fall out of time*. (emphasis in original)[1]
>
> A cancer diagnosis changes you in this way: you don't want to be taken for dead. You don't want other people to look at you and read death into you or onto you.[2]
>
> This is a story about time. About coming from the darkness to the light. I always thought time started when I was born and ended when I died. Didn't you? It all started a long time ago in black and white. And now it's a fact of life. There's no logic here. No beginning, middle or end. It's a journey through the shadows of a city. A map. The wrinkles on my face are where the map gets folded over. And over.[3]

Introduction

Survivorship suggests first and foremost a temporal relation. It speaks back to the endurance of a past trauma and looks forward to a future that it wills into being through the overcoming of adversity. Cancer survivorship is a statement in the present perfect (of having survived) that speaks a desire for the future that it knows is uncertain (when does remission become survival?). To survive is, by way of its etymology, to live above, beyond or beside something; it refers to a 'living longer than' that revises previous expectations of time. The temporality of cancer survivorship is always provisional and contingent, requiring adaptation and improvisation (see Bryson[4]; Bryson & Stacey[5]; Berlant[6]). Time becomes newly relational, undoing the neat sequential flow of past, present and future.

One way to think about cancer survivorship is through the performative scrambling or warping of temporalities that accompany diagnosis, treatment and prognosis. *Contra* the conventions governing modern calendar and clock time

(and the linear teleologies of normative life narratives that flow from time's forward march) cancer introduces a more haphazard mix, deflecting us from any sense of life's proper path. In losing the comfort of time's reassuring illusions, we are confronted with the fragility of a life robbed of these stabilising fictions; we struggle not to feel as if we are 'falling out of time,' to repeat Gunhild Hagestad's phrase with which we began this chapter.[1 p205] To have the past undone and the future made unpredictable brings with it the unbearable sense of the presence of the present. As Lochlann Jain has put it: 'The biomedical prognosis, as one of these technologies of presencing, stands out in this dispersed set of cancer culture's materializing practices'.[7 p78] The 'living-longer-than' of survivorship demonstrates this warping of time perfectly: in the first instance, the cancer diagnosis presents the shock of 'living-shorter-than' had previously been expected; the temporality of survivorship then replaces the 'shorter-than' with the 'longer-than,' but the one remains embedded within the other. The 'longer-than' following a cancer diagnosis is haunted by 'the living-shorter' than the life imagined before it. For Jain, the term 'cancer survivor' references a 'simultaneous sense of life and death'.[7 p77] The representational space that makes no sense within conventional temporal fields is what Jain refers to as 'living in prognosis',[7 p78] a living in what she calls 'the folds of various representations of time'.[7 p80] We might refer to this as cancer's time warp.

This article traces the warped temporalities of cancer survivorship, exploring its queer dimensions by combining theoretical discussions with readings of two lesbian interventions that speak back to normative visions and narrations of healthy and diseased bodies: Barbara Hammer's 2008 experimental film, *A Horse Is Not A Metaphor* (hereafter *Horse*), and Peggy Shaw's 2008 collaborative performance monologue with Clod Ensemble, *MUST the inside story* (hereafter *MUST*). The former combines documentary and poetic styles to produce a personalized cinematic narration of surviving ovarian cancer; the latter stages a biographical anatomy lesson for the audience through a series of monologues performance accompanied by live music. Each explores survivorship through the intensity of endurance and desire. But if *Horse* moves us between the spaces of anguished torment and serene beauty through the filmic language of bodily presence, *MUST* holds us in the tension between the particular physicality of the body on the stage and a sense of the strata of its accreted histories whose connections to the vitality of the physical world are gradually built up through stories of its illnesses, injuries, loves and losses. In very different ways, both pieces undo any conventional sense of time's linear, causal dynamics, offering instead the perceptual disturbances that mark a body returned to its present through the physical and emotional demands of life-threatening illness. To cite the epigraphs with which we began, this rest of this chapter traces the coalescence of the unfamiliar contours of the temporality of illness ('falling out of time'), the physical presence of mortality (as others 'read death into you or onto you') and the occluded traces of past histories (as we 'journey through the shadows of a city').

Cancer's time warp

Anthony Vidler has argued that in the warped spaces of modernity, the subject is caught in 'spatial systems beyond its control […] attempting to make representational and architectural sense of its predicament'.[8 p1] Taking our cue from Vidler, we begin to conceptualise the warped temporalities of cancer survivorship by thinking about how the subject struggles to make sense of a body beyond its control, or, as Jain[7] puts it, what it means 'to live in prognosis'. If the 'spatial system' in question here is the body that now houses malignancy, then cancer warps time in so far as it compresses, as well as extends, our temporal orientations: the future rushes towards us as the present of 'treatment time' seems interminable. Cancer generates an uncanny sense of our bodies that slips between its familiar contours and its newly strange sensations and appearance. Following Vidler, Strathausen[9] suggests that we can only understand warped space through Freud's notion of the uncanny, which captures 'modernity's oscillation between exposure and repression, between location and displacement'.[p15] The feeling of the uncanny, as Donald[10] explains, originates in the 'disquieting slippage' between 'a place where we should feel at home,' the familiar, and 'the sense that it is at some level definitively unhomely' or 'unheimlich'.[p81] This focus on the oscillation between something familiar and something strangely disturbing, and the finding of the latter within the former, prompts us to think about how cancer warps the temporality of the body as we try to hold together that sense of unfamiliar familiarity post-diagnosis, throughout treatment, and into prognosis. Whilst any illness warps time to some extent, cancer does so in particular ways through the combination of its initial hidden presence, its circuitous routes of presentation, its secret mobilities and its uncertain return: healthy bodies secretly housing a deadly disease; the treatment may feel worse than the illness; the sense of health in the future is not to be trusted. In these ways, cancer undermines our sense of time's sequential flow, of the causative agency of prediction and outcome, of genealogical histories of kinship and relatedness, and of

the narrational flows of personal biography. In short, cancer warps our temporal perceptions of our own bodies, which, however illusory, anchored the modern subject in anxious desire for certainty and predictability.

As we slip between the spaces of past, present and future, which no longer flow in the direction of our desires or obey the causal sequences of our self-narrations, we may that cancer has confused the boundaries between feeling healthy and feeling unwell, between looking well and being ill, and between reading and misreading the signs of our bodies. Jain suggests that 'prognosis affects every dimension of time, not just the future; the past becomes equally mysterious and unknowable'.[7 p83] We should, she argues, replace *the survivor* as the figure of hope or cure and often as the basis for an 'identity formation around cancer' with an *elegiac politics* that makes room for loss, grief, 'contradiction, confusion and betrayal' in a culture that is 'affronted by mortality'.[7 p90][i] To live in prognosis would mean facing cancer's time warp and refusing the normative reassurances of claiming the identity of survivorship.

The C word and the L word revisited

Jain's eloquent critique of the identity of survivorship introduces a number of problems with conventional conceptualization of time which have been at the heart of recent debates about how sexual and temporal norms are mutually constitutive. Our discussion of how recent lesbian work might speak back to the temporal heteronormativities of cancer survivorship revisits the mutual implication of sexuality and illness discussed in Stacey's much earlier cultural study of cancer, *Teratologies*,[11 p65-96] and in Audre Lorde's[12] *Cancer Journals* before it. Exploring the continuing traces of stigmatisation that brought the C word and the L word into a shared critical frame in Stacey's previous account, we track the double valence of normative discourses upon which it rests. In the last decade, lesbian writing on the subject of cancer, such as Catherine Lord's[13] *The Summer of her Baldness: A Cancer Improvisation* and Mary Capello's[2] *Called Back: My Reply to Cancer, My Return to Life*, have explored cancer cultures' normativities.[ii] Cappello, for example, narrates an account of being given a Styrofoam cup 'into which was lodged a tiny […] figurine, topped with a rosebud […] from which hung the message in bold black print […] "This Bottle of Hope was made for YOU""[2 p23] she responds with a mixture of nausea at the 'pinkification', fury at the capitalized second-person address, and fascinated bemusement at the whole concept of someone hand-making this for a person they do not know. Here the imperative to assign hope to futurity is condensed into an infantalising femininity which turns the breast (and its potential loss) into a metonymic sign: the threat of gender disturbance that breast cancer generates is disavowed through an excessive over-presence of feminine clichés.

The cultures of cancer survivorship are saturated in the shaming imperatives of heteronormative discourses, as Jain[14] demonstrates in her article 'Cancer Butch' which describes how the infantalising pink kitsch of breast cancer culture (see Ehrenreich[15]) provides a repeated redoubling of femininity that 'fissures through the entire biomedical complex of cancer treatments'.[15 p504] As Sedgwick[16] writes, spending time as a totally bald woman following chemotherapy is a lesson in the social construction of gender that feels a bit like an 'adventure in applied decontruction'.[p11][iii] When diagnosed with breast cancer, it was the cancer not the breast that offered what Jain[14 p504] calls the 'defining trauma' of gender designation; Sedgwick's first thought was: 'Shit, now I guess I really must be a woman'.[17 p202-3] The trauma of diagnosis here concerns gender and sexual normativites, as well as about facing one's mortality. Jain[14] draws on Sedgwick[16,17] to argue that 'at least one aspect of the shame of breast cancer for those who inhabit nonnormative genders lies in the seeming destiny of biological gender'.[14 p505] Cancer survivorship thus becomes a question of not only surviving the illness and its treatments but also of surviving the sudden intensification of normalizing requirements of its anxious cultures.

Recent debates about the heteronormativity of temporality in queer theory have suggested that 'queer time' might be contrasted with 'straight time', which is designated problematically normative: 'evolutive, teleological, apocalyptic, paranoid [because anticipatory]'.[18 p231-2][iv] Put simply, straight time is seen to regulate sexual orderings through legitimizing particular social processes which organize how we live and imagine everyday life. Matthew Helmers[19] sums up these debates succinctly as follows:

> Contemporary feminist and queer theorists tend to critique temporal constructions through demonstrating ways of experiencing time that distort regular past-present-future constructions. For example, Elizabeth Freeman slows down normative time through her concept of 'temporal drag'; Heather Love feels the affective pull of history and thus orients her time towards a backwardness; Judith Halberstam presents a compressed time that is, according to her, oppositional to the domestic; Lee Edelman suggests a Lacanian temporality no longer grounded in an investment in a future guaranteed through reproduction and the Child; and José Muñoz emphasizes the future as a unique space of queer

possibility'[p4, unpublished]

Life-threatening illnesses, such as cancer, inevitably interfere more generally with conventional clock time and with normative notions of a progressional life-course in ways that might be read through Martin Heidegger's phenomenology of disjunctive temporalities.[20] But for those whose lives repeatedly placed them on the edge of a sociality organized through heteronormative temporalities there is a further queerness to cancer's time warp. Already out of kilter with time's reassuring deceptions, cancer makes visible (and visceral) for some the structural parameters of time's exclusionary illusions. If cancer makes some people feel as though they are 'falling out of time'[1] – out of the usual rhythms and routines of everyday life – then, for those whose queer lives have already been marked out by some sense of being out of step with the conventional organization of time (what Helmers[19] calls that 'para' or 'beside' of particular queer temporalities), cancer's disturbance to the time of the body may retrace the previous allusiveness of feeling in step with time. As Lee Edelman[21] puts it, writing of queer temporalities, 'we are never at one with our queerness; neither its time nor its subject is ours'. What he refers to as 'the queerness of time's refusal to submit to a temporal logic'[p188] demonstrates how theories of queer temporality share a critical stance with longer philosophical critiques of modern time (Heidegger, Bergson, Lacan, Derrida).

To speak of cancer's queer time warp is both to harness the temporal pull of queer (sub)cultures,[22] the constitutive outside that is also an alongside (or a beside), and to acknowledge that such queerness (re)claims its alterity only to reveal the fictionality of the cohesion and linearity of the normative inside of modern time. Thus, if we should, as Annamarie Jagose, has argued, be wary of reifying queer temporality, by employing that adjectival 'queer' to throw 'a proprietary loop around properties or characteristics that have long been theorized as at the heart of "time" or, for that matter, "history"',[23 p186] then we might be equally intent on exposing the absence of concern with the structuring dynamic of the 'heterosexual/homosexual distinction' in those critiques of the temporality of modernity.[16 p157] The deeply unstable character of modernity's foundational claims about temporal flow is revealed by the uncanny disturbances of the queerness of time and our embodiment of it.

Not a metaphor

In Sontag's books *Illness as Metaphor*[24] and *AIDS and Its Metaphors*[25], she makes clear how stigmatized illnesses (like cancer and HIV and AIDS, and TB before them) are vulnerable to heightened metaphorical designation. She writes:

> […] it is hardly possible to take up one's residence in the kingdom of the ill unprejudiced by the lurid metaphors with which it has been landscaped.[24]
>
> […] some of the onus on cancer has been lifted by the emergence of a disease whose charge of stigmatization, whose capacity to create spoiled identities, is far greater.[25 p101]

What Sontag rightly saw as the power of metaphor in the blame cultures surrounding stigmatized illnesses has had particular resonance for thinking about how cancer affects those with already stigmatized sexualities. As Sontag[24] herself discussed in relation to HIV and AIDS, fear of the disease is articulated through a distancing condemnation of it, sometimes more sometimes less explicit, as self-generated and morally reprehensible. What Judith Butler[26] once referred to as the 'dreaded identification' with 'uninhabitable categories,' those 'abject zones of sociality' which 'threaten the cohesion and integrity of the subject'[p243] captures precisely how 'the charge of stigmatization' with its 'capacity to create spoiled identities' (as Sontag[24,25] puts it above; see also Goffman[27]) brings the shame of non-normative sexualities into the shared frame of the heightened affect generated by the presence of a disease such as cancer.

But, as Capello's[2] memoir shows, metaphorisation is impossible to resist since the intensity of the cancer diagnosis makes the person read everything as a sign of what is to come:

> Notice, notice, notice a feeling of being bludgeoned, not by the news but by this affect. […] To read or not to read. That is the question. […] In the week of waiting for the news and still hereafter–after "getting it"–my readerly apparatus goes a little crazy. The world suddenly seems full of messages for me. Every sign a harbinger.[p14]

As Capello[2] suggests, a cancer diagnosis transforms everyday encounters into symbols of the future, producing an investment in reading the signs of one's destiny at the very moment one has been robbed of agency. Cancer's time warp here is reimagined as futurity's desire to reveal itself to us in signs.

The title of Barbara Hammer's 2008 film (*A Horse is Not a Metaphor*)[v] speaks directly to Sontag's[24,25] refusal of the metaphorical that gives force to the stigmatisation of both sexuality and illness. An experimental film about this lesbian filmmaker's diagnosis of and treatment for stage three ovarian cancer, *Horse* combines poetic and documentary styles with music by experimental vocal artist Meredith Monk. The film's

title references Sontag but its diegesis moves the problem of metaphor into the materiality of embodiment to which we are returned by both illness and sexuality: a horse is not a metaphor in that it does not represent something other than itself; it is not a metaphor in that it does not stand in for the expression of something already known about the human; and it is not a metaphor in that it does not follow the logic of substitution. The horse in question here draws us instead into a sense of the materiality of being alive. Just as Sontag urged us to undercut the damaging power of metaphorical thinking about illness, which blamed particular personality types or sexual subcultures for the onset of disease, so *Horse* reconfigures the dynamic vitalities of human and horse in ways that echo Donna Haraway's[28] notion of 'companion species'– those entanglements which are 'knotted from human beings, animals and other organisms, landscapes and technologies'.[back cover] Like Sontag[24,25], whose own writing on illness is of course full of metaphors, Hammer's filmmaking both deploys and deconstructs symbolic connections and poetic associations between the diseased body and the desiring body, and between the terror of diagnosis and the will to survive. Her title, perhaps like Sontag's[24,25] original intervention, speaks a refusal that is also an enactment of the impossibility of stripping illness of its symbolic force: disavowal is always also an instantiation. *Horse* creates the imaginative space that holds us in the tension of this paradox: cancer and its treatments may reduce us to the physicality of the present that generates an urgent tendency towards compulsive over-reading. Using the materiality of film (as in much of her previous work, see Dyer[29]) to push towards a spectatorship constituted through an intensified sense of presence and a longing for signs of survival, Hammer immerses her audience in the dilemmas of which Sontag[24,25] wrote so eloquently.

Combining a relatively conventional narrative structure that moves from diagnosis and the first of several rounds of chemotherapy through to an extended eighteen-month remission with a more characteristic experimental aesthetic of repetition, slow motion, superimposition and extreme close-up, the film both offers a story of hope based on sequential direction and undoes any certainty of predictive futurity.[vi] The documentary sections of the film set in the hospital during chemotherapy treatments are filmed by Hammer and her partner of twenty plus years, Florrie. Their relationship functions as both foreground and background in the film's structure and project. The conventional singular point of view of the invisible documentary filmmaker is transformed into a lesbian collaboration, mediated through the spectator who registers the intimate distance of their shared fear in superimposed close-ups of their faces (Figure 1), or of Hammer's ghostly figure passing across Florrie's direct look to camera (Figure 2).

The more experimental shot sequences using Hammer's (sometimes naked) body placed in natural landscapes (woods, lakes, mountains), echoes its trademark use in some of her early work which explored the pleasures and problems of representing lesbian sexuality on the screen (see Dyer[29]); it resurfaces here both to trace the contours of a survivorship haunted by loss, death and bereavement and to celebrate the physical joys of vitality and of desire in those spaces of remission (see Figures 3 and 4). These sequences are combined with documentary footage of Hammer riding horses in the Catskill Mountains of Woodstock, New York, in New Mexico at Georgia O'Keefe's Ghost Ranch and in the Big Horn Mountains at Red Reflet Ranch in Wyoming.[vii] Reminiscent of her earlier search in previous work for another vision of Nature, one which might yield a queerer dynamic of body, desire and natural landscape, these scenes of Hammer's sheer pleasure in riding and filming horses in these magnificent settings both deliver the hope of a personal futurity and remind us of the chemotherapy scenes (discussed below) where the figure of the horse inspired the requisite mental endurance for the procedures and treatment.

The desire for cancer survivorship makes it hard to resist


Figure 1


Figure 2

Figure 3

Figure 4

the reassurance of narrative structures that flow from past to present to future (as in the heroism of the clichéd triumph-over-tragedy genre, see Stacey[11]) but the visceral and psychic disturbances incurred through cancer diagnosis and treatment implode conventional temporalities, turning reassuring formal progression into a partial comfort. *Horse* brings together both modes of time within the same frame: cancer generates the need for narration (a progress narrative is always preferable); treatment warps the time of the body, moving the patient into the uncanny sense of its simultaneous familiarity and strangeness, or into the disturbing feeling of slipping between the two orientations.

Horse delivers a certain over-presence of vital bodies in the temporal present of the film's diegesis, both in Hammer's own body and in those of the horses on the screen. In the rehearsal of diagnosis, an extended cry of terror carries across cuts between shots of Hammer's naked body curling (fetally) toward an elemental vortex of light and water (Figure 5) and the spirit of the refusal caught in the eye of the rearing horse (Figure 6).[viii] In the sequence of the insertion of the needle in preparation for chemotherapy, shots of Hammer reluctantly acquiescing and submitting to the next round of poison that might heal her body (Figure 7) are intercut with slow motion shots of the beauty and pain of the untamable force of rodeo horses (Figures 8 and 9).[ix] In the midpoint sequence (after nine chemotherapy treatments), a close-up shot of Hammer's

Figure 5

Figure 6

Figure 7

Figure 8

Figure 9

Figure 10

regrowing fine white hair is multiplied into nine shimmering almost bald heads, as the sound of effortful breath and female vocalise lead us from the textures of the human body into a superimposed shot of a single horse galloping across an open landscape: a vision of distinct capacities to thrive (Figures 7 and 10).[x] As Hammer says in one interview, '"Survivor" has never seemed to me to be the right word for a person who lives with cancer. I would choose a word that signifies flourishing, a sense of well-being, exaltation and love of life. The horse is not a metaphor, but a living, breathing creature of power and pride that I join in this moment-by-moment living'.[xi]

This desire to dwell in the present, and to generate a spectatorship that is also of this present, arguably defines the film's aesthetic project.[xii] As *Horse* moves the spectator through the cycles of chemotherapy and out into the hopeful space of remission, it also holds us in the materiality of present time through its exploration of cinema's formal temporalities. Shifting between Hammer's documentary desire to record her experience in this lesbian collaboration and her deconstructive reassemblage of shots exploring the beauty of both horse and human moving through landscapes, *Horse* becomes the occasion not merely to place the spectator in the present but also to turn spectatorship into an encounter with the presence of the present. Through this technology of presence, it is not that we are made aware that we are in time, but rather that we are of time, as it is of us.

Being of time, horse and human vitalities become the filmmaker's sustenance throughout the emotional turmoil of the treatment. Drawing on memories of wanting to own horses from childhood onwards, Hammer describes the horse as the figure of freedom and beauty. Throughout the film, the co-presence of human and horse is repeatedly brought into close alignment through superimposed close-up shots of hair, eyes, profiles and through a mimicry of posture and stance. A co-presence of form and movement emerge in echoed posture, gesture, (see Figures 11 and 12). But this is not a vision of co-presence based on identification with what the human imagines the animal's incomplete subjectivity to represent,[30,31] but rather, the film's deconstructive strategies *put in process* a connection between the shared liveliness of the two based on the halting flow and repetition of the music and images. Hammer's films have always flirted with the possibility of moving beyond cliché in a turn to Nature to provide visions for living otherwise, and most especially to find images of lesbian desire and sexuality (see Dyer[29]). But here, as elsewhere in her work, in so far as Nature provides the space for utopian fantasies of escape and recovery, the deconstructive formal moves undercut any lingering romantic notions of Nature's essence. Instead, we

Figure 11

Figure 12

Figure 13

Figure 14

see and hear fragments and repetitions that disturb temporal continuity and linearity even as they increase the intensity of vitality.

The close-up shots of the fingers feeling the texture of Hammer's own regrowing white hair after chemotherapy and of the equine grey mane are the best example of this (Figures 13 and 14). In *Horse*, extreme close-up shots of the death and regrowth of the grey human hair and eyebrows of Hammer as chemotherapy patient are followed by those of the grey coat of the horse.[xiii] It is the texture of each that lingers as much as the visual matching, or even yearning for regrowth. The film moves beyond an aesthetics of identification, taking us into the sensuous spaces of the materiality of all life forms through its insistence on formal experimentation with the particularity of film as matter. The cinematic alignments of human and horse also expose the desire behind such a visual rhyming through techniques that both declare their artifice (see Figure 15), and leave the audience with the pleasurable sense of the textures of the 'companion species', as Haraway[28] puts it.

In exploring the survivorship of cancer, *Horse* places the spectator within what Laura Marks has called a haptic visuality, 'the way vision itself can be tactile, as though one were touching a film with one's eyes';[32 p.xi] as put succinctly by Marks, this might be thought of as a 'visuality that functions like a sense of touch' which enables the viewer to 'experience the cinema as multi-sensory'.[32 p22-3] Emphasising the embodied perception of the spectator, this way of thinking about film allows us to reconsider how the relationship between self and other might be one based less one based on identification than on co-presence. Haptic cinema 'encourages a bodily relationship between viewer and image'.[32 p164] Whereas Marks[32] takes as her corpus what she calls 'intercultural films,' those which use formal experimentation to explore their politics of displacement, hybridity, diaspora and the memory of home (even one never lived in), *Horse* works through the temporal disturbance of illness by bringing the force and relationality of the body into a sensuous present. In *Horse*, the deconstructive styles of sound and image reveal the deceptions of time's predictive promises. As the conventional contours of sequence and flow unravel through the temporal swerves of diagnosis and treatment, so the cancer patient's body is immersed more deeply in the materiality of its own present. The repetitive chemotherapies become the technologies through which the patient's body must submit to the present through the promise of the future. Survivorship is the reward. And yet, healing the body with its poisons, the treatment also transforms it and demonstrates its unstable and ever-changing cellular

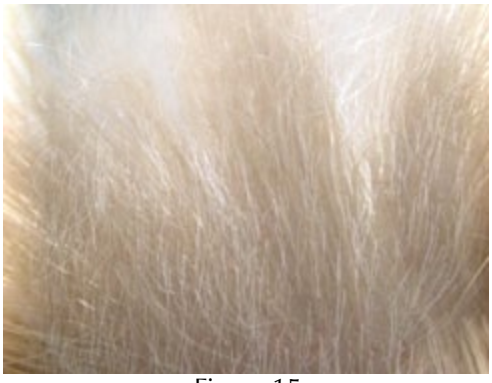

Figure 15

composition, making the present an impossible object that is by definition always already lost.

Horse brings us into proximity with our embodiment of the uncanny nature of time through its instantiation of cinema's particular temporal relations. For Strathausen, the uncanny is present in the cinema since it is premised on something presumed dead being 'brought back to life' and beginning 'to haunt the living'.[9 p15-17] As Laura Mulvey[33] suggests, cinema 'combines, perhaps more perfectly than any other medium, two human fascinations: one with the boundary between life and death and the other with the mechanical animation of the inanimate, particularly the human figure'.[p11] Photography shares with cinema that sense of preserving past time, but while the single image of the photograph 'relates exclusively to its moment of registration,' the film strip has 'an aesthetic structure that (almost always) has a temporal dynamic imposed on it ultimately by editing'.[33 p13). It is this particular combination of the still and the moving image, of the 'now-ness' and 'then-ness,' that makes the cinema so uniquely compelling as a technology of hidden stillness.[33] Through its exploration of the temporal relationalities of still and moving images, and of the shifting histories of black-and-white and colour sequences, and of the vital infectiousness of human and non-human materialities, *Horse* brings to the surface the secret stillness of cinema's animating capacity, generating a haptic visuality full of both the pleasure and pain of troubling ontological insecurities.

Anatomic time

MUST is collaboration between performance artist Peggy Shaw (well known for her work as part of the lesbian duo Split Britches)[xiv] and Suzy Willson, artistic director of the Clod Ensemble[xv]. The live performance comprises music by the Clod Ensemble, back projected magnified visual slides of microscopic cells, organs, nerves, bones and muscles, and Shaw's one-woman performance of eleven short monologues (published as a text subtitled: *a Journey through the Shadows of a City, a Pound of Flesh, a Book of Love*.[34][xvi] The monologues are sometime more narrative, sometimes more poetic, and mostly use the first-person voice in such a way as to undercut our expectations of any straightforwardly autobiographical mode of presenting the history of one's body. The visual slides are all transparent images of microscopic enlargements from the Wellcome Library, such as the 'cells of the upper respiratory tract' and the nerves and hair cells in the vestibular (organ of balance in the inner ear)'. The vastly magnified scale of these images, together with their contrasting colouration, brings to the stage (and to the book that now accompanies the CD of the performance) an aestheticised sense of the body's interiors. This sequence of slides appears on the back of stage screen, as the music is played live from the side to accompany Shaw's narration of her own 'inside story'. The title promise of revelation (confession even) is undercut by Shaw's stylized butch performance in her 1940s noirish suit and tie (Figures 16 & 17), with a suitably generic voice-over retrospection, which imitates a Hollywood masculinity characterised by surface play and the absence of interior insight. If the generic pastiche of masculine disclosure suggests butch interiority might be equally unavailable, *MUST* complicates such alignments by moving us into the affective spaces of poetic narration of this queer body's desires and diseases, its abnormal growths and its injuries, its treatments and its surgeries, its birthing and its aging,

Unlike *Horse*, which foregrounds cancer diagnosis and treatment, *MUST* embeds cancer survivorship in the multiplicity of survivorships of butch life. Cancer is one amongst many of the events that have made this particular life precarious (see Butler[35]). Time is multiple and illusory, the queer body an uncanny record of its passing. One critic called *MUST* 'an exquisite lesson in anatomy, a journey underneath the skin, a mapping of the human body in which sites of love and loss are placed under the microscope and

Figure 16

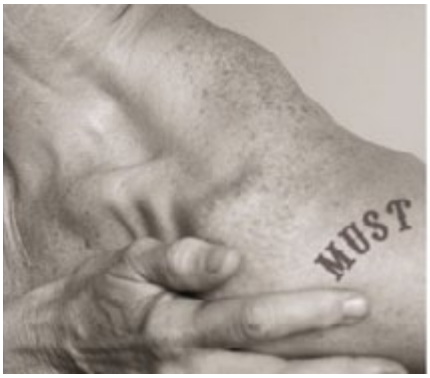

Figure 17[xvii]

analysed with a forensic gaze'.[36][xviii]

The whole performance turns the stage into a medical school and the audience into Shaw's students. Like the Elephant Man before her, she takes to the stage to turn her medical history into a show. The imperative of the show's title, which appears also as a tattoo on Shaw's naked shoulder on the book's cover (see Figure 17), remains ambiguous: it signals a command (to live, to desire, to survive), a compulsion (to have, to control, to return to) and a necessity (to perform, to become, to continue). 'Must' is also a word that refers to the damp, stale smell of mould and decay; it is the odour of age and endurance. And it is an alternative spelling of 'musth,' that annual period of heightened sexual excitement in certain large, male mammals (especially elephants), during which violent frenzies can occur. In Monologue 5, the smell of her rough elephant skin plays perceptions of the butch body back to the audience:

> Can you smell the years of sun on my skin making it rough like an elephant's hide, or are you too busy thinking I look like Marilyn Monroe?

But if this is 'open-heart surgery of the artistic kind, performed without anaesthetic' (ibid), the revelatory promise of the confessional first person genre is transformed into a poetic journey into the strange sense of connection and disconnection between the performing body's surface and depth. Known for her butch stage presence in previous shows such as *You're Just Like My Father* and *Menopausal Gentleman*, Shaw turns autobiographical revelation into the seductive refusal of gender intransigence.

> Would you like to see my body?
>
> I'm sixty-four and I'm lucky:
>
> I have both my breasts still,
>
> Safe, inside my suit.
>
> I can't lie down to be examined; it makes me feel like I will die. It scares me to expose the front of my chest without my arms covering it. I am feeling foolish in your room–like in the ladies room–a bull in a china shop […]
>
> The reason I get mistaken for a man is my neck. It's my Adam's apple that's throwing you off. My Adam's apple combined with my suit and tie is what's confusing you. My thyroid cartilage and my cricoid cartilage combine to challenge you. (Monologue 5)

Addressing the audience through this anticipatory mode which redirects the voyeuristic desire to other the butch body, Shaw performs herself through an intimate knowledge of the codes of gender and sexuality which work to depersonalise her own story, even as we may invest it with the thrill of live confession. Finding the spaces in between the biological and the cultural, the performance draws out how other people's readings of this body have formed it as much as its own desires, or rather, how the two fold back onto each other.

Performing a narration of her own medical history through shifting generic registers that move us from family sagas and sexual histories to poetic remembrance and scientific description, Shaw's cancer is only one small part of a much longer story. Cancer survivorship here is inextricable from surviving not only other serious medical traumas but also from surviving as in a normative culture that has yet to accommodate the butch lesbian. Since we are told at the beginning that this is a story about time, we wonder what kind of 'inside story' can be told if there is no beginning, middle or end? Inviting us to take a close look at the body, its scars, its folds, its wrinkles, its skin, its asymmetries, Shaw enacts the perceptual problems of apprehending the totality of the body's history as a linear temporality. Biographical narrations help to defend against the body's unfamiliar turns, those interferences or interruptions that introduce an uncanny sense that our body is only partly our own. Even though the body seems to be a continuous physicality in one sense – we can point to the scars and feel the joint pain – in another, these traces of its history can feel like fictional narrations of someone else's life as they solidify through repetition. What does it mean to think of our bodies in the singular? Is the body that endured childhood injury the same as the one that had cancer? Is the body that yearned for sex with women the same as the one that gave birth to a daughter? Is the body that died for a few moments the same as the one that now performs on stage? Monologue 5 rehearses a biographical narration of 'the body multiple' that turns the uncanny of discontinuous temporality into a comic condensation.[xix]

> I have been thirteen bodies in my life.
>
> This is only one of them.
>
> I cracked my pelvis. I broke my heels. I smashed my knuckles on my right hand. I smashed my knees in the woods. I fell off the porch and got a stick in my eye. The wind was knocked out of me when I smashed into a tree. I cut open my hand when my grandma died. I was on crutches for six months when I jumped off a fence. I had fourteen spinal taps curled up in a ball like a fetus. I was born with broken clavicles. I broke both heels. I got pneumococcal meningitis when I slept with a woman for the first time. I died for three minutes. I was in a coma for two weeks. I had mononucleosis and couldn't kiss a boy for a year. I had cancer on my face and got twenty-eight stitches. I had a lump removed from my breast. I have lumps on my forearms and the front of my thighs where I store my original thoughts. I smashed out my two front teeth on the ice fighting over a girl. I had a baby.

The coloured slides (as backdrop on stage and monologue markers in the book) become the landscapes of interiority that accompany our journey inside these bodies; but they also take us further away from human physiology, out into other landscapes of texture, pattern and formation. Magnified to this point of abstraction, the slides are as much an artistic, as they are a medical presence. Taking us into the body and out beyond it into the associated world of natural forms, the images remind us of rocks, of plants, of fibres and of textures. The body's presence as blood, bones, skins, organs is made present to us only through injury, breakage, illness or disease, and yet it bears the traces that should remind us we are part of the materiality of the world.

> A couple of hundred million years ago, before you were born, my body was joined together to form one land mass. Slowly my twelve plates started moving away from each other. My continents were dancing to the music of deep time. A dance of incredible slowness. Powerful enough to throw up the mountains and pour away the oceans.
>
> My tectonic plates have always rubbed and exploded next to each other. Their edges are sites of intense geologic activity. The doctors gave me beta-blockers so I wouldn't cause a volcano or an earthquake. […]
>
> Sshh. You can hear the plates of my skull moving as I talk and the plates of my hips moving as I walk. Can you hear all my bones fitting together as I keep living? (Monologue 10)

If the body performed on stage has a history that cannot be captured in time, it has a materiality that is hard for all of us to grasp: the uncanny sense of the embodiment of time. Through the performance of its material histories *MUST* returns the body to time.

Finalities

Both *Horse* and *MUST* present us with ways of thinking about the C word and the L word beyond the heightened metaphorical spaces opened up by the stigmatization criticized by Sontag. Each speaks back to the normativities governing gender and sexuality that intensify with illness by offering a poetics of materiality through which to explore the proximity of desire and disease in one particular body. Pushing beyond the body's limits and out into the imaginative spaces of the physical world from which it becomes inextricable in the face of mortality, each work returns us to the ways illness insists upon the impossibility of halting time: the absent presence of the filmed body which was once in front of (and here also behind) the camera and now appears on the screen before us; the rehearsed liveness of the performing body which presents itself on stage but cannot be captured except in ways that transform it.

The extent to which cancer's time warp here belongs to queer temporality depends upon whether the queerness refers *only* to the odd, the uncanny, the indeterminate and the undecidable (in which case, any connection between the strangeness of modern time and lesbian sexuality that resurfaces with cancer may remain incidental and contingent) or, if, instead, cancer's time warp in *Horse* and in *MUST* is queer in the sense that sexuality is already present in this disturbance to temporality. In so far as queer always carries with it the traces of sexualities deemed undesirable and perverse (though these may be not be determining in predictable ways), then such connections move beyond an analogous and into an ontological register. Cancer's queer time warp in *Horse* returns the lesbian body, marked by its previous sexual audacities on the screen, to the sign of disturbed temporality through malignant illness. Given Hammer's prominence as a lesbian filmmaker whose work has carved out experimental spaces for a poetics of lesbian desire for nearly 40 years, it is impossible not to read the temporality of her body's agony and ecstasy as defined by its battle against its sexual disqualifications. Shaw's butch presence in both her performance style and her live physicality supply queerness to the biographical disclosures that structure the piece and belie the apparently incidental mention of her desire for women in a long history of accidental and unexpected encounters with illness, doctors and hospitals in *MUST*. Here, as in her foundational contribution to queer performance work with Split Britches, the sexuality of temporality is constitutive.

Cancer in both cases warps a time already unsettled by sexual illegitimacies. Just as *Horse* exposes the underside of the filmic image to celebrate our vital placement in the materiality of the present, so *MUST* reads the archaeology of the performer's body to trace its part in multiple scales of history. Cancer survivorship in each case becomes a poetic narration of desire and disease through the queering of temporality. To cite one of Hammer's previous films, 'bent time' is both general and particular: cancer warps time but in so doing reveals time's false promise of linear sequentiality or of the predictability of futurity. Queering time shifts presence into a disjunctive register. But in so doing, perhaps all it can show us is the problem of apprehending time's uncanny unknowability and of coming into proximity with our own materiality and thus, of course, our own mortality.

Notes

[i] For a discussion of the conventional triumph-over-tragedy confessional memoir, see Gilmore[37].

[ii] For a discussion of Lord's experimental memoir, see Bryson and Stacey (forthcoming).

[iii] This phrase was reworked / adopted by Mary Bryson as the name of her blog written during her own experience of cancer in 2008: 'Adventures in Deconstruction, Field Notes from a Cancer Battle Ground Where Queer Life Meets Precarious Life Head On'. See: http://brys.wordpress.com/

[iv] As we go on to discuss, there may be problems with setting 'straight time' and 'queer time' as oppositions to each other, as is argued in the 2007 GLQ journal roundtable on queer temporalities: 'I wonder about the ease with which we reify queer temporality, that adjectival "queer" throwing a proprietary loop around properties or characteristics that have long been theorized as at the heart of "time" or, for that matter, "history." [….] Acknowledging these [Derridean, Lacanian] and other intellectual traditions might make us hesitate to annex the queerness of time for ourselves. Rather than invoke as our straight guy a version of time that is always linear, teleological, reproductive, future oriented, what difference might it make to acknowledge the intellectual traditions in which time has also been influentially thought and experienced as cyclical, interrupted, multi-layered, reversible, stalled–and not always in contexts easily recuperated as queer?' (Jagose, in Edelman et al.[23p186-7]).

[v] Hammer B. A Horse is Not a Metaphor. http://www.barbarahammer.com, 2008.

[vi] To view 3 excerpts from the film (with filmmaker's permission): http://www.youtube.com/watch?v=_tbT89S6TAw; http://www.youtube.com/watch?v=Q22nK1NY-e0; http://www.youtube.com/watch?v=oT2UP5N_C1Y

[vii] The details of these locations are taken from: www.babarahammer.com/archives/155 (last accessed 21/11/2011)

[viii] An extract from the diagnosis sequence is available at the first of the web addresses cited above in footnote vi.

[ix] An extract from this scene of the insertion of needle at the beginning of a chemotherapy treatment can be seen at the second of the web addresses above.

[x] An extract from this midpoint in treatment sequence can be seen at the third of the web addresses given above.

[xi] Quotation from: barbarahammer.com/archives/155, (last accessed 29/5/11).

[xii] For a discussion of the 'structure of feeling' of Horse, see Bryson M, Stacey J.[38]

[xiii] The problem with hair loss following chemotherapy is not only the baldness but the presence of dead hair before it falls: its surprising volume, the labour of gathering it up, the chill of its absence, the insects that can enter ear, nose and eyes without it.[11 p84]

[xiv] See: http://www.splitbritches.com/

[xv] The music was composed by Paul Clark. The piece was performed with live music at the Wellcome Collection, London November 2008. MUST was commissioned for the Art Injections series, the performance platform for the Clod Ensemble's Performing Medicine project. This project provides training to medical students and healthcare practitioners using the performing and visual arts.

[xvi] These monologues are also available with the music as a CD (Clod Ensemble 2009).

[xvii] MUST the inside, Peggy Shaw in collaboration with Clod Ensemble. Image by Eva Weiss.

[xviii] http://www.guardian.co.uk/culture/2009/aug/24/must-the-inside-story-review, (last accessed, 10.06.11

[xix] This refers to the title of Annemarie Mol's[39] book, The Body Multiple: Ontology in Medical Practice.

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Abstract
Nursing associations' choices to engage in community environmental health transpires in a complex decision-making context in which a number of issues compete for their attention and a number of factors influence their choices. Given the complexity of this decision environment, theoretically informed research can lead to understanding about the dynamics, supports, and constraints shaping nursing associations' decisions. We propose a conceptual framework to guide research to understand whether and how nursing associations' take action for community environmental health. The framework depicts nursing associations' priority setting and policy advocacy for community environmental health embedded in a policy decision-making context in which internal association factors and external factors at all system levels (local to global) influence the organizational choices and actions taken.

Key words community environmental health, conceptual framework, decision-making, nursing associations, socio-ecological systems change

Priority Setting and Policy Advocacy for Community Environmental Health by Nursing Associations: A Conceptual Framework to Guide Research

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Introduction

Nurses and other health care professionals have the ability to influence system and policy change for improved community environmental health.[1] Influencing system and policy change requires that nurses organize, speak, and act as a united front provincially/territorially, nationally, and internationally.[2] Nursing associations provide vehicles through which nurses, as a collective and with partners, can take political action across system levels.[3-5] However, environmental health is one of many policy issues that are of concern to the nursing profession.[6] Thus, nursing associations are charged with making choices about which policy issues should take precedence and what strategies should be taken. Little research is available that explores how nursing organizations chose among competing priorities, and in particular social and environmental public policy issues that involve cross disciplinary, jurisdictional, and sector collaborations.[7]

This paper proposes a conceptual framework that depicts nursing associations' priority setting and policy advocacy for community environmental health. The framework was developed for the purpose of guiding doctoral research. We begin with a background that provides conceptualizations of what we refer to as community environmental health and community environmental health policy. Descriptions of the community environmental health policy context and the need for a nursing presence in shaping policies are provided. We examine and report the evidence that describes nursing associations' policy work for community environmental

health. Using socio-ecological whole systems change lens, we then propose ways forward for understanding nursing associations' policy choices and actions. We conclude by proposing a conceptual framework that depicts nursing associations' priority setting and policy advocacy for community environmental health. The implications of the framework for research and nursing associations' priority setting and policy advocacy are discussed.

Background

Community environmental health

In its broadest definition, behavioural, social, natural, and physical components make up the total human environment.[8] In relation to health, Pruss-Ustun & Corvalan[8] suggested a practical definition, whereby environment is more narrowly conceived as "all the physical, chemical and biological factors external to the human host, and all related behaviours, but excluding those natural environments that cannot be reasonably modified".[p21] Recent nursing literature underscores the reciprocity of human and natural systems that co-exist and co-evolve. For instance, Laustsen proposed that the term ecosystem more accurately depicts human-environment health as it encompassed "the dynamic, interrelating, and relational nature of organisms and their environments".[9 p44] Attention is drawn to the intricate relationships among biotic and abiotic relationships that comprise the human-health ecosystem. Scholars have argued that healthful human-environments are produced by people participating within their surrounding environments in ecologically sound ways.[10-11] Furthermore, human-environmental health is shaped by practices, conditions, and relationships at the local, sub-national, national, and global scales.[12] Building on this work, we use the term community environmental health in this paper to refer to human-ecosystem health, generated through human participation with natural, physical, chemical and biological systems and supported through ecologically sound practices and policies at different levels of geographic scale and time (note this conceptualization does not include occupational environments).

Community environmental health policy

Multi-disciplinary, multi-sector, and multi-jurisdictional public policy responses are needed in order to address the complex and multi-causal nature of community environmental health issues.[13-14] Broadly, public policy refers to both action and inaction by public authorities to address a problem or interrelated set of problems in the interest of larger groups, organizations, or communities (distinguished from case advocacy that aims to solve problems for individuals or families)[15-16] When applied to community environmental health, public policies refer to those that address human-ecological health. More specifically, community environmental health policies aim to promote healthful practices, conditions, and relationships for improved human-ecological health.

Three categories of community environmental health policies for which nursing could advocate: those that affect the healthfulness of settings, such as homes, workplaces, schools, or communities; those that influence the quality of ecological systems such as water, air, land; and those that target the local, sub-national, national, or international governments that are responsible for policies that influence the health of human environments.[11,17] These policies employ a number of mechanisms, referred to as policy instruments, including regulations and standards, taxes and charges, voluntary agreements, subsidies and financial incentives, information, and research and development.[18] Most often packages of policies are required to address community environmental health problems along "multiple points of interaction or multiple points in the chain of cause and effect".[14 p24]

Community environmental health policy context

Stakeholders engaged in community environmental health issues are immersed in a complex policy field involving diverse and policy arrangements, multiple actors, multiple sectors, and multiple jurisdictions with varying constitutional authorities. Community environmental health policies are created and administered by various government departments, agencies, and sectors, often with shared constitutional authority but diverse mandates.[17] In addition to political leaders, and depending upon the community environmental health issue, a number of other stakeholders could also be involved including the public, media, scientists, industries, and non-profit organizations.[19-20] Ambiguity and disagreement about the problems, their solution, and the evidence, as well as incomplete evidence add complexity and challenges for those attempting to influence community environmental health policy.[14,21]

Need for a stronger nursing association presence in community environmental health

Recent reports suggest nursing associations should

have a stronger presence in advocating for community environmental health and propose a range of ways they could contribute.[22-26] Nursing associations are encouraged to provide education and share information with nurses, the public, and other professional groups;[22-23,27] to join coalitions for improved environment conditions (e.g. reduce air pollution, urban redesign, increased public transit; caps on emissions);[23] to develop position statements;[24] to conduct research[24], to lobby legislators and governments for stricter environmental legislation and policies and investment in renewable energy,[23-24,27] to encourage other international professional bodies and their members to lobby their governments to promote sustainable environments,[27] and to advocate for governments and international agencies to mitigate the impact of industrial and economic policy on the environment.[24] The International Council of Nurses[25] suggested national nursing organizations could play a strategic role in reducing global environmental health hazards and be part of multi-sectoral measures to mitigate the impact of climate change on populations, particularly for those most vulnerable.[26] Thus, there are a number of community environmental health issues, strategies, and targets for which nursing associations could take action.

Examining the evidence for nursing associations' engagement in community environmental health

We conducted a literature review to identify research that explored or explained how nursing associations were engaged in community environmental health policy setting and advocacy. Using a search strategy designed with the assistance of a professional librarian, six electronic databases from the years January 1999 to October 2010 were searched (Refer to Table 1 for further details about search terms for database searches). In addition to the database search, a manual search of reference lists was conducted for retrieved articles (e.g. editorials, commentaries, reports) that were directly related to nursing organizations involvement in environment. The search also included a grey literature of websites for Canadian and international nursing organizations, nursing academic institutions, the Canadian government, and health organizations (Refer to Table 2 for search terms used for grey literature search). The combined search yielded 1,864 papers.

Table 1: Search terms for databases

SH Terms for Nursing Organization	MESH Terms for Environment
(MH "Nursing Organizations+") or (MH "Student Nurses Organizations+") or (MH "State Nursing Organizations+") or (MH "Nursing Organizations, International+") or (MH "National Federation for Specialty Nursing Organizations") or (MH "New Zealand Nurses Organization") or (MH "Nursing Organizations Alliance") or (MH "State, Provincial and Territorial Nursing Organizations+") or (MH "American Organization of Nurse Executives")	(MH "Natural Environment") or (MH "Environment") or (MH "Work Environment+") or (MH "Environment, Controlled+")

Table 2: Search terms for grey literature search

Key word searches	Sites searched
a) Environmental health in nursing based websites b) Nursing organization or nursing association in other websites	Nursing websites examined: 13 Canadian nursing organization; the International Council of Nurses; the American Nurses Association; and several state nursing organizations that had publications related to environmental health (e.g. newletters, position statements) including the Maryland Nurses Association and Texas Nurses Association, and specialty organizations such as the American College of Nurse-Midwives and Oncology Nursing Society. Other websites examined: EnvirRN University of Maryland School of Nursing; Canada's Department of Health and Department of Environment; Friends of the Earth; and Canadian Physicians for the Environment; World Health Organization

Screening entailed a three-stage process using pre-determined inclusion and exclusion criteria starting with titles, followed by abstracts, and then full text review of papers. (Refer to Table 3 for further details about inclusion and exclusion criteria.) Papers that did not meet inclusion criteria were eliminated. When uncertainty existed about the eligibility of papers based on either the title or abstract assessment, full articles were retrieved. A total of 162 papers were retrieved for abstract or full review. (Refer to Table 4 for further details about yields from literature search.) These articles were then screened using the inclusion and exclusion criteria.

Findings from literature review

Only one study[28] was identified that reported nursing associations' work for community environment health. This extremely low yield suggests this is an underdeveloped area of study. However, the literature review also revealed the substantial public policy work undertaken by nursing associations for community environmental health, which is primarily charted in editorials or commentaries, discussion papers, reports, reflective reviews, and historical accounts (with no formal research methodology). This anecdotal evidence described nursing associations' involvement in a broad array of community environmental issues including green health care, pesticide legislation, green energy, climate change and Kyoto Accord commitments, and environmental carcinogens and exposures.[19,22-23,29-32] A number of tactics have been employed to address community environmental health. For instance, nursing associations have conducted surveys to identify public concerns, and to explore nurses' needs related to their community environmental health practice.[5] They have responded to concerns by developing background papers,[22-23,31] position statements,[25,27] and environmental health principles.[33] Some nursing associations have lobbied for pesticide and carcinogen legislation, environmentally responsible activity in the health sector, and safe drinking water.[17,25-26,28-29,32,34] Some have participated in interdisciplinary and government committees (e.g. Friends of the Earth, Environment Canada)[22] and engaged in community environmental health initiatives involving many partners (e.g. medical associations, industries, and scientists)[31] as part of their community environmental health efforts. However, the absence of empirical research to investigate this work leaves minimal opportunity to understand the factors that support or hinder their choices or actions.

This anecdotal evidence further points to the complex environment in which nursing associations' make choices

Table 3: Inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
a) Described work undertaken by a nursing organization b) Original research including qualitative and quantitative research and systematic reviews c) Described community environmental health issues c) Published in English d) Published between January 1999 and September 2009	a) Studies about independent nurse priority-setting or policy advocacy efforts b) No research design or methodology described c) Theses, dissertations, discussion papers, commentaries, and editorials

Table 4: Yields from search

Database	Total finds	Yield
CINAHL	481	77
PubMed	276	23
HealthStar	102	9
ABI Inform/Global	762	43
Cinoebdex	243	10
Greenfile; Web of Science/ BIOSIS; Scopus	Yields to specific earth, physical, and chemical sciences (links to human health not part of research)	0
Total	1 864	162

and take actions for community environmental health. There are a number of issues for which nursing associations could take action. Addressing community environmental health entails a series of independent and collaborative efforts. Tactics may include direct (e.g. lobbying) or indirect (e.g. developing position statements) efforts. Collaboration for community environmental health, in turn, may involve any number of actors from diverse disciplines and sectors and involve efforts with national, sub-national, and local governments. In this context, understanding the dynamics, supports, and constraints shaping nursing associations' community environmental health work would benefit from a socio-ecological lens.

Understanding choice through a socio-ecological systems change lens

In a recent scoping review,[7] it is argued that given the considerable intricacies of nursing organizations structural arrangements and systemic environments, the particular challenges encountered when addressing cross sector health and social policy, and the paradoxical responses by organizations exposed to common events and conditions, a socio-ecological whole systems perspective would be appropriate to understand their policy decision-making processes. Exploring nursing associations' decision-making from this perspective views whole systems change as "uneven, nested cycles of adaptation that evolve within closely coupled, complex socio-ecological systems over time."[35 p2]

More specifically, whole systems socio-ecological thinking as described by Gunderson and colleagues[12,36] and as applied to understanding and managing health systems change[37] could facilitate the exploration of contextual factors and their interplay in shaping individual and organizational choices, and dynamic changes that occur at varying times and across system levels. Furthermore, nursing associations and related systems (e.g. legal system) are believed to co-evolve over time through "interplay between processes and structures that sustains relationships on the one hand and accumulates potential on the other."[12 p102] MacDonald and colleagues[7] further argued that attention to closely coupled professional, legal, social, economic, political, and ecological systems may lead to the identification of any number of leverage points or blockages. This socio-ecological perspective is complemented by the decision-making literature, which identifies decision-making as a social process embedded within complex systems. We consider this literature in the next section.

Decision-making: A social process embedded in complex systems

Vroom and Jago[38] suggest decision-making by organizations is a social process that can be understood through examination of both its prescriptive and descriptive dimensions. The prescriptive dimension looks to the rules that are applied to rational groups to facilitate decision-making.[38-39] Understanding the prescriptive dimension of nursing organizations' decisions for community environmental health, for instance, would require attention to the types of problems the decision-makers identify, to the types of data used to make judgments, and to the set of decision rules used to adjudicate among alternatives. The descriptive dimension, on the other hand, is concerned with how decision-makers actually decide (not how they ought to decide) and the patterns, regularities, or principles in the way groups chose in given situations.[38-39] Understanding nursing organizations' decisions for community environmental health would require an examination of the processes of decision-making and the determinants that shape choices and actions. These determinants include both "hardware" and "software" components.[40]

Authors[40] have argued that questions related to health policy decisions have been skewed by a focus on a system's "hardware" such as levels and types of human resources and organizational structures and legislation. However, human activity systems (such as organizational decision-making for public policy) that include human actors who have foresight and intentionality, can attribute different meanings to what they perceive, can communicate, and can use technology[12,41] would benefit from more attention to "software components" or the social processes, practices, and ideas that drive decisions. Software components include "ideas and interests, values and norms, and affinities and power that guide actions and underpin the relationships among system actors and elements."[40 p 2] Software components are evident in institutional theory, which contributes to systems theory by drawing attention to institutional influences that operate to support or constrain organizational behaviour and choices.[42]

Institutional theory: Attention to the software context for decision-making

According to institutional theorists and researchers,[19,43-46] institutions are established when actions are repeated, given

similar meaning, and become widely accepted. These institutions may not be readily apparent or known, but operate to regulate behavior, and to shape goals, priorities, standards of practice, and codes of conduct.[43] While institutions are often resistant to change, scholars further contend that organizations possess the autonomy to make purposeful, strategic, and opportunistic choices.[44]

More specifically, Scott[43] contends that three broad forms of institutional factors help explain organizational behaviour and decisions: regulative, normative and cognitive institutions. First, regulative factors refer to formal rules, policies, laws, or regulations, which exert their pressure through forms of coercion, threats, or inducements.[45] Organizational behaviours are thus driven by a need for expedience or compliance. Examples of regulatory factors potentially relevant to nursing associations' choices include governance models, by-laws, codes of ethics, and government regulatory or corporation acts.

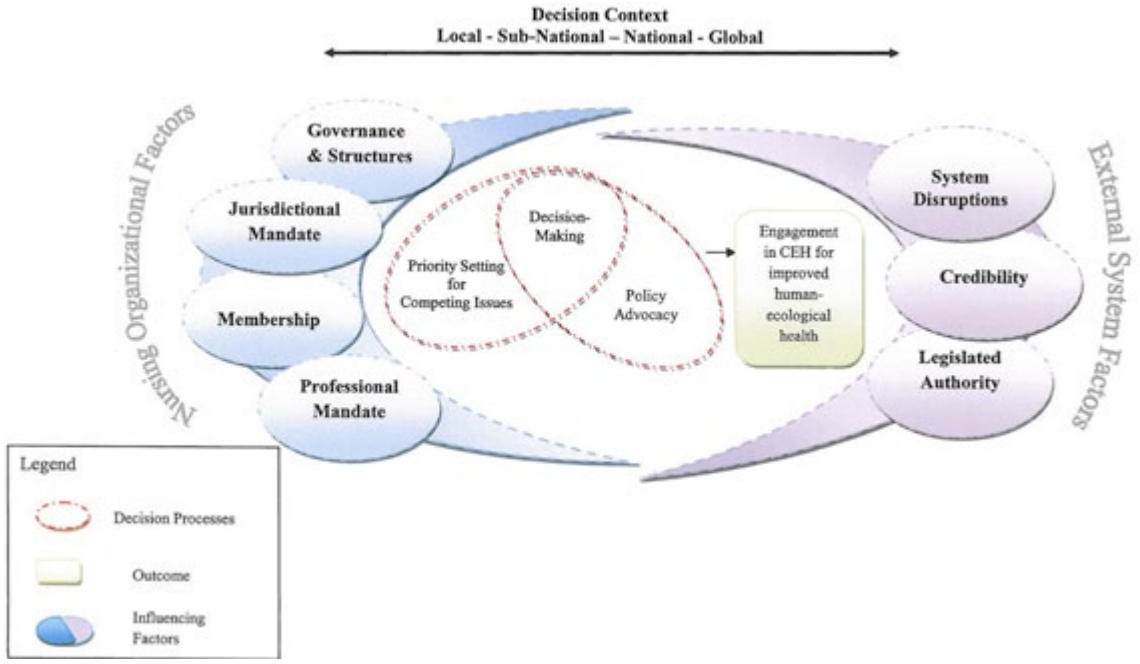
Second, normative factors refer to traditional mores, informally sanctioned obligations, and rules-of-thumb, which exert their pressure through informal rules that structure expectations, standards of performance, and expected relationships. Organizational behaviours are thus driven by perceived social obligations. Normative factors are reflected in nursing associations' professional mandates, certifications, intra-professional relationships, and collaborative partnerships.

Third, cognitive factors are shared understandings, logics, and cultural meanings about how things work or should be done. They exert their pressures by encouraging the adoption or mimicking of other successful organizations in an effort to gain legitimacy. In this case, organizational behaviours are often taken for granted.[47] Cognitive factors potentially relevant to nursing associations' choices include beliefs about why community environmental health problems exist and the roles of government in solving public problems. Institutional theory has contributed to organizations, professions, and policy research[47-50] and holds promise to inform research exploring factors and their mechanisms that influence nursing associations' policy work.

Development of a conceptual framework

Complementary theoretical perspectives

Socio-ecological whole systems change explains the broad context and processes for change across all system levels.[12,35-36] Institutional theory draws more detailed attention to specific contextual regulative, normative and cognitive institutional factors and their mechanisms for influencing organizational decision-making. Using these complementary perspectives, research approaches would include efforts to gain knowledge related to: a) the nature and scope of nursing associations' engagement in community environmental



health; b) the perspectives and beliefs leaders hold about how nursing associations make decisions or how they conduct policy advocacy; and c) the social context or institutional influences (i.e. from related professional, legal, social, economic, political, and ecological systems) in which choices are made and action is taken; and d) the interplay of internal and external factors and their mechanisms that operate across discipline, jurisdictional, and sector boundaries and at different time scales. Based on tenets of whole systems thinking and institutional theory we propose a conceptual framework to guide such research.

Overview of conceptual framework

The conceptual framework depicted in Figure 1 represents nursing associations' priority setting and policy advocacy leading to engagement in community environmental health. Major components of the framework include decision-making processes and influencing factors, which constitutes the decision context. A recent scoping review[7] undertaken to investigate priority setting and policy advocacy by nursing associations identified several factors both internal (governance and governance structures; membership; jurisdictional mandate, professional mandate) and external (legislation, credibility, system disruptions) to the nursing associations that influence their policy choices and actions. Concepts from these findings informed the development of the framework.

Nursing associations' decision-making for engagement in community environmental health is embedded in a policy decision-making context in which internal association factors and external factors at all system levels (local, sub-national, national, and global) influence the organizational choices and actions taken. At the core, decision-making includes priority setting for competing policy issues and policy advocacy (represented by overlapping ovals with broken lines in the figure). Priority setting and policy advocacy choices are interdependent (represented by overlapping ovals). The outcome of these choices (represented by the square) concerns whether and how nursing organizations are engaged in community environmental health policy issues. Decision processes are shaped by internal and external factors (represented by half-moon crescents with broken lines to indicate their ability to influence decision-making). Regulatory, normative, and cultural factors within the internal and external environment are interrelated (represented by overlapping ovals with broken lines). Within this context nursing associations retain the autonomy to take deliberate, strategic, and opportunistic action to influence priority setting and policy advocacy.

Together the framework proposes factors internal and external to nursing organizations that can both create opportunities or narrow options for their choices of policy, for ways they advocate, and for the outcomes from their policy efforts. A more detailed explanation and supporting evidence for the components of the framework are described in the following section.

Framework components

Decision-making

Priority setting. Part of the decision-making process includes setting priorities among competing policy issues. Priority setting refers to the ways in which decisions by nursing associations are made for the allocation of its human, financial, and/or material resources. This includes the identification and selection of relevant stakeholders; the selection of criteria and values upon which to adjudicate decisions and ways to weight those decision criteria; ways to identify, gather, manage, and synthesize evidence; and mechanisms for reviewing and evaluating decisions and their consequences.

Policy advocacy. Policy advocacy processes are the ways in which nursing associations attempt to influence structural and system-level decisions. This involves working across discipline, jurisdictional, and sectoral boundaries. Policy advocacy processes include stakeholder analysis and inclusion processes; the use of multiple types of evidence; navigation through various stages of the policy change cycle; deployment of efforts in various settings, and use of a range of strategies and tactics.

Engagement in community environmental health. In this framework, the outcome from decision processes includes engagement (or not) in community environmental health. Engagement includes both the choice to address community environmental health issues and the actions taken to influence policy decisions for human-ecological health.

Decision context: Internal organizational factors

Governance. Governance represents the set of organizing and monitoring activities that describe how nursing associations' boards or councils do their jobs. Structures required for the board / council to do their job include designated authority and division of tasks, operating procedures, rules, bylaws, strategic plans, and goals. The degree of buy in from governing bodies, the formality of decision structures, lines of authority, and supporting organizational documents influences the choice and degree of engagement in policy initiatives.

Membership. Membership represents nurse registrant and other supporters (e.g. individuals, corporate, group membership) and their contributions to nursing associations' policy efforts. The homogeneity or heterogeneity of membership influences associations' access to resources and their ability to reach consensus or speak in unity. While advocacy efforts may be enhanced when resources are pooled, conflicting interests and mandates may diminish intra-professional collaborative efforts for community environmental health.

Jurisdictional mandate. Jurisdictional mandate represents the associations' territorial responsibility across local, provincial/territorial, national, or international boundaries. Nursing associations operating at various jurisdictional levels target different levels of the political system and vary the use of direct (e.g. lobbying) and indirect (e.g. public awareness campaigns) approaches. National and sub-national nursing associations will experience different supports and challenges in their collaborative endeavors (e.g. opportunity to intimately know political leaders).

Professional mandate. Professional mandate represents the beliefs members of the nursing associations hold about their social obligation (what the profession ought to do) to address community environmental health. Community environmental health will compete for attention or for preferential treatment in nursing associations' that attend to broad policy interests.

Decision context: External system factors

Legislative authority. Legislative authority represents government regulations, policies, or legislation that provides the legal authority for the existence and purpose of the nursing associations. Nursing associations articulate their potential contribution and roles and engage in community environmental health initiatives when policy advocacy is included as part of their mandate and mission statements. Fear of violating the law or dual mandates (e.g. regulatory and professional) diminish policy advocacy for community environmental health.

Credibility. Credibility represents the perceptions or assumptions held by the public, government, and other stakeholders from outside the nursing association or the profession about the expertise or contributions nursing associations can appropriately make to community environmental health. Associations that have the confidence of those outside the association have increased political power, opportunities for participation, and use direct advocacy tactics. Indirect tactics are used when nursing associations advocacy efforts are ineffective or they are excluded from decision tables.

System disruptions. System disruptions represent environmental shifts or events that occur outside of the organization and its control that create opportunities for engagement, change the nature of relationship among stakeholders, shift resources, and alter the urgency of issues. Nursing associations may respond to system disruptions by enhancing actions for policy issues for which they were already committed, by taking action for new policies, or by diminishing or withdrawing efforts.

Contributions / implications for nursing research

The framework offers a depiction of concepts and their relationships regarding nursing associations' engagement in community environmental health. The framework draws particular attention to internal organizational factors and to external system factors, and provides a starting point to identify institutional factors and their mechanisms (e.g. coercion, compliance) that shape nursing associations' choices and actions for community environmental health. The framework provides an opportunity to inform research to understand how nursing associations make choices among competing professional/practice and public policy priorities, how they advocate for public policy and systems change, and the supports or challenges they may face when attempting to address public policy issues.

One way forward would be to conduct case comparisons across nursing associations with diverse organizational features (e.g. mandates, membership configurations), across various jurisdictional settings (e.g. provincial/territories and national boundaries), across geographic boundaries (e.g. Canada and United States countries), and involving diverse actors (e.g. government, industry, non-governmental organizations) to identify cross-cutting themes that contribute or constrain nursing associations' public policy efforts. Identifying patterns and ambiguities would require exploration of change from multiple perspectives and sources including, for instance, the perspectives of staff and directors and data from organizational documents and archives. Exploration should span time scales to understand diverse and differential rates of responses that may result from multiple smaller and bigger changes moving at different speeds across different levels of the system.

Implications for nursing associations' priority setting and policy advocacy

This conceptual framework draws attention to the need to

understand how nursing associations set policy priorities and factors and mechanisms that support or restrict their efforts. Understanding the factors and mechanisms that support priority setting and policy advocacy can underscore leverage points and blockages, which in turn can be used to plan the most receptive time to address a policy issue, the stakeholders who need to be involved, and the most appropriate targets and strategies.[51-52] Drawing on these opportunities can help nursing associations meet their vision, mission and goals, and lead to successful policy choices/efforts.[52-56] Failure to acknowledge leverage points and blockages may undermine nursing associations' attempts to meet their objects or prevent associations from implementing their policy preferences. Priority setting choices and actions may be made in reaction to past experiences, rather than in response to the most pressing needs of the communities they serve. Opportunities may be lost to maximize organizational efforts and subsequent health gains for the resources available.[51,57]

Conclusion

We argue that nursing associations' priority setting and policy advocacy occurs within a complex decision-making context whereby there is a dynamic interplay of internal organizational and systemic external factors that influence whether and how they take action for community environmental health. Given that organizational responses can vary and change over time within this context, research approaches are required that permit an in-depth exploration of these dynamics. We provide a theoretically and empirically informed conceptual model rooted in tenets of whole systems thinking and institutional theory to guide research investigating how nursing associations makes decisions and factors that influence those choices. In constructing this framework, we have provided a way to consider how social influences and their mechanisms may operate to shape nursing associations' engagement in community environmental health. Future research guided by this framework can lead to better understanding of decision supports and constraints and thus areas for potential action to enhance priority setting and policy advocacy.

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3

Résumé
Un projet collectif professeurs/étudiants explore l'expérience clinique d'étudiants infirmiers francophones issus d'immigrations récentes et de minorités visibles. Comment construire une approche méthodologique sensible aux attitudes défensives douloureusement apprises lors de la migration et les menant à développer des stratégies de survie? L'article retrace la méthodologie derrière les méthodes que le sujet-connaissant, un comité de pilotage, décide d'utiliser pour étudier cette problématique taboue. Les résultats relatent la justification des choix procéduraux pour la participation estudiantine dans une action et une recherche visant un changement social. Ils mettent en lumière le sens critique pour confronter les enjeux de dangerosité sociopolitique lorsqu'un problème local devient tout-à-coup un enjeu de société. Les étudiants minoritaires tentent de communiquer leurs perceptions de discriminations vécues dans le stage clinique. Les contraintes sociales les placent toutefois devant un dilemme: « dire ce que je veux dire » ou « me taire pour éviter des représailles et me faire accepter ».

Mots clés francophones en situation minoritaire, formation, immigration, méthodologie participative, recherche-action

Étudiants infirmiers francophones d'immigrations récentes et de minorités visibles: comment étudier un sujet tabou?

HÉLÈNE LAPERRIÈRE

Quelle approche pour une problématique émergente?

L'arrivée grandissante du personnel infirmier francophone provenant des « minorités visibles » impacte la gouvernance de la formation, la gestion et la prestation des services de santé offerts aux communautés linguistiques francophones en situation minoritaire au Canada. Dans la capitale nationale, les étudiants francophones en sciences infirmières proviennent de plus en plus de ce sous-groupe. Ils vivent les situations minoritaires multiples: francophones, immigrants, avec statut précaire et classés comme minorité visible.[1,2]

La propension actuelle des immigrations internationales vers la formation en sciences infirmières au Canada continuera de s'accroitre. Les récentes politiques d'immigration ciblent l'immigration des populations provenant des pays considérés francophones[3] et ayant une formation professionnelle en santé[4] pour les provinces hors-Québec. Les perspectives canadiennes pour 2017 suggèrent que les personnes provenant des minorités visibles constitueront la moitié de l'ensemble de la population des grandes villes comme Vancouver et Toronto, et de 28% dans la région d'Ottawa.[5] La Loi sur l'équité en matière d'emploi décrit les minorités visibles comme étant les personnes « autres que les Autochtones, qui ne sont pas de race blanche ou qui n'ont pas la peau blanche ».[6 p2] Dix groupes constituent officiellement les catégories de minorités visibles, soit les Chinois, les Sud-Asiatiques, les Noirs, les Philippins, les Latino-Américains, les Asiatiques du Sud-Est, les Arabes, les Asiatiques occidentaux, les Japonais et les Coréens.[5]

Il y a une nécessité pédagogique de mieux connaitre les conditions de ces étudiants immigrants récents en majorité

issus de minorités visibles.[7] Cette connaissance est un défi de taille. Les immigrants ont souvent vécu les migrations forcées, avec des demandes d'asiles politiques et des déracinements violents, afin de parvenir à des conditions de vie meilleures.[8] Les immigrants francophones de l'Ontario vivent à la fois des situations économiques difficiles, dans lesquelles ils subviennent aux besoins des familles et communautés culturelles laissées dans leur pays d'origine, tout en tentant de surmonter les défis de l'intégration à la société (marginalisation, emploi précaire, pauvreté et difficultés d'adaptation).[9]

En Ontario, 31,7% des « minorités raciales francophones » [terme officiel de l'Office des affaires francophones] détiendraient un diplôme universitaire par rapport à 14,7% chez les francophones en générale; par contre, le taux de chômage est de 11,5% chez ces minorités raciales contre 6,2%.[9,10] Enfin, les francophones issus des minorités visibles confrontent la double minorisation, soit la « minorité linguistique dans un Ontario majoritairement anglophone, minorité visible dans un Ontario français majoritairement de race blanche ».[9 p10;11] Aussi, le statut minoritaire a un impact sur le sentiment d'appartenance à sa propre communauté. Par exemple, les francophones indiquent un plus faible sens d'appartenance comparativement aux anglophones, sans compter la violence symbolique[12] qui peut conduire à l'oppression intériorisée, soit la « haine contre soi-même » ou le «racisme intériorisé».[9 p12]

Malgré ces constats, l'implantation d'un programme d'enseignement prône encore une homogénéisation des pratiques, même en présence de caractéristiques culturelles, ethniques, linguistiques, socioéconomiques et sociopolitiques diverses.[13] Guinier et Sturm[14] ont posé le problème des minorités perdantes dans un système éducatif élaboré pour et par les groupes dominants - linguistiques et culturels. Pour mieux appuyer les étudiants des programmes francophones en situation minoritaire, il faut oser démystifier leurs efforts personnels et collectifs d'insertion au marché du travail bilingue. Trois types de défis ont déjà été définis comme importants, soit les défis interculturels, la conception de la formation et l'affirmation professionnelle.[15] Y a-t-il des facteurs d'appartenance linguistique, sociale, ethnique ou spirituelle qui différencient les apprentissages qui se font dans la formation infirmière francophone en situation minoritaire?

Toute approche objectivée de recherche[16] obtiendra d'abord et avant tout les réponses du souhaitable sociale (social desirability).[17] Les participants possèdent souvent une trajectoire traversée par les persécutions, les discriminations et les marginalisations qui affectent leurs familles. Le répondant pourra orienter sa réponse selon ce que le chercheur désire entendre ; une réponse « désirable » pourrait aider le participant et sa famille à sortir d'une situation frôlant l'intolérable.

Sous la forme d'une recherche-action, ce projet a donc exploré l'expérience étudiante dans la formation infirmière en stages cliniques d'un programme francophone en situation minoritaire. Le projet visait trois objectifs: (1) produire des données, des observations et des connaissances préliminaires avec la participation active des étudiants issues des communautés immigrantes récentes et minorités visibles dans la formation en sciences infirmières; (2) expérimenter l'adaptation méthodologique nécessaire à la population participante; et (3) accroitre le degré de validité et de faisabilité des approches participatives expérimentées pour mieux fonder un projet de recherche plus élaboré.

Visant à répondre au deuxième objectif, ce papier essaie d'illustrer le processus de recherche, selon une logique exploratoire, donc inductive, et participative, produite de l'interaction avec les acteurs concernés. Ce type de démarche nécessite une traduction autre; l'ordre habituellement attendu étant séquentielle, linéaire et présupposé. La démarche parcoure une trajectoire en spirale, dans laquelle chaque «étape » est comprise comme un « moment », au sens sociologique du terme. L'article vise à rendre plus explicite cette approche méthodologique, inspirée des perspectives interactives, participatives et ethnographiques selon les vues contemporaines de Howard S. Becker[18] et Luc Lassiter.[19] La recherche d'une dialectique entre une linéarité présupposée, un « ordre de conception » et celui de « la réalité du processus de production » est une difficulté à laquelle je [auteure de l'article] m'attaque en m'inspirant de l'anthropologue des sciences, Bruno Latour,[20] avec la construction du sens «produit».

L'historique de la problématique et sa pertinence pour l'enseignement

Le point de départ fut de reconnaitre que les obstacles à l'apprentissage exigent l'élargissement de la conception formelle de « l'enseignement ». L'établissement de relations de confiance est particulièrement important afin de créer un espace d'expression libre sur des sujets pouvant être potentiellement tabous, comme les obstacles à l'intégration égalitaire des étudiants issus des communautés immigrantes francophones. En 2008, trois échanges entre professeurs et étudiants (santé et service social) avaient pointé des dimensions importantes à étudier pour l'amélioration

des stages cliniques, soit de « prendre conscience de nos trajectoires individuelles et culturelles, les identifier et les décrire (comme étudiants, professeurs, immigrants, minorités francophones) ».

Aussi, nous - professeurs de sciences infirmières et service social et étudiants de la discussion exploratoire - avions souligné une autre dimension, celle de « plusieurs niveaux d'interaction dans l'apprentissage par stages : le lien entre professeur et étudiants; entre précepteurs – étudiants – professeurs, professeurs cliniques – étudiants – coordinateur de stage; professeurs cliniques – milieux de stage » (notes de la chercheure, mai 2008). Les étudiants notaient une « tendance à répéter les mêmes types de rapports vécus à l'Université dans nos rapports professionnels au sein des institutions de services sociaux et de santé, des organismes communautaires; que ces rapports soient participatifs ou directifs (notes de la chercheure, mai 2008).

Pour leur part, les professeurs cliniques, ayant participé à un atelier en mai 2009,[21] ont manifesté leur intérêt pour travailler les dimensions socioculturelles afin d'améliorer l'enseignement et l'apprentissage. La méthodologie participative allait tenter de favoriser une meilleure compréhension entre étudiants/professeurs/direction/milieux de stage. L'étude de ce processus pouvait servir de cas exemplaire pour d'autres unités scolaires concernées par la formation d'étudiants issus des communautés immigrantes.

Le but d'expliquer la méthodologie en tant que sujet-connaissant collectif

En sciences infirmières, il est ici primordial de distinguer la méthode et de la méthodologie.[22] La « méthode » doit être entendue dans le sens de guide d'instruction, pouvant être réduite à un synonyme de procédurier et de recette. Quant à elle, la « méthodologie » implique la remise en question ainsi que la justification explicite du choix d'un problème et des méthodes utilisées, tout en considérant les dimensions d'interpellation identitaire, de l'imagination, de l'intuition pragmatique influencées par les contextes socioculturels et sociopolitiques.[23]

Dans leur « Dictionnaire critique de la sociologie », Boudon et Bourricaud[24] sont clairs quant aux distinctions. « Contrairement à une confusion courante, cette notion [méthodologie] désigne, non les techniques de l'enquête empirique et de l'analyse des données, mais l'activité critique qui s'applique aux divers produits de la recherche ».[24 p369] Ainsi, on parle de « démarche » en sociologie pour indiquer non pas les opérations des livres de « méthodes » (observations, questions, recueil de données, cadre théorique, hypothèses, vérification et analyse), mais la manière de voir et écouter : une « posture qui se distingue par le point de vue pris sur les choses ».[25 p1]

Le philosophe Baskar[26] a défendu la thèse que notre connaissance de la réalité est essentiellement dérivée de nos sens, ou des instruments qui les prolongent, de telle sorte qu'il n'existe pas de critère au-delà de l'expérience humaine qui permette de vérifier empiriquement l'exactitude des croyances existantes sur la nature de la réalité. Référant à Baskar, des auteurs en approches communautaires[27] ont montré comment la connaissance est construite et située socialement. Dans une vue « baskarienne », le regard expert unidirectionnel face à l'objet d'étude se déplace en un regard bidirectionnel dans lequel le « sujet connaissant », comme « acteur social » d'une situation vécue, connait à partir des expériences.[27] Il est physiquement en interaction avec le problème. Le « sujet connaissant » est influencé par les évènements : il réajuste son regard analytique au fur et à mesure de l'action et des nouvelles informations – voir les nouvelles représentations sociales du problème - qui surgissent. Plus encore, les autres acteurs sociaux impliqués comme sujets connaissant transforment eux-mêmes leur propre regard critique tout au long de l'expérience collective.[27]

Cette posture permet de produire des connaissances pertinentes à la pratique durant son action. La méthodologie exige une activité critique qui informe sur la justification explicite et fondée des choix procéduraux. C'est avec ce regard « ontologique » que le lecteur doit ici regarder le « va-et-vient dans l'information » pour mieux saisir les choix méthodologiques, soit « les fondements des méthodes choisies » qui se retrouvent à plus d'un endroit et la description du processus méthodologique qui est « volontairement » étalée à travers le manuscrit pour illustrer l'activité critique du « sujet-connaissant » collectif (le comité de pilotage : Laperrière, Zúñiga, Couturier, Abdi & Vulmirovik) qui mènera au produit de la recherche sur un sujet tabou et délicat – la discrimination.

Les pistes d'exploration : une recherche et une action

La recherche-action est un choix épistémologique qui cadre bien avec cette problématique « subreptice » en sciences infirmières. Elle défend la notion que l'étude de l'humain et du social nécessite une méthodologie autre que celles utilisées dans les « sciences dures ». Kurt Lewin a été le premier à utiliser le terme « recherche-action » dans les années 40,

principalement dans son article intitulé “Action Research and Minority Problems”.[28] De manière générale, la recherche-action tend à regarder les facteurs (forces) qui influencent une situation pour apporter un changement social.[29-31] Cependant, une brève archéologie du savoir en recherche-action montrera que ce sont principalement les auteurs Latino-Américains[32-37] qui ont pointé vers la dimension politique de la recherche, en incluant la communauté comme participant aux décisions méthodologiques et à la problématisation de l’objet de recherche, dans une volonté de transformation radicale de société.[38,39] Cette perspective est associée aux mouvements sociaux et à l’éducation populaire.[40]

La méthode d’action et de recherche suivie

À partir d’une perspective d’éducation populaire, cette recherche-action implique une action collective et une recherche.

La partie « action » est la réalisation d’un documentaire par six “stagiaires-journalistes” sur l’expérience des stages cliniques. Dans le cadre de Mission Satisfaction (octobre 2009-mai 2010), cette action vise à mieux connaitre le point de vue étudiant sur les défis entourant leur progression dans les milieux de pratique. La partie « recherche » analyse les résultats des mini-reportages réalisés par les étudiants participants, engagés aussi comme assistants de recherche de 1er cycle. La méthodologie inclut un « comité de pilotage » du projet, composé de professeurs – Hélène Laperrière (École des sciences infirmières), Lucie Couturier (Consortium national de formation en santé – CNFS volet Ottawa), Ricardo Zúñiga (Service social – Université de Montréal) et d’étudiantes diplômées issues principalement de la population-cible - Rahma Abdi (candidate à la maitrise en Service social – Université d’Ottawa) et Biljhana Vulmirovik (infirmière, Santé publique Ottawa). Les échanges systématiques se réalisent par des séminaires de délibération sur le processus de la recherche-action. Ce dispositif allait permettre d’analyser le processus démocratique des approches participatives et les enjeux reliés à une recherche avec des participants immigrants récents et de minorités visibles.

La perspective d’éducation populaire dans une recherche-action

L’approche d’éducation populaire propose une méthodologie radicalement participative. Elle souligne le caractère relationnel des connaissances recherchées, la mise en commun des faits et des significations. La recherche s’enracine dans le quotidien d’une action collective.[41] Dans la formation de futurs médecins et leur sensibilisation aux quartiers populaires, Vasconcelos, Frota et Simon dépassent la notion de « visite » comme pratique de participation, en faveur d’une complète insertion auprès des acteurs locaux dans leur milieu, afin de mieux comprendre ce qu’ils pensent.[42] Cette approche va au-delà des limitations techniques du groupe focal; elle suggère une perspective dialogique impliquant la proximité et l’échange mutuel avec les participants de l’expérience partagée.

Les expériences étudiantes sont rapportées par la médiation des stagiaires-journalistes, et à partir d’un projet empirique auquel ils ont contribué. Les stagiaires-journalistes, formellement engagés comme assistants de recherche, sont invités à donner leur opinion dans le recueil, l’analyse et la présentation des résultats. Les médiateurs étant en proximité culturelle à la population avec lesquels ils travaillent; ils sont essentiels pour leur « être », pour « ce qu’ils sont », et pour leurs « caractéristiques capable de s’engager avec les autres à travers leurs habiletés naturelles.[43] Un intermédiaire transporte une signification sans la transformer, tandis qu’un médiateur transforme, traduit, distord et modifie la signification des éléments.[20] Les stagiaires et assistants de recherche ne sont plus de simples intermédiaires (transmetteurs passifs) de connaissances qui connectent un réseau; ils ont l’autonomie professionnelle d’adapter la communication selon le contexte et les situations.

L’activité scientifique se retrouve toutefois coincée entre celle de démonstration et démocratie.[20,44] La démonstration veut montrer l’évidence avec un contrôle maximum des variables, tandis que la démocratie désire engager la participation populaire en laissant tomber le total contrôle des évènements.[44] Callon a questionné les présupposés du débat public organisé avec l’engagement de gens profanes.[45] Les règles et procédures marginalisent les profanes dans les prises de décisions techniques; ainsi seulement un groupe restreint d’experts serait apte à participer puisqu’ils sont les seuls à comprendre le fonctionnement. Pour notre part, nous encourageons une participation décisionnelle des étudiants chercheurs de niveau baccalauréat dans la prise de décisions dans tous les évènements du processus de recherche, soit la définition des objectifs, la collecte des données, l’analyse et l’interprétation, ainsi que la diffusion à un public externe (étudiants de leur classe, professeurs cliniques et théoriques, direction). La stratégie n’est pas anarchique : elle exige du professeur une capacité d’inclure l’étudiant comme un apprenti. Un maitre enseigne des compétences à l’étudiant, qui dépassera le rôle d’assistant pour accéder à celui d’interlocuteur avec pleins droits, soit un «créateur

et producteur autonome » et un « sujet connaissant et participant aux diverses étapes de sa reprise de pouvoir ».[46 p51] La valeur d'un maitre se mesure dans l'originalité de ses disciples.

Le caractère exploratoire et collaboratif

Il est essentiel d'insister sur le caractère exploratoire et collaboratif du projet. Il suggère la collaboration directe des étudiants, engagés comme « assistants de recherche » (stagiaires-journalistes) en tant qu'interlocuteurs dans l'observation et l'analyse des situations qui leur sont quotidiennes en stage. Le bilan de l'analyse s'actualiserait dans une action de diffusion sous forme d'un documentaire destiné au corps professoral et la direction.

La formation des étudiants francophones issus des communautés immigrantes et de minorités visibles, principalement en sciences infirmières, est un sujet tabou. Le sujet rend mal à l'aise. Les craintes face à une étude explicite sur ce sujet portent principalement sur le dévoilement d'une situation socialement défiante. Faisant suite aux recommandations d'étudiants de ce groupe-cible dans des activités antérieurs, nous avons opté de poursuivre cette étude. Nous croyons qu'elle permettrait d'améliorer la qualité de l'enseignement en travaillant directement aux sources de ce tabou principalement au sein des expériences du stage clinique. Étant donné la montée croissante de ce sous-groupe dans la formation infirmière francophone, nous considérons qu'il y a des bénéfices à traiter ouvertement de ce sujet, surtout avec les étudiants concernés.

L'ajout de l'ethnologie collaborative

La perspective des stagiaires-journalistes rejoint celle de l'approche ethnologique collaborative.[19] « Ethnologique » par le fait que les étudiants engagés sont invités à saisir l'atmosphère de l'expérience de stage, dans laquelle ils sont eux-mêmes insérés afin de partager leurs impressions en tant que sujets critiques. Le stage est le milieu d'insertion académique pour l'intégration des futures professionnelles de la santé dans leurs milieux de travail. Les stagiaires-journalistes ont une connaissance expérientielle de leur milieu, ce qui peut profiter à leur analyse ethnologique (culturelle, linguistique).

En cours de stage, les étudiants travaillent, étudient et développent l'exercice de la pratique professionnelle dans le contexte de la vie quotidienne et réelle du milieu de stage. Ils engagent des rapports sociaux avec l'autre (usagers, familles, membres du personnel soignant, préceptrices, professeurs cliniques, etc.). Expérience « Collaborative » par le fait qu'elle n'est plus une conséquence accidentelle du travail sur le terrain. Elle est plutôt une condition préalable à la structure du design de recherche et à la dissémination des résultats.

Les participants dépassent le rôle de simples "informants". Ils s'actualisent comme "consultants" du terrain qui participent au processus d'écriture – formalisée comme une « ethnographie ».[19] Une recherche collaborative signifie travailler côte-à-côte avec une variété de valeurs et de points de vue. Elle suppose une éthique de la négociation et de la délibération.[19,47,48]

La co-construction d'écriture

Vu le caractère exploratoire, aucun questionnaire défini à l'avance n'est utilisé, de telle sorte que les étudiants puissent librement exprimer leurs opinions et leurs perceptions de l'atmosphère des stages sans qu'il y ait des variables préalables qui dictent leurs propos. Dans leurs tâches, ils n'auront pas à passer un questionnaire - que nous aurions préalablement construit - à leurs collègues (celui-ci n'est pas la perspective méthodologique d'une exploration). En tant que collègues et personnes insérées dans une expérience commune, ils se parlent mutuellement de manière naturelle. Ils pourront ramener au groupe de stagiaires-journalistes des commentaires et des situations observées qui les touchent. Ce sont des thèmes et thématiques émergentes au cours du processus qui correspond à une phase de pré-recherche formelle pour eux.

La collecte et l'analyse des données se réalisent en co-construction d'écriture entre les étudiants et les chercheurs-responsables. Ce choix méthodologique traduit nos intérêts pour le caractère nécessairement exploratoire d'une invitation qui permettra de laisser aux étudiants, en tant que journalistes-stagiaires, la formulation et l'analyse des thèmes qui émergent de leurs propos sur les expériences et les perceptions subjectives. L'utilisation du reportage journalistique s'avère une stratégie pour permettre cette co-interprétation et co-construction dans un langage commun accessible entre nous (professeurs et étudiants). Nous croyons que cette base expérientielle est une condition préalable pour le développement d'une compréhension apte à devenir le fondement de leur incorporation à une recherche formalisée.

La conception d'assistant de recherche de 1er cycle comme « stagiaire-journaliste »

Calepin à la main, les stagiaires-journalistes recueillent leurs

perceptions de l'expérience en cours de stage clinique. En termes méthodologiques reconnus, cette perspective créatrice rejoint celle d'une approche ethnologique[49] qui cherche à identifier les valeurs et les observations des faits permettant d'esquisser un concept de culture. Dans ce projet, le concept de culture s'exprime par une normativité implicite qui oriente le comportement des individus et des institutions (transcendance, rapport des classes, facteurs de justification de la normativité socio-juridique dans la formation par stage clinique); normativité implicite, car les individus et les institutions l'internalisent en modifiant inconsciemment leur style personnel.

C'est donc sous un angle culturel que les étudiants cherchent eux-mêmes les perceptions vécues. Les étudiants parlent naturellement à leurs collègues à la pause-café et mettent des mots sur l'atmosphère du stage, qu'ils interprètent subjectivement. C'est cette subjectivité que nous voulons préserver pour mieux nous connaitre (chercheurs responsables et stagiaires-journalistes). Ils peuvent ramener des commentaires de leurs collègues au groupe d'appréciation partagée sous forme de thèmes ou thématiques émergentes, mais sans pour autant être obligés de rapporter exactement les propos à l'aide d'une technique de recueil de données par verbatim.

À partir de leurs notes, ils éditent des mini-reportages dans le format d'une page journalistique, à laquelle ils ajoutent des titres évocateurs et des photos symboliques. Au cours du trimestre académique, les stagiaires-journalistes se rencontrent aux trois semaines dans des « groupes d'appréciation partagée ». Chacun partage alors son article et participe aux décisions sur les futures thématiques étudiantes à investiguer chez les stagiaires au cours du stage. Lors du dernier groupe d'appréciation partagée, correspondant à la fin du trimestre, les stagiaires-journalistes regroupent leur reportage de manière synthétique pour finaliser le documentaire.

Les groupes d'appréciation partagée (GAP) pour la mise en commun

Les groupes d'appréciation partagée ont été générés par un projet précédent,[50] réalisée avec ma participation active. Leur logique est celle de créer des groupes qui réunissent des acteurs d'un projet communautaire, pour mettre en commun leurs perspectives sur l'action commune. La participation égalitaire recherchée est non pas seulement une éthique politique, mais, aussi, une conscience acquise avec les groupes de participants que les approches directives ou semi-directives négligent la pression du souhaitable social dans les réponses.

Les cinq rencontres des groupes d'appréciation partagée rapprochent "action" et "recherche". Au début, les professeurs-chercheurs animent les GAPs; toutefois, l'animation pourra être dévolue au groupe selon leurs compétences. Ces rencontres se déroulent dans un lieu et au moment qui convient aux participants. Les stagiaires-journalistes doivent accepter de participer à l'action et à la recherche. Ils signent à la fois un contrat comme assistant de recherche et un formulaire de consentement. Les participants sauront toutefois qu'ils peuvent quitter ces deux postes sans contrainte autre que l'annulation du contrat de travail et le retrait des GAPs. Dans ce contexte, ils agissent comme étudiants et praticiens réflexifs[51-53] pour recueillir des impressions, des opinions et des évaluations sur les aspects des stages cliniques en sciences infirmières vécus au quotidien parmi leurs collègues.

La collecte et analyse collective des données

Une grille valorise les discussions libres lors des partages en GAP sur les mini-reportages de chaque participant : Quels étaient les personnes, évènements ou situations impliqués?; quels étaient les problèmes ou thèmes principaux abordés? Sur quelles questions de recherche d'information portait plus spécifiquement le contact ? Quelles nouvelles hypothèses, spéculations ou intuitions ce contact a-t-il suggérées sur la situation de terrain (stage clinique) ? Quelle devra être la priorité du stagiaire-journaliste lors du prochain contact et quel type d'information devra-t-il chercher à obtenir ?

L'utilisation des données au fur et à mesure qu'il deviennent une compréhension partagée de leur expérience permet de (1) planifier le prochain contact; (2) suggérer des codes nouveaux ou modifiés; (3) améliorer la communication et la coordination entre les stagiaires-journalistes participants à l'étude; (4) servir de support à l'analyse elle-même [54]. Les échanges ne sont pas enregistrés par souci de confidentialité. Des notes sont prises sur papier et redistribuées aux participants pour s'assurer leur accord sur les opinions exprimées. En tout temps, ils peuvent retirer des parties qui ne leur conviendraient plus.

La définition et les limites des formes d'encodage

Les instruments d'encodage des données ne peuvent être complètement définis puisqu'ils s'élaborent avec les participants et sur le terrain en cours de l'action. Les regroupements conceptuels tourneront autour de "thématiques" et "thèmes générateurs"[22,55] déterminées

par les groupes. Les thèmes générateurs ressortent dans les mini-reportages, lesquels peuvent inclure également des photos ou illustrations symboliques qui expriment en quelque sorte des métaphores sur les préoccupations retenues en cours de stage.

L'utilisation de la métaphore comme tactique de réduction rapide des données possède les propriétés d'outils de condensation, d'identification de patterns, de décentration et de possibilités de relier les découvertes à la théorie.[54] La codification et l'analyse des thèmes se réalisent par délibération et négociation. Le plus tôt possible après la réunion, les professeurs-chercheurs retranscrivent les échanges dans une synthèse des thèmes, dans lequel ils concentrent les informations sélectionnées afin d'être délibérées de nouveau avec les participants lors de la prochaine réunion de GAP. La confirmabilité des données et leur validité viennent de la confirmation des sources d'informations par les participants. La condensation des données sans codification par support logiciel préserve le potentiel intuitif d'analyse et permet la contextualisation de l'analyse.

Les dimensions éthiques particulières liées à l'expression formelle écrite

Le projet propose une éthique étudiante, une qui dépasse la socialisation aux mœurs intellectuelles des professeurs. Il s'agit d'un nouveau rapport de collaboration. La pratique éthique se fonde sur quatre engagements[19] : (a) la responsabilité éthique et morale avec les étudiants concernés; (b) l'honnêteté à propos du processus terrain; (c) l'écriture accessible et dialogique et (d) la lecture, l'écrit et la co-interprétation collaborative avec eux. Dans ce sens, nous avons l'obligation de les tenir au courant de ce qui se passe dans un rapport d'intérêts communs.

La délibération en groupe d'appréciation partagée permet de mieux cerner les enjeux que les étudiants soulèvent sur leurs expériences. Nous avons confiance qu'ils puissent agir comme juges pour censurer les parties des résultats qui pourraient leur occasionner des problèmes, par exemple, des jugements de valeur sans fondement ou qui ne tiennent pas compte des susceptibilités et des droits d'autres personnes. Aussi, deux étudiantes diplômées francophones de communautés immigrantes participent aux discussions. Leur apport renforce l'analyse collective des risques de la divulgation des expériences à l'extérieur du groupe et de poser des jugements de valeur publiques.

Le fait de partager avec le groupe les données recueillies n'est-il pas en soi un moyen de libération?[20,55] L'analyse collective de l'éthique de la représentation permet de reconstruire de façon critique la représentation des expériences d'étudiants issus des communautés immigrantes et minorités visibles dans les stages cliniques en sciences infirmières. La pratique éthique voudra que l'on délibère ensemble afin d'accepter « le résultat comme le meilleur possible dans les circonstances actuelles, et à apprendre à s'accommoder de leurs limites ».[56 p141]

Le bris éthique serait celui dans lequel nous utiliserions des méthodes pour forcer une fausse représentation qui pourrait changer l'interprétation des faits, mais aussi les jugements de valeur que les gens se font sur la base de la représentation[56] du groupe concerné: étudiants, immigrants, minorités visibles (par exemple, en omettant la délibération avec les étudiants). Le bénéfice de la recherche pourrait être d'obliger à réviser et redéfinir la représentation actuelle de ce groupe basé sur le sens commun et permettre à d'autres voix de se faire entendre pour cette redéfinition.

Des résultats percutants : que faire?

Nous sommes à l'étape de la problématisation, soit de poser et d'identifier le problème. Parmi les résultats préliminaires, notons les sentiments d'impuissance des étudiants, la peur, le stress de l'échec, l'injustice, la discrimination linguistique et raciale, ainsi que le leur état psychologique affecté : ces sentiments ressentis par les étudiants font du stage une expérience traumatisante pour certains. Aussi, l'apprentissage dépend des dimensions subjectives de la relation entre les étudiants et le professeur. Il y a les sentiments douloureux de se sentir traité de manière inégale par la différence d'âge, les facteurs raciaux, le vécu.

Les étudiants ressentent une discrimination systémique, laquelle provoquerait de "fausses raisons" pour annoncer un échec probable et le justifier à l'avance. Si la subjectivité joue un rôle important dans la perception, il y a des résultats objectifs et concrets qui peuvent en résulter. L'échec d'un stage suscite des transformations particulières de la trajectoire de vie de l'étudiant francophone issu des immigrations récentes et des minorités visibles. Il y a des situations dans lesquelles l'étudiante-mère a dû envoyer ses enfants dans son pays d'origine pour se concentrer aux études. Bien qu'elles soient des « perceptions » de la part des étudiants participants, ces perceptions ont une forte influence sur le degré de satisfaction de la qualité de l'expérience universitaire qu'ils exprimeront aux audiences à l'intérieur et à l'extérieur de l'Université.

L'utilisation du théâtre populaire comme alternative à l'écrit

Une deuxième phase (Phase II) proposait le passage à l'action : le projet « Pouvoir » améliorer l'expérience de stage clinique: la rencontre collective des multiples acteurs et le passage à l'acte ». Suite à un remue-méninge avec les six stagiaires-journalistes de la Phase I, l'action synthétise les suggestions étudiantes proposées. Un outil d'éducation populaire (théâtre populaire) a servi de médiation à partir de vignettes du vécu des étudiants (Phase I) pour mobiliser l'expression des points de vue sur l'expérience de stage.

Les participants de la Phase I ont été prioritairement invités à poursuivre leur engagement comme assistants de recherche dans cette Phase II. Il correspond au processus de diffusion des connaissances de la recherche-action. Une troupe professionnelle spécialisée dans le théâtre social a été engagée (http://www.derivesurbaines.org/). Le metteur en scène a écrit trois scénarios (moins de dix minutes chacun) à partir des résultats de la recherche-action (voir Figure 1). Les étudiants assistants de recherche participèrent aux négociations sur le texte retenu. La représentation a eu lieu lors d'un Théâtre-Forum le 1er décembre 2010 (Figure 2).

Figure 1: Les actrices Julie Grethen et Catherine Boutin interprètent le vécu de deux étudiantes en échec : une immigrante récente et une autre née au Canada.

Figure 2: Choix étudiant de l'affiche publicitaire: Deux poids, deux mesures

Suite aux suggestions des étudiants participants, nous sommes présentement à une Phase III pour élargir à une campagne de sensibilisation avec des affiches et l'utilisation du vidéo tiré du théâtre, un journal-documentaire écrit avec bandes dessinées, des séminaires éducatifs, une formation continue des enseignants et des étudiants (le communautaire universitaire), un site Facebook, le tout ouvert à la collaboration active d'autres écoles intéressées comme Éducation et Service social.

Analyse et discussion à poursuivre

Il est important de souligner le silence de la parole écrite des stagiaires-journalistes dans leurs mini-reportages au cours de la recherche. Il peut être un mélange complexe de crainte et de colonisation interne, soit d'une autocensure apprise. Le projet de travail suggérait la constitution d'un collectif égalitaire entre les professeurs organisateurs et les étudiants concernés. Ceci n'efface pas les difficultés des étudiants qui incluent la visibilité minoritaire, les situations d'immigration récente, les responsabilités familiales dans le pays d'accueil et dans le pays d'origine, le travail souvent à plein temps, etc. Comment peuvent-ils parler des discriminations vécues sans risquer de les rendre connues au-delà des cercles intimes?

La communication écrite des praticiens s'adresse, d'abord, à un interlocuteur de confiance pour partager leurs expériences, sentiments, observations, réflexions et, ensuite, à un inconnu ayant droit de juger (un évaluateur quelconque). En tant qu'enseignants d'écoles professionnelles, voulons-nous inviter à une voix écrite autonome qui s'adressera à une communauté plus large que celle des milieux académiques?

Le verbal permet de choisir l'interlocuteur avec qui je partage mes craintes et d'ajouter l'information non verbale au contrôle de mon propre discours ; le non verbal augmente la marge de manœuvre d'une expression qui échappe au contrôle et à la sanction. L'écrit, quant à lui, lui enlève le pouvoir de sélection de ses interlocuteurs. Les écrits sortent du contexte intime. Plus encore, quand les praticiens essaient de défendre leur souci d'action sociale et de changements, ils voient leur première intention d'expression, encore en balbutiements, être dévalorisée et mal interprétée par les critères formels d'un savoir dire institutionnalisé.

À certains moments, le caractère exploratoire éveille l'anxiété: avez-vous un questionnaire formel ? Ils peuvent avoir déjà bien appris à suivre le chemin d'opprimé-étudiant à oppresseur des interviewés, des étudiants dans un assistanat directif et la progression dans une échelle de contrôle des étapes de la recherche qualitative hiérarchisée. Est-ce que la « science normale »[57] est la seule que nous voulons enseigner, imposer ?

Notre préoccupation se situe d'abord et avant tout dans les enjeux de la communication — verbale, non verbale, écrite — à un interlocuteur de confiance pour partager nos expériences, nos sentiments, nos observations et nos réflexions ou à un inconnu, qui restera anonyme, qui a le droit de juger. Le verbal permet de choisir l'interlocuteur et d'ajouter l'information non verbale au control de son propre discours ; le non verbal augmente la marge de manœuvre d'une expression qui échappe le contrôle et la sanction.

Le travail était organisé pour respecter la capacité d'expression des étudiants journalistes issus d'immigrations récentes et minorités visibles. Ce qui pose le problème des dangers du dévoilement de personnes et situations aux acteurs sociaux qui contrôlent le pouvoir dans ces situations. L'expérimentation soulève une question centrale pour les études à venir. Dans la tension inévitable entre l'expression d'une expérience personnelle et l'imputabilité qui la guette, quelle est la pression qui devient un bâillon des «données premières » ?

Du journal intime aux personnalités publiques sur Tweeter, de la mode anonyme à l'habillement provocateur, la communication reste sous le contrôle de l'émetteur. L'écrit, quant à lui, implique une visibilité qui échappe au sujet, qui lui enlève les pouvoirs de sélection de ses interlocuteurs. Les écrits restent — et restent au-delà des intentions du sujet. Ils peuvent être sortis de contexte, ils peuvent être déconnectés des intentions premières. L'utilisation du théâtre [58-59] est une alternative que nous avons utilisée pour présenter le point de vue de participants « anonymes » par la médiation d'acteurs professionnels qui interprètent le contenu intense d'un sujet tabou au public externe.

Reconnaissances

Je tiens à souligner l'engagement des membres du comité de pilotage à la recherche-action : Ricardo Zúñiga (Université de Montréal), Rahma Abdi et Biljana Vukmirovic (infirmières graduées), ainsi que la collaboration de Lucie Couturier (CNFS-volet Ottawa) dans les premières phases du projet. Tout au long du processus, nous avons compté sur le soutien du Doyen Denis Prud'homme (Faculté des sciences de la santé, Université d'Ottawa) pour mieux comprendre et orienter notre projet. Le projet a été rendu possible par les fonds de démarrage et du programme Mission-Satisfaction de la Faculté des sciences de la santé/Université d'Ottawa. Tiré des résultats de la recherche-action, l'auteure a coordonné la

production d'un outil multimédia intitulé « Deux Poids, deux mesures » pour des fins éducatives et de conscientisation. Il présente les trois scénarios du théâtre-forum et le témoignage d'experts. Il est distribué par le Consortium national de formation en santé – volet Université d'Ottawa (CNFS). Vous pouvez le commander à : http://www.cnfs.ca/produits/deux-poids-deux-mesures .

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Résumé
Cet article présente une analyse détaillée de la professionnalisation du nursing au Québec (Canada). L'emphase porte sur deux variables principales qui permet de mieux comprendre les aspects genrés de la profession et sa féminisation persistante. Le cas québécois, présenté dans le cadre de cet article, et étudié dans son contexte canadien, permet d'identifier plusieurs éléments qui ont conduit à faire du care le fondement du nursing. L'auteure retient deux facteurs principaux, qui se trouvent à l'intersection de rapports de classe, de genre et d'ethnicité dès les débuts de la réforme du nursing : le rôle précurseur des réformatrices et les origines confessionnelles du nursing. La combinaison de ces facteurs explique la persistance d'une ségrégation sexuelle aussi exceptionnelle dans le monde du travail.

Mots clés care, féminisme, gendre, nursing, Québec, XX^{e} siècle

Du nursing au care : le genre d'une profession

YOLANDE COHEN

Introduction

La tension persistante entre féminismes/ maternalistes et féminismes/ égalitaires a conduit à de nombreux débats, où ces dichotomies, bien souvent paralysantes, ont grevé durablement les capacités d'agir des femmes. Une des solutions entrevues depuis le début du siècle par les féministes égalitaires, a été de proposer la mixité, dans les métiers pour faire sauter le verrou des professions fermées aux femmes et réservées aux hommes par la tradition, le patriarcat. Toutefois, si les femmes sont entrées en nombre dans les professions dites masculines (médecine, pharmacie, droit, etc.), il n'en va pas de même pour les professions dites féminines. Ainsi dans le domaine des sciences infirmières, la relation étroite qui existe entre le genre (féminin) et la vocation d'infirmière comme on l'appelait alors, a longtemps été revendiquée comme étant au fondement de la profession. Il a fallu attendre les grandes réformes du nursing à la fin des années 1940 pour que les porte paroles de la profession proclament haut et fort leur volonté d'en faire une profession mixte, ouverte aux hommes. Mais, il est plus facile de l'annoncer que de réaliser un tel programme; la composition actuelle (à 80% féminine) de la profession infirmière témoigne de la difficulté de cette transformation, et suscite encore de nombreuses interrogations sur ce qui maintient ce cloisonnement professionnel, avec tous les problèmes que cela implique : questions de champ de pratique propre, de statut, de salaire, de reconnaissance, etc.

Or le nursing n'est pas la seule profession qui soit confrontée à ce type de problème. La majorité des fonctions/professions qui relèvent du care, du soin aux autres, du souci des autres, de la relation d'aide, s'inscrivent dans des constructions

sociales fortement genrées qui renforcent les différences sexuelles (du féminin et du masculin), plutôt qu'elles ne les dépassent. J'aimerai ici revenir sur les éléments qui ont conduit à faire du care la clé de voute d'une vision de l'intervention sociale, où le rôle des organisations caritatives de femmes a été déterminant, et proposer quelques pistes de réflexion à partir du cas du nursing.

Le cas québécois, que j'ai particulièrement étudié dans son contexte canadien, permet d'identifier plusieurs éléments qui ont conduit à faire du care le fondement du nursing. Je retiendrais deux facteurs principaux , qui se trouvent à l'intersection de rapports de classe, de genre et d'ethnicité dès les débuts de la réforme du nursing: le rôle précurseur des réformatrices et les origines confessionnelles du nursing. La combinaison de ces facteurs me semble expliquer la persistance d'une ségrégation sexuelle aussi exceptionnelle dans le monde du travail.

Le nursing : une vocation pour les femmes

C'est au sein du large mouvement philanthropique anglo-protestant actif dans la plupart des provinces canadiennes que les principes fondateurs du nursing sont élaborés au Québec par une petite cohorte de femmes. Militantes de la première heure de ce mouvement, les pionnières du nursing ont recours à une rhétorique commune pour établir le care comme base d'une nouvelle profession. Elles parviennent rapidement à imposer un double concept au nursing : découlant de la charité judéo-chrétienne, le care relèverait de qualités attribuées en propre aux femmes seulement, mais ne peut être pratiqué qu'à la suite d'une éducation formelle, acquise dans des écoles appropriées et sanctionnée par des diplômes. Ce discours sera nuancé selon les régions par des associations aux convictions ethniques et religieuses différentes : quelques infirmières franco-catholiques au sein du Canada français (pas seulement au Québec) et une majorité de femmes anglo-protestantes au Canada anglais (y compris au Québec). L'influence de la réforme du nursing britannique marque les étapes préliminaires d'organisation et l'adoption de nouveaux critères d'enseignements du nursing dans tout le Canada. La plupart des surintendantes et infirmières chefs recrutées par les premiers grands hôpitaux canadiens ont été formées dans les toutes nouvelles écoles de nursing en Grande Bretagne (St-Thomas) ou aux États-Unis (au Bellevue Hospital de New-York par exemple).[1] Les hôpitaux canadiens anglais sont alors très intéressés à engager leurs diplômées, ce qu'ils font dès les années 1900 comme on le constate en Ontario et au Québec. Miss Machin, qui vient du St-Thomas en Angleterre (1875) est engagée par le Montreal General hospital (MGH) pour y fonder une école d'infirmières et diriger et gérer l'hôpital. Dénonçant les conditions déplorables de travail, elle est rapidement remplacée par une diplômée de Boston et puis par la célèbre Norah Livingstone, diplômée du New York Hospital Training School for Nurses. À Toronto, c'est une diplômée de Bellevue, Jean I. Gunn qui obtient l'ouverture de l'enseignement supérieur en nursing, réalisée par une graduée du King's college à Toronto, Kathleen Russel. Ethel Jones, qui entreprend sa formation au Winnipeg General Hospital et obtient son diplôme du Teachers College, (Columbia University) à New York, sera engagée pour établir l'école de nursing à l'université de Colombie Britannique. Flora Madeline Shaw, qui étudie d'abord au MGH, et obtient son diplôme du Teachers College, est recrutée par l'université McGill.[2,3] Cette petite cohorte d'infirmières graduées deviendra rapidement l'élite du nursing canadien anglais. Partie prenante du mouvement réformateur, ces graduées reprennent à leur compte certains préceptes bien compris de Florence Nigthingale pour développer la profession : une formation appropriée aux femmes d'une certaine moralité, qui ont la vocation du soin aux autres, et qui veulent acquérir les savoirs techniques et scientifiques pour devenir des infirmières professionnelles. Elles s'approprient également la fameuse formule de Nightingale, « si toutes les infirmières sont des femmes, toutes les femmes ne peuvent pas devenir des infirmières » (« if every nurse is a woman, not all women could become nurses »), qui légitime la création de ces écoles d'infirmières à travers le Canada. Ce mouvement célébré par de nombreuses historiennes comme le moment marquant de la réforme du nursing et de sa modernisation traduit en fait la tentative d'imposer le modèle (canadien) anglais et plus précisément anglo-protestant à travers tout le Canada. Un des effets de la réforme est précisément d'étendre ce modèle (anglo-protestant) à l'ensemble des provinces grâce à des principes jugés essentiels et véhiculés par les mêmes associations qui les ont élaborés.

Outre les nombreuses écoles qui voient le jour dans les grands hôpitaux du Canada durant cette période d'essor d'une idéologie dite progressiste du nursing, des critères d'uniformisation de la pratique infirmière sont élaborés, et l'enregistrement du titre consacre la reconnaissance légale de la nouvelle profession. Au Canada, comme aux Etats-Unis et en Grande-Bretagne, des femmes de la bourgeoisie, des médecins éclairés, actifs dans les mouvements hygiénistes en particulier, ainsi que d'autres professionnels, soucieux d'insuffler des changements se rassemblent pour réformer en profondeur le monde de la santé (administrateurs d'hôpitaux,

hommes d'affaires, avocats, etc.). Animés d'une commune détermination scientiste, établie sur la foi dans le progrès de la science, ils réclament l'avènement d'une science du soin, laïque et d'une organisation hospitalière établie sur des critères professionnels. À leurs yeux, le soin devait s'émanciper de ses origines charitables, pour devenir une profession, séculière, détachée de son rapport confessionnel. Pour ces réformateurs protestants surtout (et quelques catholiques), imbus des bienfaits de la laïcité, l'orientation professionnelle vise essentiellement à conférer un statut et un salaire à ces femmes, qui faisaient ce travail bénévolement ou payées de façon aléatoire ainsi qu'une possibilité de carrière à certaines femmes dévouées et qui voudraient s'instruire.

Les nombreuses femmes impliquées dans ce mouvement de réforme, y voient l'opportunité d'ouvrir des carrières féminines dans le secteur de la santé, qui découleraient ¨naturellement¨ des qualités féminines de soin, et qui leur permettraient d'avoir un travail rémunéré, sans transgresser les assignations sociales à des rôles sexués. Elles considèrent également le nursing comme une profession, qui aurait des rapports complémentaires avec celle des médecins : les savoirs infirmiers seraient des savoirs-propres et conçus de façon autonome tandis que les pratiques infirmières dépendraient du diagnostic médical. Ces savoirs féminins deviennent la base des enseignements infirmiers dans les écoles de nursing. L'image des rôles féminins complémentaires à ceux des hommes, propre à la rhétorique victorienne correspond également à cette fonction; dans ce contexte leur perception de la complémentarité n'implique pas leur subordination, mais la séparation des rôles entre médecins et infirmières, sur les conceptions alors répandues de la séparation des rôles sexués.

Cette question de la complémentarité-subordination des rôles a longtemps été débattue par les féministes. Des différences de classe existent entre les pionnières du mouvement philanthropique et hygiéniste, souvent des grandes dames de la bourgeoisie éclairée, et les pauvres recrues qui se trouvent contraintes d'adopter le langage moralisateur et féminin de leurs bienfaitrices.[4-6] Ces femmes de la bourgeoisie, blanches et protestantes (Wasp) sont ainsi sévèrement critiquées par les féministes pour avoir établi le nursing sur le modèle de la profession médicale. Ce serait la faute originelle du nursing puisqu'elles n'ont pas réussi à lui conférer l'autonomie (professionnelle) ni l'expertise (académique) de cette profession.[7-9]

Cette critique doit pourtant être nuancée, car cette évaluation ne tient pas compte du rôle du care, que ces femmes ont rajouté comme un ingrédient essentiel dans la réforme des soins. Le processus de reconnaissance sociale du care, comme élément distinctif de la pratique et de l'enseignement du nursing, va ouvrir une brèche immense dans le système de santé et plus largement dans le monde du travail pour les travailleuses sociales, les hygiénistes, etc.

Mais pour que cette reconnaissance du care soit véritablement prise en compte comme pouvant légitimer une profession, il a fallu débarrasser le care de ses vestiges religieux. Ainsi, à l'examen du cas québécois, le contexte confessionnel dans lequel ces rapports de genre s'exercent, montre combien la morale religieuse, particulière à chaque groupe confessionnel, imprègne le care.

Comment a-t-on remplacé l'idéologie charitable par des rhétoriques professionnelles? Quels rôles les mouvements réformateurs anglo-protestants ont-ils eu face à la toute puissance du modèle pluri-séculaire de soins établi au Canada français? S'agit-il d'une bataille entre deux modèles de nursing? Dans ce débat, qui se mène aussi bien sur le terrain de la rhétorique que de la pratique, seul le modèle qui donnera l'apparence d'avoir véritablement réussi à débarrasser le care de ses ancrages religieux, pourra l'emporter.

L'analyse de la rhétorique des associations professionnelles d'infirmières que nous avons menée pour le Québec au XX^{e} siècle montre en effet que la plupart se débarrassent des vestiges confessionnels des premières associations philanthropiques pour donner une dimension neutre et laïque au nursing réformé.[10] On verra que si en théorie ce projet se veut inclusif, en pratique il vise à neutraliser le pouvoir des associations et congrégations catholiques (et juives dans une moindre mesure), toutes puissantes dans le système de santé du Canada français (ignorant l'effort fourni par ces congrégations pour intégrer en leur sein l'aspect professionnel). En d'autres termes, ces associations professionnelles dites neutres imposent aux groupes confessionnels du Québec les modalités d'application de la réforme anglo-protestante du nursing au Canada. C'est pourquoi il importe que l'on s'arrête sur le processus qui a conduit à la laïcisation du nursing.

Aspects confessionnels du care et difficile laïcisation du nursing au Québec

La laïcisation du nursing, souvent considérée comme inéluctable, ou comme étant le fruit de la poussée scientifique, est présentée par nombre d'historiennes, comme la pierre angulaire de sa modernisation. Ainsi la réforme se présente dès le départ comme confessionnellement neutre. L'historiographie, essentiellement anglophone du nursing,

reprend cette hypothèse de départ des réformateurs, et propose une interprétation de la réforme du début du siècle comme le moment où le nursing rompt avec ses origines confessionnelles pour devenir une profession laïque et séculière. Par un curieux effet de rhétorique, sont considérés comme non confessionnels les discours qui se présentent comme tels. Pourtant en pratique, la laïcité suppose que soient abolies les barrières confessionnelles longtemps étanches entre les différentes communautés. Or, il faut savoir que la laïcité proclamée des réformateurs anglo-protestants était non seulement une version édulcorée du social gospel,[11] idéologie anglo-protestante militante, mais aussi une arme de guerre contre le modèle franco-catholique de soins (à qui l'on enviait sa structure institutionnelle et sa toute puissance). En faisant comme si cette laïcité signifiait l'abolition de références religieuses dans la réforme du nursing, l'histoire du nursing fait l'économie d'une discussion essentielle sur le rôle du protestantisme en tant que facteur déterminant dans la réforme du nursing au début du siècle et dans la conception du care qu'il va promouvoir.

Il s'agit donc ici de prendre en compte le facteur religieux, comme élément central de l'analyse. Plus encore, le facteur confessionnel nous apparait essentiel pour comprendre la définition même du soin (care). En omettant ce facteur, on considère la victoire du modèle anglo-protestant de réforme comme un processus naturel de modernisation du nursing au Canada. Car en assimilant laïcité à modernité, le modèle anglo-protestant s'est en fait approprié l'idée de progrès, reléguant ainsi toutes les autres pratiques de soins à des formes traditionnelles et même rétrogrades. En effaçant son lien avec la religion, il souligne celui des autres (en particulier pour les catholiques). C'est pourquoi, il me semble indispensable de rétablir les influences réciproques des groupes confessionnels dans la structuration du champ sanitaire tant au Québec qu'au Canada où les congrégations d'hospitalières catholiques et protestantes sont omni-présentes. Comment ces deux modèles qui se sont développés séparément (chacun dans sa communauté) se sont-ils réformés ? Le développement de la science est-il à l'origine de ces changements ? Le processus par lequel s'effectue la domination du modèle anglo-protestant de soins, très peu formalisé puisque essentiellement établi sur les charités privées, sur les institutions catholiques de santé multi-séculaires est intéressant à analyser.

Les historiennes du nursing s'entendent pour attribuer au développement scientifique et médical l'origine de la réforme des soins infirmiers au tournant du siècle dernier. Dans ce contexte, le rôle pionnier et exemplaire de Florence Nigthingale est essentiel puisqu'elle aurait permis au nursing de sortir des pratiques charitables et douteuses dans lequel il baignait, pour amorcer le tournant médical et plus tard professionnel. Toutefois son influence sur le nursing canadien me semble avoir été largement exagéré. S'il est indéniable que la figure légendaire de Florence Nightingale a marqué la réforme du nursing au Canada anglais, l'application de ses principes d'éducation vise à surmonter l'énorme disparité qui existe entre les pratiques traditionnelles du care, et celles en vigueur dans l'ensemble du Canada français. Entre les mains des congrégations catholiques d'hospitalières, le système d'apprentissage et de pratique du nursing en faisait un des modèles enviés par tous ses contemporains. Les congrégations catholiques de soignantes éduquées et dévouées avaient mis en place un système très efficace de soins infirmiers au sein des premiers hôpitaux fondés au Canada français.[12] Il suffit de voir le rôle des ordres religieux dans la construction des grands hôpitaux comme les Hotels-Dieu de Montréal et de Québec,[13] et l'apport de leur expertise dans le traitement des patients et de l'assistance aux pauvres. Très vite leur expertise en tant que fondatrices, propriétaires ou gestionnaires d'institutions de santé (hôpitaux, dispensaires ou autres) est reconnue et appréciée.[14] Le modèle hiérarchique, calqué sur celui des communautés religieuses catholiques, y est dominant, de même que l'idéologie de la charité chrétienne aux plus démunis et de la rédemption par les soins. Au contraire des sociétés protestantes qui laissaient cette activité de soins aux organisations philanthropiques et à la bonne volonté des élites, le caractère systématique de l'organisation des soins dans le milieu catholique est frappant.[15] D'ailleurs, certains observateurs contemporains ne s'y trompent pas et considèrent le système de santé mis en place par les congrégations féminines catholiques comme largement supérieur à celui des anglo-protestants, et pas seulement au Québec mais en Alberta aussi.[16] L'étendue du réseau mis en place, le pouvoir que les hospitalières y détiennent et la qualité de la formation qui y est dispensée leur confère une réputation enviée à travers le Canada jusqu'aux tous débuts du XX^{e} siècle.

Aussi les histoires de gardes-malades ignorantes, ivrognes et peu qualifiées qui alimentent et légitiment la réforme préconisée par Nigthingale et ses émules canadiennes sont des histoires qui reflètent plutôt la réalité des soins dans les communautés anglo-protestantes. Cette réforme se donne d'ailleurs pour objectif de mettre fin à ces pratiques douteuses du nursing en recommandant un modèle assez proche de celui, pratiqué par les congrégations franco-catholiques, où

l'éducation formelle au sein même de l'hôpital mènerait à une forme plus élevée de reconnaissance professionnelle.

- La professionnalisation à deux vitesses du nursing au Québec et les résistances au care

Si les deux modèles partagent la même vision du nursing inspirée de la charité chrétienne et du dévouement féminin, les processus qui mènent à la reconnaissance des soins infirmiers comme profession, différent radicalement. Pour les anglo-protestants, l'alliance contractée avec les élites médicales garantit en quelque sorte l'adoption du modèle professionnel par l'ensemble du mouvement philanthropique. Au contraire, ce modèle est rejeté et redouté par les élites franco-catholiques. Soucieuses de maintenir leur autonomie à l'égard des médecins en particulier, mais néanmoins enfermées dans un carcan hiérarchique et autoritaire, ces congrégations adoptent le modèle holiste où elles peuvent contrôler l'accès à la profession en se dotant d'organismes internes de représentation (syndicats et associations professionnelles sous leur contrôle direct et en conflit constant entre eux). Le manque de cohésion de ce modèle (plus ou moins laïcisé selon que l'on se trouve à Montréal ou à Québec, et selon les congrégations) et l'appui de certaines élites éclairées à la réforme (accusées par le clergé d'être vendues aux anglo-protestants) fera vaciller le modèle franco-catholique qui succombera sous les coups de boutoir de l'universalité de la réforme inspirée par Nightingale-Fenwick et véhiculée par les sociétés anglo-protestantes.[3,17] La volonté d'établir une éducation formelle dans des institutions séparées des associations charitables, la mise en place d'associations professionnelles autonomes (avec leurs revues et comités de déontologie indépendants) et la légalisation de la profession par l'enregistrement constituent les trois étapes majeures de cette professionnalisation des soins infirmiers. À Montréal même, les pionnières obtiennent l'appui des médecins et des grands hôpitaux anglo-protestants. Face à elles, les institutions hospitalières catholiques apparaissent crispées sur leurs privilèges, fermées aux laïques et hostiles aux pouvoirs concurrents (des médecins, des administrations publiques, des associations, etc.). Ainsi, contrairement à ce qu'on en a dit, ce n'est pas par opposition à la science ou à la médecine, qui ont toute latitude pour se développer dans les Hotel-Dieu par exemple, que le modèle franco-catholique perd du terrain, mais dans son opposition initiale à la déconfessionnalisation du care et donc à sa professionnalisation. Même à l'hôpital Notre-Dame, où les Sœurs Grises tentent d'accompagner le processus de professionnalisation et d'en tirer profit (en devenant elles-mêmes des infirmières graduées des grandes écoles de nursing nord américaines) le processus de laïcisation et de professionnalisation est lent et douloureux, car pour ces dernières, le care reste relié à la vocation religieuse et féminine.[15,18]

Le mouvement de professionnalisation oppose ainsi des visions différentes du nursing au Canada, du début des années 1920 à la veille de la seconde guerre mondiale. Deux grands types d'organisation du nursing se trouvent en présence. L'un, qualifié de traditionnel et inspiré du modèle franco-catholique est basé sur une vision confessionnelle du care (charité, vocation, service, etc.). Diversifié car il dépend étroitement de chaque congrégation d'hospitalières, ce modèle offre une formation interne aux sœurs hospitalières au sein des hôpitaux de leur congrégation, mais il est entièrement confessionnel et ne permet pas véritablement de carrière aux laïques. Ce sont essentiellement des religieuses, qui pratiquent, enseignent et exigent la vocation, que l'on verra devenir des professionnelles du nursing, avec quelques laïques célibataires dans les années 1920; la proportion laïques-religieuses ne s'inversera qu'après les années 1940. De son côté, le modèle anglo-protestant semble avoir débarrasé le care de toute référence à la religion, et son attrait réside dans son recrutement relativement ouvert à toutes les femmes. Certes, seules les jeunes femmes de haute vertu pourront-elles accéder aux écoles d'hôpitaux, pour y être formées par des matrons ou des infirmières graduées laïques provenant des grands hôpitaux nord-américains et canadiens. Les profils de carrière y sont également plus flexibles, établis sur des critères professionnels, même si les qualités personnelles demeurent largement présentes. En fait jusqu'aux grandes transformations dûes à la seconde guerre mondiale, le nursing est l'affaire d'une petite élite de femmes, religieuses et célibataires au Canada français, blanches et éduquées au Canada anglais. Dans les deux modèles, on le voit, les caractéristiques de genre et de religion ont été intégrées au sein même de la fonction de care, dont l'apprentissage est désormais essentiel pour être habilité à donner des soins aux autres. Il nous faut donc davantage élaborer sur la question du care.

La bataille pour la professionnalisation

Si c'est encore au sein des associations philanthropiques que sont élaborés les fondements du care (comme un système de soins aux autres, établi sur des valeurs de charité chrétienne et de qualités féminines au service des malades), la question qui se pose pour les secondes et troisièmes cohortes d'infirmières, formées en leur sein, est la place que le caring va occuper dans la professionnalisation du nursing.

On tente bien de les énoncer autrement, comme des qualités et compétences qui peuvent être acquises par tous pour exercer la profession d'infirmière, en tâchant de les détacher de la vision charitable (religieuse) et genrée du soin aux autres. Même si le don de soi pour remédier aux maux des autres, le dévouement tout féminin au patient, la rédemption du malade et le salut des âmes, sont remplacés par des compétences similaires (l'attention, la surveillance, l'hygiène, l'organisation du travail, etc.), le care reste très profondément ancré dans cette double identité. Les principales étapes du mouvement de professionnalisation du nursing signalent bien les moments où il est confronté à cette imprégnation de la formation et du recrutement des infirmières par les préceptes religieux, et par l'identité de genre.

Au Québec, la confrontation des deux modèles de care présents au Canada, rend l'histoire de la professionnalisation des infirmières particulièrement significative. La prédominance du modèle anglo-canadien au Canada se heurte de plein fouet aux institutions religieuses franco-catholiques qui ont la haute main sur l'éducation et la santé au Québec. La première bataille a lieu à propos de la loi sur l'enregistrement des infirmières, en 1920 qui sera largement amendée parce qu'elle vise une réorganisation globale du système de santé, qui échapperait ainsi au contrôle des congrégations religieuses. Mais le mouvement en faveur de la professionnalisation des infirmières est également repris par des associations féministes franco-catholiques comme la Fédération Nationale Saint jean Baptiste (FNSJB), ou celles des infirmières graduées appuyées par des médecins éclairés. En donnant plus de pouvoir aux professionnels, en particulier les médecins, pratiques courantes déjà dans le milieu anglo-protestant au tournant du XX^{e} siècle mais inédites et redoutées dans le milieu franco-catholique, les conseils d'administration parviennent à éroder le pouvoir des congrégations religieuses dans leurs hôpitaux, et établissent la suprématie des professionnels laïques, comme dans le nouvel hôpital francophone, l'Hôpital Notre-Dame. Ainsi, les questions complexes de spécialisation des services de soins, entre le care et le cure, entre professionnels de la santé et administrations hospitalières laïques par exemple seront-elles abordées dans un contexte de grande polarisation entre ces deux principaux modèles (celui des anglo-protestants étant repris presque intégralement par les communautés juives, à partir des années 1920).

En moins de 20 ans, de 1920 à 1940, le système multi-séculaire de santé mis en place par les congrégations franco-catholiques, et dominant au Québec se voit ainsi ébranlé dans ses fondements. Certes, le tournant scientifique pris par la médecine et la domination rapide de ce secteur ainsi que l'intervention progressive de l'État provincial et dans une certaine mesure fédéral, comme instances de régulation contribuent bien sûr à modifier le système de santé. Ces transformations majeures ont-elles eu raison des modèles désormais jugés trop vétustes de nursing, préconisés par ces congrégations ? L'association de la réforme anglo-protestante du nursing à la modernité, à la science, à la professionnalisation des soins et à la laïcité n'est-elle pas abusive ? L'histoire plus détaillée de la réforme engagée dans le milieu franco-catholique permet d'apporter un éclairage différent sur l'ensemble de ces transformations. Si en effet le monde des hospitalières franco-catholiques est déstabilisé au début du XX^{e} siècle, les processus de changement qui le traversent n'en sont pas moins importants. Il est intéressant à cet égard de noter à quel point l'historiographie canadienne sur le nursing a peu pris en compte la complexité du système très élaboré mis en place par les hospitalières catholiques, pourtant fort présentes au Québec, en Alberta et dans d'autres provinces canadiennes. Ainsi, en rendant explicites les composantes protestantes et catholiques dans les différentes conceptions du care, on peut voir que la modernisation du nursing au Québec apparait davantage comme résultant de la tension entre ces deux modèles, plutôt que comme l'application du modèle anglo-protestant.

On a beaucoup insisté sur la résistance des congrégations catholiques à la « nécessaire modernisation du système de santé », amorcée au début du siècle, comme preuve de leur anachronisme. D'où l'importance de le réformer. Ainsi du côté des réformateurs se trouvent des médecins éclairés, de généreux philanthropes et des pionnières du nursing qui se trouvent en face d'une institutionnalisation très poussée des services de soins occupant tout le terrain dans les grands hôpitaux. Or si l'on étudie de près ce modèle, on voit bien que ce n'est pas tant le fait religieux qui pose problème que l'hégémonie du système mis en place par les franco-catholiques qui entrave le libre exercice des professionnels. Au contraire de ces institutions structurées et pratiquement fermées aux laïques, les hôpitaux anglo-protestants, également imprégnés de ferveur chrétienne, apparaissent plus propices au déploiement de tous ces nouveaux pouvoirs. D'ailleurs, quelques médecins et infirmières catholiques (considérés comme éclairés) n'hésiteront pas à s'associer aux réformateurs pour réclamer une plus grande place dans les conseils d'administration des hôpitaux, le contrôle et la responsabilité thérapeutiques, etc. Pour ces derniers, la modernisation des soins signifiait leur libération des contraintes souvent personnelles ou familiales, à l'égard

des patients et des directions d'hôpitaux.

La professionnalisation des soins effaçait aussi le caractère sacré et intime du rapport au patient ou de la relation d'aide, pour faire place à un rapport plus objectif, quantifiable et marchand. Ainsi l'avènement des services de soins spécialisés est activement soutenu par une croyance absolue dans le bien fondé de la science. La vocation devenant obsolète aux yeux de ces nouveaux professionnels, et ce en dépit des discours des pionnières qui recommandent toujours la dévotion et la vocation comme condition essentielle d'accès à la profession, l'on doit rapidement remplacer le discours religieux par des pratiques de soins professionnelles et scientifiques. C'est ainsi que durant toute la première moitié du XX^{e} siècle, les congrégations mettront en œuvre une série de réformes du nursing, s'engageant aussi dans l'acquisition d'une formation supérieure, la mise en place d'associations de graduées, de revues professionnelles, etc.

Le meilleur exemple est celui des Sœurs de la Charité, ou Sœurs Grises. Elles prennent rapidement une position centrale dans le réseau catholique d'éducation supérieure en nursing aux Etats-Unis et au Canada. Leur engouement pour une éducation basée sur des principes de charité et de science a longtemps dominé le milieu de l'enseignement supérieur en nursing. Leur rapide adoption des principes de professionnalisation des soins a également permis de placer une grande partie de leurs membres et de leurs diplômées, souvent laïques, à des postes de pouvoir (principalement comme directrices de soins infirmiers, gestionnaires de grands hôpitaux, à Notre-Dame, par exemple, ou comme enseignantes dans les écoles d'hôpitaux). Ainsi, elles contribuent à la forte mobilité sociale de jeunes filles venant souvent de milieux ruraux défavorisés et qui s'engagent dans des carrières fulgurantes au sein de la communauté d'abord, en dehors par la suite, comme en témoigne la carrière d'une de leurs étudiantes laïques, Alice Girard, première doyenne de la faculté de nursing.[19]

Ici, les distinctions de classes qui jouent de façon importante dans le secteur anglo-protestant du nursing, comme de nombreuses historiennes l'ont montré, opposant l'élite (blanche, bourgeoise et urbaine) du nursing aux infirmières sous-payées et peu qualifiées (rurales et pauvres), ne sont pas du même ordre dans le secteur franco-catholique, du moins avant 1947 et l'apparition des infirmières auxiliaires. C'est pourquoi il est difficile de dire si la professionnalisation du nursing représente l'imposition de la domination des femmes des classes bourgeoises sur les autres femmes, ou si elle a permis à un plus grand nombre d'accéder à une profession : le débat reste ouvert. Mais la question de l'origine de classe des infirmières me semble devoir être subordonnée aux deux autres variables, religieuses et de genre. En fait, on le voit, les modalités de fusion ou de disparition des origines religieuses du care dans le processus de professionnalisation sont quasiment achevées avant 1950. Ce qui résiste davantage, ce sont les origines genrées du care.

Épilogue : l'ambivalence en héritage (1950 à nos jours) ou comment dé-genrer le care…

Ces années de réforme ont légué un autre héritage à la profession infirmière, celui des savoirs féminins. En s'appropriant des savoirs féminins relatifs au care, les pionnières ont réussi à définir un ensemble de compétences exclusives, qui confèrent une légitimité à leur revendication d'autonomie. Cette expertise, adroite combinaison de morale religieuse et de connaissances bio-médicales fut à la base de l'enseignement du nursing pendant toute la première moitié du XX^{e} siècle. Progressivement la morale sera remplacée par l'enseignement des humanités et sciences sociales, les sciences bio-médicales prenant une place plus grande avec la spécialisation accrue. Mais c'est à partir de 1950, date à laquelle la mixité devient le discours officiel du nursing, que l'on cherche à se débarrasser à tout prix de l'identité féminine du nursing.[20,21] Parallèlement à l'effort déployé en faveur de la laïcisation complète du nursing, les associations d'infirmières ne veulent plus d'une expertise sexuée. Toute une nouvelle rhétorique entoure désormais l'acquisition des valeurs du care, incarnée par plusieurs écoles de pensée, issues surtout de la psychologie et des sciences sociales. Sous l'influence des écoles de pensée scientifiques, les références à la religion et au genre sont effacées des manuels d'enseignement et des nouvelles théories d'enseignement et de recherche en sciences infirmières voient le jour (Hildegard Peplau et Ida Orlando par exemple.[22,23]) Toutefois, il serait intéressant de comprendre pourquoi, quelles que soient ces nouvelles définitions, le caring reste aussi étroitement associé au genre féminin (que ce soit dans les pratiques infirmières, ou dans l'enseignement des sciences infirmières). Nous avons tenté de montrer ce que l'actuelle théorie du care devait aux savoirs féminins dans notre livre sur la discipline à l'université de Montréal.[24]

Dans tous les cas, la volonté de neutraliser les savoirs infirmiers (après les avoir détachés des identités personnelles et religieuses) et d'introduire la mixité dans la profession est présente depuis la fin des années 1950. Pourtant la profession infirmière reste l'une des professions les plus identifiées au genre féminin. Doit-on alors conclure avec Bourdieu que cette forte ségrégation sexuelle de la

profession infirmière est l'effet de la domination masculine ? Le modèle élaboré par Epstein[25] conclut à un processus de ségrégation professionnelle qui se reproduit et se consolide parce qu'établi sur des habitus et des représentations genrées (gender boundaries). Dans ce cas-ci, et notre étude le confirme, la profession s'est construite d'abord et avant tout sur des identités féminines (compassion, caring) et religieuses, au moins jusqu'en 1950. Les tentatives multiples des organisations professionnelles de désenclaver le nursing du féminin n'ont pas transformé radicalement ces données (que ce soit en prônant la reconnaissance de cette contribution féminine, durant la première moitié du XX^{e} siècle, ou en tâchant de la faire reconnaître comme un service neutre). Avec Joan Tronto on pourrait dire que la valorisation sociale du care, comme valeur commune non identifiée à un genre, pourrait peut-être faire sortir le nursing de cette impasse.[26] Nul doute que cette démarche, où la compassion n'est pas seulement une commodité ou un service professionnel mais aussi une valeur partagée et reconnue par l'ensemble de la société, est au cœur du questionnement contemporain sur la division sociale du travail et de l'équité dans les rapports entre les hommes et les femmes. Car le care, comme soin aux autres, est encore massivement dominé par les femmes, que ce soit dans le marché du travail rémunéré ou domestique et gratuit. Et c'est cette aliénation du travail de soin des femmes qui reste problématique. La compassion que Joan Tronto envisage comme une nouvelle morale commune risque bien d'être le prolongement de la charité judéo-chrétienne du début du siècle dernier. Si cette vision d'une morale profane peut apparaître attrayante, l'utopie serait de lui enlever en plus de son caractère sacré, son ancrage dans les identités de genre.

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Commentaire/Commentary

Michel Foucault: A Man of a Thousand Paths, a Thousand Faces, and a Thousand Emerging Relevancies – Continuing His Analyses in Pursuit of Our Present for the Sake of Our Future

RUSLA ANNE SPRINGER

> I'm perfectly aware of having continuously made shifts both in the things that have interested me and in what I have already thought… the books I write constitute an experience for me… An experience is something you come out of changed. If I had to write a book to communicate what I have already thought, I'd never have the courage to begin it. I write precisely because I don't know yet what to think… in so doing, the book transforms me, changes what I think…When I write, I do it above all to challenge myself and not to think the same thing as before… this lesson has always allowed me to conceive them as direct experiences to tear me from myself, to prevent me from always being the same (n/p).[1]

Introduction

Michel Foucault, relentless erudite scholar; militant intellectual,[2,3] borne of the tradition extending from Hegel to the Frankfurt School by way of Nietzsche and Max Weber[4] was described at the time of his death by those closest to him as a man possessing "very special difficulties".[2 p.xi] He was a complex, many-sided character, whose personality was almost impossible to discover beneath his many masks and successive disguises.[2] However, despite the seeming impossibility of discovery and the special difficulties he arguably possessed, Michel Foucault was a man with a dazzling mind, a thousand paths, a thousand faces, and a thousand relevancies. By all accounts Michel Foucault was iconic, one of the most influential of contemporary thinkers. Indeed, Foucault's intelligence was said to have known no bounds. His corpus, ceaseless and brilliant in its pursuit of the history of systems of thought, is said to be "one of the most astonishing intellectual enterprises of all time…";[5 n/p] one that has permanently altered understandings of the institutions constituting society, and

one possessing profound implications for understanding the social norms that control bodies and minds. [5] Foucault's was "an intelligence with innumerable focuses with movable mirrors, where nascent judgment was instantly doubled by its opposite, and yet without being destroyed or pulling back".[2 p329] All of this, according to one biographer, and contrary to numerous less respectful characterizations of Foucault as "anarchist, leftist, ostentatious or disguised Marxist, nihilist, explicit or secret anti-Marxist, technocrat in the service of Gaullism, new liberal"[6 p383-4), "with profound kindness and goodness"[6 p329] was Michel Foucault[2], preeminent philosopher, champion of the anti-psychiatry movement, advocate for prison reform, and hero of gay liberation.[7]

For all that Foucault's enterprise contributed to society and our understandings of who we are today, he steadfastly rejected "the canonical roles of revolutionary guru, great-and-good writer and 'master-thinker'".[5 p.viii-ix] Indeed, he persistently avoided such honoring and adamantly refused to align himself, or to be aligned, with any of the major traditions of western social thought (phenomenology, existentialism, structuralism, hermeneutics).[3,6,8-10] This distancing arose despite his early rooting in the philosophical influences of his day, which included phenomenology, Hegelianism, and Marxism. Indeed, it was the influences of Nietzsche[11] that stimulated Foucault's outright rejection of what he called the 'mindless phenomenologies of understanding' an approach which gave "absolute priority to the observing subject…which places its own point of view at the origin of all historicity – which in short leads to a transcendental consciousness".[9 p.xiv]

It was not necessarily that these approaches were not worthy. Foucault's intention was not to deny the validity of biographies. Rather, his wonderings were whether such descriptions were enough? Whether they do justice to the immensity of discourse? In his own words, he wondered,

> whether there do not exist, outside their customary boundaries, systems of regularities that have a decisive role… I should like to know whether the subjects responsible for the scientific discourse are not determined in their situation, their function, their perceptive capacity and their practical possibilities by conditions that dominate and even overwhelm them… I tried to explore scientific discourse not from the point of view of the individuals who are speaking, nor from the point of view of the formal structures of what they are saying, but from the point of view of the rules that come into play in the very existence of such discourse...[9 p.xxi-xiv]

For Foucault[9,12] it was the historical analysis of scientific discourses as those gave history to the ways in which human beings were made subjects[13] that was always the central focus of his corpus.

The questions that concerned Foucault related to the conditions under which one speaks irrespective of topic, be it illness, economics, mathematics, cosmology, science, or language, the conditions under which human beings became subjects. "What I wished to do was to present side by side, a definite number of elements: the knowledge of living beings, the knowledge of the laws of language, and the knowledge of economic facts, and to relate them to the philosophical discourse that was contemporary with them…".[9 p. x] In other words, what Foucault wished to do throughout his intellectual enterprise was to reveal the '*positive unconscious of knowledge*'; that level of knowledge that eludes consciousness and yet is part of discourse.[9] Discourse that operates beneath the consciousness of individual subjects, all the while being productive in its endeavour, productive in the sense of influencing how individuals think and talk about things. Contrary to what those Foucault castigated for obfuscating his work through the use of such polemical labels as 'structuralist' and 'post-Marxist'[5] thought, and contrary to what those who depicted him a leftist, nihilist anarchist would have us believe, Foucault was not concerned with attempting to disrupt the validity and naturalness of science.[9] What he was concerned with, however, was the problem of the subject. He was concerned with disrupting the theory of the knowing subject by revealing the rules of the scientific discourse that gave history to the subjectivation of human beings. In other words, Foucault was concerned with exposing the rules that are not present to the consciousness of the subject. He was concerned with revealing the rules that form and transform thought. Put another way, Foucault was concerned with unmasking the rules that are implanted into the minds of subjects through discourse as a means of revealing how thought, speech, actions and behaviours are rendered helpless by its power. These are the *mechanisms* of power Foucault tenaciously strove to uncover. "I am thinking rather of its capillary form of existence, the point where power reaches into the very grain of individuals, attitudes, their discourses, learning processes and everyday lives.[5 p39] For Foucault, the observing subject "should, in the last resort, be subject, not to a theory of the knowing subject, but rather to a theory of discursive practice",[9 p.xiv] that is hinged on a historically and culturally specific set of rules, systems and procedures that organize and produce different forms of knowledge.

Foucault harshly chastised those who persisted in labeling him. "I have been unable to get it into their tiny minds"[9 p.xiv]

he states, in reference to "certain half-witted 'commentators', that I have used none of the methods, concepts, or key terms that characterize structural analyses".[9 p.xiv] Indeed, Foucault[9] appealed to a more serious public to free him from such honorable connections to which he felt entirely undeserving. He insisted that he, of all people, could not claim that his discourse was independent of the conditions and rules producing the subjects we are, of which he too was subjectivated, and of which he too was largely unaware. His seemingly harsh criticism of these less serious commentators was an expression of a mounting exasperation with his critics, who from his perspective avoided the trouble of analyzing his work and the many paths it followed, instead choosing to give it "impressive-sounding, but inaccurate" labels.[9 p.xiv]

A man of a thousand paths

In response to the critique of the evolving nature of Foucault's thought, Foucault[10] did not feel the necessity to know exactly what he was. He consistently reserved the right to (re)think and (re)work his analysis.[14] "I should like this work to be read as an open site. Many questions are laid out on it that have not yet found answers; and many of the gaps refer either to earlier works or to others that have not yet been completed, or even begun".[9 p.xii] Not unlike most individuals' interests in life and work, Foucault's too was to become someone else, someone else he was not at the beginning of his project.[10] "Do not ask me who I am and do not ask me to remain the same".[8 p.xiv] In one of his many self-critiques, Foucault described his work as simply "trails to be followed".[15 p78] For Foucault, it wasn't a matter of where his work led, "indeed, it was important that they did not have a predetermined starting point or destination".[15 p78] He thought of his work as "merely lines laid down"[15 p78] for those who read his work, and indeed for himself as well, to pursue, divert, extend, or re-design as the particular need might warrant. "They are, after all, and in the final analysis, just fragments, and it is up to you or me to see what we can make of them".[15 p79] As Gutting asks in his introduction to Foucault, why do we insist on attempts to read the life into the work of Foucault when the life of Foucault can be read out of his work?[7] Indeed, Foucault's investigations of the prison, schools, barracks, hospitals, families and all organized forms of social life are the segments that guide the path to understanding Foucault and his relentless pursuit of the present.[5]

As difficult as Foucault[3,8,16,17] was to pin down he was by all accounts a massively influential, contemporary icon.[3,5,10,11,14,18,19-24] Few thinkers have registered the kind of influence across such a diverse range of disciplines as Michel Foucault.[14] The application of his multifarious approach and distinctive thoughts on discourse, power and the subject abound in the humanities and the social sciences over the past decade, appearing more regularly in texts about health, healthcare, and nursing,[25–32] thereby opening up the space for understanding aspects of health, care delivery, and the organization of nursing work in a way not routinely thought about or represented in nursing. Foucault was the "quintessential embodiment of hyper-intelligence and frustratingly difficult 'French thought'.[3 p1] His quarter century intellectual enterprise (*oeuvre*), despite its range of objections and criticisms, its good and its bad critiques, and the still only partial character of its reception,[14] can not only be read as a "revolt against the powers of 'normalization'",[2 p.x] but also as a dynamic, coherent and comprehensive history of our present.[2,9,33-6]

Questions of our present

Foucault's many and divergent writings consistently demonstrated concern with understanding the development and organization of the institutional practices that shaped human subjectivities.[14] Something he accomplished by asking questions of our present and of the contemporary field of possible experiences.[4] In doing so Foucault revealed the secrets of the institutions' disciplinary and normalizing strategies and tactics.[14] Tactics he captures in his commentary on how risky and difficult a position it is to stand outside of discourse "pondering its particular, fearsome, and even devilish features".[37 p7] In Foucault's view, it is an easier position to "be borne along, within it, and by it, a happy wreck",[37 p8] to which he argues the institution replies:

> But you have nothing to fear from launching out; we're here to show you discourse is within the established order of things, that we've waited a long time for its arrival, that a place has been set aside for it – a place which both honours and disarms it; and if it should happen to have a certain power, then it is we, and we alone, who give it that power.[37 p38]

As Gilles Delleuze commented, Foucault's emphasis upon historicity was not necessarily all about a return to antiquity; rather it was about "us today".[2 p331] Indeed, "Foucault begins where all truly original minds begin, in the present".[24 p195] Gordon[5] concurs, commenting on the abiding concern, constant throughout Foucault's work, with questioning and understanding the fluctuating possibilities, which in Foucault's view were the necessary and contingent historical limits of intellectual discourse itself. For Foucault

the major problematic and the fundamental theme of his historical studies was that of '*pouvoir-savoir*' (power and knowledge), which for Foucault was "ineluctably a fundamental question concerning our present".[5 p.viii] Foucault worked from a position of thoughtful critical reflection "which has the form of an ontology of ourselves, an ontology of the present".[4 p96] In his own words, Foucault's aim was always "to explore not only these discourses but also the will that sustains them and the strategic intention that supports them".[36 p8]

> In short, I would like…to search for instances of discursive production (which also administer silences, to be sure), of the production of power (which sometimes have the function of prohibiting), of the propagation of knowledge (which often cause mistaken beliefs or systematic misconceptions to circulate); I would like to write the history of these instances and their transformations.[36 p12]

The ongoing relevance of Foucault

It is clear that Foucault's interests always lay in examining and understanding the fabrication of the modern subject, that is, of who we are today. He was not concerned with what we should or ought to be.[38] Rather, Foucault believed that the modern subject, who will go on existing, is a fabrication made available largely through the human sciences of medicine, biology, economics, psychology, sociology, and philosophy; disciplines that will remain relevant only until they are renewed or replaced by other practices that will impose new rules that will once again form and transform the way human subjects think, speak and act.[39]

As we move forward as modern human subjects, we will always have to talk about the world in which our navigating occurs,[39] and as such Foucault's corpus will always remain relevant and pertinent. As May argues, "it will turn out, it is often the stamp of this world that, in important ways, makes me who I am, makes us who we are".[39 p11] Therefore, as our present evolves so too will our history, and it is the contingencies that shape who we become that will provide the fodder for the exploration of those unrelentingly relevant questions of who we are today. As such Foucault will not be forgotten, nor will his corpus become irrelevant or outdated. As long as there remain projects of normalization, irrespective of discipline or context, Foucault's insights into who we are in the present will remain pertinent. As May asserts, as long as humans continue the pursuit of an understanding of "what what we do as subjects does",[39 p19] that is, as long as humans strive to understand the discursive effects of their human practices on how subjectivities, including our own, are formed and transformed, controlled and surveyed, manipulated and organized in the particular ways they are, so too will Foucault remain relevant. Foucault advanced the argument this way: "People know what they do; they frequently know why they do what they do; but what they don't know is what what they do does".[12 p187] To understand this notion of 'what what people do does', among the multiple divergent paths Foucault followed to illustrate his dogged pursuit of 'the problem of the subject' he also retraced the history of 'the art of government'. He retraced, "the thousand and one different modalities and possible ways that exist for guiding men, directing their conduct, constraining their actions and reactions…".[40 p1,2]

Therefore, for all the special difficulties, the complexity of his thought, the many-sidedness of his character, and the implied impossibility of discovering who Foucault[2] was beneath his many masks and successive disguises, for those who persist in the pursuit of understanding who we are today, who persist in understanding our present, who persist in the pursuit of the way history and philosophy intersect and interact with present actuality, and who persist in the pursuit of revealing the practices that ensnare, regulate, surround, organize, strangle, manipulate, constrain, and penetrate bodies and minds, Foucault's corpus is not only elucidative for those seriously concerned with who we are today, his work in its limitlessness will remain permanently relevant.

Pursuing the present for the sake of the future

Indeed, as a society, we are indebted to Foucault's innovative methodological manoeuvre of historicizing and politicizing the knowledge of the human sciences. His work will go on offering the means to influence the future and the change required in the political, economic and institutional regimes that produce 'truth'.[41] For the sake of our future Foucault's '*oeuvre*' opens up the space needed for considering the inherited nature of our everyday, the entities of our experiences of ourselves; our individuality and subjectivities.[11] Importantly, Foucault's unappeasable pursuit of the anonymous, yet positive basis of knowledge, as it is employed in language, "grammar and philology, in natural history and biology, in the study of wealth and political economy"[9 p.xxi] offers the means to reflect deeply, to understand, and to take responsibility for the discourses that produce human practice. As Foucault contends, such an analysis is an inquiry that aims to discover on what basis knowledge becomes possible.[9] As Julianne Cheek asserts, "if we only ever try to improve what is, it may well be the case that we never look beyond the seemingly obvious to consider what might be".[42 p391] Thus, if we leave unexamined the

beliefs / assumptions that comprise our thought our capacity to resist their influence will be undermined.[43]

Indeed, in the service of society, those who are responsible to be the 'conscience of society',[20] philosophers and intellectuals, have a responsibility to continue Foucault's pursuit of the present, to perhaps fill the gaps and answer the questions left unanswered by his too early death. To make the necessary links between the political and ethical axes of his thought,[44] for the purpose of troubling the workings of the institutions imparting power/knowledge and opening up the possibility that things could be different in the future. As Cooper[20] contends, while there may be special problems for historians of the present associated with they themselves being part of the power systems that also influences them, he insists on their duty to unblock what the subtle systems of power-knowledge have invalidated by rendering too familiar, and calls upon contemporary thinkers to tell the truth, to be the '*conscience of power*' and therefore '*the conscience of society*'. Changing something in the minds of the collective, and critically reflecting upon one's own knowledge claims will surely assist in a more complete recognition and understanding of our own conformity and our own complicity,[41] and may inspire the possibility of being, doing and thinking differently.

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