Spectators & spectacles: nurses, midwives and visuality

Alan G. Barnard BA MA PhD RN

Senior Lecturer and Acting Director of Academic Program (Undergraduate), School of Nursing, Queensland University of Technology, Queensland, Australia

Marlene Sinclair BSc MEd PhD RN RM RNT

Senior Lecturer, School of Nursing & Midwifery, University of Ulster, County Londonderry, UK

Correspondence:
Alan G. Barnard,
School of Nursing,
Queensland University of Technology,
Victoria Park Road,
Kelvin Grove,
Queensland,
Australia.
E-mail: a.barnard@qut.edu.au

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Aim. In this paper we reflect on how linear perspective vision influences the practice of nurses and midwives and to advance understanding of clinical practice in technologically intensive environments through examination of drawings by nurses and midwives and through critical analysis.

Background. There is increasing emphasis on vision in Western culture, and both nurses and midwives spend a great deal of time observing their clinical environment(s). Healthcare practitioners work increasingly in image-based realities and nurses rely on visual skills. Vision and visual representation are central to our practice and are important to examine because we look often at technology to assess people and care.

Discussion. The world in which we practise is one of meaning(s). Technological development is transformative in nature and produces changes that alter the way(s) we give care. Amongst all this change, it is unclear how we practise in environments characterized by increasing technology and it is unknown how nursing and midwifery practice alter as a result.

Conclusion. Simple drawings included in this paper highlight an important and shared experience of clinical practice(s). They emphasize the importance and scope of the visual sense and expose practitioner behaviour that has enormous implications for current and future professional development and person-focussed care provision. Experiences described in this paper require further examination and highlight substantial changes to nurse–patient relationships, health care and the way we practise.

Keywords: clinical practice, midwifery, nursing, technology, theory, vision, visualism

Introduction

There has been an increasing emphasis on vision in Western culture, and both nurses and midwives spend a great deal of time observing. Short (1997) noted that in hospitals nurses are one of a select group who are able to observe each person's body with impunity. Whether we are looking at a person in a bed, a digital display, a dripping intravenous infusion, visitors, a wound dressing, or out through a window, we interpret and understand our world(s) via the retina of our eye(s). We use light and colour as part of our nursing experience, just as we use them in our daily life and what we see is encapsulated by meaning, language and contexts. In fact, it has been noted that nurses 'have a special angle of vision by virtue of their distinctive epistemological, social, and even moral position on the front lines and at the

point of technologies on patient care' (Sandelowski 1998). Observation method demands reiter-ability of the visual object (i.e. we desire to be able to return to the visual object to detect further features of it), pattern recognition and the identification of phenomena within a figure–ground relationship.

Observations are increasingly image-based and rely on screens, printouts, lights and computer software to (re)present and interpret the condition and progress of each person (Green 1992, Williams 1997, Marck 2000, Sandelowski 2000). We look increasingly to image-based realities to find out, for example, how healthy people are, the state of their disease progress, and the presence and progress of a live baby. It is common to observe 'hyper-real' representation(s) on screens in the form of black and white pictures, colourized images, or digital displays (Barnard & Sandelowski 2001). We watch attentively to see and note – remark and comment – measure and respond – through an increasing array of *special* instruments.

Bryson (1988), Martin (1988) and Romanyshyn (1989) affirm that the modern era of Western social and cultural development (from around the 15th century onwards) has been characterized by the domination of sight. Understanding became linked to a linear perspective and increasing scientific and cultural reliance on visual field(s). For example, Romanyshyn (1989) showed that artistic representation reveals the way that increasing reliance on vision has become a way of knowing that has altered the way we interpret the world and interact with it. In fact, Romanyshyn (1989) argued that since the renaissance, Western societies have developed a new culturally-bound vision of the world that is manifest as a dream of mastery through distance. A new space has been opened between observer and observed. Linear perspective vision has enabled our interpretation of the world to alter from an ancient one in which distance and depth were interpreted in terms of spatial distance (i.e. objects were portrayed and understood only in terms of their relative size and shape), to a world in which horizontal space is emphasized across a visual plane.

In order to observe the visual plane and to make judgements about, for example, a person within it, a distance is created between the spectator and the spectacle. That is, as a result of our emphasis on vision we step back or step away from people, things, and events in order to comprehend them. Thus, (re)interpretation of modern nursing and midwifery praxis is needed in the light of these transformations and as a result of increasing technological mediation (i.e. technological interpretation and control of environments) (Ihde 1995, Williams 1997, Sandelowski 2002). It is noted that relations with technology both enhance and ultimately 'transform our perceptual-bodily experience of an environment or world' (Ihde 1995, p. 111).

The practice of contemporary nursing and midwifery has expanded beyond traditional environments such as being in close physically proximity to the person in a bed. We purposefully position ourselves in clinical contexts not only to maximize power and control over patients (van der Riet 1997), but to plan and enact care. Our new virtual world(s) of nursing challenges traditional notions of caring and practice habits (Sandelowski 2002, p. 64). Image-based practice appears sometimes to have as much life as the 'real thing' (Barnard & Sandelowski, Simon 1999). We discern a great deal about our patients as a result of how we monitor them, and there can be a perception that we know the person despite the fact that we are not physically near them. Technology challenges the importance and centrality of close physical proximity to patients because nurses are often *there* but not *here* with the person (Sandelowski 2002). In practice, vital signs are increasingly accessed via screens, machinery is increasingly a component of a patient's care environment and body systems are measured and assessed via technology.

In this paper we examine the implications of vision for nursing and midwifery practice. Analysis could focus on multiple interpretation(s), including that which arises from authors such as Foucault (1977), who emphasize the importance of power relations that arise from experts and the impact of surveillance techniques on individuals and society. However, instead our focus is specifically on interpretation of the practice implications of our increasing reliance upon vision. The paper should be read as an interpretive analysis that offers new perspectives to the challenge(s) of increasing visual representation and distancing of practitioners from people. It draws on visual theory and undertakes a critical examination of the relations between vision and healthcare provision. It highlights alternative interpretation(s) that have implications for research, theory and practice. The examination includes reflection on the meaning(s) of drawings made by Australian surgical nurses and Irish midwives that arose from research undertaken by Barnard (1998) and Sinclair (1999). Simple drawings obtained from these unrelated qualitative research projects sought to portray understanding of technology and clinical practice. Drawings reveal consistently similar diagrammatic portrayals of nursing and midwifery care, particularly in relation to spatial relations between people. Although we acknowledge that, as in the case of photography and other texts, artistic representation is contestable and open to varied interpretation (Wenestam 1984, Bruce 1997, Short 1997, Barnard & Gerber 1999, Rose 2001), it is argued that the simple drawings are remarkably similar thematically and

highlight both the language and symbols of modern practice, whilst also being powerful and meaningful portrayals of the importance of vision.

Representations of nursing and midwifery practice

In the following drawing (Figure 1) a nurse portrayed the difference between the practice of nursing with technology (technology for her meaning new, innovative and electronic machinery and equipment) and the practice of nursing without it. She explained that, on the right side of the drawing, the nurse is not with patients. She is too busy completing her roles and responsibilities to be with people for any length of time. The right side of the drawing stresses that she does *not have the advantage of technology* to assist with patient care, and both she and her patients are unhappy (as illustrated by the sad expression on their faces). On the left side of the drawing the nurse and patients *have the advantage of machine technology*. The nurse has time to sit and talk with people, care is controlled and predictable and each person is happy (as illustrated by the smiles on their faces). The drawing represents an idealized conception of gaining control of clinical responsibilities through technological intervention.

However, Figure 1 also reveals a different type of *being with the patient*. Of particular note is the move of the nurse from being next to the patient on the right hand side of the drawing (when using an intravenous infusion without and the advantage of a pump) to the foot of the bed (left side) when an electronic pump was introduced to control the treatment. The nurse has moved to a distant yet strategic position in which the environment of practice can be discerned by the eye. She has moved away from the person. This drawing could be dismissed as a unique representation of nursing

practice, but comparison with other drawings reveals a common portrayal of distancing.

In the next drawing (Figure 2) the nurse explained that she is positioned at an axis point where her visual sense is used to assess, monitor and control care. Key visual cues related to the care environment are represented as the window (outside world), the machinery of health care [boxes with lines etc. (internal world)] and the patient (in the bed). The nurse has positioned herself strategically at the foot of the bed in order to observe the patient as well as the internal and external worlds.
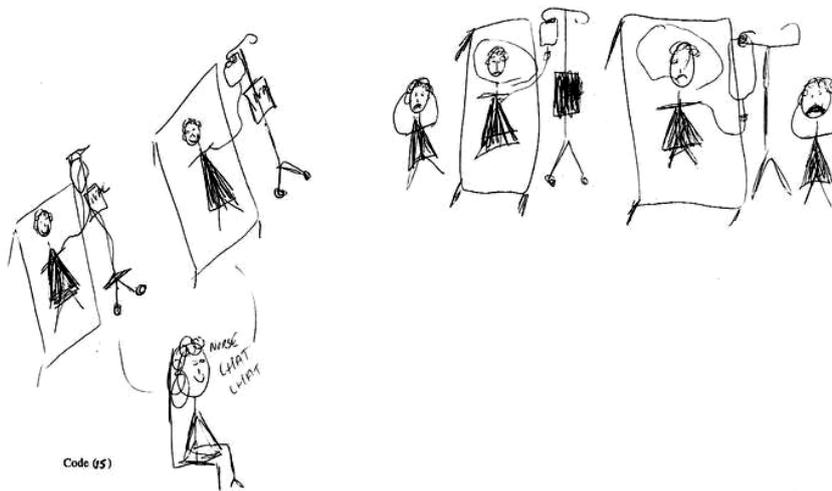
When asked to explain Figure 2, the nurse stated:

Nurse: ...the patient is lying there without much control, they're just the recipient of the technology and of the care...there's no real interaction. The nurse sitting at the bed has access to two or three
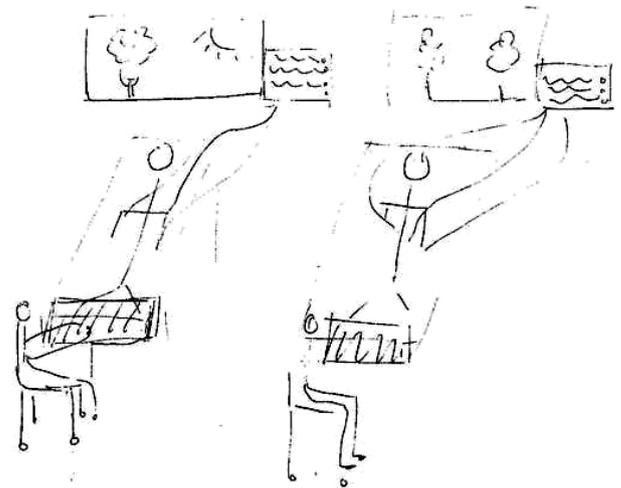
Figure 2 Control and the axis point (Barnard 1998, p. 171).

Figure 1 Gaining control with machinery (Barnard 1998).

Figure 3 Technology and control of clinical practice (Barnard 1998, p. 173).

areas – the outside, the monitor – and the nurse is translating information or being a conduit of the information to the client who is passively receiving it.

Interviewer: Why is the nurse at the end of the bed, not next to the patient?

Nurse: It's a control thing again. That's where all the documentation is centrally located, but it is also an axis point, being able to see the monitor, the patient and the outside. If they're standing next to the patient, they won't have all those inputs. (Barnard 1998, p. 171)

Similarly, in Figure 3 the nurse has positioned herself at the foot of the bed to maximize care and control.

The experience of control was central to this nurse's description of her clinical practice. She highlighted the importance of giving physical care using technology, but also the necessity of a link to the outside world:

Interviewer: Why is the windowpane painted with a lovely tree in it?

Nurse: Well, she [patient] can't see out.

Interviewer: And is that significant?

Nurse: Yes, because they're [patients] actually away from that at the moment and they can't have a part of that at the moment unless somebody brings some to them. (Barnard 1998, p. 173)

Each drawing (Figures 1–3) highlighted a physical distancing and a reliance on vision. Central to contemporary nursing and midwifery practice is the need to create order in busy, demanding and complex clinical environments. Practitioners often rely on technological mediation to assess people and control specific aspects of care provision (e.g. regulate intravenous infusions). Information provided by technology is increasingly image-based, and interpretation requires practitioners to observe a total environment that is more than, but includes, the people in the bed. Paradoxically, the drawings portray how practitioners step away from the people (bodies) to make judgement(s) about ongoing care. They rely increasingly on vision and the creation of the 'inside body' as represented through technology such as ultrasound, cardiography and digital display (i.e. instrumental embodiment).

In Figure 4 a midwife described herself as a distant observer looking upon a birthing process. Machines are depicted closer to the woman and her partner than the midwife. The midwife is drawn as an observer or spectator of the spectacle that is the birthing woman. The technology embodies a sense of control, of taking charge, of being with, but also of being distant. As in Figure 1, the machinery rather than the midwife is credited as responsible for the creation of a calm and peaceful environment.
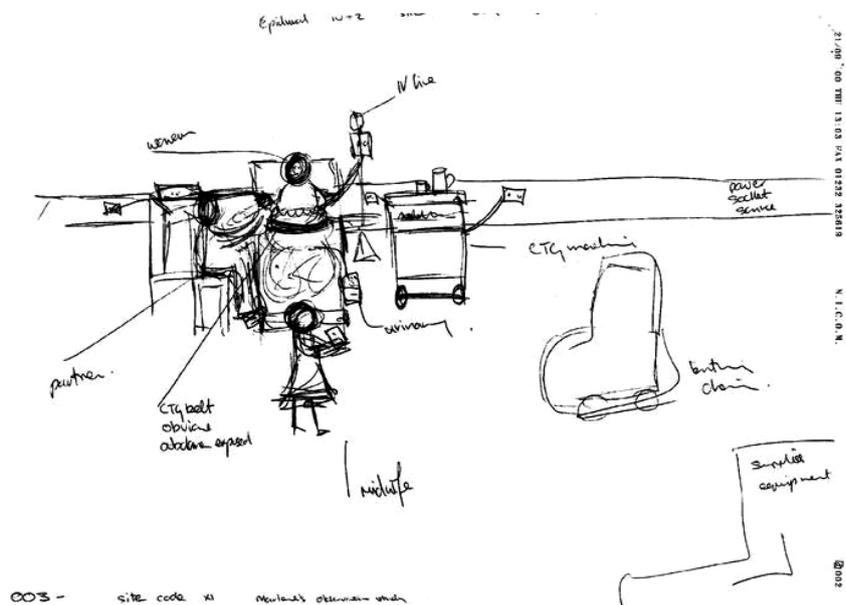

Figure 4 High technological birth: the midwife as a distant observer (M. Sinclair, unpublished data).

When asked to explain her drawing, the midwife stated that:

Midwife: Technology saves time for the midwife and gives the woman a pain-free labour…The midwife can walk around the room and pick up all the data from the machines whilst the woman and her partner remain calm and peaceful.

Interviewer: Why is the midwife at the end of the bed?

Midwife: The woman doesn't need her as much. If the woman was in pain the midwife would be at her side, holding her hand and helping her to breathe her way through the pains, but with the epidural she doesn't need to. The midwife can see the woman and the machines from the end of the bed. Everything is under control…relaxed mum, midwife and partner….

The midwife described herself as *outside the scene* [and as] *an onlooker*…gazing at technological mastery in an environment where machines monitor the woman and her unborn baby. The midwife is portrayed as a mediator(s) of technological power and energy that exists between the women-baby-machine and significant other(s).

Implications for practice: spectators and spectacles

The distance or space between the nurse/midwife and the person in the bed is a transformed space. Instrumental embodiment permits closer access to the inside body and yet as a consequence the person may be observed at distance. What is unknown at this point is whether (how) the subsequent reliance on vision hinders and/or assists human focussed care.

Visual hegemony

One interpretation is that there is hegemony or dominance of vision in nursing and Western society is dominated increasingly by surveillance practices and surveillance technology(ies) (Foucault 1977, Cheek & Rudge 1994, Lyon 2003). Nurses have always been participants in surveillance, whether through looking (gazing) at the body, measuring temperature, testing urine or viewing monitors. In addition, our participation increased dramatically during the 1990s as surveillance of biometric and diagnostic data became more intensive and extensive. Clinical data became obtainable directly from the body and confirmed the continued influence of modernity (Lyon 2003) upon society, nursing and midwifery. In fact, Romanyshyn (1989) claimed that the body in health care had been transformed from a complete and whole manifestation of our shared cultural life and death to a medicalized body that is broken into segmental parts.

This medicalized body is at an increasing distance from the observer. As a result of a pre-eminence of vision the world is viewed through an imaginary window much like a camera (as in, for example, a monitor screen). The body, with its various segmental parts, is transformed into a specimen under observation. Spectator, specimen and spectacle come together to be culturally-bound codes that represent a new way of knowing. The subsequent development of spectator–spectacle–specimen relations engenders a type of visioning that has been described as an anatomical gaze (Romanyshyn 1989).

Nurse and midwife drawings (Figures 1–4) confirm that it may be common practice to stand at distance in order to interpret and assess the progress of care. If Romanyshyn (1989) is correct, each person observed is consequently objectified and refashioned as a body part(s) with an associated monitor, tube, bag and function(s). To illustrate the point, Romanyshyn (1989) drew a comparison between medical bodies and pornographic bodies. He argued that both emphasize the range of expression associated with the body as technical function. Each epitomizes the objectification of the body and each creates a body that is apprehended through a distant and objectifying gaze. The gaze transforms the body. The medicalized or pornographic eye of the spectator seeks through humiliation and subjugation of the flesh to reduce the body (person) to that of inanimate thing (object). For example, in its most obscene and objectified sense, the pornographic body is portrayed as a vessel of sexual pleasure, erotic violence and visual delight through avenues such as the fiction of the Marquis de Sade (Henaff 1995), and as seemingly unlimited visual representations of body parts, sex acts and anonymous genitalia on the World Wide Web. Nothing escapes the eye of the observer because everything that can be quantified and accounted for is brought forth into vision.

Whether observing or gazing at a nursing/medical scene of machine(ry) – body part(s), object(s) or a pornographic scene of anonymous sexual acts – the exposure is total. There is nothing unequivocal in the mechanistic order that is created. Everything can be observed, measured, recorded and objectified. The medicalized and pornographic body could be your body, my body, or in fact, no body! Consequently there is reduced potential for human connectedness (e.g. compassionate understanding), less opportunity for subjectivity and a diminished need to 'get to know' the person. Everything that can be laid out before the observer and participant is exposed and the exposure is anatomical, functional and quantifiable (Henaff 1995).

Under these conditions we can reasonably ask whether a visual emphasis can assist the goals of nursing and midwifery and/or whether it is a 'God trick' (Haraway 1995, Ihde 2001) because we come to believe that we are all-seeing and able to

know all things at all times. The technological/scientific world of observation emphasizes everything along a linear perspective gaze in which all things along the same visual plane become equal. The subsequent distancing smooths over individual uniqueness, subjective experience and qualitative measures such as loneliness, joy or isolation. Differences between people are under-represented. Linear perspective vision emphasizes the interior of the body as observed through instrumentation, and space is filled with furniture, biochemical measurement, foetuses, beds, significant others and various paraphernalia.

Much like the classic scientific examination, we step back and away from objects to observe their movement, manifestation and function. Clinical practice becomes grounded in a condition of retreat that exposes, for example, catheters, machines, lights, a view through a window and digital screens. Body parts are displayed for the observer as a series of graphs, tubes, function(s), part(s), excrement and electrical activity. The spectator retreats from the body *in order to know it*, not as a whole, but as its composite parts that are displayed at any one moment. By distancing ourselves from the person, we gain a spectator's vision. We are with the person, yet strangely distant because we can not attain the same intimacy and connectedness as we can when we are in close physical and emotional proximity. The body in the bed continues to be *a body* but it is concealed as if it were a shadow of its real self. We see only an outline or small part of the person rather than the whole individual.

Image-based realities: visiting *other* worlds

But does vision at distance necessarily alter the relation(s) between a person–patient–nurse–midwife? Is there always objectification of experience to such an extent that it affirms the claims made by for example, Romanyshyn (1989) as both realistic and appropriate? Can viewing a screen or digital display foster an intimate relationship and is physical proximity necessary for quality care?

The problem with a clinical emphasis on solely visual representation – [visualism (Ihde 2001)], is that it is not possible for any extended period of time. Even if we seek to emphasize vision, ordinary things that are interpreted normally through all our senses occur simultaneously within environments and each person – woman – body – patient reveals for us information that should tempt all our senses. Focussing upon a purely visual environment gives the impression of control and objectification, but multi-sensory dimensions remain constant even if we (the practitioner) are not attuned to them. In fact, Ihde (2001) argues that phenomenological research demonstrates that focussing on vision by itself is a result of a deliberate manipulation of the

senses. If we do it, we do so on purpose in order to focus our attention. For example, observing a cardiac monitor focuses the spectator on a discrete body part thus enhancing the experience of visual pre-eminence. If you or I looked at an electrocardiograph we might say 'there it is – an arrhythmia'. If this observing behaviour leads the practitioner to then return to the person (e.g. to inquire how they feel), then they have made a purposeful choice to focus on the person as he or she is manifest in other ways – i.e. through other senses. If we do not *return* it is at that moment that we, rather than the technology, have made a choice to distance ourself(ves) from our patient(s) and to reject alternative senses. We create an illusion of control whilst simultaneously risking its loss. The following simple drawing to some extent describes the way one midwife understood *returning* in clinical practice.

When asked to describe her drawing (Figure 5) the midwife stressed the central importance of vision and control but went on further to explain how vision fits into her practice. She explained that:

Midwife: I think this picture shows the typical scene at an epidural birth. The woman is attached to every machine possible. She is centrally placed in bed and strapped down to the technology by the CTG machine belts around her abdomen. Her bare abdomen is exposed so that the baby can be seen from the door and the machines can be read from a distance. You can look through the window and see most of what is happening without ever going in. The woman's mother is gazing at the TV and she doesn't have to listen to her daughter go through the pain of labour. There is a computer terminal to record events and save the midwife from going out of the room. The electric fan is on to keep the woman cool. The epidural has taken the pain away and the atmosphere is calm and quiet apart from the machines buzzing and occasionally alarming. The midwife and the woman are gazing at the CTG machine and the midwife has a hand on the baby and on the machine

Interviewer: Who is in control

Midwife: Hard to say really. I like to think it is shared…I involve the woman and her partner by explaining the workings of the machines. I can take control if I want but I am comfortable caring for her with the technology. (Sinclair 1999)

The midwife was more than a spectator of birth who remained distant from the birthing woman. The practitioner was purposefully choosing when/if/how the technology was being allowed to control care and the midwife engaged in a returning role in which she sought to intervene, take charge and interpret. Even though the labour ward drawings (Figures 4 and 5) highlight spatial distance and reliance on vision, they also portray a process by which, for example, a tomograph machine became an avenue to view the life of an unborn baby. Spectators (parents/significant other(s)/mid-
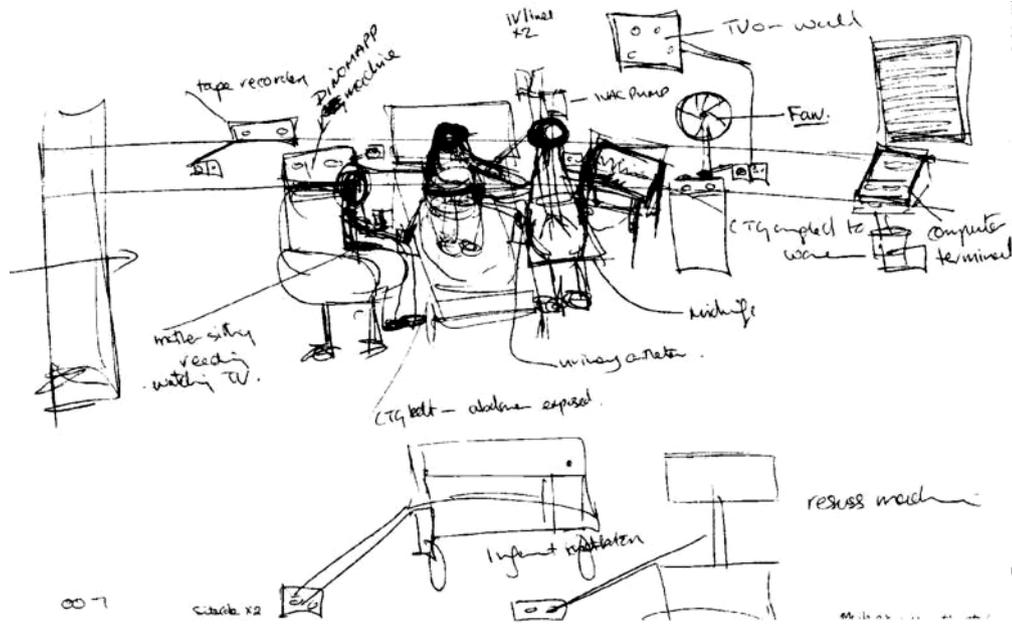
Figure 5 High technological birth: midwife as mediator (Sinclair 1999).

wives) are portrayed in Figure 5 as gazing upon the birthing event (spectacle). Representation stressed a shared gazing…there was a memorization…an observing of oneself and other…and a micro representation of the baby's life was witnessed by each person. The technology acted to reassure everyone present at the birthing event. For example, on one occasion Sinclair (1999) noted that a husband was a spectator fascinated by the prospect of observing the hitherto unknowable experience of his wife. Vision became a transforming process that was imbued with 'new-life energy'. Looking at the information provided by the technology introduced a different perspective to the birthing experience – not just a means to an end. Technology became as energy and *a force or power that revealed what had been hidden*, that is, the lifeworld of an unborn baby.

Visualism and space(s)

However interpretation to this point has been restricted by the dualistic conception that the nurse/midwife is a stable entity conceiving of the world from a universal centre on one side (spectator) and the patient is on the other side also as a stable object able to be known totally and understood. Even though this typically Western (Cartesian) perspective situates subject and object in a dualistic relation, other thinkers, such as the Japanese philosopher Nishitani, argue, much as de Saussure argues in relation to words and meaning, that an object at any one moment is understood only in so far as it is

never finite or static. Just as words and language are understood in relation to other words and sentences, so too must the world that is observed. We understand words only because they relate to other words, signs or contexts. Thus, by extension, the things we see are understood only in so far as they are interpreted in relation to other objects and contexts that come constantly into our changing visual field(s). We frame and interpret our world not because of one line of vision (much like tunnel vision) but because of what else we know and view (or can not view) within cultural, professional and social contexts. Bryson (1988) explains that when we look at anything or anyone, we see at that point in time only one perspective from a possible 360° circle. Each part of the 360° spreads out light in all directions into a total world but we see at any one moment only a proportion of the total. What enables any one visual experience to be singled out is its enclosure within a specific frame which is constructed at that moment but is never a total or complete picture.

In a surgical ward, for example, the outer limit of a person's body or physical presence can be questioned as the various tubes and cables extend our vision and the person outside into other technologies and representations of the individual. Monitors, graphs and digital readouts become real representations of the whole person at that one point in time. As in the Japanese art of Flung-Ink (*Haboku*), the notion of what is, for example, a person's body, is understood best in relation to how it extends into, and is

What is already known about this topic

- Published literature contains little research and critical examination of the implications of linear perspective vision for nursing in technologically intensive environments.
- There is minimal interpretation of the relations between vision, clinical practice and human-focussed care.
- There is limited scholarship and research focusing on artistic expression as a way to portray experience and understanding.

What this paper adds

- Healthcare technology emphasizes the visual sense and is bringing about important changes for nursing practice, skills and ways of knowing.
- In order to explain the relations between vision, technology and clinical practice it is important to examine the physical distance that can exist between nurses and patients.
- Clinical practice behaviour that involves distances between the patient and nurse may be essential for holistic quality care.

part of, its surrounding context. In the Haboku tradition representation and form have less defined space and is restricted less by notions of a predefined boundary. A painted object such as a tree might reach out on a canvas as a less and less defined shape to other spaces. The painting begins as what is obviously a picture of 'a tree' but then it extends outward on the canvas in an increasingly abstract form. The tree is still a tree, but it is not restrained within a specific area or space. It is freed as it reaches out into its whole environment. Even though the object remains the thing we nominate it to be, the tree fills other spaces that are the other unseen ways the tree might or could be viewed. So why is this type of representation important to nurses and midwives?

It may be the case that when a person (patient) is observed by a nurse or midwife at a distance in their bed, we *see* them and understand them better when the person is viewed/interpreted within the context of their whole clinical environment. In modern technology orientated healthcare environments the person (patient) infiltrates physically into space(s) in all sorts of ways. For example, it is not unusual for a patient to claim that a rhythm strip observed on a cardiac monitor is *my heart*, and a mother to say that an ultrasound picture of a baby is *my baby* and that urine in a catheter bag is *my urine*. Technology becomes both a representation and an extension of the person.

Boundaries or spaces that once defined the person fall away as their presence expands out into the whole environment that *is* them. It is any wonder that the simple drawings (Figures 1–4) express a radical decentring of the nurse and midwife. Up close to a patient in a bed the visual world of the nurse or midwife is restricted severely because the patient's body often moves out and away at numerous angles and trajectories into unseen space(s). Lines, cables and tubes that are extensions of the person's body at any one moment in time, run away from the nurse or midwife to surrounding areas that may, or may not, be viewed well up close. A void can be experienced in which the leads and tubes direct the eye of the observer (nurse or midwife) away into unseen space that is not always within their visual field. Up close our gaze is dragged away to areas that can not be seen. A nurse might complain that 'I can't see the monitor, the lights, the bag(s), the read out, or the screen'. The numerous vanishing points at the end of tubes, cords, cables, etc., do not at that moment reveal the *whole person* and it becomes essential for the nurse or midwife to retreat back and away in order to know them. The experience is highlighted by Bryson (1988, p. 91) who noted that:

Between the subject and the world is inserted the entire sum of discourses which make up visuality, that cultural construct…, visuality [is] different from vision, the notion of unmediated visual experience. Between retina and world is inserted a screen of signs, a screen consisting of all the multiple discourses on vision built into the social arena.

Conclusion

Who and what is really at the centre of the visual experience depicted by the nurses and midwives in their drawings? The world that we practise within is not just about defined shapes with stable predefined boundaries but is a world of meaning(s). Technology is transformative in nature and produces change. Amongst all this change it is unclear if we practice in environments characterized best by anatomical gaze or visualism (or both) and it is unknown when and how much we *return* to the person at opportune and appropriate moments. Although the quality of care provided by the nurses and midwives who drew the drawings included in this paper was not recorded and specific variation in the ways they may have interpreted their visual worlds is unknown, they did highlight an important and shared experience of practice(s). They each emphasize the importance and scope of

their visual sense. They expose different and important components of their patient's world(s) and healthcare practice(s) within an approach to care that depicts a distancing of the nurse and midwife from the person(body). How nursing and midwifery care responds to distancing is an unresolved and important question. The experiences portrayed through drawings highlight the importance of vision, a blurring of traditional caring/physical relations with people and altered relations with each person's (patient's) body. We live and practise increasingly in environments that are ocular-centric and representative of reality(ies). A major issue for nurses and midwives is what realities do we choose and what is the nature of our continuing relations between ourselves and others.

Author contributions

AB and MS were responsible for the study conception and design and drafting of the manuscript. AB and MS performed the data collection and data analysis. AB made critical revisions to the paper.

References

Barnard A. (1998) *Understanding Technology in Contemporary Surgical Nursing: A Phenomenographic Examination*. Unpublished PhD thesis, The University of New England, Armidale, Australia.

Barnard A. & Gerber R. (1999) Understanding technology in contemporary surgical nursing: a phenomenographic examination. *Nursing Inquiry* **6**, 157–170.

Barnard A. & Sandelowski M. (2001) Technology and humane nursing care: (Ir)reconcilable or invented difference? *Journal of Advanced Nursing* **34**, 367–375.

Bruce C. (1997) *The Seven Faces of Information Literacy*. Auslib Press, South Australia.

Bryson N. (1988) The gaze in the expanded field. In *Vision and Visuality* (Foster H., ed.), Bay Press, Washington, pp. 87–114.

Cheek J. & Rudge T. (1994) The panopticon re-visited?: an exploration of the social and political dimensions of contemporary health care and nursing practice. *International Journal of Nursing Studies* **31**, 583–591.

Foucault M. (1977) *Discipline and Punish: The Birth of the Prison*. Tavistock, London.

Green A. (1992) How nurses can ensure the sounds patients hear have a positive rather than negative effect upon recovery and quality of life. *Intensive and Critical Care* **8**, 245–248.

Haraway D. (1995) Situated knowledges: the science question in feminism and the privilege of partial perspective. In *Technology and the Politics of Knowledge* (Feenberg A. & Hannay A., eds), Indiana University Press, Bloomington, pp. 175–194.

Henaff M. (1995) Sade, the mechanization of the libertine body, and the crisis of reason. In *Technology and the Politics of Knowledge* (Feenberg A. & Hannay A., eds), Indiana University Press, Bloomington, pp. 213–235.

Ihde D. (1995) Image technologies and traditional culture. In *Technology and the Politics of Knowledge* (Feenberg A. & Hannay A., eds), Indiana University Press, Bloomington, pp. 147–158.

Ihde D. (2001) *Bodies in Technology*. University of Minnesota Press, Minnesota.

Lyon D. (2003) Surveillance technology and surveillance society. In *Modernity and Technology* (Misa T.J., Brey P. & Feenberg A., eds), MIT Press, London, pp. 161–184.

Marck P. (2000) Recovering ethics after 'technics': developing critical text on technology. *Nursing Ethics* **7**, 5–14.

Martin J. (1988) Scopic regimes of modernity. In *Vision and Visuality* (Foster H., ed.), Bay Press, Washington, pp. 3–28.

van der Riet P. (1997) The body, the person, technologies and nursing. In *The Body in Nursing* (Lawler J., ed.), Churchill Livingstone, South Melbourne, pp. 95–108.

Romanyshyn R. (1989) *Technology as Symptom and Dream: Technology as Vanishing Point*. Routledge, London.

Rose G. (2001) *Visual Methodologies*. Sage, London.

Sandelowski M. (1998) Looking to care or caring to look? Technology and the rise of spectacular nursing. *Holistic Nursing Practice* **12**, 1–11.

Sandelowski M. (2000) *Devices and Desires: Gender, Technology and American Nursing*. The University of North Carolina, Chapel Hill.

Sandelowski M. (2002) Visible humans, vanishing bodies, and virtual nursing: complications of life, presence, place, and identity. *Advances in Nursing Science* **24**, 58–70.

Short P. (1997) Picturing the body in nursing. In *The Body in Nursing* (Lawler J., ed.), Churchill Livingstone, South Melbourne, pp. 7–9.

Simon C. (1999) Images and image: technology and the social politics of revealing disorder in a North American hospital. *Medical Anthropology Quarterly* **13**, 141–162.

Sinclair M. (1999) *Midwives Readiness to use High Technology in the Labour Ward: Implications for Education and Training*. PhD thesis, Queen's University, Belfast, Northern Ireland.

Wenestam C. (1984) Qualitative age-related differences in the meaning of the word "death" to children. *Death Education* **8**, 333–347.

Williams S. (1997) Modern medicine and the 'uncertain body': from corporeality to hyperreality? *Social Science & Medicine* **45**, 1041–1049.