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This is the peer reviewed version of the following article:

Evans, A. and Traynor, M. (2014). Slavery and jouissance : Analysing complaints of suffering in UK and Australian nurses' talk about their work. *Nursing Philosophy*, 15(3), pp. 192-200, which has been published in final form at <https://doi.org/10.1111/nup.12051>.

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Slavery and *jouissance*: analysing complaints of suffering in UK and Australian nurses' talk about their work

Abstract

Nursing has a gendered and religious history, where ideas of duty and servitude are present and shape its professional identity. The profession also promotes idealised notions of relationships with patients and of professional autonomy both of which are, in practice, highly constrained or even impossible. This paper draws on psychoanalytic concepts in order to reconsider nursing's professional identity. It does this by presenting an analysis of data from two focus group studies involving nurses in England and Australia held between 2010 and 2012. The studies gave rise to data where extremely negative talk about nursing work seemed to produce, or to be expressed with, a high degree of energy, and a particular kind of enjoyment. In our analysis we focus on the nurses' apparent enjoyment derived from their expression of a position of powerlessness in which they describe themselves as 'slaves' or 'martyrs' in the healthcare system. We interpret this as *jouissance* and suggest that the positions of slave or martyr provide a possible response to what we argue is the impossibility of the nurse's role. We argue that a remnant of a quasi-religious ethic within the profession makes it acceptable for nurses to talk about self-sacrifice and powerlessness as part of their working subjectivity. We further argue that this analysis offers a new consideration of the issue of power and professional identity in nursing that goes beyond seeing nurses as simply overpowered by, or engaged in a gendered power struggle with other professional groups. We suggest that powerlessness and victimhood hold particular attractions and advantages for nurses and are positions that are more available to nurses than to other occupational groups. This research shows how psychoanalytic theory can help produce new insights into the problems and complexity of nursing and extend existing study of the professions.

Keywords: professional identity, psychoanalysis, *jouissance*, focus groups, Australia, United Kingdom

INTRODUCTION

Nursing is a gendered and contradictory profession: a new occupational opportunity for women in 19th century Britain but cast in quasi-religious and subservient terms; it promotes notions of autonomy yet experiences a limited sphere of agency; it emulates medicine's status but constantly struggles for influence and recognition. Nursing has identified with 'caring' to differentiate itself from so-called 'curing' medicine yet today in the United Kingdom that image is tarnished by scandals of cruelty and failures to care.

Nursing in the mid-19th century was pictured by Florence Nightingale and fellow reformers in terms of an ethic of service, founded on Christian ideals (Nelson, 1995). Such a framing could foster discipline and docility, and so avoid too obvious a threat to the Victorian male establishment (Rafferty, 1996). Contemporary nursing, as Nelson argues, embraces a humanistic philosophy, and in doing so, renders the Christian influence invisible while maintaining certain Christian ideals.

Other powerful expectations of contemporary nurses include that of professionalism. Nurses' emphasis on personal relationships and caring has been seen as problematic relative to conventional notions of professionalism. Writing in 1995, Davies drew attention to the United Kingdom (UK) Royal College of Nursing's (RCN's) then recent 'Value of Nursing' campaign which involved the collection and publication of a series of vignettes written by nurses which were intended to show the complex and highly relational work that they do. In a similar move in the United States prominent nursing writers

developed elaborate identifications of nursing work with fundamental human values to do with caring (Benner et al., 1996, Benner and Wrubel, 1989).

Davies' point is that if such an approach – identifying with a caring core to nursing – is adopted as a strategy for professionalization then it is likely to fail. This is, according to Davies, because there is little place for identities that are gendered female within the world of organisations and professional discourse that are both gendered male. Nevertheless, a belief in autonomy and intimate, meaning-making relationships with patients remain powerful ideals within the profession. It is this possibly unrealistic idealism, coupled with nursing's legacy of self-sacrifice, that form the twin foundations for the argument in this paper.

One early study that drew on the discourse analytic notion of 'subject positions' (Traynor, 1996, Traynor, 1999) found nurses adopting a subjectivity explicitly in opposition to what they saw as managers' disembodied preoccupation with financial matters and lack of concern for human values. Their subjectivity combined the adoption of an ethical position of caring with a vulnerability to exploitation because of this. 'Caring' was strongly identified with self-sacrifice by nurses in the study.

More than a decade later, in a study aimed at exploring femininity and risk (Rickett, 2010), the nurse participants also had idealized notions of self-sacrifice in relation to their practice. In the context of discussing manual handling, two dominant discourses were identified: the first was 'good nurses take risks' and the second was 'nursing without sacrifice'. The participants often sacrificed themselves by putting their patients' dignity before their own

safety: good nurses take risks. Ricket argued that while this was a resistance to dominant notions of how nurses should perform manual handling, it involved an idealized notion of 'good femininity' and ultimately led to the nurses' disempowerment. On the other hand, 'nursing without sacrifice', while drawing on a less feminized identity, could lead to subordination to a medical ideal of professionalism. Ricket concluded that the 'mechanisms of conformity and resistance are complex, with both working simultaneously to both resist and reproduce traditional gender roles...' (p.264).

This capacity of nurses to provide aspects of nursing care at the expense of sacrificing themselves has also been considered, in part, in relation to anxiety, as conceptualized by Kierkegaard's notion of angst (Pask, 2005). In this conceptualisation, anxiety is experienced when one is confronted with the knowledge of what one is capable of. This confrontation can be forestalled though, via routine and ritualised practice. As Pask notes, routine nursing practices were observed quite some time ago by Menzies-Lyth (1960) who argued that they, along with ritual and many other practices in nursing, were part of a group defence against anxiety.

This work of Menzies is the most well-known psychoanalytic study of nursing work. However, although there have been subsequent examinations of nursing and healthcare work which have adopted psychoanalytic perspectives (Lawlor, 2009), her work has not spawned a thriving tradition and the extension of her work from within a psychoanalytic framework has been negligible (Evans et al., 2008). The present article is an attempt to reconsider

psychoanalytic theory in relation to nursing, and employ it to investigate aspects of its professional identity.

Finally no review of innovative accounts of nursing identity would be complete without an appreciation of Paley's provocative parallel (Paley, 2002) between nursing's relationship with medicine and Nietzsche's account, in *On The Genealogy of Morality* (Nietzsche, 1994), of the origins of Judaeo-Christian religion. Paley argues that nurses, fuelled by resentment, like the weak in their relationship with the domineering aristocratic Aryans presented by Nietzsche, make a virtue of their actual lack of power by inverting, in their fantasy, the hierarchy between the powerful and the meek. All that nurses can associate with meekness, such as the notion of caring, is given a moral privilege. This is what Nietzsche – and Paley – call a slave morality. While the analysis we explore in this paper does not directly develop Paley's argument, it is clearly indebted to a tradition of thinking associated with the 'three masters of suspicion' (Ricoeur, 1970): here Freud, the others being Nietzsche and Marx.

Conceptual framework

In this paper we draw on two concepts that originated within the work of psychoanalyst Jacques Lacan (1901-1981) and which are taken up by social theorist Slavoj Žižek: the mirror stage and *jouissance*. The mirror stage is a metaphor that refers to how a young child might first see itself in a mirror, that is, see a form that appears whole, and take that wholeness as themselves. The wholeness then is a sense of completeness or unity (Lacan, 1988b). However, this wholeness is, according to psychoanalytic theory, an illusion as

the human subject is divided into a known and an unknown part. The unknown part can be considered to be the unconscious.

[it] is apparent to us at the most banal level of experience, our profound division, our profound fragmentation, our profound alienation with respect to our own motives – that this subject is other (Lacan), lesson of 20.11.1957).

Thus not only is the psychoanalytic subject not whole, its motives are not always known to itself. Nonetheless mis-recognition structures the subject's fantasy life in as much as wholeness *seems* possible (Lacan, 1988b). This illusory mis-recognition is part of what Lacan calls the 'imaginary plane'. Žižek (2005) draws on this Lacanian notion of the subject in his reworking of the idea of the illusion of full potential and identity that we will discuss later in this paper.

The second and main concept of Lacan's we draw on is *jouissance*. The word, in French, suggests both 'enjoyment', in the legal sense of enjoying certain privileges, and sexual enjoyment. This concept appears in various forms in Lacan's work; we take up the notion of the Other's *jouissance* in this paper.

The concept of *jouissance* came from Lacan's reworking of Freud's notion of 'beyond the pleasure principle'. Freud called this *beyond* of the pleasure principle, the 'death drive' (Freud, [1920] 1984). He developed this aspect of his theory after many years of noticing that his patients would compulsively repeat painful or traumatic (but familiar) experiences. He proposed that the human subject is not entirely pleasure seeking and pain avoidant and that the death drive can be understood as a 'pleasure beyond pleasure', a pleasure in the negative; a self-destructive drive (Freud, [1920] 1984). In other words, human subjects repeat painful experiences in their life, even though their

intention is not to do so. Yet this form of suffering also brings with it a kind of enjoyment or satisfaction, a fulfilment of one's 'destiny', in the sense of fulfilling the conditions that one's history has dictated, of fulfilling the conditions of one's life (Lacan, 1992a). Lacan called this form of suffering *jouissance* (Lacan, 1992b).

This paper draws on the aforementioned theory to consider a professional group. Like individual human subjects, professions have particular histories to which members are subjected and via whom that history is transmitted. As we have suggested, nursing's history is one of an ethic of duty, self-sacrifice and subservience and we argue that it is possible that this provides a 'destiny' for today's nurse in that the history of the profession bears down on the nursing subject. Further, we argue that there is a kind of satisfaction when that history is reproduced in the present, a satisfaction that is on the side of 'history' rather than the subject. The subject, we could say, is enjoyed *by* this history. In this way then there is both satisfaction and suffering.

THE STUDIES

The Australian study was initiated at a university in Melbourne, in late 2010. There was widespread concern about high attrition in the nursing workforce and the university supported the second author with a grant towards a study to investigate this topic. The study gave us the opportunity to collect data from nurses working in the Australian healthcare system and see how nurses in Australia might respond to similar questions as those that had been put to UK nurses in some of the first author's earlier studies. Australian nurses share the same Nightingale heritage as UK nurses **though by 1991 in Australia the**

bachelor's degree had been designated as the entry for nursing practice, just over twenty years before the same move in the UK (Marquis et al., 1993). The second author recruited, via requests on professional networks, eleven registered nurses (10 women, 1 man) into three focus groups. The majority of participants were experienced nurses, five of whom had over 20 years experience. They worked in advanced practice areas of nursing such as intensive or coronary care. The groups met in a private room in the university. The group was told that the researchers were interested in what kept nurses at the patient bedside when many of their colleagues had moved to non-clinical roles or had left nursing altogether. The second author put a small number of broad questions, in relation to this, to the participants and then allowed them to speak freely. This produced shifts of focus in the discussion. This was anticipated given that the focus group method was informed by the psychoanalytic notion of asking the analysand to speak freely, in the spirit of free association.

The English data included here arose from a study led by the first author into the emerging professional identity of successive cohorts of students training to be nurses, midwives or assistant practitioners at a university in London. The first focus groups were held in late 2012 in rooms in the university and the study is on-going. From their second year of study onwards, students from the range of courses are invited to participate in focus groups with the aim of discussing their place in healthcare work and their responses to their experiences working in the NHS. To date the first author has held groups with healthcare support workers training to become assistant practitioners (four groups N=38), student midwives (n=12), students studying for BSc nursing

(n=15) and postgraduates undertaking shortened nurse training (n=11), from where the data examined here originates. This group lasted approximately 50 minutes. These participants have all had a variety of work experiences during the preceding year and some have previous experience in various healthcare roles in the NHS and private sector. However, being generally early in their career they form a contrasting sample to the Australian study.

The authors transcribed audio recordings of the groups. The ethics boards of each university approved the studies.

Analysis

The authors conducted the first analyses inductively, that is, listened to all audio recordings and read the transcripts to gain a sense of the topics discussed, paying particular attention to the structure of talk, for example turn-taking, repairs, overlaps. The transcripts were then re-read by both authors and discussed in detail after the authors had each independently noted particularly strong apparent expressions of powerlessness or victimhood in both sets of data. Having knowledge of Lacanian ideas we decided to pursue this particular line of analysis and see what light these ideas could shed on the data and whether this analysis could extend current thinking about power and identity in the nursing profession. No formal coding procedures were used.

FINDINGS

We discuss two extracts drawn from a dataset characterised by highly negative talk about nursing work. These extracts are not atypical examples.

The first is from one of the Melbourne focus groups. It is part of a free-flowing discussion about the workplace advantages that the nurses described doctors as enjoying over themselves and how they believed doctors are given recognition that nurses do not receive:

Nurse 3: I think nurses are their own worst enemy when it comes to respecting each other sometimes.

Nurse 1: I agree with you regarding nurses respecting each other, there's a huge issue ... even with the doctors at our hospital, they'll allow you to do so much when the mood suits them, like they're going out for the night, but when the mood doesn't suit them, they're very quick to put you in your place. So I am not sure I agree with you about respect.

Nurse 3: I think because we're seen as professionals or we need to uphold that we're professionals, we need to act that way as well and not be intimidated by the doctors ... you're a professional so you have every right to speak up and do things your way and not let them bully you or intimidate you because you're a professional as well.

Nurse 2: ...When you've got a situation like that, [if] you've got a charge nurse who'll stand up for you -

Nurse 3: - and support a junior

Nurse 2: - if they know that a doctor or someone has been exceedingly rude - and we all know how rude some of these people can be - it's alright for mature people, they can stand up for themselves, but for the junior staff, it stops them from speaking up again, you know.... They'll think twice before they think to voice an opinion unless they've got a charge nurse that will be their advocate. And I'm not sure how many charge nurses out there would be their advocates. Because the charge

nurses, let's face it, these days in the private sector, not only are the patients your clients but the doctors are also your clients. So who are the nurses?

Nurse 3: slaves

Nurse 2: yeh

[muffled word and laughter from the other nurses]:

Nurse 1: What did you say?

Nurse 2 and 3: Slaves, the slaves!... [general laughter]

Nurse 1: slaves, ah

The nurses, while invited to talk about their work, talk of doctors and their working conditions. The doctors are cast as colleagues who 'allow' the nurses to do various technical tasks 'when the mood suits them', who can be rude and are seen as 'clients' of the hospital, whereas the nurses are not. Instead the nurses cast themselves as slaves to the doctor, and in some instances to the hospital as well.

The second extract comes from a group of nurses training in London. As mentioned, being early in their career they form a contrasting sample to the Australian study. One subject of discussion concerned the surprises that they had encountered during their work in various National Health Service (NHS) organisations, referred to as 'Trusts'. In this extract participants talked about a realisation that working conditions for nurses could be poor:

Nurse 4: sometimes the staff are working on the top floor and the staff room is like on the ground floor. A nurse has like fifteen

minutes tea break or something by the time you've had your tea, go downstairs it's time to come up (laughter).

Moderator: so you think this sends a bad message to the staff?

Nurse 3: Yeah because you're not actually being valued, you're not being appreciated. The Trust is not looking after you so ... it will really affect –

(overlapping talk)

Nurse 3: you're working like three hours and you have a fifteen minute or half an hour break, you need to sit down and relax, sometimes the staff room is packed with nurses and you don't have the space to sit down. Sometimes you spend your fifteen or thirty minutes standing up –

(laughter)

Moderator: so that was surprising, you feel like you're going into a profession where often you feel you're not valued?

Nurse 3: yeah, you're not valued. It surprised me about that, that nurses are not valued to be honest.

Nurse 2: I think the NHS depends a lot on good faith and they like to use like emotional blackmail. This is my experience ... It's kind of like, well you shouldn't be complaining because, you know, there's sick people and they need the money rather than like refurbish your tea room. ...

Moderator: so what were you saying, you said emotional blackmail?

Nurse 2: yeah I think the whole sort of 'oh its sick people' and you can't expect to have a certain standard of - like facilities and what not. You know what I mean?

Moderator: so how does that message get around?

Nurse 2: it's just a general consensus I think, a culture of martyrdom (laughs)

Others: Martyrs! Martyrs! (laughter)

Nurse 1: cheap nurses

In a parallel to the Australian extract, the provocative use of a negative label for nurses, in this case as martyrs, leads to an energetic affirmation from the group as a whole. It should be noted that even these relatively inexperienced students appear to identify with the notion of a nursing 'culture of martyrdom'.

Analysis: The obstruction is moved from the inside to the outside

Hegel's dialectic of the master and slave in *Phenomenology of Spirit* (Hegel, [1807] 1977) is a starting point of our interpretation of this data. His brief account of the stages of development of human self-consciousness has been taken up widely by subsequent thinkers exploring the complexities of human society, by Marx, Lacan and Žižek, for example. Hegel is concerned to describe the development of self-consciousness. For Hegel, consciousness is relational. He describes the stages of the encounter of one self-consciousness with another. In order to fully realise its own self-consciousness, each demands recognition from the other and they become engaged in a life-and-death struggle. However, the death of one self-consciousness would result in the absence of an other self-consciousness to acknowledge the existence of the first. Rather, then, than fight to the death, one subject yields to the power of the other hence a relationship of master and slave is established. However, though it at first appears that the master

has the higher realisation of self-consciousness, Hegel points out that it is the slave. One reason is that since the slave has been shaken to the core by fear of death, he has experienced independent consciousness of himself which the master has not. Another is that the slave, who has been put to work by the master, finds the lasting satisfaction of seeing his will embodied in the objects of his labour, which the master does not. It is the slave who holds a direct relationship to production and nature. The optimistic lesson from the master-slave dialectic would be that the full realisation of our capacities as subjects in the world requires an encounter between two consciousnesses that is constructive rather than destructive (Atkins, 2005). However while Marx took up this influential account in his theory of labour and alienation, Lacan referred to it in order to illustrate aspects of his theory (for example, see (Lacan, 1988b, pp. 286-7)) and subsequently Žižek used this image as part of his argument **about the impossibility of human subjectivity**.

In order to do this Žižek discusses definitions of class antagonism (Žižek, 2005). Class antagonism, he says, proposes an impossible relationship between the two parties of the class struggle. For example '[a]s soon as I recognise myself, in an ideological interpellation, as a "proletarian" I am engaged in social reality, fighting against the "capitalist" who is preventing me from realizing fully my human potential, blocking my full development' (Žižek, 2005, p 273). For Žižek the illusion with social antagonism is that abolition of the oppressing party will bring with it a full identity **to the oppressed** and human potential will be realized. However, according to Žižek:

'...it is not the external enemy who is preventing me from achieving identity with myself but every identity is already itself blocked, marked by an impossibility and the external enemy is simply the small piece, the rest of reality upon which we "project" or "externalize" this intrinsic, immanent impossibility ...' (Žižek, 2005 p. 274).

Our suggestion is that the talk in our focus groups shows a nursing discourse at work which attempts to move the obstruction to 'full nursing' from an intrinsic impossibility to an external frustration. This allows nursing to maintain a fantasy that autonomy is possible and that fully caring relationships with patients are also possible and will bring deep satisfaction and recognition for the profession. It is with the doctor, or the manager, as external enemy, where the impossibility is positioned, rather than with nursing itself.

We should, of course, point out that we are not discounting the clear differences and privileges afforded the medical profession or managers nor, for that matter, the clear power differences effected by patriarchal and managerial systems (we will return to these at the end of our paper). We acknowledge these forces, but they are not the fundamental cause of the dissatisfaction spoken about by nurses in this analysis.

In the talk of nurses involved in our studies we find nurses responding to the call from professional ideology to be fully identified with the nurse whose compassion for her patients is brought together with her autonomy in order to act in their best interests and to find self-actualisation in this. However, this identification with an ideal is problematic, not just because of external constraints but intrinsically (following Lacanian theory) because achieving full potential, or wholeness, is impossible; the subject is always divided, as we

have argued, and thus always deficient. Nurses, we suggest, therefore need to provide themselves with an explanation for why this project fails, of why their experience does not live up to the ideals of the profession described earlier. This explanation comes in the form of the external overbearing Other, the doctor, or manager, or bureaucracy, or staff shortages (or a conspiracy of all of them). To face the intrinsic impossibility of the role of nurse and of autonomous professional identity provokes considerable anxiety. It would mean rejecting the very ideology that is the basis for nurses' understanding and valuing of their identity. The situation is potentially highly unstable. But what gives this apparently unsustainable situation its stability? How might we account for the repetition of complaint and outrage that we have collected in our research in different settings?

The pleasure of powerlessness

Our answer, crudely put, is that being a victim **can serve** a number of purposes. As we have suggested, a psychoanalytic interpretation suggests that the slave can avoid facing certain unsettling questions by continually understanding their lack of fulfilment as the responsibility of another. Also repetition of talk of victimhood and self-sacrifice can pleurably intensify nurses' sense of their moral identity as those whose deep commitment to their duty to others renders them vulnerable to exploitation. To quote Žižek again:

My description of the circumstances whose victim I was can be entirely truthful and accurate, but this very enunciation of my predicament provides me with a surplus-enjoyment: the report on my victimisation, by means of which I impute the guilt to others and present myself as...innocent...always provides a deep libidinal satisfaction. Founding one's identity on a specific injury can be a source of deep satisfaction... (Žižek, 2005 289)

We can hear in the talk from the focus groups an energy in the depth, inventiveness and sustained and repeated nature of the complaints made by the nurses. As we have said, the death drive that Freud proposed can be understood as a 'pleasure beyond pleasure', a pleasure in the negative, a self-destructive drive. In the case of this research we see this drive in operation in the way that it offers to nurses the possibility of a surrender which promises a release from conflict and tension concerning the impossibility of the work that they do and the identity they are expected to take up.

DISCUSSION

So what are we to make of this? As with an analysand, we start with a consideration of history. In nursing discourse, as we have mentioned, there is a history of Christian duty and service (Bradshaw, 2009), that is, of potential servitude. While late twentieth century nurse leaders have attempted to free nursing from a Christian ethic of duty and self-sacrifice, this capacity to be free of one's history is not quite so easily achieved. It is therefore not surprising that a notion of servitude and sacrifice, expressed perhaps in extreme terms as 'slavery' and 'martyrdom', speaks itself through these nurses, in contemporary times, be they many thousands of miles apart.

Both groups participate in an historical discourse of nursing that has been passed down to them from their forebears. Lacan (1988a) spoke about the passing down of an historical discourse into which the subject is integrated. He claimed that, for example, the father makes mistakes that the son is "absolutely condemned to reproduce" because these mistakes are bequeathed to him, not only because he is the son, but also because he is the

next link in a circuit of discourse. This passing down from one generation to the next can be considered in relation to groups other than the family, a profession for example. Indeed we can consider what is passed from one generation of nurses to the next.

This 'passing down' of discourse, this repetition is beyond the pleasure principle, as Freud ([1920] 1984) suggested. What gets passed down and on is not of the order of pleasure, as the words of the nurses show. However, like the son who is condemned to reproduce the mistakes of the father (Lacan, 1988a), they are condemned to reproduce the mistakes of their forebears in nursing and, unable to stop the movement of the discourse, they pass it on, they repeat it. This repetition that continues through the generations – in this case a generation of nurses – is as if the nurses in our focus groups are being pursued by their destiny (Freud, [1920] 1984), one of slavery and martyrdom.

This mention of slaves returns us to Žižek and his work on class antagonism. Žižek (2005) argues that the notion of 'full human potential' is illusory, but even so it can still be sought after in phantasy. Perhaps the nurses stay locked in this struggle with the doctors or hospital management, lured by the promise, in phantasy, of full human potential, in their case of autonomous professional practice and satisfying relationships with patients. This, of course, is speculation, as we do not have access to the nurses' unconscious fantasies about their work. Nonetheless the lure of an unconscious fantasy of full human potential could provide an explanation for their remaining in this 'antagonism' with the doctor or manager, casting themselves as slaves, when **one might think that** they could walk away and leave this history behind. This

illusion of 'full human potential' might be perceived in many ways, however we suggest that it blocks the difficulties and inadequacies that nurses encounter when confronted with their own limitations in relation to the sick and sometimes dying patient, and the limits of their own organisational authority. If we take up this proposed phantasy of the nurses, then we might consider how this leads to a certain kind of enjoyment being produced. For it is in phantasy that we find the locus of *jouissance*. This particular enjoyment that is beyond pleasure is 'located' here (Safouan, 2000). Lacan contented that '[O]nly my formulation of phantasy enables us to reveal that the subject here makes himself the instrument of the Other's *jouissance*' (Lacan 1977, p.320). As noted, this enjoyment that Lacan called '*jouissance*' is beyond Freud's pleasure principle yet is not in itself pleasurable (Zentner, 2012) to the part of the subject to which they are identified: the ego.

CONCLUSION

In this paper we have attempted to add something, albeit speculatively, to understandings of professional identity within the complex context of nursing work in healthcare systems by looking to psychoanalytic theory. We suggest that nursing's particular history can make a position of powerlessness acceptable and attractive for nurses at work who are faced with the 'impossibility' of their role. Previous studies have tended not to understand a position of powerlessness as serving a purpose **in terms of the identity work that nurses might engage in**. In our data it is possible to hear that the nurses, while they might complain, are still in the place of dutiful servitude. We are not claiming that the kind of subjectivity we have presented above is universal among nurses however, our data from two different geographical settings do

suggest that it is more than a local phenomenon and is evidence of a far-reaching discourse at work. Finally, our analysis has not foregrounded gender as an explanation for nurses' talk. Nevertheless, the historical background of the nursing profession and the context of nursing work as gendered is clearly not something that we would discount.

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