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Perioperative nursing and the politics of presence: Challenging hierarchy through relational knowledge

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Abstract

This reflection offers a critical examination of perioperative nursing through the lens of feminist epistemology, which examines how gender and power shape what is recognized as legitimate knowledge, and standpoint theory, which understands knowledge as situated and shaped by one's social and professional position. Within highly technical and hierarchical surgical environments, perioperative nurses rely on relational, embodied, and anticipatory knowledge that remains undervalued in dominant biomedical discourse. Perioperative nursing expertise is expressed through ethical presence, vigilance, advocacy, and clinical judgment informed by experience and pattern recognition. Such judgment may be described as intuitive when its underlying knowledge is not readily articulated; however, intuition in expert practice can reflect accumulated experiential knowledge rather than an absence of clinical reasoning. Drawing on care ethics and nursing philosophy, this work traces how patriarchal systems devalue relational knowledge and uphold authority through standardization and control. Perioperative nurses navigate steep power gradients while anchoring continuity, moral accountability, and patient safety. From this perspective, such nursing labour constitutes a form of epistemic resistance; resistance to dominant assumptions about whose knowledge counts and what forms of knowing are considered authoritative. Reframing perioperative practice in this way invites broader recognition of relational competence as central to ethical, effective, and just healthcare delivery.

Keywords: perioperative nursing, feminist epistemology, standpoint theory, relational knowledge, epistemic resistance, nursing knowledge, care ethics

What if the heart of healthcare was found not in authority, but in attunement? Where outcomes are tracked and efficiencies celebrated, relational wisdom can escape notice; yet it is often the quiet presence that helps hold complexity together (Benner, 2024). This perspective illuminates perioperative nursing as a relational foundation of surgical care, where care itself becomes a way of knowing, responding, and leading.

Suggested citation: Dunn, J. (2026). Perioperative nursing and the politics of presence: Challenging hierarchy through relational knowledge. *ORNAC Journal, 43*(2), 10–15. https://doi.org/10.5737/ornac18210

Perioperative nursing brings together technical expertise with sustained attention to the patient and the evolving surgical situation. Nurses integrate knowledge of the patient, procedure, equipment, team, and clinical environment while coordinating care across professional roles and established lines of authority (Chellam Singh & Arulappan, 2023; Reato et al., 2025). Much of this expertise develops through proximity, experience, pattern recognition, and relational attunement, allowing nurses to interpret what is occurring within the broader context of the patient's care (Benner et al., 2011; Tanner, 2006).

However, because perioperative nursing knowledge is deeply embedded in practice, its intellectual foundations can be difficult to see. Clinical judgments develop through experience and sustained engagement with patients and clinical situations. With increasing expertise, nurses may recognize meaningful patterns and grasp the significance of changing situations without relying exclusively on explicit, rule-based analysis (Benner, 1984; Benner et al., 2011; Tanner, 2006). Intuition, understood in this sense, is a dimension of expert clinical judgment grounded in experiential knowledge and pattern recognition, rather than an alternative to clinical reasoning. Within highly technical and hierarchical clinical environments, this raises an important epistemic question: which forms of knowledge are recognized as expertise, and which remain less visible because they are relational, embodied, experiential, or difficult to formalize?

Drawing on feminist epistemology, standpoint theory, care ethics, and matriarchal ethics, this reflection examines how perioperative nursing knowledge is produced, recognized, and valued within professional and knowledge hierarchies. Feminist epistemology considers how knowledge and claims to expertise are shaped by social position, gender, power, and the conditions under which knowing occurs (Haraway, 1988; Harding, 1991). Standpoint theory extends this concern by proposing that what people are able to know and perceive is influenced by their social and professional location, and that those

positioned differently within systems of power may have access to forms of knowledge that remain less visible from dominant positions (Collins, 2000; Harding, 2004). Care ethics direct attention to relationship, interdependence, responsiveness, attentiveness, and responsibility as morally significant dimensions of practice (Gilligan, 1982; Tronto, 1993). Matriarchal ethics, as used here, emphasize relationality, reciprocity, care, interdependence, and life-sustaining forms of social organization rather than authority grounded primarily in hierarchy or domination (Goettner-Abendroth, 2012). Together, these perspectives provide a way of examining epistemic hierarchies, i.e., the often-implicit ranking of some forms of knowledge, ways of knowing, and knowledge holders as more credible, legitimate, or authoritative than others (Antuna-Casal & Rios, 2026; Bhakuni & Abimbola, 2021; Fricker, 2007).

Guided by these perspectives, the reflection considers how relational and embodied ways of knowing contribute to clinical judgment and patient safety, how professional structures shape the authority afforded to nursing knowledge, and how relational approaches to power offer an alternative understanding of leadership within surgical care. In doing so, it asks what becomes possible when perioperative nursing knowledge is recognized as credible, given appropriate weight, and relational competence is understood as integral to safe, ethical, and collaborative care.

Hierarchies of Knowledge and Relational Ways of Knowing

To understand how perioperative nursing operates within, and at times resists, established structures of authority, it is necessary to consider how patriarchy shapes professional hierarchies and the ways in which different forms of knowledge are valued. Patriarchy is more than a system of men ruling over women; it is sustained through social and institutional arrangements that have historically privileged hierarchy, control, abstraction, and detachment while assigning less authority to relationality, embodiment, interdependence, and care (Connell, 2005; Federici, 2004; Gilligan, 1982; Merchant, 1980). Within healthcare, these values are embedded in professional norms and institutional practices that influence whose knowledge is regarded as authoritative and which forms of knowing are recognized as legitimate (Davies, 1995; Freidson, 1970; Foucault, 1963/1973).

Feminist scholarship challenges the assumption that knowledge is produced from a completely neutral standpoint. Instead, it understands knowledge as situated: what people notice, understand, and can contribute is shaped in part by their experiences and their position within social and professional relationships (Haraway, 1988; Harding, 1991). This perspective does not reject scientific or objective knowledge. Rather, it draws attention to the social and institutional conditions through which knowledge is produced, interpreted, and granted authority. Within healthcare, this shifts attention to how professional position and the recognition of different forms of knowledge can influence whose expertise is trusted and which forms of clinical judgment are heard and acted upon (Freidson, 1988; Veeger-Nuijens et al., 2026).

Relational approaches to knowledge extend this argument by questioning the assumption that legitimate knowing must be detached, abstract, or independent of human relationships. Feminist scholarship has demonstrated that knowledge may also develop through experience, dialogue, attentiveness, and relationship (Belenky et al., 1986; Haraway, 1988). Relational knowledge, as used here, refers to knowledge that develops through sustained attention to persons, interactions, and context, allowing clinical situations to be understood through both available information and the relationships and circumstances that give that information meaning. Care ethics, an ethical approach that understands care, relationships, and responsiveness to the needs of others as central to responsible action, builds on this relational understanding. It emphasizes attentiveness to the needs of others, responsibility for responding to those needs, and responsiveness to how care is experienced and received (Gilligan, 1982; Tronto, 1993).

These perspectives do not suggest that relational ways of knowing are inherently feminine or position relational knowledge against technical or scientific knowledge. They challenge hierarchies that grant greater authority to abstraction and detachment than to knowledge developed through embodiment, experience, and relationship. Relationality, from this perspective, forms part of the process through which situations are perceived, interpreted, and understood and is therefore integral to clinical expertise.

Collectively, feminist epistemology and care-based approaches provide a framework for examining how knowledge and authority intersect in healthcare. They draw attention to forms of knowing that may be clinically consequential while remaining less visible because they are experiential, embodied, relational, or difficult to codify. They also invite consideration of how different forms of knowledge contribute to understanding and responding to complex clinical situations. These tensions are not unique to perioperative practice. Across healthcare, standardized and task-oriented approaches can shape nursing practice and constrain opportunities for critical engagement (Dunn, 2025). At the same time, clinical expertise develops through the integration of knowledge, experience, reflection, and repeated engagement with clinical situations (Benner, 1984; Tanner, 2006). This intersection of knowledge and authority provides the foundation for examining perioperative nursing knowledge and the expertise it represents.

Professional Power, Voice, and Epistemic Resistance

Recognizing perioperative nursing knowledge does not necessarily mean that this knowledge carries equal authority within clinical practice. Healthcare hierarchies have developed within historical and professional structures that have positioned medicine and nursing differently in relation to authority, expertise, and care (Davies, 1995; Freidson, 1970). These differences are particularly visible in the perioperative environment, where highly technical practice and close interdisciplinary collaboration coexist with distinct professional roles and established lines of authority. From a feminist perspective, power operates through formal positions and decision-making authority as well as through the recognition of knowledge: whose observations are considered credible, whose concerns receive attention, and whose judgment can influence what happens next (Harding, 1991; Haraway, 1988).

Possessing clinically important knowledge and having that knowledge recognized are therefore distinct. Forms of knowledge that are difficult to formalize or separate from the circumstances in which they arise may receive less recognition within systems that privilege standardization, technical expertise, and positional authority (Antuna-Casal & Rios, 2026; Essex et al., 2026). What is at stake is whether nurses' knowledge is recognized as credible and given appropriate weight within clinical environments.

The consequences become particularly important when nurses must give voice to what they know. Speaking up in perioperative care may involve questioning a plan, identifying a discrepancy, drawing attention to a subtle change, advocating for an anaesthetized patient, or interrupting the progression of care when safety is at risk (Hartmann et al., 2025; Mulugeta et al., 2025). In these moments, clinical knowledge encounters professional authority directly. A nurse must recognize when something requires attention and communicate that concern in a way that can influence the actions of others. Yet hierarchical relationships can influence who feels able to speak, whose concerns are taken seriously, and how readily established authority can be questioned (Hague et al., 2025; Mulugeta et al., 2025). Contributing nursing knowledge to patient care, therefore, depends on both the capacity to speak and the conditions that enable that knowledge to influence practice.

Feminist standpoint theory helps illuminate this relationship between position, knowledge, and voice. Perioperative nurses occupy a distinctive position within the surgical environment, attending simultaneously to the patient, procedure, equipment, team, and emerging risks. This position may make aspects of the clinical situation visible that are less apparent from other professional positions (Harding, 1991; Hartmann et al., 2025). When hierarchy limits the credibility or influence afforded to these observations, potentially important knowledge may remain unheard until a concern has escalated (Hague et al., 2025; Mulugeta et al., 2025). For example, a perioperative nurse who identifies a discrepancy in the surgical count may recognize a potential safety risk and the need for the discrepancy to be resolved before the procedure progresses. The safety value of this knowledge, however, depends on the nurse both recognizing the concern and being able to voice it so that it is taken seriously and acted upon by the team.

This is where the concept of epistemic resistance becomes useful. Epistemic resistance can be understood as challenging assumptions about whose knowledge counts, and which forms of knowing deserve authority. In perioperative nursing, such resistance may occur through everyday practices: naming a concern, questioning what has been taken for granted, persisting when an observation is initially dismissed, advocating for the patient, or bringing relational and experiential knowledge into clinical decision-making. Nursing resistance has similarly been described as potentially ethical action when nurses challenge practices or conditions that conflict with their responsibility to patients (Peter et al., 2004). For example, when a nurse continues to raise a concern after an initial dismissal because their assessment suggests that the patient may be at risk, persistence becomes more than speaking up; it challenges the assumption that another professional's judgment should automatically carry greater authority. From this perspective, speaking up can become an enactment of professional responsibility through which nurses assert the clinical relevance of what they know.

Relational knowledge can also function as resistance when nurses preserve attentiveness, human connection, and responsibility within environments increasingly shaped by efficiency, standardization, and technological demands (Robinson, 2020; Tronto, 1993). Such resistance preserves space for relational and experiential knowledge alongside technical expertise and other forms of clinical knowledge. Often, the relational dimension of this work begins before the patient enters the operating room. Surgery can be accompanied by anxiety, uncertainty, and a diminished sense of control, making communication, reassurance, and person-centred care important dimensions of the perioperative experience (Gamst-Jensen et al., 2026; Seguro et al., 2026). Through preoperative encounters, nurses attend to patients' concerns, preferences, relationships, and understandings of what is about to occur. In doing so, they develop knowledge of the person that can be carried forward into the intraoperative period, when the anaesthetized patient can no longer speak for themselves. Maintaining attention to the patient as a person while responding to the technical demands of surgery ensures that relational responsibility remains part of what is considered relevant to safe and ethical care. Advocacy, vigilance, and relational accountability can therefore challenge hierarchies of knowledge by asserting the relevance of nursing knowledge within clinical

decision-making (Aqtam, 2026; Essex et al., 2026). Seen in this way, power in perioperative practice extends beyond formal positions of authority to include the capacity to bring knowledge into clinical decision-making, interrupt a course of action, and influence what happens next.

Relational Leadership and the Ethics of Interdependence

Although professional authority is commonly associated with hierarchy, position, and the ability to direct the actions of others, relational approaches offer another way of understanding leadership. From this perspective, leadership can emerge through responsibility, attentiveness, collaboration, and the capacity to sustain relationships around a shared purpose. Care ethics support this understanding by emphasizing human interdependence and the responsibilities that arise through relationships with others (Gilligan, 1982; Tronto, 1993, 2013). Leadership, viewed in this way, is expressed through how people exercise responsibility within relationships and how they contribute to the conditions necessary for collective action.

Matriarchal ethics offer a related perspective on power and social organization. As used here, matriarchy refers to an egalitarian orientation grounded in reciprocity, mutual responsibility, and interdependence; it differs from a reversal of patriarchal authority in which women simply occupy the dominant position. Matriarchal thought, instead, offers an alternative to social arrangements organized primarily through domination and hierarchy (Goettner-Abendroth, 2012). It emphasizes relationships sustained through reciprocity, responsibility, and care. This perspective is particularly relevant to perioperative practice, where safe care depends on multiple professions whose knowledge and responsibilities differ but remain deeply interconnected (Shi et al., 2026; Wei et al., 2026). Men belong in perioperative nursing. Medicine belongs in relationship. Care belongs to everyone. These principles preserve professional roles and clinical authority while supporting a relational conception of leadership in which authority is exercised within relationships of mutual dependence and shared responsibility.

Perioperative nursing provides a practical expression of this form of leadership. Nurses coordinate people, information, equipment, patient needs, and changing clinical circumstances across the surgical experience. Much of this work occurs without formal command and is enacted through communication, coordination, advocacy, continuity, and responsiveness to changing conditions. Care provides an ethical orientation for this work by connecting authority with responsibility: to notice what a situation requires, communicate concerns, coordinate action, advocate for the patient, and intervene when necessary. Through these practices, perioperative nurses help create coherence within the surgical environment and contribute to the conditions in which people can work together safely and effectively (Fletcher, 2004; McCormack & McCance, 2010).

This form of leadership reflects the interdependent nature of surgical care. Surgeons, anaesthesia providers, nurses, and other members of the perioperative team bring different forms of knowledge, responsibility, and expertise to a shared clinical situation (Shi et al., 2026; Wei et al., 2026). Recognizing this interdependence shifts attention toward how these contributions are brought together in the interests of the patient. Nursing and medicine contribute distinct but interdependent forms of expertise to the collective work of surgical care.

Relational leadership also reframes power. Alongside formal authority, power can arise through relationships that enable knowledge to circulate, concerns to be heard, responsibilities to be coordinated, and collective action to occur (Essex et al., 2026; Fletcher, 2004). Power, from this perspective, lies in the capacity to influence what becomes possible within the team, while sustaining responsibility to the patient and to one another. Perioperative nurses exercise this form of leadership from within the surgical team, contributing their knowledge, influence, and professional responsibility to the relationships through which safe, interdependent care becomes possible.

Conclusion

Perioperative nursing makes visible a form of clinical expertise that is technical, relational, embodied, and responsive to context. Through sustained presence, nurses develop knowledge grounded in experience, proximity, vigilance, relationship, and responsibility for the patient across the surgical experience. Recognizing relational competence as clinical expertise, therefore, expands what is understood to constitute knowledge in perioperative practice. How such knowledge might best be made visible, recognized, and transmitted within perioperative practice and education warrants further exploration.

This recognition matters for patient safety, professional authority, and epistemic justice. Nursing knowledge can influence care when it is communicated, regarded as credible, and given appropriate weight in clinical decision-making. Professional hierarchies that limit whose knowledge carries authority may constrain the contribution of clinically important observations and judgments, particularly when relational, embodied, and experiential knowledge does not resemble dominant forms of expertise. Supporting the full contribution of perioperative nursing expertise, therefore requires clinical environments in which nurses can give voice to what they know, have their knowledge taken seriously, and exercise the professional authority necessary to act on that knowledge.

The politics of presence is ultimately a politics of recognition: whose knowledge is heard, whose judgment carries weight, and whose expertise is permitted to shape care. Perioperative

nurses practise at the intersection of technology and relationship, individual expertise and collective responsibility. Their presence carries knowledge of the patient, the procedure, the team, and the subtle changes through which risk can emerge. Recognizing this contribution means affirming nursing knowledge as knowledge, advocacy as leadership, and relational competence as expertise. This does not require diminishing other forms of expertise; rather, it recognizes that technical knowledge and relational responsibility belong together in the collective work of surgical care. Perioperative nurses have always embodied the connective tissue of surgical care. Recognition is not a gift; it is an overdue act of justice.

About the author



Jennifer Dunn, MN, RN, PhD(c), is an Assistant Professor in the School of Nursing and Midwifery at Mount Royal University in Calgary and a doctoral candidate in Nursing at the University of Saskatchewan. She brings more than two decades of clinical nursing experience to her teaching and scholarship. She holds a Bachelor of Nursing from the University of New Brunswick (2000) and a Master of Nursing from the University of Lethbridge (2024), where she was supported by the Alberta Graduate Excellence Scholarship. Her doctoral work is supported by a Canada Graduate Research Scholarship from the Social Sciences and Humanities Research Council of Canada (SSHRC). Her research examines nursing through historical and relational lenses, with particular attention to how nursing culture, traditions, power, and experiences of silence shape professional identity, voice, and moral agency. Her work is grounded in perioperative nursing and explores how broader systemic and relational forces influence nurses' everyday practice, leadership, and professional lives.

Conflict of interest

None declared.

Funding

None declared.

Article submitted: February 12, 2026

Accepted for publication: August 17, 2026

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