

Critical Posthuman Nursing Care: Bodies Reborn and the Ethical Imperative for Composting

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Abstract

Nursing care is an embodied and co-creative, world-building practice made hypervisible in pandemic times. A traditional praxis that became a professionalized care practice, nursing bares the indelible mark of the ideologies that have come to shape the discipline, like whiteness, patriarchy, and capitalism to name a few. Embracing a critical feminist posthuman and new materialist perspective, in this paper we advance the notion that nursing care is a situated and embodied endeavor that cannot and should not be disconnected from sites of care, people receiving care, and the powers that structure care relations. Even in idealised contexts, nursing care is shaped by the confines of these forces. We tease out ideas that have molded nursing across time and within the epoch of the COVID pandemic. We draw upon imagination inspired by Arundhati Roy, and the pandemic is a portal, an opportunity for rebirth, as well as the speculative traditions of science fiction and Afrofuturism. Care practices are proposed with a critical posthuman perspective, in the spirit of Haraway's idea of composting. Composting is used metaphorically as actions to morph and decay the boundaries beyond traditional notions of care based in humanism. We imagine this in an effort to rethink what worlds we want to co-produce, a call to action where care can be revisioned as an arena where nurses, people, all matter, all creatures and worlds are co-created.

Key words: Affirmative Ethics, COVIDicene, Critical Posthumanism, Feminist New Materialism, Nursing Care, Nursing Historiography

An embodied practice, nursing is a co-creative, world-building endeavor closely tied to care and caring. In this paper, we make sense of embodiment and body using a posthuman lens and think of being embodied as material, contextual becoming without clear boundaries neither of the individual nor human (Goodley et al., 2021); meaning “the embodied, embedded and sexuated roots of all material entities, humans included” (Braidotti, 2022, p. 11). For us embodiment is a lived entanglement, always interdependent of human and more-than-human matter, a geosocio-temporal focal point, which grounds our discussion of nursing and care. Nursing, both noun and verb, has since the 1860s undertaken an effort toward professionalization with shifts from community-based to institution-based care, from body work to reliance on increasingly complex technologies, from informal and socially-transmitted *care work* praxes to complex institutional paths for education and licensing. The professionalization of nursing as a care practice is linked to legitimacy and power, bound up with white supremacy, patriarchy, colonialism, and capitalism, ideas others have written about, thoughts we will further explore in this paper (De Sousa & Varcoe, 2021, pp. 4–5; Jenkins et al., 2021, p. 4). The guiding theories in modern professional nursing arise from western philosophy of science, episteme also dominated by forces of a white cisheteropatriarchal, christian supremacist hegemony and are deterministic of what constitutes knowledge (Braidotti, 2019, pp. 6–9; Peters, 2019, pp. 888–89).¹ Prioritizing these hegemonies leads to shaping care around one-size-fits-none, evidence-based knowledge practices which obscure situated and embodied knowledge, a reality rarely examined or even acknowledged in nursing. Embracing a critical feminist posthuman and new materialist perspective, we advance the notion that nursing

care is a situated, embodied endeavor without equating embodiment with independence, “as if the entanglement of living did not matter” (Tsing, 2015, 5). Care cannot and should not be idealized, disconnected from sites of care, people receiving care, and the powers that structure relations, attending to Puig de la Bellacasa’s admonition that, “not only do relations involve care, care is itself relational” (Puig de la Bellacasa, 2017, p. 198).

Recognizing the situatedness of care is one step towards recognizing the dominant powers that shape the relations of care (Puig de la Bellacasa, 2017). To see that that care is situated requires us to dissect the systematic problems that are entangled with care. To realize fully what care potential nursing holds, however, requires the discipline to unpack the historical baggage it carries, recognizing the strategies and discourses nurses and the public use to distance nursing from the folks intended to benefit from it. This includes interrogating who and what we mean by “we” in these arrangements, following Puig de la Bellecasa’s thinking on the feminist “we”; that is, nursing does not pre-exist its relatings (Puig de la Bellacasa, 2017, p. 200). To explore this, we first examine the politics of nursing and care, laying out the complex terrain for thinking about nursing. We then outline how nursing as a discipline imposes white empiricism on nurses and folks in care alike, entangled with christianity, creating the foundation for nursing’s alleged moral high ground. From there, we use a critical posthuman feminist analytics to examine potentials for nursing care. In an effort to rethink what worlds we want to produce, we conclude with what we believe to be a precondition to make this possible, a call to composting where care can be imagined as an arena where nurses, people, and worlds are cocreated.

As presently constructed, we must acknowledge our positionality as a collective of

¹ We use selective capitalization deliberately, following the logic of abolitionist, writer, and professor Jenn M. Jackson. We elect not to capitalize words rooted in hegemonies of whiteness, including “white,” “european,” “western,” “christian,” among others. Via Twitter, Jackson noted, “Not capitalizing the ‘w’ in white is a systemic disruption which

decenters whiteness with respect to other groups. That should be the purpose of capitalization” (see Tweet at <https://twitter.com/JennMJacksonPhD/status/1289887875362729984>). We wish to unsettle, disrupt, and decenter in a similar fashion.

white nurse scholar activists. Within this collective, we also occupy a myriad of other positions and identities. Among us are US-based settler colonizers and EU-based white immigrants. We are individually cis, feminine, masculine, immigrant, genderqueer, fat, queer, straight, disabled, and able-bodied. We use english as a first or additional language, trying to make our texts as accessible as possible, recognizing that academic texts and complex language are additional privileges we think from. We recognize limitations in our perspectives that are embedded in eurocentric and anglo-american contexts of care. We all share privilege conferred by whiteness and varying degrees of connection to christianity. We benefit from many of the powers we critique, commit to situating ourselves, becoming as aware as possible about the biases manifest in our embodied care, and dismantling oppression as we cocreate care matters for our collective present/future. We also understand that with these places of privilege, limitations are inevitable in our situatedness. Our collective is open, fungible, and boundless. We invite your engagement and critique as well as welcoming collaboration.

Unlearning in the COVIDicene

The COVID-19 pandemic renders nursing hypervisible as nurses confront the limitations of their workplaces, their governments, and the political economies that shape the COVIDicene, an assemblage bearing the indelible mark of pandemic times (Perron et al., 2020). This hypervisibility both challenges and reifies what it means to be a nurse, what the public understands about nursing, constantly constructed, collapsed, reconstructed. We understand care as a social function which is embedded in the materiality of being human. Caring and care are neither contained by nor property of nursing as a discipline or practice. Nursing is a proliferate care practice all over the world as people are born, live, age, and die -- and has been for millennia, long before nursing was codified as a professional practice. Moreover, nursing as a care practice will likely persist long past the decay of the contemporary institutions upon which nursing bases its human,

professional, and disciplinary identities. Nursing is presently caught in tension between the work of navigating institutions, professional practices, and the realities of nurse work in stark contrast with ideal and idealized desires for care. To persist in the face of this relentless and contradictory forecast, nursing as a discipline must untangle and unlearn the order of things to make space for alternate realities in the present/future. This endeavor means embracing the speculative worldbuilding that nursing does in dyadic encounters and scaling that practice to the impending and present mire.

Nurses are at the forefront of dealing with human, nonhuman, other-than- and more-than-human matters in COVID-19 times. In the context of providing care, nurses encounter people impacted by climate change and systemic inequities, navigating bodily waste, healthcare waste, emotion, vaccines, personal protective equipment (PPE), and public opinion. Nurses are caregivers situated in the material and affective worlds and, as such, are in high demand in a present/future where stability cannot be taken as a foregone conclusion. Nurses forge more-than-human care connections with folks dying of COVID, effectively rendering themselves—and the people in their care—cyborgs composed of interconnected, irreducible, kinetic matter relating with all forms—human and nonhuman. The cyborg image calls to us, intimating that we are all constituted in and through fungible, provisional, and impermanent human and nonhuman assemblages. Dwelling in and attending to these borderlands suggest to us a rich topography of compostable imagination and possibility. That possibility is called the planetary (Chakrabarty, 2021, p. 3), it is called nursing, it is also called care. Here, now, elsewhere in human and nonhuman pasts where real, outer, inner, and virtual spaces implode—mapping the articulations and re/making among cosmos, animal, human, machine, landscape—it is the process of “making kin” (Haraway, 2004, p. 110).

These cyborg-care relations in the pandemic are embodied through the use of cell phones, the internet, virtual interpreters, and video-conferencing apps to facilitate final family farewells, not to mention the innumerable pumps, monitors, wires, and apparatuses used to

sustain life, gather data, assess status, and document! document! document! Bill! bill! bill! The emotional and physical consequences for nursing in pandemic times include concern for self, safety, and mental health. Many nurses worldwide have left the profession as a result (Ross, 2020, pp. 439–440). During the COVID-19 pandemic, narratives of heroism and sacrifice ascribed to nursing abound, often in the absence of institutional support and protective equipment, prominent by virtue of nurses' unique role in public life amid the collective but differentiated disaster experience of the pandemic (Smith & Foth, 2021, p. 17). This burden is compounded by the exogenous projection of the ideals and expectations of nursing care in complex neoliberal configurations. Nurses and nursing are implicated and contingent on the production of care in this relational way; however, this also produces an opportunity to interrogate the power relations of these configurations and understand how other futures are possible.

The proliferation of capitalism and complete capture of healthcare within a neoliberal enclosure has led us to a trajectory of a potential future that will likely be disastrous. As outlined in her 2007 text, *Shock Doctrine*, Naomi Klein points to the crisis state that has come to characterize our daily lives under free market capitalism. Klein asserts that manufactured, enforced disaster states capture policymaking, creating the conditions necessary for politicians and corporations to use precarious conditions as a subterfuge to institute unpopular policy. This occurs as everyday people are so occupied with daily life in crisis times that resisting is impossible (Klein, 2007, pp. 11–15). Survival becomes the order of the day, a reality exaggerated for historically oppressed folks and communities, including those nurses themselves who are part of minoritized communities. This enforced crisis mode is a tactic that makes space for the creep and collusion of draconian policy and corporate piracy. This is a feature, not a bug. It doesn't have to be this way.

The truths that inhere in Klein's (2007) vision of *Shock Doctrine* are manifest in the failures of the just-in-time PPE supply chain, in the destitution the welfare institutions that would have once been responsible for responding to

pandemic. We all know—as nurses, as people seeking care—that healthcare systems were grossly inadequate (particularly in the united states) LONG before the pandemic, meted out along necropolitical lines, the political power to decide who lives and dies and when—often imperatively traversed by profit (Mbembe, 2019; Braidotti, 2020; Hopkins Walsh & Dillard-Wright, 2020, p. 11). This includes the inaccessibility of services, poor working conditions both in the pandemic and before, unsafe staffing ratios, entrenched whiteness, and the neoliberal priorities of the financial bottom line. The media is littered with example after example of institutional and disciplinary disaster with the COVID “crisis” being amongst the most recent. In this capitalistic morass, the work of nursing has become conflated within economic processes called care, acts to be counted, priced, marketed, bought, sold, packaged, and even studied and theorized as missed (Hopkins Walsh & Dillard-Wright, 2020, 6–8). Care is not a possession or commodity, it is a mutual, reciprocal, relational, and *meaning-full* human and multispecies process, highlighting the imperative to resist the commodification of nursing care and the idea of nurses as commodifiable, value-added caregivers (Dillard-Wright & Shields-Haas, 2021, pp. 299–201).

Nursing, Care Politics

Concepts of care and caring are central to nursing. We start to lay out the complex terrain for thinking about nursing by first, looking at the gendered and feminine implications of nursing. Concepts of care are frequently undertheorized and taken as an uncomplicated, categorical “good.” The care work of nursing has historically—as well as presently—carried gendered and racialized implications, a product of the maternal politics that developed contemporaneously with the development of nursing as a discipline. Western hierarchies of thought position the work of nursing as reproductive labor, which is deprioritized, a given that is taken for granted under capitalist political economies (Andrist, 2006, p. 5; Duffy, 2011, pp. 5–6). This, however, is only a partial accounting for care. Care and the moral authority afforded to notions of care—nursing, maternal, private, otherwise—

gives way to a sort of cover. The cachet of being “most trusted” by the public exculpates nurses, enabling/empowering/encouraging us to avoid critical power analyses. This maneuver elides the ways in which nursing has simultaneously served as a positive force in the world as well as an insidious and pernicious technique of power, depending on the positionality of the object of nursing’s care.

Nurses are consistently ranked the most trusted professionals in the united states and the united kingdom (UK) (Enloe, 2021, p. 7). And yet—perhaps for this very reason -, notions of trust are also intertwined with gendered roles and expectations in nursing, a profession that is decidedly white, feminine, and cisheteronormative (Duffy, 2011, p. 46). These factors contribute to nurses holding little power, reinforcing images of idealized nurses as denying their subjectivity in service and producing nurses that appear harmless and tame. In a recent symposium entitled “Feminists Theorize COVID19,” feminist theorist Cynthia Enloe excavated some of the tensions that inhere in the politics of nursing in an essay entitled “Femininity and the Paradox of Trust Building in Patriarchies during COVID-19.” Here, Enloe explains that public trust in nurses can be explained by public perception of powerlessness, an accommodating and willing receptacle for the anxieties of the public in the face of crisis (Enloe, 2021, p. 6). This, Enloe asserts, is largely due to the work of Florence Nightingale, the Lady with the Lamp, inescapable icon of nursing’s pristine image and ambition. Enloe—as many others before her—casts Nightingale as a feminist reformer who elevated nurses above their previous station (Enloe, 2021; See also, Chinn, 1982; Showalter, 1981). Nightingale’s rehabilitation efforts raised nurses up out of their former slovenly drunken ways, as Enloe (2021) notes, and imbued a certain authority and respectability (para. 7). Despite public trust of nurses, nurses are rarely afforded recognition as political agents (Enloe, 2021), a reality that ossifies nursing, reducing the discipline to its affective role while curtailing possibility for action.

What Enloe (2021) fails to reckon with, however, is the relative *power-full-ness* of nursing ensuing from Florence Nightingale’s

intervention. Well before Nightingale, nurses and other women healers were, by and large, autonomous, subject to the whims of patriarchy in some respects, but distinct from medicine (Ehrenreich & English, 2010, pp. 18–20; Group & Roberts, 2001, pp. 28–29). This abruptly ended in much of Europe alongside the Scientific Revolution in the 17th and 18th centuries as physicians sought to assert their authority, a reality that came later to the United States (Group & Roberts 2001, pp. 28–33). Nightingale entered into an already-fraught environment and, though her efforts did subjugate nurses to the now-dominant physician class, Nightingale mobilized a moral authority conferred by her white middle class femininity in efforts to jettison the “untrained, drunk, and slovenly” (Enloe, 2021, p. 7) nurses that immediately preceded her. In this process, Nightingale imposed an order on nursing that excluded many: certainly the “untrained, drunk, and slovenly,” but also, those women who failed to live up to Nightingale’s expectations of white respectability, folks like Mary Seacole, a self-styled doctress, herbalist, and entrepreneur from Jamaica who tried to join Nightingale’s efforts in Crimea but was turned away, a function, perhaps, of her “somewhat dusker skin” (Seacole, 2019, p. 57) than those nurses Nightingale favored. This gives rise to questions about the values and ideals of nursing, particularly when nurses and the public continue to invoke Nightingale almost 200 years later.

This discussion lays a complex terrain for thinking about nursing, both past and present, deeply intersectional and contingent. But even as nurses are not “given” a seat at the policy table, politics are still at play, particularly if we embrace literary theorist Kate Millet’s (2016) definition of politics as power structured relationships. In using this definition, it is clear that nurses are and always have been engaged in politics. Returning to Enloe’s (2021) intersectional analysis of care and invocation of Nightingale, it is prudent to note that Nightingale herself served the British Empire as an advisor weighing in on the status of “native” schools and hospitals around the world (Nightingale, 1863). Nightingale leveraged white colonial power to secure nursing’s legitimacy as a discipline, and, in turn, exerts a seemingly inescapable gravitational pull on

nursing's historiography (Stake-Doucet, 2020). Further evidence of Nightingale as nursing's historical center of gravity resides in Enloe's invocation of Nightingale as a feminist icon (Enloe, 2021, 7).²

Asserting a feminist identification for Nightingale is itself precarious. Certainly, the work Nightingale undertook paralleled liberal efforts like woman suffrage, but Nightingale herself was "brutally indifferent to the wrongs or the rights of [her] sex," a view expressed in a letter to her feminist contemporary, Harriet Martineau (Cook, 1914, p. 365). Nightingale's chief contribution to a feminist discourse was making respectable for middle class Victorian women a discipline previously understood as sullied (untrained, drunk, and slovenly, if you will), though this reality is only partial and only for the "right" kinds of women. And what influence has this had for nursing? Nursing as a discipline *sometimes* pays lip service to feminism, yet it coopts feminist rhetoric without the substance, replicating the kinds of white maternal politics that were so useful in securing white woman suffrage in the united states (DuBois, 1991, p. 40). Looking no further than the American Nurses Association (ANA), which purports to represent all registered nurses in the united states, there is evidence that further undermines the notion that nursing is feminist. The ANA only supported the 19th amendment beginning in 1912 and actively opposed the Equal Rights Amendment as late as the 1950s (Geister & Thompson, 1954; American Nurses Association, 2016). Additionally, the ANA has further entrenched the whiteness of nursing in the united states, segregated as it was (and remained) well into the 20th century (Hine, 1989). The ANA continues to enforce a *de facto* racial and class segregation, choosing not to represent the interests of licensed practical nurses or certified nursing assistants, avenues of entry to nursing that are more frequently open to people of color and folks from the lower socioeconomic strata in the US (Fontenot & McMurray, 2020, pp. 273–274).

² We also recognize that, in talking about the function of Nightingale in the nursing imaginary, we are further centring her in the discourses of nursing. Our hope, however, is to recognize the ways Nightingale functions as a simulacrum, romanticizing and

Ultimately, the precarity of nursing as reproductive labor in a capitalist political economy presents a hazard for nursing and for the public, both. Enloe (2021) points to the trust with which nursing is imbued, an artifact of the pristine and maternal qualities Nightingale prioritized. This creates an unnuanced universalism that obscures some important—if less than flattering—dimensions of nursing. This itself—the historical ontologies the discipline uses to define itself and those projected by the public—is a political operation, one that reproduces white cisheteronormative expectations for nursing. Nursing absence from the policymaking table, from the definition of care, is a political entanglement, following Foucault, where power is exercised at innumerable points of confrontation (Foucault, 2012, pp. 26–27). This also fails to account for the power nurses wield over people in their care, the power nurses possess to keep healthcare afloat—or sink it. Hemmed in by the politics and respectability of professions, the legacy of Florence Nightingale, nursing often does not appear to have power or choices even if it does have trust. This is illusory, in part because the vital reproductive work of nursing is fundamental to the functioning of the healthcare system itself. Relying then on a class analysis, potential avenues for the exercise of collective power become apparent, such as withholding its valuable labor. Having unpacked nursing, politics, and care in the preceding section, we now turn to the manufacture of whiteness in nursing as a function of white empiricism.

Making Nurses Under White Empiricism

As presently formulated, nursing functions as colonialism, reproducing imperial discipline and imposing normative white cisheteropatriarchal expectations, drawing dimensions of its Victorian legacy into the present. The professionalized discipline itself is scaffolded atop the british imperial project, Florence Nightingale herself an agent of empire, dedicating her considerable talents to maintaining the health of occupying british forces in India (Nightingale, 1874). Nightingale

sanitizing the work of nursing. This may give us traction to dismantle what is not working in nursing and build back in ways that are more just, more equitable, more sustainable in increasingly precarious planetary circumstances.

(1863) also meticulously and voluminously wrote about the health outcomes of Indigenous children in residential schools across the British Empire. This work documented the health burden of native peoples in the colonial period, though without considering the impact of colonial life on colonial subjects, a statistical collation and cultivation of docile imperial bodies. This project was not limited to Nightingale. Howell and collaborators (2013) note in their discussion of the Colonial Nurses Association that, while causes of disease shifted throughout the 19th and 20th century, “the underlying role of the nurse continued the same: she used the tools of personal as well as public ‘hygiene’ to create both physical and cultural boundaries around her white patients and herself, setting colonists apart from their colonial setting” (Howell et al., 2013, p. 338). The work of nursing in the colonial context was not limited to care, but rather to create space and hierarchy that subjugated colonial subjects contingent on notions of health and hygiene.

While it may be tempting to assume that this past is behind us, that is not the case. These colonial roots also have implications for nursing’s present. The colonial impulse on which nursing is founded reproduces white imperialism, as Waite and Nardi (2019) suggest, an “unmarked standard and professed to be obsolete and irrelevant” (p. 19), obscuring the persistence of colonialism in nursing and the whiteness it produces. This persistent imperialism, conscious or otherwise, means that nursing reproduces white empiricism. In the section that follows, we examine the ways in which nursing functions as a colonial endeavor, consolidating a white empiricism in its efforts to gain legitimacy beginning in nursing’s early professionalized days and extending into the late 20th century.

Addressing the complexities of physics, Black queer feminist astrophysicist Chanda Prescod-Weinstein theorizes the primacy of white empiricism as the chief knowledge system for physics. She asserts that “white empiricism comes to dominate empirical discourse in physics because whiteness powerfully shapes the predominant arbiters of who is a valid observer of physical and social phenomena” (Prescod-Weinstein, 2020, p. 421). This is complicated by

a sort of disciplinary monism found in the sciences, a “one right way of doing physics” that demands both reverence and respect, refusing plurality as well as the possibility that positionality may deflect epistemic outcomes (Prescod-Weinstein, 2020, p. 422). This goes even further, Prescod-Weinstein notes, where the fact that Black women experience, identify, and name racism works to undermine their credibility, their lived experiences doubted by white disciplinary hegemony (Prescod-Weinstein, 2020, pp. 423–424). This, Prescod-Weinstein notes, manufactures prestige asymmetry, in which standpoints of white scientists are prioritized over those of Black standpoints. White empiricism is a triple-threat, a form of epistemic oppression that denies knowledge competency based on a knower’s identity in the face of empirical data, all the while refusing to recognize the ways in which white supremacy curtails scientific knowledge (Prescod-Weinstein, 2020, p. 426). Prescod-Weinstein’s work is deeply resonant for the discipline of nursing.

Like physics’ entanglement with (and as) white empiricism, professionalized nursing’s white empiricist roots are both temporal and spatial, linked up with racialized and gendered expectations around care and around what it means to be a science. Following feminist critiques of early science, the orderly collection of empirical data about the world encoded a particular kind of (implicitly white and masculine) structure, animated in part by biblical imperatives to order, cultivate, control the earth—dictates handed by God to Adam, picked up by the likes of Francis Bacon and his contemporaries and scientific successors (Lloyd, 1996). This created something of an imperative, the idea that expansion and knowledge at the expense of nature were the rightful and necessary purview of mankind. In this maneuver, nature is cast as feminine whilst the natural historian/early scientist is cast as masculine knower of nature, master, and godhead (Lloyd, 1996; Merchant, 2006, p. 517). While the binaries this constructed—good/evil, masculine/feminine, white/Black, culture/nature—are reproduced as the Scientific Revolution became the Enlightenment, their origins are distinctly religious in nature. This is

apparent in Bacon's protoscientific utopia *New Atlantis*, in which the christian island of Bensalem was hallowed as an ideal of scientific society (Bacon, 1900). This arrangement subtly shifts institutional authority from the religious to the scientific without upending the order of things.

This kind of quasi-religious, deeply hierarchical order is the foundation for european humanism, the basis for the enlightenment. During this period, concepts around the scientific method, the understanding of the earth and cosmos, the meaning of fact, empiricism, and democracy were denuded of their prior religious connotations and refashioned as humanism (Braidotti, 2013, pp. 14–15; Chakrabarty, 2021, pp. 68–81; Braidotti, 2020, p. 466). This is a critical transformation: The values beginning to develop that underpin our current assumptions around politics and democracy, of course, but also the truth value of science and the primacy of these ideas has taken hold and serve as the organizing ethos for much of contemporary life. These values, which developed through the 18th century as the enlightenment unfolded, created the philosophical foundations for empiricism, enforcing critical assumptions around objectivity, including who is allowed to know and what can be known, a point Prescod-Weinstein (2020) makes clearly.

Though this trajectory is deeper, longer, and more complex than accounted for here, we will leave it for now with the understanding that the empiricism that undergirds so much of what is understood as scientific—in nursing and beyond—is rooted in humanism, which in turn, is rooted in religious order. The kinds of universals that spring forth from this arrangement are not and cannot be equitably applied for all people because they are rooted in inequity, a precarious proposition indeed for nursing theory and nursing philosophy. Nursing as a discipline has several points of origin, rhizomatic tendrils that converge and clash. One point of origin for professional nursing is Nightingale, as Enloe (2021) and the rest of the world know. But prior to Nightingale's interventions—and before nursing's fall into disrepute in europe—nursing was frequently the responsibility of women in the home or religious

orders, who received special dispensation to work with the ill (Robb, 2017, p. 22). The implications of nursing's now semi-subaltern religious roots will be examined more closely in the section that follows; but first, we turn to a contemporary move in the discipline of nursing, the (re)territorialization of nursing as science in aspirational efforts of the mid-20th century.

In the late 1950s, nursing leaders in the united states began a concerted and intentional endeavor to establish nursing as a distinct *science* (Tobbell, 2018, p. 63). A confluence of factors led to this outcome, not the least of which was a post-World War II push in nursing for professional and educational autonomy, a defense against the encroachment of hospitals and medicine in the provision of nursing education (Andrist, 2006, p. 16). Notably, efforts to organize for better working and learning within hospital schools were thwarted by the American Medical Association and the American Hospital Association (Andrist, 2006, p. 16). Nursing schools during this period moved away from hospitals, and collegiate programs proliferated (Tobbell, 2018, p. 64). Alongside other technical and scientific advancements of the Cold War period, nursing leaders found themselves underprepared to keep pace with the increasingly complex needs of people in their care (Tobbell, 2018, p. 64). Embracing this ethos of techno-optimism afforded nursing some distance from the ill-repute of what historian Margarte Sandalowski called "body work" (Sandelowski, 2000, p. 10). These factors encouraged the development of nursing as a science.

Becoming a scientific discipline meant packaging up nursing as a science. This meant developing scientific theories to guide and explain nursing work, further developing nursing research, and developing educational programs, including a research doctorate, though few existed before the 1970s (Tobbell, 2018, pp. 65–66). Before this time, nursing faculty desiring doctoral preparation sought PhDs in other fields, frequently bench science as well as social and biomedical sciences. Along with the development of doctoral programs came research funding, federal funding mechanisms, and a version of nursing as science legible to the broader community of scientists (though this

was frequently a challenge) (Tobbell, 2018, p. 70). Developing the science was often fraught, the care work of nursing unruly, unwilling to be forced into the sorts of tidy and testable empirical confines that a positivist version of science might prefer. However, embracing this kind of white, masculine empiricism (like that which Prescod-Weinstein described for physics) afforded nursing added proximity to white patriarchy, an arc toward a kind of legitimacy that trades in both moral authority of nursing's religious legacy and the paternalistic certitude of capital-s Science. In the section that follows, we will explore what moral high ground nursing supposes for itself, the roots of this piety, and the implications therein for nurses and those in their care alike.

Navigating the Piety of the Present

Professional nursing as rendered in Nightingale's likeness bears a colonial and patriarchal past/present.³ Enmeshed in this way, we advance the concept of "the piety of the present," attending to the ways in which nursing values are both weaponized for and lead to complicity with regimes of racism, violence, colonialism, and oppression. This pattern holds true for the communities and people nurses accompany in care as well as against nurses themselves (Rabelais & Walker, 2021, pp. 894–95). This parallels the operation of christianity as a motor for the expansion of western empires around the world, an empire of attitudes and beliefs as much as economic extraction. This includes the exportation and cultivation of white christian values including piety.

Piety is the state of being pious: spiritually pure, virtuous in deed, *faith-full*, obedient, religiously devoted—attributes and expectations that imbue medicine's Hippocratic oath (McPherson, 2021, pp. 926–927). Piety as a virtue demands particular attributes: sacrifice, martyrdom, unflinching loyalty to cause, a religious sensibility (McPherson, 2021, p. 928). Many of the expectations and desires imposed on/embraced by nursing are scaffolded on the persistent reification of Nightingale, exalted and saintly "Mother of All Us Nurses," Victorian

nurse *cum* proxy mother *cum* angel. That her vision and virtues continue to capture both nursing and the public's imagination about nursing to this day reinforce the persistence of her image. These portrayals are explored in further depth using the metaphor of the "Vitruvian Nurse" in a paper by the authors writing here (under review). The Vitruvian Nurse is shorthand, an application of feminist posthumanist Rosi Braidotti's Vitruvian Man to the discipline of nursing, a critique of advanced capitalism (Braidotti, 2013). The Vitruvian Nurse is an idealized trope of devoted, selfless, human female perfection full of gendered, racialized images and expectations: cisgender, chaste, feminine, characterizations ultimately collapsing towards mechanisms of power, control, and discipline. The Vitruvian Nurse as the sacrificing, devoted, nurse-mother also arises from nursing's deep historical connection to eurocentric christianity.

Some of nursing's religious roots are documented in Dock and Stewart's 1938 text, *A Short History of Nursing: From the Earliest Times to the Present Day*. The front piece of the book includes a marvelous illustration of nursing's pious origins using text and illustrations to visualize movement across nursing history including, rooting the origins of "nurse" in the breastfeeding mother (Dock & Stewart, 1938). The breastfeeding mother gives way to goddesses of healing and then priestesses, which become early christian deaconesses and ecclesiastical virgins. Eventually, men make their way into the trajectory of nursing as monks, and Franciscan friars assume the role of nursing, a peak in the lineage of nursing. This arc abruptly slopes downward, arriving at the image of the secular servant nurse, hunched and clutching her bucket and apron, shades of untrained, drunk, and slovenly pre-Nightingale nurses. The trajectory is then restored to its upward arc; this auspicious lineage ultimately arrives at its apex, the professional public health nurse pictured as Nightingale, the lady with the lamp. In this "Great Chain of Nursing," the healing practices

³ Here it is critical to note that other stories, other points of origin, other influences also contribute to care traditions that inflect nursing. Our intent is not to suggest that Nightingale narratives are

in some way singular and definitive, but rather, breaking with many in the discipline itself, making space for alternate readings of our disciplinary history.

of nurses are conflated with religious christian ideals and images, a persistent and pernicious discourse for nursing.

Framing nursing as a “calling” invokes overt tropes of christian service, trading on gendered stereotypes of selflessness tied to religious life. This influence is likewise apparent in nursing theories explicitly founded in christian philosophies like the work of a French Jesuit priest, scientist, philosopher named Pierre Teilhard de Chardin. Teilhard de Chardin’s writings are frequently cited in prominent nursing theories that are the foundation for pedagogies and epistemologies being taught today in undergraduate and graduate nursing degree programs around the globe. While some nurses may choose to align professional knowledge practices within systems of personal religious beliefs, there are perils in entrenching nursing in moral, sacrosanct, and spiritual high ground, particularly when predicated on the values of white christendom. Risks here include unreflexive and judgmental use of moral authority, positioning idealized nurses outside and over care rather than engaging as a cocreative and relational care practice. This grounding hazards the reproduction of toxic power dynamics, supported through nursing’s dominant whiteness and proximity to white cisheteropatriarchy. Affixing nursing to some moral high ground deflects challenges to power, imbuing nursing care with mythical narratives of benevolence, godly will, and godly work. With this comes expectations of care embedded in normative whiteness, further roiled in received christian values like suffering as the path to heaven and colonialism and christianization guised as white saviorism (Tamale, 2020, pp. 176–177).

Religious nurse images can easily be found today in internet searches yielding innumerable depictions of nurses with halos and angel wings, standing alongside Jesus figures, in poses of crucifixion, and through more explicit connections in a common verse called “The

Nurses Prayer’, which is still taught today in some church-affiliated schools of nursing (Price, 1965). This has lent itself readily to commodification: Printed in multiple forms found online like wall art, t-shirts, and postcards, the “Nurses Prayer” was also found on the opening page of the *Art and Science and Spirit of Nursing* textbook used in nursing education beginning in 1965 (Price, 1965). Variations on the nurse’s prayer are numerous but most include verses of selfless devotion, as in: “especially Dear Lord, help me to remember the true purpose of my vocation, that of selfless service, and dedication to the weak and despairing in body and spirit”⁴. The poem gestures at epistemic, ontological, and axiological roots for (some of) nursing, an indoctrination to the roles and values of the discipline, inculcating aspiring and current nurses into the “vocation.” Published in a mid-20th century nursing textbook, these threads persist, weaving into the immediate, the future. This is the imperative to speak to the piety of the present.

Our attention to the piety of the present here invites nurses (and those who may one day require nursing care) to examine the enmeshed histories of christendom and professional nursing. The vestiges of christian thought that inflect nursing theory are not neutral. white christendom is connected deeply to violence and oppression, colonization, elitism, classism, patriarchy, imperialism, genocide, epistemicide, and systemic racism in the past and in the present (Tuck & Yang, 2012; Waite & Nardi, 2019, pp. 18-23; Bell, 2021, pp. 6-10). These connections run deep⁵ and the linkages to nursing theory give rise to many. In nursing theory, this looks like commingled colonized threads of Indigenous knowledge systems, co-opted and appropriated epistemologies repackaged as nursing without due credit given to the non-european or Indigenous cultures where they originated. These threads are both pervasive and implicit, unspoken white supremacy and patriarchy encoded within the

⁴ From blog post Nurse Buff *30 Nurse Prayers that will Inspire Your Soul* November 14, 2021, <https://www.nursebuff.com/nurses-prayer/>

⁵ Historian Adnan Husain (Twitter handle @adnanahusain) was featured on podcast *The Red Nation* on January 10, 2022. Husain discussed the link between the modern war on terror and religion

as imperialism, reframing christianity as “Christendom,” signifying the early conflation of christianity with ethnic whiteness and the development of “crusading societies,” part of an ongoing project of racial capitalism and settler colonialism. <https://podcasts.apple.com/us/podcast/the-red-nation-podcast/id1482834485?i=1000547386598>

policies and research priorities nurses are taught to uphold, first in educational institutions and then in care environments. They become enshrined in the writings and embodied practices of nurses, leaders, and scholars (Bell, 2021; Rabelais & Walker, 2021, pp. 894–895).

The connections we have made so far lead us to understand that nursing care is not created equal for nurses, people, or societies. As a profession, then, nurses are not entirely worthy of the title of most trusted profession (Rabelais & Walker, 2021, pp. 894-895). Nurses can and do engage in violence against individuals and groups of people, a reality that is propagated further by failing to recognize and act upon the instances where nursing has power to change outcomes if they chose (Dillard-Wright, 2021, p. 3). Nurses are complicit in violent care practices found in prisons and detention centers, and nurses have been implicated in genocides in the Holocaust, forced sterilizations, and in murders in Indigenous boarding schools and other violent colonial projects around the planet.

For more recent examples of the violence of care by nurses we turn to events from the pandemic year 2020. Canadian officials uncovered video proof of nurses' unequivocal complicity in the death of a hospitalized mother of seven, an Indigenous woman who was taunted with bigoted insults by nurses, ignored, care cruelly withheld as she lay dying (Bilefsky, 2021). In another example, Dr. Susan Moore, a Black physician in Indiana, videotaped her experiences, describing in detail the cruelty and overt racism she experienced at the hands of nurses and doctors. She posted the video documenting this to her Facebook page two weeks before dying of COVID (Democracy Now! 2020). Dr. Moore said that physician staff blamed the nurse for bungled care. In a statement made after Moore's death, Indiana University Health president and CEO wrote, "It hurt me personally to see a patient reach out via social media because they felt their care was inadequate and their personal needs were not being heard" (Murphy, 2020, para. 2). He went on to empathize with those caring for Moore, seeing "the perspective of a nursing team trying to manage a set of critically ill patients in need of care who may have been intimidated by a knowledgeable patient who was using social media to voice her concerns and critique the care they were delivering" (Murphy, 2020, para. 2). And yet, in the video left by Dr. Moore, she narrates the ways in which physicians

and nurses alike repeatedly failed her: delayed her diagnostics, doubted her pain level, withheld pain medication, and threatened to send her home under the cover of darkness.

These are abhorrent but all too common examples of the violence of nursing care practices. Care practices are relational: individual choices by nurses directly impacting individual care. But they are also situated. Care plays out on a terrain of byzantine power structures, modes of care inseparable from the environments in which care is created, linking care to the forces of control, production, efficiency, and cost under neoliberalism regimes of care (Dillard-Wright & Shields-Haas, 2021, p. 198). In this way, it is possible to understand the failures of nursing care in the COVIDicene as a function of what Rosi Braidotti would call the posthuman convergence which describes the current meeting of 4th industrial revolution and 6th extinction, a time where decentralized technologies are at the top of biopolitical hierarchies and humanity considers it is own mortality on the planet (Braidotti, 2013, p. 59). World ecologist Jason Moore's concept of the Capitalocene echoes this sentiment, where "cheap" labor and "cheap" resources encourage relentless consumption and extraction (Moore, 2016). This gives us a schema for thinking about nursing within neoliberal enclosures of advanced capitalism, to which we now turn.

Nursing within Advanced Capitalism

Following Braidotti (2013), that nursing bends towards contemporary modes of managerial (re)production is relevant because "capitalist transformation challenges the very essence of our nursing identity as we ask the question of whether we have ever been nurses" (Dillard-Wright et al., 2020, p. 134). In a new materialist sense, nursing in the global North has been territorialized through the process of professionalization, rooted in both white empiricism and delusions of Nightingale. As Thorne (2021) editorialized in "Slow Death by Policy Manual," good nursing care under our current regime is defined by operations managers as adherence to codified policies and routines. This capture is complete, and, in this arrangement, nurses are disempowered from care decision-making, undermined by administrative discipline and control. This constrains nurses, rendering them unable to fully

embody creativity, intelligence, and expertise, a cage of our own creation. The professional care project of nursing is entangled with the context of its production in the hyper capitalization and individualization of societies, a dialectic that reproduces neoliberalism while undermining the autonomy typically reserved for professions in the name of efficiency, quality, safety, reimbursement, bottom line (Hopkins Walsh & Dillard-Wright, 2020).

Advanced capitalism under neoliberalism is predicated on individualism (Smith & Willis, 2020, p. 61). As nursing work is increasingly enclosed in a capitalist healthcare system, nurses and the people in their care alike face a mandatory self-sufficiency. Here, following Wynter (2015), we note that self-sufficiency does not confer self-determinacy. Whilst we are all interdependent to some degree with other materialities, for example animals—humans included—and the world around us we may make decisions about our care. In other words, care and nurse work has become reterritorialized from an embedded practice of material communities to the over-individualized fallacies of nurse and people in their care that are promoted today in paradigms of person-centred care. We recognize that “our professional endeavors have never been free from the crucible of capitalism, subject to ever-increasing exogenous pressures of the insurance industry, the tyranny of evidence-based practice, and the health care system’s bottom line” (Dillard-Wright et al., 2020, p. 142). This picture is further supported by Deleuze who argues that boredom and burnout are mechanisms of advanced capitalism (Deleuze, 1995). This is particularly relevant for nursing in the context of the neoliberal enclosure of nursing within a capitalist healthcare system.

Modern nursing is cast in the mold of Europe’s neoclassical, elitist, Caucasian form, embossed with misogynistic views of gender, caring, and nursing as reproductive labor. This gets tangled up in the axioms of advanced capitalism under neoliberal regimes. Professional nursing has been produced alongside oppressive, binary, gendered expectations of selflessness, self-sacrifice, care, and emotional labor found within the idea of the Vitruvian Nurse discussed above. Nursing and

care work is complicit with some of these restrictive worlds that are made because of the way care is framed - as a moralistic practice overlaid on the people being cared for, therefore, we continue to see the need to reframe care with other ways of imagining it.

Critical Posthuman Possibilities for Affirmative Ethics as Nursing Praxis

Our theoretical approach to nursing care is from a new materialist perspective, in particular a critical posthuman perspective, because it makes other possibilities of care perceptible. These readings enable us to envision care—specifically nursing care—against the grain of the neoliberal and advanced capitalist capture by which commodified care is all too often restricted, an ethical intervention. Critical posthuman approaches to care are by no means the only alternative models of care; however, we work with this because of the critical feminist genealogies from which they grow (Rose, 2012; Plumwood, 1993; Wynter, 2015; Gilligan, 1983). These other possibilities of care are situated within the geo-socio-political production of care yet work with power to make these conditions perceptible and to not overlay moral values, moreover, proceed ethically—yet these ethics are speculative and not predetermined (Noddings, 2013). These ethics of care are affirmative, inclusive, confused, and speculative.

When we describe nursing care as confused or speculative, we use this in a Spinozan way where “self-knowledge must share the inevitable confusion of bodily awareness” (Lloyd, 1994, p. 20). That is to say, we—nurses, humans, beings, others—exist in states of confusion all the time, a function of the realities unfolding before us. How we make sense of this confusion comes to matter and make meaning. Patterns of matter (that come to matter) exist in ratios of motion and rest, and we can anticipate and expect things to happen in certain ways, which they often do, which is true as much for nursing as for other modes of caring. Being confused here means becoming attuned to relations, but also retaining a critical eye. It is not simply acceptance and acquiescence. It is making the moments survivable while recognizing and reckoning with broader scales of abstraction as well. To exist in

an unconfused state is to say that we can foretell the future, that the future is predetermined, and that there is a transcendental plan awaiting our future. This transcendental plan is often layered with white, cisheteropatriachal capitalist notions of power and world-making.

Existing with confusion and speculation is to exist in a way of making meaning from our situated knowledges while being reflective of the restrictive possibilities and imaginations from which meanings are being made. This is not to argue that, with speculation, we have no agency (in some ways) to approach how worlds are made. We, as affective assemblages, agents in these configurations have differing degrees of agency depending on the relationality and our situation within it. We make meaning from what is and is not perceptible, as we proceed through and make our worlds, and these are agential acts. The ways in which we make meaning are what matters. If we ignore or take for granted the ways in which we are making meaning and assume these are pre-defined, then we are imposing theoretical and imaginary ways of being onto everchanging worlds. These imagined realities and moral imperatives are - in the hegemonic traditions of the west, at least—deeply rooted in white cisheteropatriarchy. Instead, we should make our worlds with affirmative and pragmatic power relations that are situated and affective (Lloyd, 1994, p. 20).

We—speaking here of the authorial “we”—do not presume that, following Lloyd still further, as embodied and situated human beings, nurses—or any other!—are empty vessels. We approach situations with knowledge and experiences which diffract and influence the ways in which we make worlds—everything is contingent on these histories and presents and will guide our future. However, speculative ethics is about acknowledging these histories, the ways in which they create our understandings and productions of power, and then making worlds in ways that are caring, *care-full* and matters of care. Here, the mind, it seems, is both the judger of confusion and something whose very being consists in confusion. To follow Spinoza, we must both think of ourselves as knowing subjects, with particular perspectives on the world, and

place ourselves outside that perspective, to think of relationships among ideas that include ourselves. (Lloyd, 1994, p. 21)

Therefore, we should anticipate confusion as a way of making our worlds. We can never understand and perceive the totality of our world. Instead, we should be cognisant of our confusion and the implications for the worlds we create. In the case of nursing, the ways in which we make our worlds involve the care that we do and have direct implications for ourselves as caregivers and those we care for. We must attend to the values that we are imposing with our care with speculation and affirmative ethics to not impose exploitative and restrictive power relations.

Puig de la Bellcase (2019) frames care within materialist, ecological, and relational paradigms of care. Building on foundational works of critical posthumanism and feminist new materialism, we approach care from a de-centred and post-anthropocentric perspective that cannot be planned in advance. Puig de la Bellcase champions Haraway’s approach to care and the ways worlds are made to illustrate that care must be (and always is anyway) situated in human/nonhuman relations to be non-exploitative. Forms of care which plan certain futures for humans or assume moralistic versions of human within models of care will reproduce restrictive and prohibitive models of humanity. Rather, “care is everything that is done (rather than everything that ‘we’ do) to maintain, continue, and re-pair ‘the world’ so that all (rather than ‘we’) can live in it as well as possible” (Puig de la Bellcase, 2017, p. 161). This leaves us with diaphanous entanglements, wrapping us together. We embrace these weblike speculative and ethically affirmative approaches to care. Speculative ethics are affirmative ethics because we become aware of where we are talking from or how power relations are or can be made perceptible. More recently nursing scholars have started to position nursing care with critical posthuman theories because of the affirmative ethics and contra-capitalist possibilities (Smith & Willis, 2020, pp. 60–61; Adam et al., 2021, pp. 2–4). We will now explore how nursing can care through

shared understanding of the situated realities. Nursing care neither separates itself from those being cared for nor cares from a moral high ground, but moreover, embraces the speculative characteristics around the ways in which worlds are made.

Bodies Reborn: Rebirth as Kinship

In re-learning care and caring in the COVIDicene, nurses must acknowledge the tentacular connections that Donna Haraway calls SF: strings/fibers, science fiction, speculative fabulation, speculative feminism, science feminism (Haraway, 2016, p. 10). SF encompasses the idea that threads, bodies, ghosts, all matter, all creatures link us nurses, us people, through space and time to the concepts that we are presenting here, including the historiography and scaffolds of the birth of nursing—christianity, humanism, science, the philosophy of science, what it means to be a woman, an angel, a hero--white feminism, and the oppressive and violent forces of systemic racism that arise from these embers. These strings are the binding force that are not only reactive but can also be active and affirmative. SF starts with a shared understanding of embodied and embedded locations and conditions of oppression in caring and demands that together with and alongside people and communities, we dream and imagine affirmative and empowering alternatives. These alternatives are based on the shared understandings we make as we practice care with people, places, communities, the environment - the SF.

We now invite you to imagine a rebirth with us—speculative fabulation, unlearning, and unknowing as care. Although the concept of bodies reborn can be construed as religious and evangelical in its framing, we see it in a posthuman awakening **not** emanating from connections to christianity but diffracting away from the oppressive colonial roots, attentive to the realities they have and continue to create. We envision being reborn again as a rebirth from the compost of the COVIDicene and from the piety of our present—catapulting us through the portal of the pandemic (Roy, 2020). We authors as nurses, as people-scholars-activists have been presented with an opportunity to engage in reckoning with a concept that posthuman scholar Francesca Ferrando and

others call *poiesis*, the creative process of bringing forth from nature, the nursing of a blossom into bloom, decentering the white Vitruvian Nurse of humanism, composting SF for a more posthuman process of caring (Ferrando, 2019, pp. 40–41; Paquette, 2021). During this poetic rebirth, Ferrando suggests that the outcome is unknown, but the process itself is revealing—the moment of truth (Ferrando, 2019, p. 41).

Posthuman care and caring require that nurses enjoin the folks in their care as coequal worldbuilders, embracing all as part of the process of *poiesis*. However, this deep reflection and conscientious positionality are not the only ways forward. If we recognize the critical potentials evinced by care as a contextualized assemblage of continual rebirth, we can recognize the earthy tendrils that bind us all together, looking to people as experts in their care needs and lived experiences. This connects us further to the assembling practice of making kin, the idea of relationality to all matter human, nonhuman and more-than-human (Alaimo, 2010; Haraway, 2016; Braidotti, 2019). We lean into this path even as we acknowledge the messiness of posthuman concepts like making kin as being co-opted from Indigenous knowledge practices and beliefs, and we authors wonder how to navigate this as white settler colonizers. We also recognize our complicity in “the settler moves to innocence” located within pronouncements such as these (Tuck & Yang, 2012, p. 10). We see and feel the limitations of our perspective, bound to our positionalities as settler colonizers who have benefited/do benefit from colonial land dispossession and white supremacy. We acknowledge that “nurturing a habit of discomfort” is necessary but insufficient (Boudreau Morris, 2017, p. 456). Despite the messiness and unfinishedness, we are inspired by the idea that commitment to a project is an act of creativity. This paper is part of an ongoing project, part of a larger conversation for nurses and the people and communities we accompany, with aims of more relational care for the planetary system, for human and more-than-human, antiracism, equity, justice, liberation from oppression and oppressive structures. From here we leave you with our closing ideas for what could possibly come next.

Conclusion: Envisioning Posthuman Caring (for Cyborgs)

Here we have unraveled some of the threads and thrums that form the weave of nursing care. This is a starting place for envisioning and then co-creating care possibilities and praxis for more affirmative and ethical *care*: “But over and above all else, we also need to develop different ways of caring, a more transversal, relational ethics that encompasses the nonhumans” (Braidotti, 2020, p. 466). Planetary collapse, species extinction, aging populations, and global pandemics highlight the fundamental importance of care. These events also highlight the role of nursing across the world in caring for each other human and nonhuman, and ourselves as humans, without perpetuating the *humanizing* project of coloniality (Jackson, 2020, pp. 45–82; Paquette, 2021, pp. 8–12). In current times, care work by nurses takes on urgency further amplified and exaggerated throughout the COVID-19 pandemic and ongoing climate emergencies, where the interdependence of human and more-than-human is now visceral within *the planetary* (Chakrabarty, 2021, p. 7). We invite nurses and the people we nurse to open up paths, demanding, reflecting, acting towards a more relational, radical posthuman nursing. And we acknowledge the tension that comes with this proposal. First, our perspective is situated and partial, and is not exhaustive of other possibilities and positions. That is why we invite others to engage with us to critique and develop these concepts further. Second, we are aware that our proposal might not be the right path, hence, we are open to the possibility of failing in our endeavor. Still, we see the necessity of pursuing our endeavor nevertheless as an act of social justice, being committed to the project, materializing other possibilities of care and caring within nursing, and learning, growing and redirecting as the situation unfolds.

Following multispecies feminist philosopher Donna Haraway (2016), we endeavor to “stay with the trouble” as we interrogate the fundamental problematics that arise from the white heteropatriarchal christian origin for nursing in the context of current world events and planetary political crises. In this particular snarl, we locate a particularly wicked

entanglement of religious dogma and humanist hubris that needs tilling. Tendrils that connect “knots of diverse intra-active relatings” (Haraway, 2016, p. 60) in nursing means avoiding quick and tidy (non)solutions without first reckoning with the dark and powerful forces that have shaped and currently shape our disciplinary practice/education. This is the entry point in which we challenge the contemporary productions of nursing and diffract it towards a call for speculative ethics in care. Abolishing the piety of the present for a radical and relational kinship with human, nonhuman, and more-than-human matter helps to instead envision nurses as composting bodies reborn, offering a critical posthuman and new materialist lens for caring for people and communities and our nurse selves.

Ultimately, we offer neither solutions nor concrete conclusions. Instead, in the spirit of critical inquiry with an eye towards affirmation, we persist in asking the types of questions most often heavily policed, denied, ignored, resisted, and restricted within nursing academe. In doing so, we feel that equity and justice are the ethical purview of nursing and desirable ends unto themselves. As scholars we understand critical nursing theory and philosophy as liberatory praxis, insights learned from Black feminist scholar bell hooks (1991). To paraphrase educator Kelly Clark/Keefe (2010), care and caring are **alive** in the bodies of nurses and in the relationships we create with people—as people alongside the communities we accompany. We close with unfinished lines of flight in haiku, inspired by Haraway’s 2016 *E-Flux* piece with images by Stephens, Sprinkle and Toy (see Haraway, 2016, p. 2), ideas we will compost together as our posthuman nursing project unfolds:

*Composting is hot.
Caring is relational.
Wellbeing is care too*

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#CompostCollaborative

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