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Commentary/Commentaire

Commentary

Politics of nursing leadership: reflecting on the 29th Congress of the International Council of Nurses and on nursing organizations' political role more broadly

COLLECTIVE OF AUTHORS*

The International Council of Nurses (ICN) recently held their 29th Congress in Montreal, Canada, July 1-5, 2023. It was the first in-person congress to be held by the ICN since 2019 and it was co-hosted by the Canadian Nurses Association. About 6000 nurses, nursing students and researchers from 126 countries participated in the 5-day event.

ICN purports to "represent nursing worldwide, advance the nursing profession, promote the wellbeing of nurses, and advocate for health in all policies. Our vision is that the global community recognizes, supports, and invests in nurses and nursing to lead and deliver health for all." The congress, a biannual international event, represents an important opportunity to network and meet fellow nurses from around the world. And yet, the congress did not rise to their aspirational vision. With this editorial, we wish to provide a critical perspective on the event, emphasizing what it revealed about the global politics of nursing leadership. An open and transparent discussion on political issues that affect nurses and people who require nursing care is imperative. We are thankful some of us were able to speak to colleagues in the leadership of the ICN and CNA about our concerns. However, we believe this discussion needs to be brought to, and involve, a broader nursing audience, as these issues are not limited to this particular congress or ICN itself. Furthermore, we hope to reach nurses and nursing students who may not have felt able or safe to question or critique aspects of the congress or any other nursing event.

A major observation was the noticeable disconnect between the formal professional leadership of nursing organizations, and the participants at the congress, many of them also leaders within grassroots and social justice organizations. This disconnect was particularly visible in the lack of nursing voices from Indigenous and Black communities, despite healthcare, and in particular nursing care, having been identified as key spaces that have harmed people from these communities. Opening events were filled with spectacle and pageantry. For example, Indigenous dancers were featured as entertainment during the opening ceremonies, but Indigenous nurse leaders did not participate in the opening remarks or welcome participants on their land. It was clear that cultural displays were of significant relevance but the sole focus on culture does very little to challenge the hegemony and Eurocentrism upon which our countries are built, causing harm and moral distress to a number of delegates. Many land acknowledgements were uttered by conference organizers and speakers, yet these fall flat without further calls for responsibility and accountability from organizations regarding their participation in contemporary colonial systems. Land acknowledgements are performative if not contextualized and turned into a call to action towards redress and Indigenous sovereignty (1-2). Space must be consistently made for Indigenous nursing voices leading the work on the decolonization of nursing to ensure that decolonization and anti-racist efforts undertaken by non-Indigenous nursing groups do not amount to performative allyship or perpetuate underrepresentation, tokenism, epistemic inequities, and violence (3).

Underrepresentation, exclusion and epistemic violence occurred however through the sidelining of discussions on anti-racism work within nursing, which created tension and harm for nurse attendees doing decolonial and anti-racist work. Of more than 100 sessions, only two explicitly addressed racism within nursing and the healthcare workforce: a symposium and a concurrent session (4), with a few more being relegated to e-poster presentations. The symposium, which consisted of pre-prepared questions to leaders of the American Nurses Association and the Canadian Nurses Association asked by a white woman, was fit in the program at an inconvenient and disadvantageous time (7h15 in the morning), in one of the smallest rooms of the venue. Most participants had to listen to the panel from an overflow room. This was not the first session that faced overflow issues, with people at the door guarding against further admittance to a room some attendees had specifically traveled great distances to enter. Despite the importance of this topic, the symposium lasted only one hour, leaving many questions and concerns unaddressed. Many participants left frustrated, hurt, even traumatized (5). Ultimately, the symposium conveyed a sense of self-congratulation even as it failed to really address the difficult question of racism within nursing.

Many of the volunteers were nurses from Africa or of African descent, who had paid thousands of dollars to attend and worked many hours unpaid (6), as the conference began around 7 am, and sessions wrapped up at 8:30 pm. There did not seem to be concerns regarding the disparity between the whiteness of organizers and most attendees, and the blackness of these guests who provided crucial support to the congress through their unpaid labour.

Indigenous and nurses of colour were not the only ones underrepresented, shortchanged, or excluded. Considerations of 2SLGBTQ+ persons and their needs were few, especially with consideration of trans folks (7). This was particularly painful in the context of a US Supreme Court ruling, issued just a day prior to the congress, upholding the exercise of discrimination in the name of religious liberty (8). This ruling effectively sanctions discrimination against 2SLGBTQ+ people, further eroding the civil and human rights of queer and trans people in a time of surging anti-queer and anti-trans sentiment (9-10). There was no mention on any of the panels of this particular ruling, of ongoing anti-trans media representation in Canada, the United States and the United Kingdom, of the way nurses' care to trans persons can be legally prohibited (11), or of the increasingly hostile sociopolitical and healthcare environments that harm 2SLGBTQ+ persons.

There were no sessions dedicated to transgender and gender diverse nursing care. Instead, papers on unified themes were scattered through other sessions with tenuous relevance to the other papers. Much like papers on Indigenous health, individual papers on transgender and gender diverse care were distributed in conflicting sessions with unrelated content. Content on gender equity did not address the serious issues in policy and legislation cited above nor others that were brought up in the question period, such as nursing roles and supports in working with 2SLGBTQ+ refugees and migrants. Content included some very basic terminology using dated resources, several references to American drag culture, and no acknowledgement of the concrete legislative, policy, work, or health systems barriers that trans, nonbinary, and gender and sexual orientation minorities face—including within nursing itself and within the congress itself (for example, during a talk about trans youth, two audience members were heard regendering any pronouns the presenter mentioned about their study participants). As with presentations on Indigenous health, antiracism, and decolonization, the question and discussion periods relevant to 2SLGBTQ+ care were far too short to allow for reckoning and substantial engagement with these complex issues.

In contrast, the congress afforded a wide-open space showcasing how corporate think engulfs nursing in the neoliberal rationalities and managerial logic that is contributing to the ongoing commodification of nursing practice and "services." This was apparent in the exhibition space, but it also spilled into the congress programming. For example, one of the panel discussions was about the economic value of nursing in healthcare "markets," urging nursing leaders to quantify practice and promote strategies that reduce "wasteful care" so nursing can become more visible in economic and fiscal calculations. Instead of interrogating the economic logic of nursing, the discussion prioritized the quantification of productive economic value, which functions to supress the values in relational caring and "being with" patients. This approach devalues important emotional and affective dimensions of nursing care, which become invisible and irrelevant in the discourse of profitability. From this sort of "lean" perspective, care that cannot be quantified and counted is assumed to be time wasted—a waste that should be eliminated. It also carries the risk that nurses are considered too "expensive" a resource with no particular value added and are thus deemed "seamlessly" replaceable with less costly personnel or robotics. Rather than giving nurses space to confront such widespread neoliberal ideologies and managerial rationalities that threaten the profession and its social mandate, the congress was a missed opportunity to engage nurses from around the globe in critical dialogue that collectively envisions health and social systems not predicated on reductionism, commodification, exploitation, and exclusion.

Interestingly, one the central themes of the congress was leadership. Fourteen sessions were explicitly dedicated to nursing leadership and many more alluded to it. However, leadership continues to be discussed in ways that reinforce the current state of affairs, failing to problematize how leadership and management can perpetuate critical problems in nursing, especially harmful policy orientations. This fixation with leadership, often symbolized by high level managerial positions within healthcare organizations, underscores a key problem: the disconnect between the harshest lessons learned these past few years (including in the wake of the COVID-19 pandemic) and the focus of highly visible nursing events, such as this congress.

Part of this disconnect stems from the pandemic constituting a historically significant breaking point. Throughout each wave, thousands of nurses worldwide asked their surprisingly discreet professional bodies to speak out as nurses faced both a deadly virus and equally lethal pandemic mismanagement. Yet, few organizations meaningfully answered that call, leaving nurses to fend for themselves. Despite world and health leaders' seemingly increased respect for the nursing workforce, nurses' rights and wellbeing have continued to plummet worldwide, with devastating effects. This 29th edition of the congress conveyed a sense of 'business as usual', yet there is nothing usual, nothing normal about the times we face as nurses. A profound fracture has occurred that has worsened the health outcomes of populations, communities, and nurses themselves, with the most deleterious effects disproportionately impacting persons of colour, persons with disabilities, women, gender diverse persons and persons who live in poverty. Nurses continually speak out and act against these realities, against inequities, against unsafe care practices and against dangerous work conditions—and they often pay a high price for doing so. During the pandemic in particular, their continuous efforts and advocacy to expose wrongful pandemic management decisions helped catalyze public discussions about nurses' and healthcare professionals' role in defending the public interest and became a significant driver of the development of whistleblower protection legislation worldwide (12-14). Alongside these nurse leaders on the ground, nursing organizations should have been a highly visible and vocal public contributor to these social debates but their engagement with such critical issues has been minimal, inconsistent, or nonexistent (at the time of writing, the term "whistleblowing" does not appear on the website of the ICN or the Canadian Nurses Association, for instance).

A global meeting like the ICN congress provides a crucial opportunity to take stock of such events and their brutal lessons, and to rethink how we must change in order to pursue our social mandate. But this can only happen if nursing leaders and organizations see it as a priority. Sadly, this did not seem to be the case here. For example, some of us attempted to tackle this issue through a proposal for a master class on political advocacy and leadership to address the unrest that is harming nursing and driving nurses away from the profession, only to be turned down "due to the limited number of master class slots." Yet seven master class slots were exclusively allotted to a repeat presentation on robotic assisted surgery while three others were allotted to a virtual reality platform. What made these topics so suddenly urgent for our profession that they would be given such disproportionate, privileged exposure? The fact these master classes were led by corporate sponsors provides a bitter, disappointing answer to this question.

Leadership discussions divorced from important sociopolitical questions that nurses and patients must confront everyday are an empty promise. Traditional leadership structures were developed by and for dominant structures, groups, and ideologies in nursing, following the imperialist trajectory laid out since their very beginnings. The politics of these leadership structures can only evoke transformative practices that actually reproduce new forms of managerialism, new forms of colonization and new forms of abuse (15). This gives way to an inability—or unwillingness—to question and challenge the role of organized, professionalized nursing in contemporary healthcare, economic and policy systems that harm patients, communities, and nurses.

Time and time again, nurses have shown their willingness to step up, be creative and collaborate on new scales to protect patients and care systems more broadly. But nurses need new tools—new ideas, new analyses, new advocacy, new leaders—to confront these troubling times. They also need a more powerful, more consistent presence in public realms. More than position statements occasionally disseminated through websites and social media, nurses need to see their leaders take up more space with more critical ideas in public discussions, social debates, and the media. Further, massive gatherings such as international nursing conferences are opportunities for creating a collective call to action, mobilizing and further deploying nurse advocacy and mutual aid networks, for normalizing political discourse and action, for embodying anti-racist and decolonization work, and for challenging harmful economic ideologies that corrode care systems. Grassroots nursing leaders are emerging around the world in fights for social justice, but these leaders are often not found within professional organizations. We demand accountability and more substantial action from nursing organizations themselves, through a more meaningful engagement with the politics of care and nursing leadership. Nursing activists and leaders on the ground will continue to rise and lead our profession towards greater care equity and social justice. Will nursing organizations keep up?

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Commentaire

Dimension politique du leadership infirmier : réflexion sur le 29e Congrès du Conseil international des infirmières et, plus largement, sur le rôle politique des organisations infirmières

COLLECTIF D'AUTRICES*

Le Conseil international des infirmières (CII) a récemment tenu son 29e Congrès à Montréal, au Canada, du 1er au 5 juillet 2023. Il s'agissait du premier congrès en personne organisé par le CII depuis 2019 et il était co-organisé par l'Association des infirmières et infirmiers du Canada (AIIC). Environ 6 000 infirmières, étudiants en soins infirmiers et chercheurs de 126 pays ont participé à cet événement de cinq jours.

Le CII affirme "représenter les soins infirmiers dans le monde, à faire progresser la profession infirmière, à promouvoir le bien-être des infirmières et à plaider pour la santé dans toutes les politiques. Notre vision est celle d'une communauté internationale qui reconnaît, soutient et investit dans les infirmières et dans les soins infirmiers pour montrer la voie et assurer la santé pour tous." En tant qu'événement international bisannuel, le congrès offre une occasion importante de créer des réseaux et de rencontrer des infirmières du monde entier. Et pourtant, le congrès n'a pas été à la hauteur de sa vision ambitieuse. Par le biais de cet éditorial, nous souhaitons apporter une perspective critique sur l'événement, en mettant en lumière ce qu'il a révélé sur la politique globale du leadership infirmier. Il est impératif de mener une discussion ouverte et transparente sur les enjeux politiques qui affectent les infirmières et les personnes qui ont besoin de soins infirmiers. Nous sommes reconnaissants que certains d'entre nous aient pu partager leurs préoccupations avec des collègues de la direction du CII et de l'AIIC. Cependant, nous estimons que cette discussion doit impliquer un auditoire infirmier plus large, car ces questions ne se limitent pas à ce congrès particulier ou au CII lui-même. En outre, nous espérons toucher des infirmières et des étudiants en soins infirmiers qui ne se sont peut-être pas sentis capables ou en sécurité de remettre en question ou de critiquer certains aspects du congrès ou de tout autre événement infirmier.

L'une des principales observations a été le décalage notable entre les leaders professionnels formels des organisations infirmières et les participants au congrès, dont beaucoup sont également des leaders d'organisations communautaires et de justice sociale. Ce décalage était particulièrement visible dans l'absence de voix infirmières provenant des communautés autochtones et noires, bien que les soins de santé, et en particulier les soins infirmiers, aient été identifiés comme des espaces clés dans lesquels des personnes issues de ces communautés ont subi des préjudices. Les événements d'ouverture ont été placés sous le signe du spectacle et de l'apparat. Par exemple, des danseurs autochtones figuraient comme source de divertissement lors des cérémonies d'ouverture, mais les leaders infirmiers autochtones n'ont pas participé aux discours d'ouverture et n'ont pas accueilli les participants sur leur territoire. Il était clair que les manifestations culturelles étaient d'une grande importance, mais l'accent mis uniquement sur la culture ne permet guère de remettre en question l'hégémonie et l'eurocentrisme sur lesquels nos pays sont construits, causant du tort et une détresse morale à un certain nombre de délégués. De nombreux énoncés de reconnaissance des territoires ont été prononcés par les organisateurs de la conférence et les intervenants, mais ils restent lettre morte si les organisations ne sont pas appelées à assumer leurs responsabilités et à rendre des comptes quant à leur participation aux systèmes coloniaux contemporains. La reconnaissance de territoire demeure une performance si elle n'est pas contextualisée et transformée en un appel à l'action en faveur de la réconciliation et de la souveraineté autochtone (1-2). Il faut continuellement faire place aux voix des infirmières autochtones qui mènent les efforts sur la décolonisation des soins infirmiers afin de s'assurer que les efforts de décolonisation et de lutte contre le racisme entrepris par les groupes infirmiers non autochtones ne se résument pas à une alliance performative ou ne perpétuent pas la sous-représentation, la diversité de façade, les injustices épistémiques et la violence (3).

La sous-représentation, l'exclusion et la violence épistémique se sont toutefois manifestées par la mise à l'écart des discussions sur la lutte contre le racisme dans les soins infirmiers, ce qui a créé des tensions pour les infirmières participantes impliquées dans les efforts antiracistes et de décolonisation. Sur plus de 100 sessions, deux seulement ont explicitement abordé le racisme dans les soins infirmiers et chez le personnel de la santé : un symposium et une session concomitante (4), quelques autres ayant été reléguées à des présentations par affiche électronique. Le symposium, qui consistait en des questions préparées à l'avance et posées par une femme blanche aux dirigeants de l'American Nurses Association et de l'Association des infirmières et infirmiers du Canada, a été mis à l'horaire à un moment inopportun et désavantageux (7h15 du matin), dans l'une des plus petites pièces du site. La plupart des participants ont dû écouter le panel depuis une salle de débordement. Ce n'était pas la première session sujette à des problèmes de débordement, avec des personnes à la porte empêchant toute nouvelle admission à une session à laquelle plusieurs participants espéraient spécifiquement accéder suite à un long déplacement. Malgré l'importance du sujet, le symposium n'a duré qu'une heure, laissant de nombreuses questions et préoccupations sans réponse. De nombreux participants sont repartis frustrés, blessés, voire traumatisés (5). En fin de compte, le symposium a donné l'impression d'un sentiment d'autosatisfaction alors qu'il n'a pas vraiment abordé la question difficile du racisme en soins infirmiers.

De nombreux bénévoles étaient des infirmières originaires d'Afrique ou d'origine africaine, qui avaient payé des milliers de dollars pour participer au symposium et travaillaient plusieurs heures sans rémunération (6), alors que la conférence débutait à 7h et les sessions se terminaient à 20h30. Il ne semblait pas y avoir de préoccupations liées à la disparité entre la prédominance blanche de la majorité des organisateurs et participants, et la prédominance noire de ces femmes qui fournissaient un soutien clé au congrès grâce à leur travail non rémunéré.

Les infirmières autochtones et de couleur n'étaient pas les seules à être sous-représentées, lésées ou exclues. Les personnes 2SLGBTQ+ et leurs besoins ont été peu abordés, surtout en ce qui concerne les personnes trans (7). Ceci était particulièrement blessant dans le contexte d'un arrêt de la Cour suprême des États-Unis, rendu la veille du congrès, confirmant l'exercice de la discrimination au nom de la liberté religieuse (8). Cet arrêt sanctionne véritablement la discrimination à l'encontre des personnes 2SLGBTQ+, érodant encore davantage les droits civils et humains des personnes queer et trans à une époque où les attitudes anti-queer et anti-trans montent en flèche (9-10). Aucune des tables rondes n'a fait mention de cette décision particulière, de représentations médiatiques anti-trans persistantes au Canada, aux États-Unis et au Royaume-Uni, de la manière dont les soins prodigués par les infirmières aux personnes trans peuvent être légalement prohibés (11), ou des environnements sociopolitiques et sanitaires de plus en plus hostiles qui nuisent aux personnes 2SLGBTQ+.

Aucune session n'a été consacrée aux soins infirmiers aux personnes transgenres et à la diversité des genres. Au lieu de cela, des présentations sur des thèmes communs ont été disséminées dans d'autres sessions avec une pertinence minimale avec les autres présentations. À l'instar des présentations sur la santé des personnes autochtones, les présentations individuelles sur les soins aux personnes transgenres et fondés sur la diversité des genres ont été réparties dans des sessions se déroulant en même temps, avec du contenu non relié. Le contenu sur l'équité fondée sur le genre n'a pas abordé les graves problèmes de politique et de législation cités précédemment ou les problèmes soulevés dans la période de questions, tels que les rôles et les soins infirmiers aux personnes 2SLGBTQ+ réfugiées et migrantes. Le contenu comprenait une terminologie élémentaire s'appuyant sur des sources obsolètes, plusieurs références à la culture « drag » américaine, et aucune reconnaissance des obstacles législatifs, politiques, professionnels ou issus des systèmes de soins auxquels sont confrontées les personnes trans et non-binaires et les minorités de genre et d'orientation sexuelle – y compris au sein des soins infirmiers et du congrès lui-même (par exemple, pendant un exposé sur les jeunes trans, deux membres de l'auditoire s'employaient à re-genrer tous les pronoms mentionnés par la présentatrice au sujet de ses participants de recherche). Comme pour les présentations sur la santé autochtone, l'antiracisme et la décolonisation, les périodes de questions et de discussions sur les soins aux personnes 2SLGBTQ+ étaient beaucoup trop courtes pour permettre une réflexion et un engagement substantiel envers ces questions complexes.

En revanche, le congrès a offert un large espace illustrant la manière dont la pensée entrepreneuriale engloutit les soins infirmiers dans les rationalités néolibérales et la logique managériale qui contribuent à la marchandisation des pratiques et des « services » infirmiers. Ceci était évident dans l'espace d'exposition, mais cela s'est également répercuté sur la programmation du congrès. Par exemple, l'une des tables rondes portait sur la valeur économique des soins infirmiers sur les « marchés » des soins de santé, invitant les leaders infirmiers à quantifier les pratiques et à promouvoir des stratégies visant à réduire les soins jugés « source de gaspillage » afin que les soins infirmiers puissent devenir plus visibles dans les calculs économiques et fiscaux. Au lieu d'interroger la logique économique des soins infirmiers, la discussion a donné la priorité à la quantification de la valeur économique productive, ce qui a pour effet d'étouffer les valeurs inhérentes aux soins relationnels et au fait « d'être avec » les patients. Cette approche dévalorise les dimensions émotionnelles et affectives des soins infirmiers, qui deviennent invisibles et délégitimées dans les discours de la rentabilité. Dans cette sorte de perspective « lean » les soins qui ne peuvent être quantifiés et comptés sont considérés comme une perte de temps – un gaspillage qu'il convient d'éliminer. Cela comporte également le risque que les infirmières soient considérées comme une ressource trop « coûteuse », sans valeur ajoutée particulière, et qu'elles soient donc jugées remplaçables tout simplement par du personnel moins coûteux ou par des technologies robotisées. Plutôt que de donner aux infirmières un espace pour affronter ces idéologies néolibérales tant répandues et ces rationalités managériales qui menacent la profession et son mandat social, le congrès a été une occasion manquée d'engager les infirmières du monde entier dans un dialogue critique qui envisage collectivement des systèmes sociaux et de santé non fondés sur le réductionnisme, la marchandisation, l'exploitation et l'exclusion.

Il est intéressant de noter que le leadership constituait l'un des thèmes centraux du congrès. Quatorze sessions ont été explicitement consacrées au leadership infirmier et de nombreuses autres y ont fait allusion. Cependant, le leadership continue d'être discuté d'une manière qui renforce l'état actuel des choses, sans problématiser la façon dont le leadership et la gestion peuvent perpétuer des problèmes critiques en soins infirmiers, en particulier des orientations politiques néfastes. Cette fixation sur le leadership, souvent symbolisé par des postes de direction de haut niveau en milieux de soins, met en évidence un problème clé : le décalage entre les leçons les plus dures des dernières années (notamment dans la foulée de la pandémie à la COVID-19) et l'objet d'événements infirmiers notoires, tels que ce congrès.

Ce décalage s'explique en partie par le fait que la pandémie a constitué un point de rupture historique. À chaque vague, des milliers d'infirmières à travers le monde ont demandé à leurs organisations professionnelles, étonnamment effacées, de se manifester alors que les infirmières étaient confrontées à la fois à un virus mortel et à une gestion de la pandémie toute aussi létale. Pourtant, peu d'organisations ont répondu de manière significative à cet appel, laissant les infirmières se débrouiller seules. Malgré le respect apparemment accru des dirigeants mondiaux et du secteur de la santé pour le personnel infirmier, les droits et le bien-être des infirmières ont continué à se dégrader dans le monde entier, avec des effets dévastateurs. Cette 29e édition du congrès a donné une impression « comme si de rien n'était », alors qu'il n'y a rien d'habituel, rien de normal dans les temps que nous vivons en tant qu'infirmières. Une fracture profonde s'est produite, qui a aggravé l'état de santé des populations, des communautés et des infirmières elles-mêmes, les effets les plus délétères touchant de manière disproportionnée les personnes de couleur, les personnes handicapées, les femmes, les personnes d'identités de genre diverses et les personnes vivant dans la pauvreté. Les infirmières ne cessent de dénoncer et d'agir contre ces réalités, contre les inégalités, contre les pratiques de soins non sécuritaires et contre les conditions de travail dangereuses, et elles en paient souvent le prix fort. Pendant la pandémie en particulier, leurs efforts continus et leur plaidoyer pour dénoncer les décisions erronées de gestion de la pandémie ont contribué à catalyser des discussions publiques sur le rôle des infirmières et des professionnels de la santé dans la défense de l'intérêt public, et ils ont été un moteur essentiel du développement, à travers le monde, de législation protégeant les lanceurs d'alerte (12-14). Les organisations infirmières auraient dû être un contributeur public très visible et vocal à ces débats sociaux aux côtés de ces infirmières leaders sur le terrain, mais leur engagement sur ces questions critiques a été minimal, incohérent, voire inexistant (au moment de la rédaction du présent éditorial, les termes relatifs à la divulgation, la dénonciation ou les lanceurs d'alerte n'apparaissaient pas sur les sites web du CII ou de l'Association des infirmières et infirmiers du Canada, par exemple).

Une rencontre mondiale comme le congrès du CII offre une occasion cruciale de faire le point sur ces événements et leurs leçons brutales, et de repenser la manière dont nous devons changer pour poursuivre notre mandat social. Mais cela ne peut se faire que si les dirigeants et organismes infirmiers le considèrent prioritaire. Malheureusement, cela n'a pas semblé être le cas ici. Par exemple, certains d'entre nous ont tenté de s'attaquer à ce problème en proposant une classe de maître sur le plaidoyer et le leadership politiques, afin de contrer le malaise généralisé qui nuit aux infirmières et fait fuir plusieurs d'entre elles de la profession – une proposition qui s'est soldée par un refus "en raison du nombre limité de classes de maître". Pourtant, sept de ces classes ont été exclusivement attribuées à une présentation répétée sur l'assistance robotisée en chirurgie, tandis que trois autres ont été allouées à une plateforme de réalité virtuelle. Qu'est-ce qui rend ces sujets si soudainement urgents pour notre profession qu'ils bénéficient d'une exposition aussi disproportionnée et privilégiée ? Le fait que ces classes de maître aient été animées par des entreprises commanditaires apporte une réponse amère et décevante à cette question.

Toute discussion sur le leadership dissociée des questions sociopolitiques importantes auxquelles les infirmières et les patients font quotidiennement face est une promesse creuse. Les structures traditionnelles de leadership ont été développées par et pour les structures, idéologies et groupes dominants dans le domaine des soins infirmiers, suivant une trajectoire impérialiste tracée depuis le tout début. Le caractère politique de ces structures de leadership ne peut que susciter des pratiques transformatrices qui reproduisent en réalité de nouvelles formes de managérialisme, de nouvelles formes de colonisation et de nouvelles formes d'abus (15). Il en résulte une incapacité – ou un manque de volonté – de remettre en question le rôle d'organisations infirmières professionnalisées vis-à-vis les systèmes de soins de santé, économiques et politiques contemporains qui nuisent aux patients, aux communautés et aux infirmières.

À maintes reprises, les infirmières ont montré leur volonté d'agir, d'être créatives et de collaborer à de nouveaux niveaux pour protéger les patients et les systèmes de soins de manière plus large. Mais les infirmières ont besoin de nouveaux outils – de nouvelles idées, de nouvelles analyses, de nouvelles formes de plaidoyer, de nouveaux leaders – pour faire face à cette période trouble. Elles ont également besoin d'une présence plus puissante et plus cohérente dans les sphères publiques. Au-delà des prises de position diffusées occasionnellement sur les sites web et les médias sociaux, les infirmières ont besoin de voir leurs dirigeants prendre plus de place avec des idées plus critiques dans les discussions publiques, les débats sociaux et les médias. En outre, les grands rassemblements tels que les conférences infirmières internationales sont autant d'occasions de lancer un appel collectif à l'action, de mobiliser et de déployer davantage les réseaux infirmiers d'advocacy et d'entraide mutuelle, de normaliser les discours et l'action politiques, d'incarner les luttes antiracistes et de décolonisation, et de remettre en question les idéologies économiques néfastes qui corrodent les systèmes de soins. Partout dans le monde, des leaders infirmiers émergent sur le terrain dans les luttes pour la justice sociale, mais ces leaders ne sont souvent pas présents au sein des organisations professionnelles. Nous demandons aux organisations infirmières de rendre des comptes et de prendre des mesures plus substantielles, en s'engageant de manière plus significative dans les aspects politiques des soins et du leadership infirmier. Les militants et les leaders infirmiers sur le terrain continueront à s'élever et à mener notre profession vers une plus grande équité des soins et une plus grande justice sociale. Les organisations infirmières suivront-elles?

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Abstract

Improving the rates of breastfeeding has been a prime interest of Public Health Nurses focusing on health promotional strategies as outlined by the World Health Organization. However, evidence of the perceptions held by perinatal families regarding the encouragement to breastfeed is lacking. With the goal of uncovering existing research, an integrative review was conducted, retrieving nine studies. Themes included: variables of delivery (beliefs and ambiguity), outcomes of receivers (expectations, emotions, empowerment versus pressure), and contextual factors (social, cultural, and political forces). Notable differences between the experiences of parents in differing social locations were found. The results demonstrate a need for professionals and policymakers to consider the nuanced ways in which individuals experience breastfeeding health promotional messaging. Unintended impacts of this strategy potentially widen breastfeeding inequities between the groups most and least advantaged in society. The diversity of Canadians was found to be vastly underrepresented in the literature.

Key Words Breastfeeding, Health Education, Health Promotion, Public Health

Contextualizing the Health Promotion of Breastfeeding: An integrative Review of Parent and Provider experiences in Canada

HERMANDEEP DEO, EMMANUELA OJUKWU & GEERTJE BOSCHMA

Background

Breastfeeding is a protective factor in the health of breastfeeding parents and their infants (1). However, the rates of breastfeeding tend to be particularly low in high income countries (2). The World Health Organization (WHO) recommends exclusive breastfeeding until 6 months of age, with continued breastfeeding until 2 years and beyond (3). Despite the variation of policy documents among the health authorities in Canada, the general health information regarding breastfeeding promotion is based upon the recommendations from WHO and Health Canada. The Canadian Community Health Survey in 2011-2012 found variations in breastfeeding rates across the country, with the province of British Columbia (BC) having the highest rate of exclusive breastfeeding for 6 months or more (41%), and the province of Quebec having the lowest incidence (19%) (4). This large discrepancy suggests a need to better understand the unique needs of different groups of parents in Canada preventing the ideal rates of exclusive breastfeeding from being achieved. In 2018, the Government of Canada announced an investment of $1.3 billion into promoting breastfeeding by increasing the application of the Baby-Friendly Initiative (BFI) across the country (5). The BFI is a set of guidelines initiated by the WHO and United Nations International Children's Emergency Fund (UNICEF) aimed towards increasing the rates of breastfeeding (5). Still, responses are mixed.

Despite data quantifying the rates of breastfeeding throughout the implementation of these guidelines around the world, we lack data exploring the qualitative experiences of how this health messaging is being delivered and received. Providers of this health messaging range from nurses and physicians to dieticians and lay professionals providing support to perinatal individuals, and their modes of deliveries may differ among themselves and impact how such messaging is received by the parent. There is also a large range of knowledge levels of care providers that provide infant feeding support and education. Formal education programs for care providers of breastfeeding support with standardized, approved curricula are available, however to a limited degree (6). The International Board of Lactation Consultant Examiners (IBLCE) has a certification process that provides specialized knowledge for care providers (7). However, a large variety of care providers provide breastfeeding support as a small portion of their overall scope, and therefore do not receive specialized training unless they seek it out (6). Moreover, we need nuanced understandings of the effects of social, cultural, and political structures intersecting with the promotion of breastfeeding. With overall breastfeeding rates far below WHO standards, there is opportunity to not only improve rates, but also quality of care through improved understanding of the reception of messaging. Additionally, the ways in which these rates are measured is also worth re-considering (8). Measurements of health promotion interventions need to include an evaluation of the effects of this intervention on different groups and the potential inequalities embedded throughout these effects (9). Without an evaluation of how different populations experience a health promotional strategy and their various contexts, the health equity gap between the individuals most and least advantaged in society may widen (9).

A review provides an opportunity for further exploration leading to recommendations and potential interventions that may bring nuance to breastfeeding promotion guidelines and provide further insight into the barriers preventing ideal breastfeeding rates from being achieved. Through this review, we seek to gain a deeper understanding whether the current approach serves some populations more than others, thus creating inequities in breastfeeding outcomes, and inadvertently disadvantaging parents who might for various reasons not be able to breastfeed. The main purpose of this integrative review is twofold: to explore existing evidence on the experiences and perceptions of the parents receiving this health messaging, and, in addition, to examine the perspectives of the care providers delivering this messaging in accordance with the dominant breastfeeding guidelines outlined above.

The terms used in this review include ‘breastfeeding parent’, ‘parent’, ‘perinatal individual’, and ‘care provider’. The term ‘breastfeeding parent’ refers to a parent who is breastfeeding either partially or exclusively. The term ‘parent’ is used to be inclusive of parents regardless of breastfeeding status. The term ‘perinatal individual’ includes parents and expected-parents within the spectrum of the perinatal stage. The term ‘care provider’ refers to various healthcare professionals and lay professionals such as nurses, physicians, dieticians, and lactation consultants.

In qualitative studies conducted in Scotland and England exploring experiences of breastfeeding parents, themes identified included: mixed and missed messaging, clashes between idealism and realism in terms of expectations, emotional costs, pressure and judgment for feeding choices, and the identity formation of a ‘good mother’ (10-13). One study found that breastfeeding parents in the United Kingdom (UK) expressed the need to improve the health promotion messaging by moving away from the ‘breast is best’ phrase, as such language was perceived to frame breastfeeding as a high, unachievable standard for all individuals (14). In contrast, parents preferred the promotion to focus on the normalcy of breastfeeding (14). Calls have been made for research into the relational aspects of breastfeeding interventions, specifically the ways in which health messaging and language are perceived (15). Other themes that emerged among parents in the UK in a 2016 qualitative study included: shifting the focus of education away from health impacts, encouraging the importance of each feed rather than just the need to exclusively breastfeed, being honest about the challenges, and extend education to other members of society as well (14).

Other concerns were raised with breastfeeding being socially constructed as a moral obligation of mothers, thus, being defined as a pivotal aspect of maternal identity formation (16). In Northern Ireland, researchers found a higher risk of alienation among parents who had accepted the moral imperative of ‘breast is best’ messaging but were unable to meet the goals of exclusive breastfeeding (17). Alienation was found to be a risk factor for postnatal depression (17), leading to negative behavioural health effects for both children and parents (e.g., depression, reduced quality of functioning, coping abilities and enjoyment of parenting) (18,19). Failure to meet the moral standard of exclusive breastfeeding may be internalized as failing at parenthood, which can be further unpacked through the concept of shame (20). Negative emotions, such as feelings of shame arising from breastfeeding challenges, can further hinder the ability to breastfeed due to the distress faced by a parent unsuccessfully attempting to latch their baby to the breast (21).

Experiences of Canadian parents are not well documented. Developing critical research from other countries conveys the need for a critical review of the health messaging of breastfeeding in Canada, particularly, how social, cultural, and political structures may affect different populations. Therefore, the scope of this integrative review is the examination of existing studies exploring the ways in which health promotion of breastfeeding is perceived by different populations within Canada, inclusive of both the receivers of the messaging and those delivering the messaging.

Methodology

The selected method of review for this topic is an integrative literature review. Torraco (22) differentiates this type of review from others by focusing on the creative process of synthesizing information from different perspectives and introducing a framework that has not been comprehensively used in studying the topic. The goal is to integrate existing notions with different ideas to construct a perspective that will influence future directions of research and policymaking (22).

We have used a feminist intersectionality framework. Bowleg (23,p.1) describes "Intersectionality [as] a theoretical framework that posits that multiple social categories (e.g., race, ethnicity, gender, sexual orientation, socioeconomic status) intersect at the micro level of individual experience to reflect multiple interlocking systems of privilege and oppression at the macro, social-structural level (e.g., racism, sexism, heterosexism)." Hankivsky and Christoffersen (24) argue that intersectionality is necessary to complicate analyses of Canadian health determinants to better understand how existing inequities among social groups lead to further inequities in health. While much literature exists regarding the concept of breastfeeding through the lens of feminism, we instead situate our review upon the works of Crenshaw (25) and hooks (26) acknowledging the problematic historical privileging of white women in gendered issues when utilizing a single-axis feminist lens. Therefore, the intersectional feminist lens used throughout this review aims to disrupt the singular gendered view of infant feeding.

The search strategy used to obtain relevant studies involved three databases: the American Psychological Association (APA) PsychInfo, the Cumulative Index to Nursing and Allied Health Literature (CINAHL), and the PubMed database. These databases were selected with the goal of garnering perspectives from the disciplines of nursing, psychology, and the medical community. The truncated term "breastfeed" was used with Boolean operators of AND in conjunction with OR to include the terms of "promotion" OR "education" AND "Canada" OR "Canadian". These terms were selected due to the interchangeability between promotion or education when referring to breastfeeding promotional guidelines. The results were further narrowed down through the limiters of full text or peer reviewed journals only, with the time frame set to the last decade, and English as the language of publication. The latter decision was made due to the authors' limited capacity in other languages. The decision to limit the range of years to ten was made to capture the experiences based on current social and political trends.

Initial search results were reviewed by the first author in May 2021 through careful reading of article titles and abstracts to determine which articles could be excluded from the review. The inclusion criteria included: studies exploring the experiences of either providers of or parents receiving messaging in relation to breastfeeding, studies conducted in Canada, published within the last ten years (2011/01/01-2021/05/01), and in the English language. Ultimately, sixteen (n=16) articles were retrieved from these initial results. These articles were reviewed by reading through the full text to determine if inclusion criteria (Table 1) were met, resulting in exclusion of another seven articles, leaving a total number of nine selected articles (28-36). The seven excluded articles focused either on solely measuring rates of breastfeeding, reasons for early cessation of breastfeeding, or the barriers and facilitators of implementing breastfeeding guidelines on units from a leadership perspective, but did not include inquiry into the ways health promotion of breastfeeding was perceived or experienced.

The selected studies differentiate between locations across Canada, study designs, theoretical frameworks, and the populations being studied. Three out of the nine studies focused on experiences of providers, mostly Public Health Nurses (PHNs). Five focused on perinatal individuals with varying socio-economic positionality, and one study included PHNs and mothers. The study designs include qualitative methods (n=7) and mixed methods (n=2).

Results

The results of the review have been categorized into the following themes: variables of delivery, outcomes of receivers, and contextual factors (Figure 1). This approach aligned with the integrative review process described by Whittemore and Knafl (27) of holistically representing a problem in healthcare through the extraction of variables and themes, and the subsequent displaying of such themes in a visual map of emerging concepts. We did this by reviewing the themes presented in the individual studies, and then comparing these themes across all the included studies to create links as shown in Figure 1. Variables of delivery are derived from the data gathered from the healthcare providers delivering the health promotion of breastfeeding; outcomes of receivers result from

Table 1. Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
• Qualitative, quantitative, or mixed methods • Studies exploring the experiences of either providers of or perinatal individuals receiving messaging in relation to breastfeeding • Studies conducted in Canada • Published within the last 10 years (2011/01/01-2021/05/01) • Published in the English language	• Studies conducted outside of Canada • Studies solely measuring rates of breastfeeding • Published more than 10 years ago • Systematic reviews

data gathered from perinatal individuals who have received health promotion messaging related to breastfeeding; and contextual factors include the overarching cultural, social, and political forces that came to light throughout both accounts. These concepts are visually presented as rotating gears (Figure 1) that may appear to be separate components at first glance but are all interconnected. Movement or changes in one component result in changes in the others and vice-versa. The size of each gear is representative of the weighting of each component. We determined these sizes based upon the number of times these themes were seen throughout our review.

Our analysis reviewed the following themes: variables of delivery, outcomes of receivers, and contextual factors with additional sub-themes identified among the studies in this review (Figure 1).

Variables of Delivery - Ambiguity and Beliefs

In the four studies exploring the experiences of providers (28-31) two key phenomena were observed. Firstly, ambiguity, both about the role of the provider and about their understanding of breastfeeding promotion. Secondly, studies noted the beliefs the providers carried with them from their personal and practical experiences with breastfeeding. In these four studies (28-31), the perceptions and views of the care providers demonstrate the ways in which current dominating practices fall short in representing the diversity of the perinatal individuals receiving their care, further evidenced by three studies (32-34) qualifying such recipients of care. The goal of uncovering these shortfalls is not to place blame on individual providers, but instead to critically shed light on the potential gaps in guidance for such providers to decrease the various interpretations and beliefs currently preventing a unified practice.

The participants in the studies representing care providers included Public Health Nurses (PHNs) (28,31), perinatal nurses (29), and other professional and peer providers (30). The studies were conducted in different Canadian provinces, focusing on different components of breastfeeding promotion. The key similarity among these four studies was how participants held differing beliefs about the concepts under exploration, resulting in differing practices. These components included practical applications of culturally competent care (28), health literacy (30), the Baby-Friendly Hospital Initiative (BFHI) (29), and breastfeeding care specific to late preterm infants (LPI) (31).

Nurses in two of the studies (29,31) highlighted the challenges they faced due to the inconsistent, and at times, conflicting information perinatal individuals received from care providers regarding breastfeeding. In a study conducted in Quebec for example, a province where the rate of exclusive breastfeeding at six months of age is low (4), perinatal nurses noted a lack of consistency amongst healthcare providers along the continuum of perinatal care regarding breastfeeding education (29). They expressed a lack of effectiveness in in-hospital advice provision due to conflicting information being provided prior to admission (29). This finding adds to the overall theme of ambiguity in the provision of breastfeeding education among care providers. To address the variations in messaging received by parents, Dosani and colleagues (31) concluded additional training is needed for providers regarding breastfeeding challenges, in addition to the adoption of a more coordinated approach within the healthcare team, inclusive of acute and community providers. This recommendation arose from the responses of PHNs reporting that the initiation of breastfeeding was both complex and crucial for successful breastfeeding (31). Due to this complexity, they felt a coordinated response from the healthcare team was also needed (31). The PHNs expressed further challenges in providing education to parents due to the unique complexity associated with LPIs (31). The researchers suggest PHNs provide education to parents to include the LPI's developmental stages and brain development related to breastfeeding to explain the challenges and thus providing reasoning behind the difficulties (31).

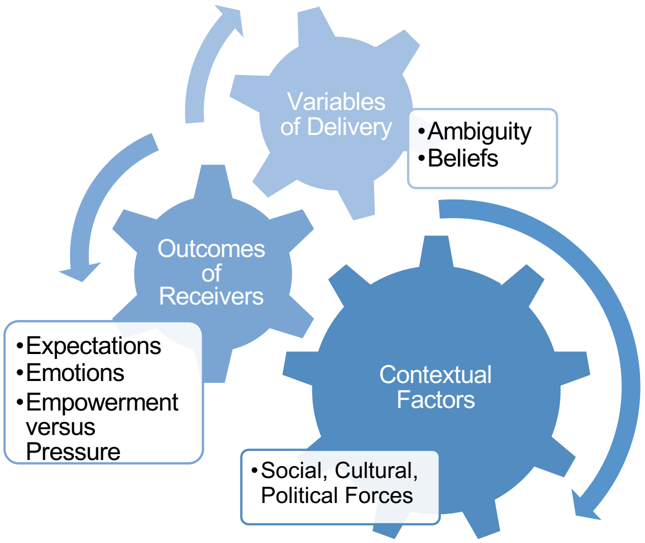

Figure 1. Concept Map of Results.

Chabot and Lacombe (29) explored the potentially positive impact of the Baby-Friendly Hospital Initiative (BFHI). One hundred and fifty-nine (n=159) perinatal nurses responded to a survey using convenience sampling, with the theory of planned behaviour (TPB) serving as the theoretical basis for the study (29). The TPB helped to understand the perceived controllability and perceived difficulty of implementing the intervention (29). The BFHI requires strict adherence to a set of steps (29). The nurses who believed they could overcome the difficulties associated with meeting all these standards were more likely to adopt the intervention (29). On the receiving end, participants in studies exploring the experiences of perinatal individuals confirmed receiving messages that varied depending on the individual care provider (32-34). Of note, Crenshaw (25,p.49) argues the need to "develop language which is critical of the dominant view and which provides some basis for unifying activity".

In the studies focusing on parents (32,33), care providers' beliefs appeared to affect the care being received. In the NICU environment, some parents experienced breastfeeding support differently depending on whether it was delivered by the nurses on the unit or the lactation consultants (32). The nurses were described as reassuring, knowledgeable, and supportive in the relationships they built with the mothers (32). Interestingly, the lactation consultants were described by some parents as pressuring and overly enthusiastic (32). The parents felt their needs were secondary to lactation consultants' goals of meeting breastfeeding targets and outcomes, thus perceiving their role in a negative light (32). In another study (33) featuring participants from a community-based program, lactation consultants in this context were perceived to be empathetic and encouraging, with supportive factors being home visits and providers' attitudes. However, participants did report negative experiences due to conflicting information and opinions received from other care providers and support persons (33). The high prevalence of conflicting information was also noted by parents in another study (34), with one participant stating "Prenatal classes say something, the nurse at the hospital said something, the [community clinic] nurse said something else... I had three different health professionals, three different messages… at a point you start wondering what is happening." (34,p.4) Researchers (34) found this report to be more common amongst parents who attended sites with low implementation of BFI.

In rural Nova Scotia, Gillis and colleagues (30) examined the engagement of health literacy within health promotion practices around breastfeeding from the perspectives of care providers along the continuum of perinatal health. They noted lower rates of breastfeeding and literacy levels in rural areas of Atlantic Canada, as compared to averages among the rest of the country (30). The participants included a range of professional and peer providers (30). Part of the challenge in implementing health literacy in health education is the lack of a clear conceptual definition (30). For this study, the researchers (30) defined health literacy as described by Zarcadoolas and colleagues, which encompasses the domains of fundamental, scientific, cultural, and civic literacy. The participants of this case study demonstrated varying beliefs within the concept of health literacy and how it applied to breastfeeding promotion (30). Fundamentally, a key belief arising in the study was health literacy often being perceived by participants as a deficit preventing those with lower rates from adequately accessing health information. Within the scientific domain, contrasting beliefs presented among practitioners: while some practitioners valued the scientific component of breastfeeding and the need to provide this scientific basis to clients, others believed the use of medical terminology hindered understanding of breastfeeding information (30). In the instances of practitioners utilizing the medical terminology, there was a lack of intervention noted for situations of clients not being familiar with these terms. Ambiguity was also quite evident in this study, specifically through the lack of consensus among participants regarding the understanding of health literacy. Different components of health literacy were being applied by different practitioners, with the domains of cultural and civic literacy being the least engaged with (30). Discussion of the two latter components is included in the contextual factors section below.

McFadden and Erikson (28) explored breastfeeding health promotion through a critical lens, with the aim of uncovering processes of racialization present in the care provided by PHNs in a western Canadian health authority. Study participants included PHNs with varying ethnocultural diversity (28). A quarter of these participants identified that English was not their first language, and a third of them reported as having migrated to Canada (28). Although data about race was not gathered, "many participants disclosed their personal identifiers including terms such as 'white,' 'Caucasian,' 'European,' 'Chinese,' and 'Filipino.'" (28,p.E15). PHNs' age spanned between mid-20s to late-50s. All participants expressed their belief in the benefits of breastfeeding (28). Additionally, most PHNs conveyed their application of breastfeeding support differed from one mother to the next, but they did not feel the differences were due to breastfeeding inequities or resulting in a lower quality of care; rather their belief was rooted in their intention to provide culturally competent care (28). Close to half of the participants held stereotypes about clients' culture and race through clients' documented last name, despite not having had any interaction with the clients at that point in time (28). These stereotypes were linked to preconceived notions of the client's race and that race's (presumed) breastfeeding practices; for example Chinese mothers and their assumed breastfeeding decisions. One nurse believed the phrase 'no milk syndrome' was a common belief held by Asian women (28). This 'syndrome' refers to the misconception that Asian women cannot produce enough breastmilk due to having smaller breasts than white women (28). This nurse did not believe this 'syndrome' to be biologically true but did view it as the shared cultural perspective of all Asian women, and therefore altered the care she provided believing she was providing culturally sensitive care (28). Furthermore, this stereotype ties into the assumption held by some nurses that Asian mothers would choose to either mix feed or exclusively formula feed, but not exclusively breastfeed. The beliefs held by individual nurses affected the infant feeding support they provided to individual parents.

Ambiguity is evident in the study conducted by McFadden and Erikson (28) in the conflicting forces affecting nursing practice. On the one hand, the WHO guidelines are based on the premise that all women are equal with regards to breastfeeding. In contrast, the widely taught notion of cultural competence instills the idea of cultures being different and the need to respect such differences. This ambiguity leads to unclear direction for the nurses providing care to women outside the dominant culture, and it inappropriately serves the women being cared for. The racialization evident in this ethnography (28) manifested in the ways the nurses believed they provided culturally competent care, including by using stereotypes to guide the support provided. At times, nurses would provide information regarding formula feeding to Chinese mothers without first assessing these mothers' feeding plan, which differed from their care of non-Chinese mothers (28). Nurse participants in this study did not see their differential treatment of Asian mothers as a form of breastfeeding inequity, but instead viewed themselves as providing care in line with their knowledge of Chinese culture (28). PHNs may not be aware that they are racializing the care they provide, but the unconscious beliefs underlying their care need to be addressed to lessen the impact of stereotypes held against some cultures and to improve the quality of care being provided to all individuals. This ethnography (28) exemplifies the intersection between infant feeding and race.

Exploring Receivers' Perspectives - Expectations, Empowerment versus Pressure, and Emotions

Experiences of the perinatal individuals receiving the health promotion messaging regarding breastfeeding have also been studied. Key themes identified in these studies (n=6) are expectations, empowerment versus pressure, and emotions (31-36). The expectations arise from the messages received by the perinatal individuals from various sources, including their environments, individual care providers, and broader society. In turn, these expectations may be interpreted as empowering to navigate and overcome the challenges associated with breastfeeding or they may be internalized as pressure to provide breastmilk to their infant despite other barriers. This interpretation provokes strong positive or negative emotions depending on whether empowerment is experienced or pressure is felt, respectively. As represented by the gears in Figure 1, changes in the variables of delivery affect the outcomes of receivers.

The theme of expectation is evident in four of the studies (31-34) included in this review. Brockway and colleagues (32) explored the 'maternal' experience in Alberta NICUs in relation to feeding preterm infants, through interviews with 14 parents identifying as 'mothers', with breastfeeding self-efficacy (BSE) theory guiding their research. A key theme was the institutional forces of the NICU affecting the parents (32). They perceived an unstated expectation that the needs of the infant eclipsed the health needs of the parent in the NICU, both mentally and physically (32). This expectation resulted from the policies in place to support the medical goals of weight gain among the infants (32). The parents felt the NICU environment reinforced the belief that their importance was merely reduced to their ability to produce breastmilk (32). The NICU environment was described as celebrating the production of breastmilk, rather than parents' efforts to meet these production standards (32). The term 'getting enough' was commonly used by the parents when referencing the success of their feeding attempts, specifically through measurable indicators of infant weight gain or the amount of breastmilk ingested by the infant (32). Parents who had left the NICU with a pumping plan experienced a large disconnect between their expectations and reality (32). The plans did not account for the overwhelming nature of managing care to an infant while pumping and breastfeeding (32).

Francis and colleagues (33) utilized focus groups and individual interviews to explore experiences of perinatal individuals participating in a community-based lactation support program located in Toronto, Ontario. This program includes breastfeeding support and education provided by lactation consultants, PHNs, and dieticians, as well as referrals to community resources, childcare support, access to a food bank, and vouchers for public transportation and grocery stores (33). Seventy-five percent (75%) of the study participants were below the Canadian low-income threshold and 85% were born outside of Canada (33). The researchers explored participants' experiences with breastfeeding in relation to the support they received (33). The key themes involved parents' feeling unprepared for the physical and practical challenges of breastfeeding, such as discomfort resulting from painful or cracked nipples, engorgement, mastitis, milk supply concerns, or a poor latch, and medical reasons for formula supplementation such as slow weight gain or jaundice (33). Practical challenges focused on the ways in which breastfeeding did not align with parents' life context, revealing a disconnect between previous expectations and the reality of the overall breastfeeding experience (33). The time commitment required to breastfeed was noted as another challenge, often in competition with the time needed for parents' other commitments (33).

Other researchers (31) explored the experiences of 11 parents with LPIs and triangulated the data using interviews conducted with 10 PHNs. Dosani and colleagues (31) utilized an exploratory mixed methods design, including quantitative data from 74 parents, inclusive of the 11 parents interviewed (31). The quantitative results indicate that only 10 parents were exclusively breastfeeding at 6-8 weeks postpartum, and 51 parents were partially breastfeeding (31). The number of parents breastfeeding at 6-8 weeks postpartum, whether exclusively or partially, represented 82% of the sample, with the vast majority not meeting the WHO recommendation of exclusive breastfeeding until six months of age (31). In the qualitative data, substantial challenges with breastfeeding emerged among parents leading to increased parental stress (31). Challenges were related to the initiation and continuation of breastfeeding with the LPI. The PHNs in the study confirmed observing these challenges (31). The gap between prior knowledge and the reality of breastfeeding a LPI rather than a term infant was highlighted by the parents. Limited psychomotor development of the LPI made a difference (31). In the breastfeeding support provided by PHNs, researchers noted missed teaching opportunities. For example, some of the PHNs' education and interventions addressed latch issues and the difficulty in coordinating sucking and swallowing, common among LPIs, but without explaining the rationale. These challenges related to feeding had a compounding effect on parents' stress (31).

Groleau and colleagues (34) conducted a qualitative case study in Quebec exploring parental experiences with breastfeeding health promotion and support, how these experiences connected to their social and embodied breastfeeding experiences, and whether variations were found among sites with different levels of BFI implementation. Of note, the sample in this case study consisted primarily of middle-class women holding university degrees (79%), with a relatively high family income, with forty-five percent (45%) reporting annual family incomes of $80,000 or more (34). Parents were interviewed at 4-12 months postpartum, with 48% of them exclusively breastfeeding at the time of the interview (34). When discussing prenatal breastfeeding classes, parents expressed they were not adequately prepared for the reality of the challenges that may present during breastfeeding; rather, they felt the class relied too heavily on presenting the health benefits associated with breastfeeding (34). Parents in the groups with higher implementation of BFI took on a more flexible approach to breastfeeding and felt more prepared to handle technical challenges due to the preparation in prenatal classes (34). Parents in the lower implementation group reported feeling unprepared to address the social barriers of breastfeeding such as family members being unsupportive of breastfeeding, with more parents ceasing breastfeeding and more often feeling guilty or being judged as incompetent (34). In contrast, parents in the higher implementation group felt better equipped to deal with social barriers and better prepared to address technical challenges associated with breastfeeding (34). A protective factor identified by this group of parents was the belief that partners, and support networks, needed to be notified of the plan to breastfeed and its potential impact on the usual domestic tasks expected of the parents (34). Partners willing to take on a greater share of household duties provided a more supportive environment for the breastfeeding parent (34). However, many of the parents reported feeling as though they needed to negotiate breastfeeding with their support networks (34).

The theme of empowerment versus pressure was clear in two of the studies (32,34). In the study exploring BSE in the NICU environment, some researchers found that the participants held conflicting views regarding the strict routines imposed on them (32). Some parents expressed feelings of reassurance, while others felt as though their feeding experiences were being interfered with (32). Despite having lactation consultants available to support mothers with their infant feeding, participants preferred feeding support from nurses on the unit (32). The 'breast is best' messaging was prevalent in this study, with some parents perceiving this message as being tied to the unit culture, resulting in pressure being placed on them to produce breastmilk. Participants held polarizing views of this 'breast is best' culture. On one end, those who successfully met their breastfeeding goals reported the pressure to breastfeed as encouraging, whereas others reported this pressure as a negative force affecting their parenting experience (32). In the other study (34), Bourdieu's concept of habitus was used by the researchers to review the social aspect of embodiment, defining the concept as "a mental disposition expressed in the body, a way of being and using the body that feels natural for the person and close ones". (34,p.2). Groleau and colleagues (34) determined habitus was not commonplace in the province at the time of the study, but achievable by empowering parents through the promotion of breastfeeding. The path to habitus requires building of social and cultural capital of the breastfeeding parent to bring about embodied change within themselves and the space they inhabit (34).

Emotions were evident in five of the studies, with the vast majority focusing on negative emotions such as guilt (31,33-34,36), and two studies (32,35) noting both positive and negative emotions. All the participants in the study focusing on the NICU environment reported full dedication to producing breastmilk, with their entire schedules revolving around pumping and producing breastmilk (32). Many of the participants reported being dependent on the breast pump even after being discharged from the NICU (32). Some parents highlighted positive emotions of feeling rewarded and happy that they successfully provided breastmilk to their infant (32). Conversely, some of the participants described reaching an emotional and psychological breaking point after returning home, resulting in the decision to quit the pump (32). These parents reported feeling disappointment and a sense of failure and grief regarding their feeding experience (32). Expressions of disappointment and regret were noted among parents that ceased breastfeeding earlier than expected (32). Guilt and failure were also noted by participants that received support through low-BFI implementation facilities, specifically due to feelings of being labelled as an 'incompetent mother' for not breastfeeding (34). Similarly, challenges with self-efficacy arose as a theme in the study set in a community-based program (33). Researchers found "many [parents] perceived that feelings of guilt, stress, anxiety, depression, loneliness, and pressure affected their ability to feed their infant and their emotional health in the prenatal and postnatal period" (33,p.6). Opinions expressed by care providers and support persons contributed to these negative emotions (33). In the study focusing on parents of LPIs, feelings of frustration and anxiety were emerged due to the additional time needed for feeding while already being exhausted, and at times, due to inadequate support provided by healthcare providers through conflicting information, a lack of anticipatory guidance, and a lack of control over their choices (31). In one example, a breastfeeding parent described a situation of neonatal jaundice requiring formula supplementation. The formula was medically indicated, however with breastfeeding often framed as a "choice", distress was felt when this choice was taken away (31).

Greene and colleagues (36) utilized narrative methods to explore the experiences of mothers in Ontario diagnosed with HIV in relation to their inhabiting a culture that dictates that 'breast is best' but not for those who are HIV-positive. A diagnosis of HIV is considered a contra-indication to breastfeeding within Canadian clinical guidelines (36). Participants were interviewed in their third trimester of pregnancy, and again at three months postpartum. Participants' ethno-cultural backgrounds included Black or African (53%), White (33%), and Aboriginal (10%), the remaining 4% identifying as 'other' (36). Other key traits included place of birth, with 48% of participants born in Canada and 45% originating from Africa, and relationship status, with 35% of participants indicating they were not in a relationship (36). When discussing participants' 'maternal' identities, a central theme was the inability to breastfeed due to HIV: "Concerns about the impact of not breastfeeding on their role and identity as a mother; feelings of loss and guilt; the surveillance of their infant feeding practices; concerns about HIV-related stigma and disclosure; and the need to develop a plan for how to confront the surveillance of their infant feeding practices as a response to concerns about stigma and disclosure" (36,p.890). Parents revealed the emotional costs of internalizing their lack of choice to breastfeed as a failure to provide the 'best' (as alleged by health messaging) for their infants, thus failing at parenthood (36). The myriad negative health consequences listed in public health messaging when attempting to encourage women to choose to breastfeed resulted in feelings of loss and guilt among women who did not have the choice. Participants also shared coping with this pressure to breastfeed by taking on a pragmatic view of bottle feeding and focusing on the associated benefits, including the involvement of support persons to feed the baby and health outcomes of formula-fed babies to include strong and healthy children (36).

Leurer and Misskey (35) utilized a mixed methods survey to explore infant feeding experiences of parents in Western Canada. The survey yielded a response rate of 35%, with participants primarily being from higher income and education levels. These parents found breastfeeding to be an emotional and personal life event (35). Overall, most participants reported a positive experience with breastfeeding, describing it as easy and challenge free. Some parents noted mixed feelings, as they experienced some difficulties, however they were able to overcome these and continued to breastfeed (35). Parents felt a sense of pride about their parenting abilities as a result of providing optimal nutrition to their infants as recommended by healthcare professionals (35). These participants felt a deepened emotional connection through breastfeeding. The relatively fewer negative experiences recounted by parents related to physical challenges, discomfort or pain, time commitment, and a sense of embarrassment when breastfeeding in front of others including healthcare providers.35 Some parents who encountered feeding challenges and thus discontinued breastfeeding sooner than they had hoped, described feelings of regret, sadness, and guilt.35 Negative emotions and a sense of disappointment or failure was a prominent theme in all of the studies exploring receivers' perspectives, highlighting the importance to think critically about the impact of breastfeeding health promotion messaging.

Synthesis of Contextual Factors – Social, Cultural, Political Forces

A key thread in the nine studies selected for this review were the social, cultural, and political contextual factors affecting all the populations' experiences regarding breastfeeding promotion. These factors affected the entire continuum of care and the ways in which the breastfeeding was experienced by each individual parent. Throughout this section, we refer to various contexts affecting the social, cultural, and political factors at play, ranging from the larger biomedical views of Western society to the micro levels of specific hospital units or communities.

In McFadden and Erikson's ethnography (28), social, cultural, and political forces were evident in the racialized care provided to parents, despite participants not always recognizing them. This study highlighted how PHNs unknowingly stereotyped their clients and the care provided through the silent racialized curriculum prevalent in Western biomedical practices. The researchers (28,p.E21) noted that "although most PHNs resisted the idea that they provide differential treatment to their clients which they understood to mean providing suboptimal care—some nurses provided examples of how their practices changed when they provided services to Chinese mothers." For example, while a standard information package is given to postpartum parents, the PHNs at this health unit used a separate 'Chinese package', which differed from the standard package by including additional information on how to use formula (28). The PHNs simply stated that this decision was made as a team to better utilize their time since they believed Chinese parents were more likely to use formula. Rather than ask parents whether they planned to provide formula, they made the assumption it would be the preferred choice and provided relevant information as standard practice. The researchers (28,p.E21) note "this example [as providing] a nuanced understanding of how a seemingly appropriate "culturally competent" practice of providing language-specific information can deviate when coupled to an essentialized, racialized assessment". There was an overall lack of holistic understanding of the structures affecting the breastfeeding experiences of the mothers receiving support from the PHNs (28).

A barrier identified by Chabot and Lacombe (29) regarding nurses' willingness to adopt a BFHI approach revolved around the perinatal individuals' social support networks. Nurses in that study identified the negative comments from support persons about BFHI as a large obstacle. Both subjective norms and moral norms presented as statistically significant among the nurses. Survey results revealed the strong influence that parents' perceptions have on nursing practice, with a higher proportion of nurses willing to undertake a BFHI approach if it were socially accepted by the parent they cared for (29). Personal values of the individual nurses also mattered, including whether the BFHI aligned with their values or whether these values conflicted with the opinions expressed by the parents being care for (29).

Gillis et al.'s case study (30) reviewing the application of health literacy within care providers' promotion of breastfeeding spoke to the contextual factors specific to the cultural and civic aspects of health literacy. Socio-cultural aspects of breastfeeding were recognized in the results of the study, with participants stating the need for a broader social response in an environment supportive of breastfeeding. The researchers (30) suggested greater practitioner involvement in improving policy and organizational practices could be achieved through an increased focus in the application of the civic domain of health literacy.

The cultural norms of the NICU identified by parents in Brockway and colleagues' study (32) revealed a 'breast is best' message being received by the parents and further perpetuated by staff. The biopower exerted over the parents in this setting was evident through the positioning of parents' needs as secondary to the needs of the infant and valuing the importance of producing breastmilk above all else. Ultimately, the pressure to breastfeed while failing to meet 'ideals' resulted in feelings of guilt, failure, disappointment, and grief for some parents (32).

In Francis et al.'s study (33), parents noted the social determinants of health and the potential impacts on breastfeeding outcomes. They suggested more awareness and focus on these determinants within breastfeeding support (33). Examples included: lower income combined with food insecurity resulting in a decreased access to healthy foods needed for adequate milk production, and the potential for social isolation and language barriers related to being immigrants in Canada (33). These researchers suggested further exploration of the social structures that influence breastfeeding, while attending to the disconnect between the promotional messaging of 'breast is best' and the realities of breastfeeding (33).

Groleau and colleagues' case study revealed cultural barriers preventing some parents from seeking breastfeeding support due to the discomfort of revealing their breasts to care providers (34). The concept of empowerment was noted when addressing cultural norms and attitudes that were unsupportive of breastfeeding. Parents receiving care from areas with higher implementation of BFI reported feeling more empowered to confront these barriers (34). The researchers argue the need to increase cultural and social capital of breastfeeding through the empowerment of parents to act as change agents within their own spaces. The promotion of breastfeeding often involves describing breastfeeding as a choice with measurable outcomes, however the more appropriate description would be that breastfeeding constitutes a social, cultural, and embodied act, with a key aim of empowerment (34).

Interestingly, the two studies in this review that recruited primarily higher income-earning, educated parents also yielded more positive results in terms of both experiences and rates of exclusive breastfeeding (34,35). The findings from these studies differed widely from the breastfeeding experiences expressed by lower income-earning parents in another study (33). The majority of the accounts of higher income-earning parents from one study related to personal journeys, with primarily individual-level challenges such as a painful latch (34). This finding contrasted with Francis et al.'s study (33) with primarily lower income-earning parents, with references to a lack of time due to obligations in other aspects of their lives, including caring for others, and the difficulty of fitting breastfeeding into the context of their lives. These parents also raised the challenges of breastfeeding in relation to the social determinants of health (33). The case study (34) involving higher income-earning parents raised concerns with social norms and the need to empower women to challenge these norms through being change agents within their communities. However, it is important to note the differences between parents of higher socio-economic standing aiming to achieve greater social capital versus vulnerable populations having a lower social capital to begin with. All three of these studies (33-35) raised concerns with the technical challenges of breastfeeding experienced by parents, and the resulting emotions of guilt and failure for those who were unable to meet their breastfeeding goals. Upon review of the quantifiable outcomes of breastfeeding, 48% of the higher income-earning participants in one study (34) conducted in the province of Quebec were exclusively breastfeeding, however according to Statistics Canada (4), the percentage of overall parents reaching this standard was only 19%. The parents from higher income levels in this study had positive experiences with breastfeeding, and many of the parents expressed a sense of pride upon overcoming technical challenges (35). In contrast, the study (33) involving lower income-earning parents found that almost all the participants reported planning and attempting to breastfeed, however ultimately reaching the standard of exclusive breastfeeding at six months was not common amongst these parents. Considering feelings of failure and guilt associated with unmet goals of exclusive breastfeeding, this discrepancy in breastfeeding outcomes between higher income-earning versus lower income-earning parents in these studies suggest vulnerable parents are at higher risk of facing detrimental mental health outcomes due to their social positioning.

Greene et al.'s study raised the intersectionality of HIV-related stigma with the pressures to breastfeed as related to Canadian public health recommendations (36). The intense social and cultural pressures to breastfeed have resulted in surveillance between parents regarding their feeding choice, and subsequently, parents who do not breastfeed are challenged to disclose their reasons for this 'choice' (36). The parents in this study revealed instances of lying or preparing excuses for their infant feeding choices, with the intent of concealing their HIV diagnosis and the stigma that may ensue. The encouragement of breastfeeding in public health messaging may not have considered the effects of framing breastfeeding as a choice that results in better health outcomes in comparison to formula feeding in situations where breastfeeding is contra-indicated, however the inadvertent consequences on vulnerable populations remain and need to be addressed from a policy standpoint.

Limitations

We reviewed studies involving some populations within Canada, however our systematic search did not yield results representative of all care providers, perinatal individuals, and parents in Canada. Our decision to limit our search to English-only publications excluded studies published in French. As a result, all studies reporting research conducted in the province of Quebec were not captured. Further research is also needed to uncover the experiences of individuals who may face inequities in the breastfeeding care they receive, including but not limited to the Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, and Two-Spirit (LGBTQ2S+) population, Indigenous individuals, and non-English speaking individuals. Additionally, our review did not include a population of parents who do make the informed choice to use an alternative infant feeding method rather than breastfeeding. The experiences of these parents are not captured within our results, however they are relevant.

Conclusion

An integrative review of the literature was conducted to determine the state of available evidence in the experiences of perinatal individuals and care providers in relation to breastfeeding health promotional messaging in Canada. There were nine studies identified that explored this phenomenon, and the populations represented in the research was vasty under representative of the diversity in Canada. The limited experiences explored raised concerns of a 'breast is best' culture, noted the unintended outcomes of guilt, shame, failure at parenthood, and highlighted how the needs of all parents were not adequately met. The emotional impacts of not meeting expected breastfeeding outcomes were noted across the studies, with parents of lower socio-economic positioning being at higher risk of 'failing' at breastfeeding. Policymakers involved in setting standards should consider the experiences of parents, care providers, and the intersection of social, cultural, and political structures to improve not only the rates of breastfeeding, but the quality of care being received by different groups of individuals. Quality improvement of clinical and public health guidelines should be undertaken to address the ambiguity faced by the care providers referring to such guidelines, and challenge care providers to critically reflect upon their own beliefs that may be affecting the breastfeeding care they provide

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2

Résumé
Pour concevoir l'agir complexe de la pratique infirmière, les théories auraient avantage à adopter un mode de pensée systémique qui reconnait le caractère interdépendant de la vie humaine. Nous supposons que cela permettrait d'appréhender les visées de santé dans la discipline infirmière. Dans cet article, nous proposons de recourir à l'idée des capabilités d'Amartya Sen. Les capabilités, soit l'ensemble des libertés réellement possédées par les individus, reconnaissent les multiples dynamiques personnelles, sociales ou environnementales qui permettent à chacun de vivre la vie valorisée. En positionnant les capabilités pour la santé comme finalité, notre proposition conçoit que l'agir complexe de la pratique infirmière s'engage dans des activités qui transforment des ressources en capabilités. Cela prend forme par la participation des personnes soignées et par la création d'un environnement favorable. Notre proposition évoque alors un espace d'interdépendance réciproque, une réflexivité des infirmières, ainsi qu'un positionnement stratégique pour cheminer vers la santé.

Mots clés agir complexe, capabilités, pratique infirmière, processus de conversion, théorie infirmière

L'idée des capabilités de Sen pour concevoir l'agir complexe de la pratique infirmière

JÉRÔME LECLERC-LOISELLE, SYLVIE GENDRON
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Introduction

La pratique infirmière évolue dans un espace mouvant et transitoire qui caractérise le 21e siècle. La professionnalisation de multiples acteurs, la technologisation des rapports sociaux et géopolitiques, la mondialisation de l'accès aux savoirs et aux ressources, ainsi que les iniquités sociales croissantes complexifient l'organisation, l'environnement et l'agir de la pratique infirmière. Cet agir peut être conçu comme étant complexe, signifiant qu'il est constitué d'une variété d'acteurs, de ressources, de normes et de savoirs en interaction (1). Cet agir n'est pas circonscrit à l'infirmière en elle-même. Il comporte plutôt des émergences imprévisibles, source de solutions nouvelles ou innovantes en termes d'engagement politique des infirmières ou de développement d'approches collectives et collaboratives pour la santé (1,2). L'agir complexe est alors porteur d'agilité pour les infirmières qui s'activent pour la santé des gens, dans une diversité de contextes (1).

Pour déployer l'agir complexe de la pratique infirmière, et sa capacité inventive dans un monde incertain, différentes idées, perspectives et théories s'offrent à nous (3). Toutefois, dans la discipline infirmière, les théories semblent plus souvent utilisées pour guider ou orienter le raisonnement clinique des infirmières (4,5). Qu'il s'agisse de théories intermédiaires (6) ou de théories spécifiques aux situations (7,8), le corpus théorique de la science infirmière à l'ère de pratiques basées sur des résultats probants (9) vise plus couramment un certain niveau de généralisation et de prédiction explicative (4).

Sans nier le confort intellectuel et la valeur de telles théories, d'autant plus lorsqu'elles sont dérivées de méthodes scientifiques rigoureuses, leur adoption majoritaire pour guider la pratique infirmière implique des conséquences (10,11). Parmi celles-ci, nommons des théories présumées représenter la réalité qui sont composées d'entités mesurables et reliées linéairement; le caractère parfois descriptif, plutôt que réflexif de ces théories; un penchant (uni)disciplinaire qui semble limiter l'apport d'autres systèmes de pensée; ou un idéal de prédictibilité (3,10,12,13). Par ailleurs, plutôt centrées sur des enjeux du monde occidental, nombre de théories infirmières comportent le risque de marginaliser des idées, des valeurs et des savoirs différents ou divergents, atténuant ainsi leur portée réflexive et critique (14,15,16,17). Fondées sur une épistémologie scientifique dominante (18), il n'est pas rare que des théories infirmières tendent à reléguer des réalités sociales et politiques alternatives à des situations militantes, qui pourtant, expriment des enjeux contemporains générateurs de l'agir complexe de la pratique infirmière (17,19). De telles théories, supposées objectives, risquent d'imposer des angles morts sur des réalités sociales qui, en l'occurrence, échappent aux infirmières (12). L'idée que de telles théories puissent guider la pratique infirmière dans un monde mouvant et incertain est, pour le moins, hasardeuse.

Ainsi, l'agir complexe de la pratique infirmière ne peut être réduit à une rationalité scientifique productrice de théories prédictives, objectivantes ou (uni)disciplinaires. Nous proposons qu'une telle pratique gagne à être conçue selon une rationalité d'intelligibilité portée par des sujets qui ne connaissent que leur expérience du réel, sans pour autant postuler que leurs connaissances reproduisent la réalité telle qu'elle est (1,20). Cette proposition d'intelligibilité prend appui sur la pensée systémique complexe de Jean-Louis Le Moigne (20). Dans cette épistémologie, toute connaissance est construite par des sujets à partir de leur expérience du réel et de leurs représentations de l'action observée et vécue (20,21). La connaissance est un outil qui permet à chacun de cheminer dans le monde. La démarche systémique vise à rendre intelligible cette connaissance construite, par le biais d'une approche de modélisation des phénomènes perçus complexes (2); modélisation susceptible d'amplifier le raisonnement, pour produire une action délibérée au sein du phénomène (22), qu'est ici la pratique infirmière. Par cette pensée reliante et systémique (20,21), l'agir complexe de la pratique infirmière met alors l'accent sur les interdépendances entre les acteurs, leurs activités de soin, leurs savoirs, leurs valeurs et leurs environnements (1). Des théoriciennes infirmières comme Martha Rogers ou Margaret Newman ont d'ailleurs déjà proposé des conceptions reliant l'infirmière à de multiples processus sociotechniques générateurs de santé et de bien-être (23,24) suggérant que la reliance systémique n'est pas une idée nouvelle pour les théoriciennes infirmières.

Pour concevoir et déployer l'agir complexe, une rationalité d'intelligibilité de la pratique infirmière suppose l'explicitation de l'intentionnalité de cette pratique (1,22), en cohérence avec des valeurs, des principes, des savoirs qui sont constitutifs de la discipline infirmière. En termes contemporains, la santé, l'équité et la justice sociale sont généralement reconnues comme étant des visées essentielles de la pratique infirmière (1,25,26). De telles visées rappellent l'actualisation du potentiel d'autonomie des humains (27), l'accessibilité aux ressources nécessaires pour être en santé (28) et des valeurs de liberté (29), autant d'idées explorées par des penseurs de la discipline, sans toutefois tendre vers l'intelligibilité d'une pratique infirmière poursuivant ces visées.

Nous proposons ici une exploration de l'idée des capabilités d'Amartya Sen pour concevoir et déployer l'agir complexe de la pratique infirmière. L'intentionnalité de cette pratique serait celle d'un engagement envers l'ensemble des libertés réellement possédées par un individu pour être et faire ce qu'il a raison de valoriser (30), autrement dit, pour vivre la vie valorisée. Ici, les libertés ne concernent pas seulement les libertés formelles des individus (leurs droits d'agir), mais aussi et surtout leurs libertés réellement possédées d'être et de faire. Le potentiel théorique de cette idée a déjà été évoqué pour l'étude et le développement de pratiques soignantes (31,32,33) mais demeure inexploré en sciences infirmières. Le but de cet article est alors de conceptualiser une pratique infirmière conçue comme agir complexe en prenant appui sur l'idée des capabilités de Sen. Dans ce qui suit, des idées d'Amartya Sen seront introduites pour saisir les possibilités qu'offre sa pensée pour concevoir l'agir complexe de la pratique infirmière. Une proposition théorique, développée à partir de ses idées principales, sera ensuite présentée et détaillée. Celle-ci offre une fenêtre sur le caractère relationnel de l'agir complexe de la pratique infirmière et sa nature sociale, stratégique et réflexive pour la santé.

L'idée des capabilités d'Amartya Sen

L'œuvre d'Amartya Sen, récipiendaire du prix de la Banque de Suède en sciences économiques en mémoire d'Alfred Nobel, remis par la fondation Nobel de 1998, traite du développement humain et de la justice. Il propose le néologisme de « capabilité », contraction des mots capacité et liberté, pour désigner une liberté réellement possédée par un individu pour être et faire ce qu'il a raison de valoriser (30,34). Au départ, Sen (35) propose l'approche par les capabilités comme alternative à l'usage d'indicateurs de richesse comme seules mesures du bien-être individuel. Il postule que la richesse représente des ressources possédées par les gens, mais ne fait pas état de leur capacité réelle à les utiliser. En effet, le bien-être d'une personne n'augmente pas nécessairement avec la quantité de ressources possédées. En proposant l'idée des capabilités comme indicateur de bien-être individuel, Sen (30) met l'accent sur la vie que les gens ont raison de valoriser, c'est-à-dire sur ce qui est considéré comme bon, par chacun, en termes d'aspirations, d'objectifs ou de préférences individuelles. Cette raison est déterminée par la rationalité des individus et ne doit pas être substituée par autrui. Elle doit cependant pouvoir être engagée dans un dialogue afin de l'exposer et de la partager (36). Pour l'agir complexe de la pratique infirmière, l'idée des capabilités sollicite alors un questionnement sur la nature et le processus de création des libertés réellement possédées et nécessaires à chaque vie humaine, plutôt que sur les ressources possédées par chacun.

L'intérêt des capabilités repose dans leur valeur tant instrumentale, qu'intrinsèque (36). D'une part, leur valeur est instrumentale, car les capabilités reflètent les libertés réellement possédées par les individus à œuvrer aux finalités qu'ils valorisent pour eux-mêmes, notamment des activités valorisées pour soi, ou encore dans des causes jugées importantes, notamment en termes d'engagement social pour des besoins en santé, environnementaux, humanitaires, politiques ou économiques. De ce point de vue, il est possible d'apprécier ou d'évaluer l'atteinte des capabilités. D'autre part, leur valeur est intrinsèque, car l'idée des capabilités comporte la liberté de choisir la vie que chacun a raison de valoriser. Le focus de cette approche est de créer des libertés réelles, sans intentions normatives quant aux choix qui en découlent.

Suivant les idées de Sen (37), la vie comprend un ensemble de modes de fonctionnement qui composent les êtres et les faires des individus ('beings and doings'), soit l'ensemble des états et des activités de la vie humaine. Par exemple, ces êtres et ces faires peuvent prendre la forme d'être bien nourri, d'être heureux, de mener ses activités sans douleur, de dormir ou de se déplacer. Ces êtres et faires n'impliquent pas nécessairement une activité motrice; être oisif est un mode de fonctionnement, au même titre que de marcher. Par ailleurs, les modes de fonctionnement résultent d'un choix, volontaire ou non, effectué au travers de l'ensemble des capabilités possédées par un individu. Pour illustrer la distinction entre les notions de capabilités et de modes de fonctionnement, Sen donne l'exemple d'une personne qui a faim et d'une personne qui jeûne. Être affamé et jeûner représente le même mode de fonctionnement (i.e. ne pas s'alimenter). Cependant, dans le premier cas, la capabilité de manger est absente; tandis que dans le cas du jeûne, il s'agit d'un choix exercé par l'individu. Une personne qui jeûne possède alors davantage de capabilités que la personne qui est affamée, car elle pourrait aussi choisir de s'alimenter. Par cet exemple, l'on comprend que les capabilités représentent l'ensemble des libertés réellement possédées par les individus (p. ex. s'alimenter et/ou ne pas s'alimenter), et les modes de fonctionnement représentent l'actualisation observable des capabilités en êtres et en faires.

Le processus de création de capabilités est nommé « conversion » (38). Il s'agit du processus par lequel divers facteurs permettent de convertir (ou non) des ressources en capabilités (Figure 1). Ces facteurs de conversion (38) réfèrent à des dynamiques personnelles, sociales et environnementales qui favorisent (ou inhibent) la conversion de ressources en capabilités. Ils incluent, notamment, l'âge, le genre, la condition physique, le niveau de littératie, le réseau social, les politiques publiques, les normes sociales, les lieux physiques et les environnements bâtis dans lesquels la personne vit. Ils sont dynamiques et s'inter-influencent. Par exemple, la littératie d'un individu sera influencée, voire déterminée, par les politiques publiques et les normes sociales relatives à la scolarisation. Ces facteurs coexistent avec les ressources à la disposition d'un individu, c'est-à-dire l'ensemble des acteurs, des biens et des services à sa disposition (35). Cela étant dit, la possession de ces ressources ne garantit en rien la possibilité réelle de les utiliser. Les ressources en elles-mêmes sont inutiles si elles ne sont pas considérées en relation avec les facteurs de conversion

La Figure 1 représente les idées retenues pour concevoir et déployer l'agir complexe de la pratique infirmière dont l'intentionnalité est celle d'un engagement auprès des personnes soignées afin qu'elles vivent la vie qu'elles ont raison de valoriser.

Dans cette figure, le processus de conversion de ressources génère des capabilités, c'est-à-dire des libertés réellement possédées par un individu, pour être et faire ce qu'il a raison de valoriser au quotidien. Il importe de spécifier que dans ce processus, les modes de fonctionnement représentent l'actualisation observable des capabilités en êtres et en faires, lesquelles sont issues de choix, volontaires ou non. Ainsi, les modes de fonctionnement ne correspondent pas d'emblée aux possibilités réelles d'être et de faire ce qui est valorisé ou à prendre acte et à choisir pour soi. Ils sont, en partie, configurés par des processus de conversion, comprenant à la fois les ressources à disposition et les facteurs de conversion. Ces processus de conversion relèvent autant de l'individu que de son environnement et sont clés dans la création de capabilités.

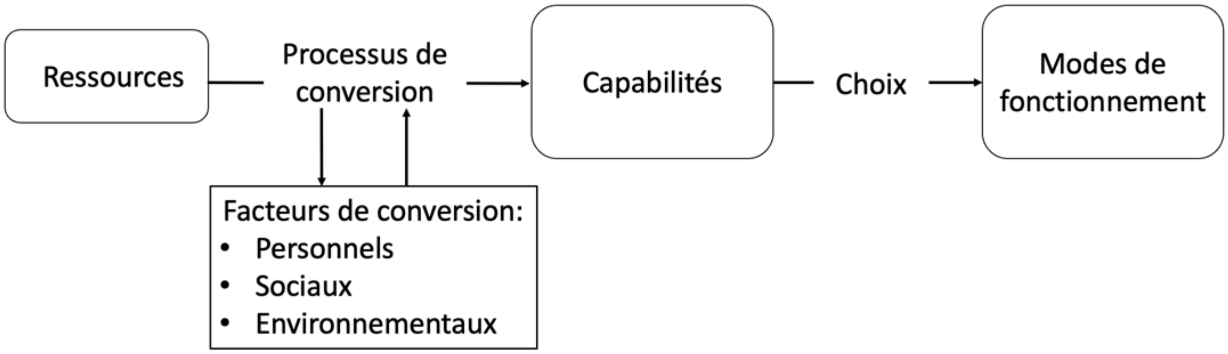

Figure 1 – Représentation schématique des idées retenues de l'approche par les capabilités de Sen, inspirée de Robeyns [38]

Bien que l'approche de Sen (37) soit centrée sur l'individu, elle n'est pas individualiste. Les capabilités sont profondément sociales, considérant les facteurs de conversion et les ressources mobilisées (39). Les capabilités possédées par un individu pour vivre la vie qu'il a raison de valoriser, relèvent autant de l'individu que de son environnement social, politique et culturel, comprenant la pratique infirmière. Cela traduit alors une dimension collective à cette approche, où Sen (36) soutient la pertinence des discussions contextualisées à l'environnement local pour déterminer, de manière rationnelle, les capabilités à poursuivre. La nature sociale des capabilités nécessite en effet une forme d'action collective pour s'y engager de manière cohérente (36). Sans souhaiter établir une liste fermée de capabilités, Sen postule qu'une entente, située et évolutive, permet de s'engager collectivement vers certaines capabilités jugées importantes localement, comme pourraient l'être l'accès à certains soins ou services, l'expression politique ou religieux ou la reconnaissance non-discriminatoire des vies humaines. Cette approche flexible permet alors de reconnaître la diversité des aspirations, des objectifs et des préférences individuelles.

Différemment, l'idée des capabilités a aussi été centrale aux travaux de Martha Nussbaum, philosophe américaine du droit. Lui reconnaissant des fonctions à visées normatives, plutôt que centrées sur la possibilité de chacun de développer ses capabilités, Nussbaum considère que les sociétés devraient viser un seuil minimal de capabilités humaines pour tous les citoyens, et ce, afin de vivre une vie digne (40). Pour ce faire, elle propose une liste de dix capabilités humaines qui devraient être garanties à tous et utilisée comme outil de planification et d'évaluation des politiques publiques (40). Cette conception, plus universaliste apparaissait moins porteuse à notre projet que celle de Sen qui lui privilégie une approche communicationnelle et délibérative, reconnaissant la diversité des vies humaines.

L'agir complexe de la pratique infirmière comme processus de conversion

Dans ce qui suit, nous proposons une mise en relation des idées de Sen pour concevoir l'agir complexe de la pratique infirmière comme un processus de conversion qui participe à la création de capabilités pour les êtres et les faires que les personnes soignées ont raison de valoriser. Cette idée de conversion n'est pas propre à l'agir complexe de la pratique infirmière, car d'autres pratiques sociales s'inscrivent dans ce processus. Toutefois, nous proposons que cette idée s'incarne de manière distincte chez les infirmières du fait de leur engagement envers la santé des personnes soignées.

Pour élaborer notre proposition, six documents de référence de Sen (30,34,35,36,37,41) ont été sélectionnés pour leur apport évolutif au développement de l'idée des capabilités. Dans l'étude de ces documents, nous désirions identifier des idées qui permettraient de concevoir la pratique infirmière comme un système d'action complexe, en prenant appui sur la rationalité d'intelligibilité d'une pensée systémique et donc le principe de modélisation susceptible de produire une action délibérée (20,21). L'étude initiale des documents a été réalisée graduellement par le premier auteur à partir d'un canevas d'analyse construit selon les dimensions d'une conception complexe de la pratique infirmière. Cette démarche cherchait à identifier des concepts dans la pensée de Sen qui contribueraient à distinguer les interactions entre les acteurs, les activités, l'espace-temps et l'intentionnalité d'une telle pratique (20,21).

Portés par un raisonnement abductif, trois concepts ont été proposés, soit les ressources, les facteurs de conversion et les capabilités. Pour chacun, des procédés de lecture-écriture, incluant la prise de notes et la rédaction de fiches synthèses, ont été réalisés par le premier auteur. Individuellement, chaque concept a fait l'objet de discussions entre les membres de l'équipe de recherche, pour assurer une compréhension commune quant à leur définition, leur portée et leur adéquation avec l'intention de la démarche. Une fois circonscrits, ces trois concepts ont été mis en relation, par le premier auteur, en prenant appui sur une démarche systémique de modélisation (22) par le biais de schémas comportant des formes graphiques et textuelles. Cette démarche était réalisée par des allers-retours entre les écrits de Sen, le développement de la modélisation et l'écriture. Lors des rencontres de travail avec les co-auteurs, la modélisation en développement faisait l'objet de discussions, notamment sur l'intelligibilité de la proposition pour la pratique infirmière, sur la relation entre les concepts et sur la cohérence avec la pensée de Sen. Graduellement, ce travail s'est éloigné de propositions descriptives, pour tendre vers une forme analytique, qui a permis d'explorer les liens entre la pensée de Sen et les différentes dimensions de la pratique infirmière dans une visée de santé.

La Figure 2 représente notre modélisation de l'agir complexe de la pratique infirmière, conçu comme processus de conversion. Cela signifie que nous concevons la pratique infirmière comme génératrice de capabilités pour la santé, lesquelles émergent de la conversion, par la pratique infirmière, d'une diversité de ressources. Dans la figure, on y distingue, à gauche, les acteurs, incluant les soignants, les proches et les personnes soignées, ainsi que leurs ressources et capacités en transformation; l'espace de cette pratique en termes de lieux de soins, d'environnements organisationnels et de dynamiques sociales et politiques. Au centre, on y retrouve les activités infirmières qui transforment des ressources en capabilités, par la participation des personnes soignées ou par la création d'un environnement favorable. Finalement, la section de droite fait référence à l'intentionnalité de cette pratique qui s'incarne de manière distincte chez les infirmières du fait de leur engagement envers la santé des personnes soignées, ce que nous nommons des capabilités pour la santé. La flèche courbe qui traverse le modèle signale la temporalité récursive et non linéaire de cette pratique, ainsi que la réflexivité inhérente à cet agir complexe. Autrement dit, les mécanismes inhérents à l'agir complexe de la pratique infirmière comme processus de conversion, sont contextualisés aux expériences et aux dynamiques sociales et politiques, s'inter-influencent, se potentialisent, et se génèrent sans toutefois présumer d'une prédictibilité ou d'une généralisation explicative.

Trois idées qualifient l'agir complexe de la pratique infirmière comme processus de conversion, soit 1) une finalité de capabilités pour la santé, 2) les activités infirmières qui transforment des ressources en capabilités et 3) les ressources en transformation. Ces trois idées, qui constituent le processus de conversion, seront successivement décrites. Afin de mettre en exergue et d'illustrer ces idées, divers moments d'une situation clinique de pratique infirmière auprès d'une personne en fin de vie à domicile seront développés. Cette situation permettra de relier ces trois idées et de représenter comment l'agir complexe d'une pratique infirmière comme processus de conversion peut se déployer.

Une finalité de capabilités pour la santé

Nous proposons que l'agir complexe de la pratique infirmière comme processus de conversion, poursuit une finalité de capabilités pour la santé. En réalité, ces capabilités pour la santé ne peuvent qu'être supposées; elles ne sont pas observables en soi. Leur actualisation, en modes de fonctionnement, nécessite l'observation, l'évaluation et la documentation de résultantes du soin qui peuvent agir comme intermédiaire pour concevoir, par abduction, les capabilités pour la santé. Ainsi, les modes de fonctionnement revêtent un caractère informateur sur l'impact souhaité des actions posées pour la conversion de ressources vers des capabilités.

Dans la pratique infirmière, les capabilités pour la santé peuvent prendre plusieurs formes pour les personnes soignées. Par exemple, auprès d'une personne en fin de vie, ces capabilités pour la santé pourraient être la possibilité d'une mort jugée digne, celle de vivre des bonheurs au quotidien, celle d'avoir un bon contrôle des symptômes, comme la douleur, celle d'exprimer ou de réaliser ses préférences quant aux modalités de décès ou celle de pouvoir participer activement à une vie sociale ou communautaire jusqu'à la fin. Comme finalités de l'agir complexe de la pratique infirmière, ces capabilités pour la santé expriment l'ensemble des projets poursuivis et concertés entre les acteurs.

Étant inscrites dans divers lieux, environnements organisationnels et dynamiques sociales et politiques, les capabilités pour la santé doivent pouvoir faire l'objet de discussions locales. Dans la pratique infirmière, cela vise à favoriser une concertation entre différents acteurs pour une action qui, sans devoir être consensuelle, peut être partagée ou déterminée comme étant un compromis acceptable, dans une situation singulière. Il va sans dire que les capabilités pour la santé sont inscrites dans des cadres normatifs, qu'ils soient de nature déontologique, réglementaire, législatif ou organisationnel. Sans être immuables, ces cadres orientent la finalité de capabilités pour la santé, et la pratique infirmière qui y participe.

Contextualisées aux ressources présentes, les capabilités pour la santé sont reliées aux conditions de vie réelles des personnes soignées. En l'occurrence, les acteurs du soin, incluant les infirmières, devraient considérer les possibilités réelles qu'ont

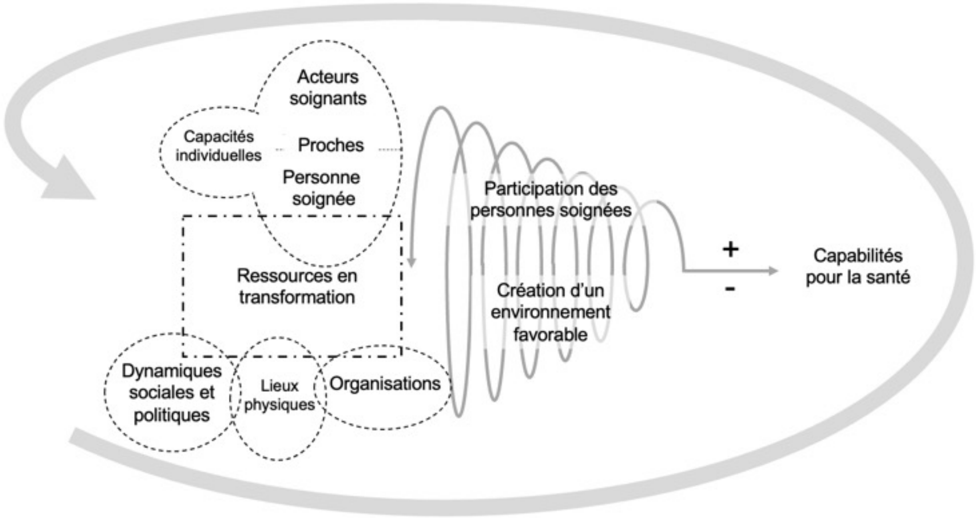

Figure 2 – L'agir complexe de la pratique infirmière, conçu comme processus de conversion

les personnes à utiliser les ressources à disposition, plutôt que de s'en tenir à leur disponibilité. Dans une conception de l'agir complexe de la pratique infirmière, cette distinction recadre le discours sur les déterminants de la santé servant de modèle d'action en sciences infirmières (42). La disponibilité de ressources, comme un logement salubre, un emploi stable, un système d'éducation accessible ou la sécurité alimentaire ne sont pas des fins en soi. Une finalité de capabilités pour la santé réclame la possibilité réelle pour les personnes soignées d'utiliser ces ressources pour vivre la vie valorisée. Par exemple, une personne qui a accès à de la nourriture n'a pas nécessairement de capabilités pour sa santé si elle n'a pas d'argent pour faire ses achats, de connaissances sur la préparation des aliments ou même un réfrigérateur pour leur conservation. Une finalité de capabilités pour la santé implique une mise en relation de l'agir complexe de la pratique infirmière avec les conditions de vie réelles des personnes soignées.

Les activités infirmières qui transforment des ressources en capabilités

La deuxième proposition renvoie à la nature des activités infirmières : il s'agit d'activités qui transforment des ressources en capabilités, permettant de relier les personnes soignées au contexte dans lequel elles vivent. Cette idée de reliance exprime la nature contextuelle et contingente des ressources. Au travers des dynamiques sociales, politiques ou culturelles qui circonscrivent les possibilités réelles des individus (p.ex. en termes d'accès ou de connaissances), les activités infirmières peuvent contribuer à transformer des ressources en capabilités pour faire en sorte que les personnes soignées puissent être et faire ce qu'elles ont raison de valoriser. À partir de notre démarche, nous proposons que ces activités de transformation de ressources en capabilités puissent prendre deux formes potentielles : la participation des personnes soignées et la création d'un environnement favorable. Ces deux types d'activités sont présentées séparément. Cependant, ils sont complémentaires, l'un reposant sur le déploiement de l'autre.

La participation des personnes soignées:

Afin que les personnes soignées développent des capabilités pour leur santé, à l'intérieur des contraintes du monde dans lequel elles vivent, nous proposons que l'agir complexe de la pratique infirmière déploie des activités visant à solliciter leur participation active au processus de conversion. Nous identifions deux principales activités infirmières qui peuvent favoriser cette participation : développer des connaissances et des compétences individuelles et créer des espaces de dialogue ouverts et réflexifs.

Premièrement, participer activement à la conversion de ressources en capabilités pour la santé exige, pour les personnes soignées, des connaissances et des compétences. Cela s'exprime notamment en termes de littératie en santé ou numérique, de connaissances quant à leur situation de santé, de compréhension générale du système de santé ou de compétences pour communiquer avec les divers intervenants. Par exemple, si une personne en fin de vie ne sait pas comment utiliser des ressources numériques pour accéder à des services communautaires, si elle a de la difficulté à naviguer dans son réseau local de services par manque de connaissances du rôle des différents acteurs, ou si elle n'a pas une connaissance limitée des éléments de surveillance à réaliser en fonction de sa condition de santé, elle pourrait ne pas développer les capabilités nécessaires à la vie qu'elle valorise (p.ex. demeurer à domicile aussi longtemps que possible). Les activités infirmières d'enseignement ou d'éducation à la santé, au cœur de la pratique infirmière (43), trouvent ainsi tout leur sens dans l'agir complexe d'une pratique infirmière comme processus de conversion. Ces activités peuvent tout autant contribuer au développement des capacités individuelles des personnes soignées à comprendre des enjeux et à convertir leurs ressources en capabilités pour la santé, mais également, elles peuvent contribuer au développement des compétences des divers acteurs du soin afin qu'ils accompagnement les personnes soignées dans ce processus de conversion. Ultimement, ces activités de développement de connaissances et de compétences individuelles favorisent la capacité des personnes à choisir de participer, de la manière qu'elles le souhaitent, dans leurs soins.

Deuxièmement, pour que les personnes soignées puissent participer activement au processus de conversion vers des capabilités pour la santé, des espaces de dialogue ouverts à la diversité des perspectives, qui considèrent les préférences individuelles et qui sollicitent réflexivement la rationalité de chacun des acteurs concernés, sont requis. Ces espaces de dialogue sont essentiels dans la mesure où le processus de conversion vers des capabilités relève autant de ressources, que de facteurs de conversion personnels, sociaux ou environnementaux (36). L'aspect collectif des capabilités rend alors nécessaire la création de ces espaces où, dans une visée d'entente et de cheminement, tous peuvent s'investir. En termes d'activités infirmières, il s'agit donc de créer des espaces de dialogue ouverts et réflexifs avec les personnes soignées et les autres acteurs du soin. Spécifiquement, dans ces espaces, l'infirmière devrait élaborer et partager ses objectifs de soin et ses apports potentiels avec la personne soignée, ses proches, les gestionnaires ou les membres de l'équipe interprofessionnelle, ainsi qu'écouter et considérer leur perspective. Il s'agirait également d'accompagner la personne soignée ou ses proches dans le partage et l'explicitation de leurs volontés, afin de favoriser la cohérence des actions professionnelles. Ces espaces visent à favoriser une compréhension mutuelle en vue d'assurer la conversion vers des capabilités pour la santé, en cohérence avec la vie désirée par les personnes soignées, à l'intérieur des contraintes contextuelles, qui sont toutes aussi réelles.

Afin de favoriser la possibilité pour une personne en fin de vie de demeurer à domicile, l'infirmière pourrait créer un espace de dialogue qui tient compte à la fois de son évaluation clinique et des volontés de la personne soignée. D'une part, cet espace pourrait situer les choix de la personne dans son histoire de vie. Il s'agirait de faciliter l'expression de ses raisons, de ses valeurs, de sa vision du futur et d'identifier les ressources qu'elle considère pour la suite (p.ex. réseau de soutien, représentations de la fin de vie, des soins palliatifs et de l'aide médicale à mourir). D'autre part, l'infirmière doit être en mesure de communiquer à la personne soignée son évaluation clinique des risques identifiés pour sa sécurité ou celles qui limitent les possibilités de maintien à domicile, ainsi que la disponibilité de ressources locales, le cas échéant. Bref, plutôt que de considérer d'emblée comme raisonnable, ou non, le choix individuel d'une personne soignée, un espace de dialogue ouvert et réflexif est clé pour favoriser l'entente et la concertation des acteurs afin de cheminer dans le processus de conversion de ressources en capabilités pour la santé. Cet espace favorise la participation de la personne soignée par l'expression de sa singularité et la mise en relation de perspectives diverses, mais contributives au processus de conversion.

Il importe de spécifier que dans certaines situations, les personnes soignées peuvent ne pas exercer de contrôle direct dans le processus de conversion des ressources en capabilités. Cette possibilité peut être limitée notamment pour des raisons d'organisation sociale, de disposition des lieux physiques ou de caractéristiques individuelles. Différemment, les capabilités liées à ce que la personne valorise pour sa vie sont parfois indépendantes des choix et des actions individuelles. Ce peut être le cas des politiques organisationnelles ou de cadres législatifs qui peuvent favoriser ou inhiber le processus de conversion. Dans ces situations, les espaces de dialogue ouverts et réflexifs ont aussi une fonction, où ils permettent aux personnes soignées de partager en amont leurs préférences individuelles. Comme description des facteurs qui orientent les choix, les préférences individuelles permettent de mieux guider une tierce personne dans les actions pour poursuivre des activités qui transforment des ressources en capabilités valorisées par la personne soignée. Cela est notamment le cas chez une personne inconsciente, où le partage préalable des préférences individuelles quant aux soins pourrait permettre à l'équipe soignante de mieux les planifier, générant une flexibilité liée à l'évolution de la condition clinique. Contrairement au choix comme option définitive, qui limite la portée des options envisageables pour les capabilités, le partage des préférences favorise une expression différente de la participation. Dans la pratique infirmière, cela implique d'interroger non seulement les objectifs, mais aussi les préférences individuelles qui créent ce choix. Cela supporte une compréhension globale des enjeux et une légitimation de l'action de l'infirmière dans des situations où elle a un impact direct sur la conversion de ressources vers certaines capabilités pour la santé.

La création d'un environnement favorable:

L'environnement, qui comprend à la fois les dynamiques sociales et politiques, les organisations de soins et les lieux physiques, peut favoriser ou inhiber la conversion des ressources en capabilités. Sans un environnement propice, cette conversion est limitée, voire impossible. L'accès aux soins et aux services, le soutien communautaire, les lieux de vie et de soins, la nature des rapports entre les individus et les organisations, les conditions sanitaires, ainsi que la représentation sociale de certains groupes, sont tous des exemples de facteurs qui favorisent ou inhibent la conversion de ressources en capabilités. Cette liste, non exhaustive, illustre des conditions dans l'environnement qui requièrent des activités infirmières de nature sociale ou organisationnelle, pour participer à la conversion de ressources en capabilités pour la santé. En contexte de fin de vie, des activités infirmières de nature sociale peuvent notamment inclure la collaboration avec des acteurs du réseau communautaire pour le déploiement des soins à domicile ou les activités d'enseignement aux aides-soignants afin de réaliser certaines tâches. Sur le plan organisationnel, des activités infirmières peuvent inclure la négociation d'allocation d'aide à l'hygiène auprès des gestionnaires ou l'organisation d'initiatives de répit pour les proches, afin de contribuer à la possibilité qu'une personne en fin de vie puisse demeurer à domicile comme elle le souhaite. In fine, les activités infirmières de création d'un environnement favorable comme processus de conversion de ressources en capabilités pour la santé mettent en évidence la transformation consciente de l'environnement et, par extension, des ressources à disposition pour déployer ces activités infirmières.

Les ressources en transformation

L'idée de ressources renvoie à l'ensemble des acteurs, des biens et des services qui, dans un environnement et à un moment donné, sont utilisés dans le processus de conversion de ressources en capabilités pour la santé. Dans une conception de l'agir complexe de la pratique infirmière, les ressources mobilisées dans un processus de conversion sont diversifiées.

De prime abord, les personnes soignées et leurs proches représentent eux-mêmes des ressources. Ces acteurs de l'agir complexe de la pratique infirmière possèdent des capacités, construites au fil de leur histoire, et qui attestent de leurs possibilités d'être et de faire, autant dans la sphère décisionnelle du soin, que dans l'action quotidienne. La pratique infirmière, comme processus de conversion, sollicite la capacité des personnes de choisir et de décider, pour elles-mêmes et sans coercition, ce qu'elles valorisent pour leur vie. Les ressources individuelles des personnes, en termes de connaissances et de capacités de raisonnement critique, tout comme leurs capacités physiques et sociales, font ainsi partie de l'évaluation clinique et des activités subséquentes, pour convertir lesdites ressources individuelles en capabilités pour la santé.

D'autres ressources humaines mobilisables dans la pratique infirmière incluent les membres de l'équipe interprofessionnelle, les organismes communautaires ou l'infirmière elle-même. À celles-ci s'ajoutent des ressources matérielles, incluant les équipements, les espaces physiques, les documents et autres outils de travail; des ressources financières liées aux soins ou à l'octroi des services; des ressources informationnelles, incluant les données consignées aux dossiers des patients; des ressources organisationnelles reflétant des orientations stratégiques; ainsi que des ressources sociales et politiques, incluant les droits des personnes soignées, des lois, des politiques locales et nationales et la déontologie encadrant la pratique infirmière.

Toutes ces ressources configurent les lieux et les contextes de la pratique infirmière et sont en transformation, par leur nature transitoire. De plus, même lorsqu'elles se déploient en dehors de la pratique infirmière, les ressources transforment, récursivement, la pratique infirmière et ses ressources à disposition. Par exemple, au Québec, la modification législative de 2014 légalisant le recours à l'aide médicale à mourir a créé de nouvelles ressources pour les personnes soignées et les infirmières, permettant des capabilités qui n'étaient pas envisageables antérieurement. Différemment, des changements dans le financement des établissements de santé, le délestage du personnel soignant ou les contraintes sociales liées à la situation de la COVID-19 ont limité l'accès à certaines ressources qui étaient disponibles. Cela met en évidence que l'agir complexe de la pratique infirmière prend forme à l'intersection de diverses ressources en transformation, ce qui crée de multiples possibilités de conversion vers des capabilités pour la santé.

Discussion

Partant de l'idée de capabilités de Sen (30,34,35,36,37,41) et d'une rationalité d'intelligibilité pour concevoir et déployer l'agir complexe de la pratique infirmière dans notre monde contemporain en transformation (1), nous proposons de concevoir la pratique infirmière comme un des multiples processus de conversion de ressources en capabilités pour que les individus poursuivent la vie qu'ils ont raison de valoriser. Il va de soi que la pratique infirmière n'est alors pas seule à concourir à la création des capabilités. D'autres systèmes d'action, à divers niveaux, peuvent participer à la création de capabilités pour la santé. Notre proposition suggère toutefois que cette idée s'incarne de manière distincte dans la pratique infirmière du fait de son engagement envers la santé des personnes soignées. Cette distinction prend forme dans la finalité de capabilités pour la santé poursuivie, de même que dans les activités visant la participation des personnes soignées et la création d'un environnement favorable.

À certains égards, cette proposition rappelle la notion d'empowerment, soit la capacité d'un l'individu à exercer un plus grand pouvoir sur sa vie ou à actualiser son potentiel humain (44,45). En sciences infirmières, ce concept est fréquemment évoqué, particulièrement sous l'angle d'une idéologie néolibérale d'autodétermination, qui suggère que les personnes seraient d'emblée capables d'exercer un contrôle sur leur vie et donc seraient responsables de leur santé (et de leur maladie) (45,46). L'idée de capabilités représente plutôt l'individu comme étant « en capacité de », selon sa réalité propre et singulière. Dans ce cas, la possibilité réelle et contextualisée d'être et de faire n'est jamais acquise, ni prédéterminée en fonction de visées spécifiques, mais demeure en constante transformation.

De manière similaire, notre proposition résonne aussi avec le mouvement de soins centrés sur la personne qui aspire à reconnaître, dans les soins, la singularité de chaque individu en termes d'historicité, de valeurs et d'auto-détermination (47). Présentant un attrait certain sur le plan moral, certaines critiques ont toutefois été formulées sur l'application de tels principes, à savoir la non-reconnaissance de l'asymétrie professionnelle qui justifie la relation (48), la mise à l'écart, dans les processus décisionnels, des réseaux de relations qui constituent l'individu (49), ou encore la possibilité effective d'objectifs de vie en dehors du soin (32). À ces trois critiques, notre idée de concevoir la pratique infirmière comme un processus de conversion de ressources en capabilités pour la santé ouvre des pistes de réflexion : 1) sur la nature du rapport entre l'infirmière et les personnes soignées, 2) sur l'étendue des ressources mobilisables, et 3) sur la réflexivité inhérente à cette pratique.

Premièrement, cette proposition évoque un espace d'interdépendance réciproque entre l'infirmière et la personne soignée. La conversion de ressources en capabilités pour la santé ne correspond ni entièrement aux volontés de la personne soignée, ni aux visées de l'infirmière. Plutôt que de présumer des comportements à observer ou des actions à poser, le processus de conversion évolue en fonction des possibilités et des impératifs de chacun. En l'occurrence, l'infirmière doit évaluer non seulement comment et dans quelle mesure une personne soignée est en mesure d'agir comme agent de sa propre santé, dans son contexte de vie (32); mais également être à l'écoute de ses choix en fonction de sa vie valorisée. De plus, l'infirmière doit agir en cohérence avec ses responsabilités professionnelles et déontologiques et en expliciter la portée aux personnes soignées. L'agir complexe de la pratique infirmière comme processus de conversion de ressources en capabilités, est donc à la fois singulier et contextualisé aux réalités de l'infirmière et de la personne soignée, soulignant leur interdépendance réciproque, parfois occultée dans le mouvement de soins centrés sur la personne (49). En des termes différents, Pernet et ses collaborateurs (50) suggèrent qu'une relation de confiance mutuelle, qui permet autant une liberté d'expression chez la personne soignée, qu'une personnalisation des interventions professionnelles, favorise la conversion de ressources en capabilités. Notre proposition n'exclut pas la confiance mutuelle. En revanche, le caractère d'interdépendance réciproque ne se résume pas qu'à la nature de la relation infirmière avec la personne soignée; il relie les acteurs et leurs réalités propres dans un système d'action complexe.

Par conséquent, comme deuxième réflexion, l'idée de capabilités de Sen élargit la conception dyadique du soin entre l'infirmière et la personne soignée. Notre proposition signale que les facteurs de conversion, personnels, sociaux et environnementaux, qui favorisent ou inhibent les capabilités sont multiples et contextuels. L'agir complexe de la pratique infirmière comme processus de conversion doit se déployer non seulement dans l'espace relationnel avec la personne soignée, mais également dans des sphères sociales ou organisationnelles. Cette idée n'est pas nouvelle pour la discipline infirmière (1,26,42,51). Le rapprochement avec les acteurs de la communauté, l'identification des voies d'influence politique, la transformation des règles organisationnelles locales ou l'amélioration des déterminants sociaux de la santé en sont de bons exemples (42,52,53,54,55). Ces pratiques résonnent avec notre proposition qui fait référence à des activités de création d'un environnement favorable pour convertir des ressources en capabilités pour la santé. Toutefois, travailler dans ces sphères est parfois considéré inconfortable pour les infirmières. Leur identité politique est peu développée par manque de repères, de compétences ou d'aptitudes (54,56). Les compétences de leadership politique aux niveaux clinique ou organisationnel sont notamment peu abordées durant la formation infirmière (57). En effet, la formation initiale des infirmières mettrait davantage l'accent sur le développement des compétences techniques ou d'évaluation visant la standardisation des soins (58). Les compétences politiques requièrent plutôt le développement d'une capacité d'analyse stratégique des relations organisationnelles et opérationnelles entre les autres acteurs du soin (59), en plus de capacités de gestion du changement (60). Pour s'approprier notre proposition d'agir complexe, le développement de ces compétences serait à poursuivre.

Au vu de ce qui précède, la troisième réflexion issue de notre proposition théorique est à l'effet que la pratique infirmière comme processus de conversion de ressources en capabilités pour la santé, est un agir complexe réflexif. Partant de la finalité de capabilités pour la santé, les activités infirmières transforment des ressources (humaines, matérielles, informationnelles, organisationnelles, sociales ou politiques), lesquelles sont converties en capabilités. Ces capabilités peuvent, récursivement, transformer les ressources à disposition pour poursuivre la finalité de la pratique. Les activités d'éducation à la santé qui permettent le développement de connaissances des personnes soignées ou les activités visant à favoriser l'accès à certains professionnels soignants ou groupes communautaires peuvent notamment être données en exemple. Elles permettent à la fois le développement de capabilités pour la santé et de ressources chez les personnes soignées. De cette manière, la pratique mène l'infirmière sur des chemins possiblement différents des trajectoires standardisées ou établies, ce qui exige, chez les infirmières, un jugement critique, voire une capacité de réflexivité sur soi. La participation des personnes soignées au processus de conversion de ressources en capabilités pour leur santé, notamment par la création d'espaces de dialogue ouverts et réflexifs est d'ailleurs un élément clé de cette réflexivité vers des possibilités jusque-là non considérées (49). Plutôt que de positionner le respect des volontés individuelles comme critère absolu de légitimité du soin, les espaces de dialogue ouverts et réflexifs favorisent l'expression de la raison individuelle (30) et son élaboration au contact des possibilités réelles et des contraintes contextuelles. Néanmoins, de tels espaces, qui sollicitent le caractère rationnel des volontés poursuivies par les personnes soignées, semblent peu initiés par les infirmières (29). Les professionnels de la santé craignent parfois de remettre en question les volontés exprimées des personnes soignées (61), ce qui, en l'occurrence, limite la capacité de délibération vers des choix éclairés, contextualisés aux contraintes et justes pour la personne. Comme notre proposition sollicite ces échanges comme moyen pour cheminer, de manière réflexive, vers la finalité de capabilités pour la santé, nous considérons que les mécanismes par lesquels ces espaces se créent et se transforment seraient à cerner. Une telle étude permettrait de mettre en lumière les différentes manières par lesquels la pratique infirmière se relie à la vie réelle des personnes soignées. À cette fin, les méthodologies narratives ou celles de type « étude de cas » seraient à considérer.

Ces trois pistes de réflexion signalent autant le caractère relationnel de la pratique infirmière que sa nature sociale, stratégique et réflexive pour la santé. Une telle ouverture, nécessaire à l'inscription de la pratique infirmière dans le mouvement de soins centrés sur la personne, sollicite une capacité créative pour déployer et prolonger l'engagement envers l'ensemble des capabilités d'une personne pour être et faire ce qu'elle a raison de valoriser (30). La capacité créative est ici comprise comme un agir à la fois novateur et adapté au contexte de la pratique (62), sollicitant la raison, le savoir professionnel et la subjectivité des infirmières (63) pour créer des voies alternatives aux cadres normés qui limitent parfois les possibilités (17). Les capabilités pour la santé étant éminemment contextuelles (38), les protocoles de soins sont parfois insuffisants. D'autres dispositifs ou acteurs doivent alors être mobilisés pour déployer l'agir complexe de la pratique infirmière. Cette pensée qui relie les savoirs, les volontés de la personne soignée et des ressources suppose une créativité qui transcende l'habituel. Cela pose l'exigence d'un effort réfléchi et continu de la pratique infirmière pour développer la meilleure action en contexte (64). Quoique souhaitable chez les infirmières de tous les niveaux de formation, l'émergence d'une telle capacité créative demande à la fois des compétences de pensée critique et autonome, de même qu'un contexte organisationnel favorable à son déploiement (64,65). Peu étudié sous l'angle de la mise en application par les infirmières, nous soulignons l'intérêt de réfléchir aux manières par lesquelles la capacité créative des infirmières se construit en réponse aux réalités singulières rencontrées.

L'idée des capabilités de Sen ouvre ainsi une fenêtre sur des questionnements éthiques et politiques de la pratique infirmière. Les concepts de capabilités, de conversion et de ressources interrogent de manière critique les conditions de vie des individus et leur engagement dans la transformation du monde. Ces concepts ouvrent à considérer les divers processus de conversion qui façonnent l'expérience humaine, situant les pratiques soignantes dans la multiplicité de ces relations. Toutefois, initialement proposées dans le domaine de l'économie pour formuler des indicateurs de développement humain (30), il faut reconnaître que les idées de Sen n'avaient pas pour visée de concevoir une pratique soignante. Ainsi, nous ne pouvons prétendre que Sen soit en accord avec l'ensemble de nos propositions ou encore moins que ses idées soient transférables à une posture épistémologique particulière. Sa pensée, qui formule un cadre souple d'idées (66), a d'ailleurs été invoquée différemment par d'autres auteurs du domaine de la santé (32,49,50) ce qui témoigne de sa fécondité pour concevoir la diversité des processus sociaux et politiques qui façonnent l'expérience humaine qui est au cœur du soin infirmier.

Conclusion

Dans cet article, l'approche par les capabilités d'Amartya Sen a été utilisée comme outil théorique pour concevoir la pratique infirmière et appréhender son agir complexe. En particulier, nous proposons que le concept de conversion est porteur pour concevoir la pratique infirmière comme la voie de passage entre la diversité des ressources pouvant être mobilisées, selon les réalités contextuelles, et les capabilités pour la santé. S'agissant d'une proposition théorique, celle-ci mérite maintenant d'être mise à l'épreuve empiriquement pour explorer comment la conversion prend forme dans l'agir complexe de la pratique infirmière. Une telle étude pourrait notamment cerner des mécanismes par lesquels les infirmières génèrent des capabilités pour la santé afin que les personnes soignées vivent la vie qu'elles ont raison de valoriser.

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3

Abstract

This essay critiques physiotherapy’s dogmatically held ontology of transcendence through both the essay’s content and its stylistic form. I resist representational thought and transcendence, creatively experimenting with the generative potential of Viktor Schlovosky’s concept of making strange. I attempt to make physiotherapy strange and escape its habituation of thought by 1) intentionally plugging into disciplines outside of physiotherapy, and 2) using unconventional and unfamiliar language throughout this essay. Specifically, I draw lines of similarity between physiotherapy’s ontology and that of Christian fundamentalism. I argue that physiotherapy, like fundamentalism, dogmatically conforms to limited, incontroversial Truths upheld by the profession. Using this confluence, I illustrate how betraying physiotherapy becomes necessary in order to escape its conformist ontology. Inspired by Gilles Deleuze and Felix Guattari’s philosophy, this essay reimagines physiotherapy and its ontology as one of immanence and difference. By betraying the comfort of transcendence, affirming difference and unfamiliarity, I experiment with what else physiotherapy might do and could become.

Keywords Deleuze, physiotherapy, making strange, betrayal, transcendence

The Church of Physiotherapy: The Necessity for Betrayal

EDUAN BREEDT

Introduction

Nothing interesting begins with knowing, but with not knowing (1). The pursuit of not knowing, however, is largely not an appropriate pursuit for the physiotherapist. The entire profession is steeped in an ontology which presupposes that every dimension of being is derivative of a permanent and concrete unified foundation. There exists an ultimate Truth which lies outside the world - a transcendent ontology of being.

> There is a way to be a physiotherapist
>
> - an identity to apprehend.
>
> There is an Ideal Body which everyone ought to strive to embody
>
> - the white, male, hard, able body.
>
> There is a transcendent Form of Health
>
> - to be an autonomous, rational, self-contained, independent, individual who contributes to the capitalist machine.

Transcendence demands that we head in the “correct” direction, even if we never arrive. We must become one of them, recognize what everyone recognizes, hold the opinion that everyone holds - conform. Transcendence relies on representation. Faithfully represent the world, how it ought to be represented, how we decided it should be represented. Transcendence demands we know what physiotherapy is, we know what health is, we know what the body is, and that we know what to do, ahead of the doing.

> “Representation has only a single centre, a unique and receding perspective, and in consequence a false depth. It mediates everything, but mobilises and

> moves nothing." (1, pp55-56)

An ontology of transcendence has largely gone unquestioned in physiotherapy. It is given to us by the profession's dominant flow of opinion (2-3, p45). The constant flow of opinion can erode away at thought, creating a path, a rut, a ditch, a trench - closed off to the outside. Most of us have learned to float on our back quite comfortably while being carried through its tributaries. We forget that this "European disease," (4, p16) this 'Man' made stream, has been constructed and its construction then forgotten. It is so taken for granted that what I am referring to is nearly imperceptible; transcendence is the darkness surrounding the enlightenment (5)

> "One of the moral diseases we communicate to one another in society comes from huddling together in the pale light of an insufficient answer to a question we are afraid to ask" (Thomas Merton)(6)

For French philosopher Gilles Deleuze, the deepest dimension of being is not sedentary, but mobile. Not composed of a scaffold of identities, but by an ocean of difference (1, p41). In an ontology of difference, nothing is but everything is becoming. There are no beings, only doings: "Representation fails to capture the affirmed world of difference." (1,p55). The seduction of unified identities, those which are familiar and recognizable, produces the automatization of perception where the familiar devours the vitality of things (7). Inspired by Deleuze and Russian literary critic and writer Viktor Shklovsky, my task then is to escape familiarity and transcendence - to get outside of it. To escape, we need thought which is the result of outside forces. Thinking depends on forces which take hold of thought, outside forces (8). Thought is when "something in the world forces us to think." (1,p139).

Art as Escape

An appropriate response to physiotherapy's sedentary ontology appears to me to be the adoption of an artful predisposition - the assumption that every supposed unity has within itself the surprise of difference - its own foreign (7,9). The difference within a thing produces its unfolding (5), that which differs from itself is in agreement (9). There is always the possibility for the unfamiliar, a "surprise", or something new. Art presupposes that being is not exhausted, there remains the possibility to bring the non-existent into being. Therefore, everything at the deepest dimension of being is unrecognizable before it is recognizable. We are compelled to engage in genuine thought and genuine creation when we betray what we recognize and try to think that which is unrecognizable.

> "Art is fundamentally ironic and destructive. It revitalizes the world"(Viktor Shklovsky) (7)

Shklovsky explored what might happen when art is thought of as a device that makes the familiar strange (7). A device to invoke difference (1). A painter, sculptor, writer, poet, or philosopher are no longer merely artists, but opticians. Philosopher Baruch Spinoza, a prominent "optician," demonstrated the potential of art. He was an optical lens grinder, designing microscopic and telescopic lenses both practically and theoretically that altered philosophy's ontological terrain. Opticians increase the duration and complexity of perception, not to recognize or represent "Truth," but to perceive differently. Not representing what already exists, but inventing, giving being to what did not exist (10). Thought outside the purview of what everybody sees, something that could not previously be imagined, cannot be replicated, and takes us by surprise (11). Repressive forces force us to express ourselves, fortifying opinion and producing consensus (12,p129; 13,p6). Making the familiar strange, outside of signification and language, produces the relief of no longer having anything to say. A vacuole of ex-communication (5) or "gaps of solitude and silence", (12,p129) that obstructs the flow of opinion and constant chatter of what they say. Providing us the possibility of eventually finding something worth saying (12,p129).

What might art do in physiotherapy if we choose to define art as Shklovsky did? Our familiarity with concepts which are embedded in an ontology of transcendence and taken for granted, such as the clinic, the patient, the physiotherapist, movement, and the body, are thrust into a new milieu, driven through a new context so that it is no longer recognizable, and we are no longer speaking in the name of physiotherapy. My task, then, is to break from the flow of opinion and make the familiar strange. Art, making strange, is a means of escape. Exteriority opens out to a new milieu "like cracking the window in a house" (5,p44) to let in some "free and windy chaos." (13,p204). Or it might allow us to draw a line of flight, crash through the window and land flat on our back. Winded, not having anything to say. Blinded, but able to perceive.

This article on one level is a critique of physiotherapy's ontology, but at another level is an academic act of defiance. It asks, "what might happen if a paper intervenes and resists representation using artfulness at the level of content and form?"

Writing as Resistance

In regard to the latter, 'form', I choose to betray my entanglement with academia and its dominant representational expectation of what an academic physiotherapist is and how they should write. Speaking as a physiotherapist or representing physiotherapy renders me complicit in an ontology of transcendence, fortifying opinion and consensus. Therefore, this paper, in some ways, resists academia and is not intended to be interpreted and understood. As Deleuze and Guattari say, there are two ways of reading a book or paper:

> "[Y]ou either see it as a box with something inside and start looking for what it signifies… Or there's the other way: you see the book as a little non-signifying machine, and the only question is 'Does it work, and how does it work?' How does it work for you? If it doesn't work, if nothing comes through, you try another book. This second way of reading is intensive: something comes through or it doesn't. There's nothing to explain, nothing to understand, nothing to interpret. It's like plugging into an electric circuit." (12,pp7-8)

Through experimenting with writing, I hope to produce divergence, a multiplicity of meanings which might help us escape representation. Misread and mistranslate me, "...all mistranslations result in beauty. This is a good way to read: all mistranslations are good" (14,p5). A staccato, "roughened" rhythm in writing makes what is written unfamiliar, removes automatism in thought, increasing the difficulty and duration of perception (7). This style creates a straining in knowledge between what is known and not known: "a straining of one's whole language toward something outside it." (12,p140)

> "We go toward the most unknown and the best unknown, this is what we are looking for when we write. We go toward the best known unknown thing, where knowing and not knowing touch, where we hope we will know what is unknown. Where we hope we will not be afraid of understanding the incomprehensible, facing the invisible, hearing the inaudible, thinking the unthinkable, which is of course: thinking." (Hélène Cixous) (15)

Only there might we escape opinion and have nothing to say.

> "How else can one write but of those things which one doesn't know, or knows badly? It is precisely there that we imagine having something to say. We write only at the frontiers of our knowledge, at the border which separates our knowledge from our ignorance and transforms the one into the other." (1,pxxi)

This is an attempt at bilingualism, a minor use of language, a stammering: "being like a foreigner in one's own language. Constructing a line of flight." (14,p4). With enough resistance and friction, I hope "...a spark can flash and break out of language itself, to make us see and think what was lying in the shadow around the words, things we were hardly aware existed." (12,p141)

Machines

At the level of content this paper attempts to make the familiar strange and produce new orientations for thought by creating what Deleuze and Guattari call a machine, one which plugs into outside thought (4,16).

> "Place thought in an immediate relation with the outside, with the forces of the outside." (4,pp376-377)

The outside puts motion back into thought, not through internal movement, but by leakages to the outside. To reinstitute movement into sedentary thought requires "a plurality of centres, a superposition of perspectives, a tangle of points of view, a coexistence of moments which essentially distort representation." (1,p56). A steam engine plugs into other machines, captures energy and redirects its flow, to be productive of something. In the same vein, "when one writes, the only question is which other machine the literary machine can be plugged into, must be plugged into in order to work." (4,p4). This paper is a machine. Through experimentation and plugging into machines on the outside, disrupting flows, irrigating energy, working and reworking it, unplugging and replugging, detaching and reversing it, I find out what can be destroyed, what can be produced and what else physiotherapy might do (17).

One might even say we "steal" from the outside, where stealing is not the same as "plagiarizing, copying, imitating, or doing like." (14,p4). Stealing is propagation and grafting in botanical terms. Or splicing, sampling and mixing in audio engineering terms. I might plug into and steal from music, art, science, philosophy, geology, biology, sociology, religion, my environment, something I hear, something I remember, something I read, something which affects me, and so on. I plug it in to disrupt the intolerability of the present and produce something more tolerable. This harnessing of outside thought produces flows which escape and destroy the banality of the present, cutting off the physiotherapy flow of opinion to reorient thought in the hopes that for a moment I might "...bring some things to life [...] free life from where it's trapped [...] trace lines of flight." (12,p141).

I specifically choose to plug physiotherapy into fundamentalist Christianity. On the one hand, bringing together two disparate fields (religion and physiotherapy) further makes both strange. On the other hand, this essay is an ode to a younger me, wielding an adolescent, polemic, punk anger. A polemic that does not endeavor to fortify a particular opinion and consensus but escapes it.

This essay is an expression of a time where my religious upbringing and my physiotherapy education both followed a similar trajectory: Transcendence to immanence; identity to difference; being to becoming; capture to escape; exclusivity to inclusivity; negation to affirmation; finding solutions to posing problems; and; and; and…

This paper is me asking questions and posing problems, problems which become my truth, the answers of which are always already untrue. No doubt, there will be those who say that this paper has too many internal inconsistencies. To that I respond:

> "Do I contradict myself?
>
> Very well then I contradict myself,
>
> (I am large, I contain multitudes.)"
>
> (Walt Whitman) (18)

Betrayal

Every field needs a bit of betrayal - a bit of Judas - if it desires to have movement (19). Complacency, conservatism, and dogmatism oppose change and the new. Writer Jorge Luis Borges imagined a Judas who he describes as intuiting the necessity of the divine plan and thus the crucifixion to incite a rebellion (20). He describes Judas as sacrificing his own reputation for the divine plan. God became fully incarnate, not through Jesus, but through Judas.

Thought is imperceptible to dominant regimes of truth and stable identities. "[W]e have to counter people who think 'I'm this, I'm that'... arguments from one's own privileged experience are bad and reactionary arguments." (12,pp11-12). "The self is only a threshold, a door, a becoming between two multiplicities." (4,p249). We are always becoming, not "subjects developing into more of themselves," (5,p24) but identities which "undo the stabilities of identity, knowledge, location, and being." (21,p3). We are undoing ourselves - "[t]here is no terminus from which you set out, none which you arrive at or which you ought to arrive at [...] The question 'What are you becoming?' is particularly stupid. For as someone becomes, what he is becoming changes as much as he does himself." (14,p2). To be able to think starts by breaking the habit of representing the dogmatic image of physiotherapy (1). Betray one's sedentary Identity.

My betrayal is an intentional repealment of my discipleship, no longer being a follower of Physiotherapy as it currently stands. Betraying the sedentary physiotherapy identity is not an act of hate but an act of love, desiring a new avenue with greater movement and greater potential.

> "For, by believing passionately in something which still does not exist, we create it. The nonexistent is whatever we have not sufficiently desired, whatever we have not irrigated with our blood to such a degree that it becomes strong enough to stride across the somber threshold of nonexistence." (22,p434)

This critique elucidates why radically cutting ties with the profession's transcendent ontology and becoming a traitor prophet might be necessary for physiotherapy.

The evangelical fundamentalist physiotherapist

Believers in "Evidence-Based Practice" have discussed at length how a relatively sizable proportion of the profession practices using outdated modalities and rituals despite overwhelming evidence that many of these interventions are no better than a placebo (23). Snake oil salesmen insist "I see it work!" as they continue their faith healing, their muscle imbalance training, their myofascial release, their transverse abdominis activation.

Thank you, Plato, for your world of forms! The profession's ontological obsession with transcendent identities that it takes for granted has led us to this cul-de-sac of thought.

The fundamentalists pose motionless in the physiotherapy family photo, awkwardly holding a strained smile for a lifetime, waiting for God knows who to take their picture hoping they fill the empty frame.

With their identity comes their healing hands and magic treatments. The fundamentalists present problems as simple and provide universalizing, complex solutions shrouded in pseudoscience. They evangelize by performing dazzling sleight of hand, correcting misalignments, and obliterating taut myofascial bands. They embody a kind of guruism proclaiming "if you follow me you can achieve transcendent wholeness and health."

On their mound of meta-analysis, randomized control trials, and Cochrane reviews, the post-positivist denomination points and laughs. "How narrow-minded!" they remark contemptuously: "if only they could examine their own fallacious human nature and flawed fundamental beliefs." (23).

While the post-positivist, evidence-based therapist disentangles the transcendent claims of the fallacious trigger point therapist with one hand, the other hand is behind their back holding onto their own God. In a reactionary movement they, the post-positivists, become fundamentalists themselves. Ontologically doomed, they maintain and reinforce transcendence.

The Snake Oil Salesman is to the Evidence Based Practitioner what Satan is to the fundamentalist. Not the absolute antithesis of the divine but something much more dangerous - the demonic simulacrum, "the Same, the perfect double, the exact semblance, the Doppelgänger, the angel of light." (24,p13). A deception so complete that those who do not have eyes to see and ears to hear cannot "tell the imposter (Satan, Lucifer) apart from the "reality" (God, Christ)." (24,p13).

In retaliation, the disinterested scientist-clinicians prophecy "science is the Way to Truth! We can all achieve enlightenment, just give up your sinful flesh, your false perceptions, your ways in the world, your biases, so that you can see clearly." (25).

Truth, pure Truth, is thought of as having asymptotic fidelity which we can approximate when we exorcise our sinful corporeal selves with the double-blind randomized controlled ritual. It will wash away our "faulty subjectivity" and lived experiences so we can get at "the things in themselves." (26). Truth is omnipotent, omniscient, omnipresent, all hail.

How much easier would it be if humans stopped making the world filthy with their lived experiences, ugh.

A new king

We constructed a hierarchy, an ontology of transcendence, and rendered ourselves subordinate to God who we placed on an imaginary throne. Having become enlightened, now a scientific people, we thought God a figure much too archaic and primitive for our taste. We overthrew the king but left the phantasm of the throne. Once empty, Truth crept onto the already warm comfortable seat. So familiar and recognizable, we let Truth stay.

Although the symbols have changed, our underlying belief apparatus has remained much the same.

Scientism is the new Being of God. "With enough inquiry we will eventually discover how things are in themselves" it insists. Through our ontology of being, we view Truth, Morality, and Justice as eternal, unchanging, and objective; out there somewhere and merely needing to be uncovered.

The evidence-based practice denomination, with their essentialist agenda, asks, "what are human bodies actually and essentially like?" bringing with it the assumption that there exists a normal and ideal body we ought to strive for. Healthcare providers have the power to be the arbiters of bodies and minds (27). We sort the ideal from the non-ideal. The normal from the abnormal. The compliant from the deviant. The Christ-like from the not Christ-like. With a transcendent ontology come hierarchies of Truth, knowledge, and power.

We're told we can know the world if we granulate it and study its little bits. Bodies and their bits. We can fix it once we find out where the screw fell out. To stop and measure, we need a world that stands still, and we need concepts which can contain the world. But concepts solidify reality; they fix between rigid outlines like a camera freezes reality on the surface of the paper. To define is to confine. Concepts deform reality; reality, in its continuous movement, is richer than any concept. To quantify we need to create immobilities of the fundamentally mobile. We solidify flows (28). When we ask wave-like questions we get wave-like answers and when we ask particle-like questions we get particle-like answers.

To fix life in place, to hold it down, sedate it and stop its wriggling is very pragmatic indeed. However, we should not mistake the taxidermied specimen arranged in a life-like pose for the wild animal. But devoted to our models of health, we are enamored. Sat gnawing at the menu having mistaken it for the meal.

This is our prerogative - qualifying the qualitative. We all swim in the waters of post-positivism, but no one knows they are wet. The same form, different content. Verifiability, falsification, and replicability are the new commandments and Cochrane reviews are the books of the bible. We follow our Messiah, Evidence-based Practice, he will lead us to Truth, and it is only in Truth that we can ever be whole. From John 8:32 to John et al, 2008. As long as there is an ontology of Being and transcendence, every generation will have its religion.

Atheism is not so different from theism. It is a matter of preference for a God Being or a Truth Being

> "God is dead. God remains dead. And we have killed him. Yet his shadow still looms." (Nietzsche) (29)

God's not dead; He wears a different crown.

(I feel compelled to defend myself and explain that I am not "anti-science". (Why do I feel compelled to assure you I am not "anti-science"? What repercussions do I fear? Is this what self-regulation looks like? The panopticon perhaps, Mr. Foucault (30)? What I am, however, is anti-fascist. An ontology of transcendence, currently epitomized by evidence-based medicine, has a pernicious kind of micro-fascism that holds us captive (27). But I guess that is the nature of the beast. Categories and identities make us comfortable.)

Enough Socrates!

Needing a body (a host) to do physiotherapy to, the profession dehydrated and dissected the patient's and the clinician's body and embalmed it with the physiotherapy "regime of truth" (30). But, this taxidermied body did not sit well with those still living, so physiotherapy responded with "person-centered care". Do not be deceived by its holism; person-centered care is a trojan horse that also infiltrates patients with the physiotherapy agenda and same sedentary ontology.

Transcendent physiotherapy has convinced the therapist that they are priests - conduits of the divine - both in mind and body. The therapist, a scientist (which is another word for Descartes' rational "Man") (31), is seated in the heavens. With the knowledge of the Ideal body they are perched on the very top of the tower of Babel, given a clear vantage of the ultimate goal: incorporeality, to approximate God. That is, striving towards having no body, a convenient body, a smooth body. A body which we no longer notice, on the periphery of experience.

(Dis)embodiment.

Through this intellectual authority, the therapist carves out 'his' praxis. This is the prerogative of the physiotherap(r)i(e)st - to exorcize the body. To "correct" it and make it unproblematic. Make it Ideal, make them a (no)body, make them "Man" (31).

If we obtain "buy-in", if we lead the proverbial horse to water, maybe they will drink the stupefacient. We Socratically question, listen, foster trust, empathy, and care, so that we can lovingly show them and motivate the Truth. Educate them into submission. Tender fascism (27). And when they don't like our flavor of ideology, we remark "You win some and you lose some. You can't fix (read convert) everyone, we can only do our best. They might come back in a few years with greater readiness for change."

Love the sinner, not the sin!

Not only Man's mind, but his body too. Watch a physiotherapist closely.

> ""Like Sartre's Waiter with Bad Faith, we act inauthentically, by yielding to the external pressures of society to adopt false values and disown our own innate freedom as sentient human beings. As a physiotherapist our movements and conversation might be a little too "physio-esque". Our voice oozes with an eagerness to inform, correct, and educate; we demonstrate exercises rigidly and ostentatiously; our movements a little too precise, a little too certain. It is a clear give away, our exaggerated behaviour illustrates that we are play acting as a physiotherapist, as an object in the world: an automaton whose essence is to be a physiotherapist." (p.329)

To be a Physiotherapist is something one is rather than something one does. A therapist performatively takes up the Ideal Body by embodying him (33); Protagoras' Man; the Vitruvian Man; Descartes' Man (34).

The physiotherapy body, the proper body is "clean, neat and tidy." (35,p235)

It is a hard body, a body under control (35,p235).

It is the ontologically immobile body and the body which immobilizes other bodies.

It excludes the body of difference, the flabby impermanent body.

It is "grasping for stasis, it says 'NO' to the difference that the movement of life presents." (35,p168).

> "The cult of the tight body is the cult of a body that does not give way to the other. Jiggly flesh is obscene, ugly because it gives flesh to the body's malleability, its lack of sovereignty when it is prodded or even when it moves." (35,p235).

Intellectually taking up Man's mind gives physiotherapy something to do. Embodying Man has given physiotherapy something to be.

When the clinician speaks, words percolate through the husk of the person whom the dogmatic image of physiotherapy has emptied out. The clinician provides only that which benefits the profession: sick bodies and healthy bodies, predictability and conformity. The promotion of "more medicine, even if this means less health." (36,p85).

The therapist is blind to itself, zombified conduits of the physiotherapy regime of Truth cloaked in altruism. Physiotherapy has given all of its therapists the identity of "being a physiotherapist" to conform to. As a result, physiotherapy does not disturb thought. It keeps us very busy engaging our faculties in activities that refer back to objects of recognition (1). Thought is filled with no more than an image of itself and its own internal logic; it recognizes itself the more it recognizes things (1).

Deleuze insists that conformism of thought wed to representation and recognition has left us virtually no tools to break with that which everyone already knows. "The exercise of thought thus conforms to the […] dominant meanings and to the requirements of the established order." (14,p13). Physiotherapy thinks for physiotherapists. It gives us norms, rules, and complicity. An image of thought (1).

An immanent creator

An antidote to transcendence is immanence and its perpetual escape, interruption, asymmetry, and coalition with the outside (5).

To be a creator is a "process of 'becoming' – the what might/

could be – the creation of what is not yet, is achieved through thinking in new, perhaps previously unimagined, modes of thinking." (37,p128). The creator "will be destructive, will affirm difference, and will exist in chaos. They will reach into the unknown and produce what is unrecognizable." (38,p88).

Immanence is everywhere, without it being a universal - "It's a 'differentiator,' a 'differential.'" (12,p156). Don't mistake immanence for a new transcendent category, for then we are no better than the post-positivists. Immanence, at its foundations, is not populated by identities or an Ideal but by a field of difference. Difference detached from identities and so always already having the possibility of pressing new identities into form. Therefore, immanence holds no animosity towards identities but acknowledges that no identity is eternal, and all should be deterritorialized.

Thought, on the plane of immanence, is never like writing on a blank page. There are always sedentary identities to be destabilized. We are always struggling "against the "cliches" of opinion" (13,p204). The page "is already so covered with preexisting, preestablished cliches that it is first necessary to erase, to clean, to flatten, even to shred, so as to let in a breath of air from the chaos" (13,p204). We can create only by first destroying the conventions of opinion.

> "The conditions of a true critique and a true creation are the same: the destruction of an image of thought which presupposes itself and the genesis of the act of thinking in thought itself" (1,p139).

Necessary, creative destruction, overturns "all orders and representations in order to affirm Difference in the state of permanent revolution." (1,p53).

For thought to move, we require an exercise of intolerance for the present, calling for the destruction and death of our sedentary ontology, announcing it as insufficient, critiquing those who still believe in it, and demanding its removal (5).

> ""No artist tolerates reality." (Camus' Nietzsche) (39,p222)

A creator who is the same, creating nothing new, is no creator at all. The true Creator is never the same but always different. Being has not been exhausted - bring something incomprehensible, something that did not previously exist into the world (10). Existing on a single plane, the creator operates from a theology of radical inclusion and affirmation.

> "To affirm is not to bear, carry, or harness oneself to that which exists, but on the contrary to unburden, unharness, and set free that which lives." (40,p185)

Let go of "oughts" and "shoulds" and let us experiment with not yet, and what might be.

After all, it was Paul, who, in a moment of lucidity denied an ontology of identity (transcendence) for one of difference (immanence) allowing the possibility for the "new": "Do not lie to each other, since you have taken off your old self [transcendence] with its practices and have put on the new self, which is being renewed in knowledge in the image of its Creator [Difference in itself]. Here there is no [identity] Gentile or Jew, circumcised or uncircumcised, barbarian, Scythian, slave or free, but Christ [Difference] is all, and is in all" (Colossians 3:9-11(NIV)) [author added in brackets].

Where is the new to be found? (1)

Making the familiar strange

> "Habitualization devours objects, clothes, furniture, one's wife, and the fear of war. . . Art exists to help us recover the sensation of life, it exists to make us feel things, to make the stone stony. The end of art is to give a sensation of the object as seen, not as recognized. The technique of art is to make things 'unfamiliar,' to make forms obscure, so as to increase the difficulty and duration of perception."(Viktor Schklovsky) (7,p162)

The familiar identities which we are all expected to recognize blind us and make our fingers numb. We need poets, writers, and painters to help us see things as they are sensed and not as they are known (recognized). In this way, they are more accurately defined, not as artists, but opticians. We are forced to look again, to see for the first time, from the outside (11). Seeing, in this sense is forgetting the name of the thing one sees (41).

Sometimes we need an optician to lead us by the hand out of the village into terra nullius, outside the city walls. What if "there's something wrong in the village" (42)? This is the function of the last guru (43) The Outsider(11,44): to reveal not their universal perspective, but betray any universal perspective. To spit in its face.

> "He took the blind man by the hand and led him outside the village. When he had spit on the man's eyes and put his hands on him, Jesus asked, 'Do you see anything?'" (Mark 8:23 (NIV))

Now outside the city gates – between territories – we are provided a perspective that was not afforded to us when we were complicit with the order of things. Becoming Moses, a stammerer and nomad, always ready to deterritorialize, having "a small plot of new land at all times." (4,p161) Go to "the far side of the wilderness" where we might encounter the "strange"

(Exodus 3:1-3 (NIV)), even if only for a moment. This is the value of getting lost and not knowing where to go.

> "To move from A to B, we have to go from A to not A. We do not go from certainty to certainty, but from certainty to uncertainty, from stability to instability." (45)

Betray comfort – break the boundaries of a thing to create new limits and explore alternatives previously hidden by the city walls. Enter the transitional space between thought and unthought, no longer having "their" opinion, not knowing what might appear, not knowing what to do next, like eyes before they open (46). The liminal spaces allow us to find new becomings. An ethics of betrayal demands a radical movement away from our faculties of memory, and reflection, rejecting the comfort of the status quo.

What we need is "something in the world" to force us to think not the recognizable (that which can be recalled, imagined, or conceived), but a "fundamental encounter." (1,p139) Physiotherapy is political – and so is betrayal. We all need some betrayal, something to spit in our eyes. Circumvent the imperative of oppressive forces to assimilate our thought into common sense and discourse of "everybody knows, no one can deny." (1,p130).

We require an outside thought which violates the conventions of physiotherapy that violates us, that attempts to think on our behalf. Thinking takes place out of reach of physiotherapy's agenda. Thinking takes place when we draw a line of flight across art, poetry, philosophy, science, symptomology, and… What forces us to think is imperceptible to "the physiotherapist" and is only available to the traitor prophet if they choose it: "the truth is not revealed, it is betrayed." (47,p95). So that we might become "...someone – if only one – with the necessary modesty [of] not managing to know what every [physiotherapist] knows, and modestly denying what everybody is supposed to recognize. Someone who neither allows [them]self to be represented nor wishes to represent anything." (1,p130).

Physiotherapy's ontology – its deepest dimension of being – should no longer be sedentary. Rather, it should be active and mobile. Resist Being a physiotherapist, Being is only a matter of becoming.

We must be vigilant for problems which are given to us. The clinical problems and their solutions physiotherapists encounter do not exist out in the world waiting to be solved and resolved. We cannot know or recognize the solutions to clinical problems a priori. Rather, problems and knowing is bound up in the process of resisting, interrupting flows, escaping, and posing problems (5). Not through contemplation and reflection, but through active, engaged, experimentation we find out how else we might intervene so that a body's capacity for movements and actions might increase and flourish.

Looking at physiotherapy long and hard enough allows it to recede and lose meaning. What was once familiar (physiotherapy) becomes strange. The name is the same, but its character warps and becomes dissonant the further we walk from it. The word is now charged as if it both hungers for what it was and anticipates what it might become - a strange pulsing of both past and present. Bodies that were and bodies yet to come. Physiotherapists that were and physiotherapists that are yet to come. There is another world out there we don't know – beyond the recognizable.

"Do you see anything [new]"? (Mark 8:23 (NIV))

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APORIA
LA REVUE EN SCIENCES INFIRMIÈRES • THE NURSING JOURNAL

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