Nursing practice draws upon several different ways of knowing

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Summary

- This paper explores the proposition that nursing practice draws upon several different ways of knowing.
- It highlights difficulties often faced by practising nurses in defining what they do and hence what it is that constitutes nursing practice.
- Following formal definition and analysis of sources of literature regarding nursing knowledge, issues such as the origins of knowledge and the sources of nursing knowledge are addressed.
- The types of knowledge required to enhance nursing practice are discussed, focusing upon future opportunities and innovations in the generation of knowledge for nursing.
- Finally, recommendations are made regarding the way forward for nurses endeavouring to communicate the complexities of nursing practice.

Keywords: action research, critical science, intuition, nursing knowledge, nursing practice, professionalization.

Introduction

Demands for cost-effective health care and constant health-care restructuring suggest that the need for a deeper understanding of the nature of nursing practice, in order that we may take control over our future, has never been greater. In order to address the situation, we need to consider what nurses do and how nurses do what they do.

Aspects of nursing practice and *what* nurses do have been analysed by a number of researchers (Goddard, 1953; Revans, 1964; Fretwell, 1982); however, the *how* of nursing practice and thus the exploration of nursing knowledge is more contemporary in its attraction. There is little doubt that analysis of nursing knowledge will raise more questions than answers, yet it will take us one step further in raising critical awareness of the knowledge which is used in practice. In deepening our understanding of nursing, we may be able to clarify further how central nurses are to the provision of high-quality patient care.

This paper seeks to explore the proposition that nursing practice draws upon several different ways of knowing. Following clarification of the central issues involved by means of formal definition and explanation, analysis of prime sources of literature regarding nursing knowledge will provide an initial focus for the discussion. In developing the debate, issues such as the origins of knowledge and the sources of nursing knowledge will be addressed, examining not only *what* we know but also *how* we know. Discussion of the types of knowledge needed to enhance practice will draw the debate

together, focusing upon future opportunities and innovations in the generation of knowledge for nursing. Finally, recommendations will be made regarding the way forward for nurses endeavouring to communicate the complexities of nursing practice.

It is perhaps relevant at this point to state specific terms of reference for this paper. The development and analysis of knowledge for nursing practice are fundamental to the future of nursing. Few nurses can divorce themselves from such subject matter as it is this knowledge which shapes the practice of every nurse. With this in mind, this paper looks at the information discussed from a practitioner's perspective. It is as a nurse that the author addresses each issue, relating the discussion to everyday nursing and personal examples of practice.

What is nursing practice?

Nurses often find it difficult to define what it is that they do and hence what it is that constitutes nursing practice. Many have spent time discussing the nature of nursing and laying down their definitions of practice in order that others may question and develop their own knowledge and skills. One example of this is the 'Activities of living' model which was developed by Nancy Roper, Winifred Logan and Alison Tierney (Roper *et al*. 1980) and arose from the findings of a research project carried out on the clinical experience of student nurses (Roper, 1976). This model was the first attempt by British nurses to develop a conceptual model for nursing, and it has become widely used in Great Britain in a range of clinical and educational settings. According to Roper *et al*. (1980), nurses need knowledge concerning the physiological, social and psychological aspects of each of 12 activities of living, and about the developmental progression along the lifespan; they need the appropriate skills and attitudes to enable them to comfort and educate people and carry out medical prescriptions to meet 'seeking' and 'preventing' needs; and they need skills to carry out activities of living for those unable to do so, while helping them cope with dependence in itself.

Whilst immersing oneself in the theoretical propositions, however, it is very easy to lose sight of the fundamental reasons for the existence of nursing. In the simplest terms nurses exist to deliver nursing to patients and clients or, as Pearson (1992, p. 213) eloquently states, 'The existence of nursing is for the provision of a nursing service to those who need, seek or are directed to, nursing'. Jacox (1974) suggests that practice, or service delivery, is the beginning and end of nursing and that anything else which surrounds or cloaks practice is meaningless in comparison. Nursing is a practice, but a practice which is complex in nature. This complexity is exemplified by the difficulty that so many nurses have in explaining exactly what it is that they do (Goddard, 1953; Bendall, 1975; Taylor, 1992).

What is nursing knowledge?

Having delved into the meanings of nursing practice one immediately realizes the inextricable links with nursing knowledge. In order to explain to others what it is that nurses do and to begin to understand the complexities of nursing practice, we need to have an understanding of the knowledge that we possess (MacLeod, 1994). All nurses know nursing; however, what they know and how they know may be different due to the unique experiences of each nurse and that nurse's ability and desire to reflect upon experience (Pearson, 1992). The dictionary (Collins, 1990) defines knowledge as 'what one knows', the verb 'to know' relating to perception and

understanding of facts with clarity and certainty. This definition suggests that knowledge is a logical and definite matter; however, it offers little in the way of clarification with regard to nursing knowledge or its origins. Historically, nursing has tended to negate the contribution of those who were seen to want to *know* nursing and perhaps over-valued those who were seen to be competent in the practical elements of nursing, thus regarding nursing knowledge as rigid and unchanging (Pearson, 1992). The development of nursing has certainly been influenced by other disciplines such as psychology, sociology, physiology and anatomy. It is acknowledged that knowledge acquired from these disciplines can and does support the practice of nursing; however, it must be asserted that these do not constitute nursing knowledge. It is the practice of nursing itself which is the central issue and care must be taken to recognize this and avoid dedicating excessive time to peripheral concerns.

In our search to discover what is nursing knowledge, we must therefore explore the nature of knowledge, a subject known as epistemology. A number of authors have sought to explain the patterns or ways of knowing in nursing and it is valuable to consider their findings in order to develop critical awareness of the knowledge that is used in practice.

Ways of knowing in nursing: the literature

A name synonymous with knowledge and nursing is that of Carper (1978). In her explanation regarding 'fundamental patterns of knowing in nursing', she suggests four patterns of knowing: empirical, ethical, aesthetic and personal. Empirical knowledge is gained through systematic investigation, observation and testing and is embedded within the positivist paradigm. It is in this school of thought that much emphasis has been placed on trying to develop a scientific body of nursing knowledge in recent years. Other disciplines concerned with human beings have developed empirical knowledge and the knowledge explored by psychologists, sociologists, physiologists and others is important and relevant to nursing. Such knowledge may not be directly applicable to the practice of nursing, however, and thus becomes a part of the background understanding required for practice. Such transition of knowledge is discussed by Schultz & Meleis (1988, p. 219) as they suggest that nurses 'use knowledge from other disciplines but through reflection and imagination evolve perspectives on that knowledge which are unique to nursing'.

Ethical knowledge relates to moral issues and the need to make judgements in a given situation. In every decision that we take during our lives, it could be said that there are ethical and moral implications (Downie & Calman, 1987). Inevitably, these implications will influence not only the way we live but also our practice, and thus an awareness of ethical and moral issues can make a significant contribution to practice. Such awareness involves an understanding of different philosophical positions regarding the rights and wrongs of every nursing action. The relevance of ethical knowledge in practice is highlighted by the UKCC in the guidance provided in the *Code of Professional Conduct* (UKCC, 1992).

Aesthetic knowledge is concerned with the action of nursing and is often linked with discussions surrounding the art of nursing (Katims, 1993; Johnson, 1994). This type of knowledge involves perception, understanding and empathy and acknowledges the value of everyday experiences lived by individuals. In this respect it can be linked to the interpretive/constructive paradigm and the phenomenological movement (Masterson, 1996). Aesthetic knowledge may also be linked to those actions which we call intuitive,

and this type of knowledge will be discussed later in greater detail.

Carper's fourth pattern of knowing is that of personal knowledge. This is perhaps the most difficult to evaluate in that it requires self-awareness and is subjective. Self-awareness must impinge upon practice since our own understanding influences everything that we do (Smith, 1992). Personal knowledge is of extreme importance to all areas of our practice and it is difficult to envisage the development of practice without this essential element. For example, in specific clinical situations such as caring for a patient who is dying, personal knowledge is implicit in everything that we do for that patient. Our care is enhanced by self-awareness and the ability to realize and recognize our own mortality. It is true that our personal knowledge will have been strengthened by empirical knowledge gathered from the literature available on death and dying, and augmented through analysis of information from a range of disciplines; however, it is the personal knowledge and opportunity to reflect upon personal feelings which, although not always directly communicable to others, enables the nurse to recognize the most personal aspects of that situation and respond to the needs of that dying patient.

Taking the concept of personal knowledge a little further, Moch (1990) identifies three components of personal knowledge: experiential knowing, interpersonal knowing and intuitive knowing. Experiential knowing involves participation and thus gaining experience. This experience may then be studied and related to previous knowledge, perhaps through reflection (Clarke *et al*., 1996) or reading about the experiences of others (Younger, 1990; Darbyshire, 1994a). Interpersonal knowing, as the term suggests, comes from interpersonal experiences with others and the knowledge gained through those relationships. One might suggest that the categorization of such elements of personal knowledge is somewhat reductionist in its approach (Masterson, 1996). Exploration of such elements of personal knowledge raises a number of questions, which may produce a variety of responses and interpretations. How does Moch's intuitive knowing, an integral part of personal knowledge, differ from Carper's intuitive knowing as a part of aesthetic knowledge? Are personal and aesthetic knowledge interdependent? Such questions may in turn initiate a number of further questions; however, such analysis serves its purpose in clarifying and validating this way of knowing and thus enhancing our own understanding of such a complex process.

Continuing the theme of complexity, and indeed controversy, one of the much debated ways of knowing is the third component of Moch's classification – *intuitive knowing*, or intuition. Many authors have attempted to define intuition (Benner & Tanner, 1987; Young, 1987; Rew, 1989; Darbyshire, 1994b). Some see it as the exclusive province of expert practitioners (Benner, 1982), whilst others argue that intuition is a universal human experience (Mitchell, 1994). The subject of intuition will always provoke debate amongst nurses. Whilst there are those who truly believe that through experience and our relationships with patients and clients we develop the ability to make clinical decisions which are intuitive and have no adequate criteria or rules by which to explain our actions (Schon, 1987), there are others who see intuition purely as an analytical process which is undertaken unconsciously and, with hindsight, can be rationalized in terms of problem solving (Minsky, 1987; English, 1993). Whatever one's viewpoint, the subject of intuition and intuitive knowing is both fascinating and problematic. It has been said that intuition plays a central role in the reflective process and hence is central to our practice (Clarke, 1986; Dewing, 1990);

however, if we are in the business of providing legitimate and valid knowledge in order to define nursing, employing the positivist paradigm as our framework, then intuition proves difficult and may in fact do us a disservice (English, 1993). Such a subjective phenomenon does not conform to current requirements for evidence-based practice in health care, which should be predictable, measurable and generalizable according to doctors and economists who see this as the way forward for health care (Central Office of Information, 1995; Royal College of Nursing, 1996). It is, however, refreshing to know that the move towards evidence-based practice, and thus potential denial of personal ways of knowing such as intuition, is not universally welcomed (Carr-Hill, 1995).

The intuition debate will continue, yet it is intriguing to consider how it is that we know what to do in a given situation, what interventions will work and what should be rejected. Where does that knowledge come from and how is it that we are able to assimilate such a vast range of knowledge from nursing and a variety of other disciplines and then put it into practice? Many such questions may never be answered, as it has been suggested that we know far more than we can ever articulate (Polyani, 1958; Schon, 1983). Individuals gain a tacit knowledge within themselves which occurs over time and cannot be put into words. In the same way, nurses possess this tacit knowledge which is deeply embedded in the subconscious until it is required in a particular clinical situation (Carroll, 1988; Meerabeau, 1992).

Where does knowledge come from?

Having briefly discussed some of the literature available regarding nursing knowledge, it is important to consider the sources of this knowledge. Kerlinger (1973) identifies three prime sources: tenacity, authority and a priori. According to this view, tenacity is the form of knowing where some truth is believed simply because it has always been thought to be true. Authority is viewed as a source of knowing that results in belief about truth because an authoritative source or person says that something is true. A priori knowing is a method of knowing that depends upon reason and is not necessarily consistent with experience. These forms of knowing can all lead to the same conclusion and may even be thought of as factual or agreeing with reason; however, the difference is *how* one knows. Take for example the following: a person might state that he or she *knows* that sitting in a draught causes a cold. If asked *how* they know, they might simply state that it is so (tenacity), or that their grandmother said so (authority) or that it just stands to reason (a priori). All of these sources of knowing rest upon the idea of objectivity and that somehow that which is known is in some way removed from the person who knows.

Similarly, scientific sources of knowledge concentrate upon objectivity as they test hypotheses and examine research questions based upon empirical reality. Taking the previous example, scientific examination of the situation (sitting in draught causes colds) would be based on a testable hypothesis and tested a number of times in order to determine empirical evidence to support the claim.

A fundamental idea about reality from which traditional science developed was Descartian dualism, in which the rational mind and the 'out there' reality of truth are viewed as separate (Kenny, 1994). Historically, nursing accepted the superiority of science and scientific methods of validating knowledge; however, we have now begun to realize that there are a variety of ways in which we acquire knowledge and that fundamental to these sources is the notion of unity between the knower and what is known. A hierarchical distinction between ways of knowing, such as that proposed by Kerlinger (1973), is not particularly useful as

an approach to developing nursing knowledge. This view attempts to place science in a superior position to other sources of knowledge, and overlooks certain forms of knowing due to their incompatibility with scientific views, despite their obvious value and necessity for nursing.

In nursing we take a holistic view of our patients and clients and the world in which we live. We all have values and beliefs which cannot be broken up into rights and wrongs; these values have an undeniable influence upon health and illness. As Chinn (1985) states, our emphasis should be upon making sense of the world in terms of the present and the future, resolving the splits and contradictions that the traditionally objective methods cannot resolve, and seeking relative truth value rather than absolute truth.

Here, some of the sources of knowledge available have been outlined. Tradition and folklore still abound in nursing practice (Walsh & Ford, 1990) and are powerful sources of knowledge embedded in nursing culture. People with specialized expertise, hierarchical structures and protocols provide authority in nursing and are rarely challenged, yet when challenged such sources of knowledge are not infallible (English, 1993). Other sources of knowledge include personal experience, trial and error and logical reasoning, all of which have their limitations yet make constant contribution to our practice. Sources of knowledge should not be judged against each other, but valued in their own right as having a useful purpose. Nurses often encounter situations which require decisions and actions for which there are no scientific answers and for which such answers may be incompatible. In such situations we can draw upon other sources of knowledge and ways of knowing that will provide insight and understanding into that particular problem.

Where does nursing knowledge come from?

Nursing knowledge is derived in part from personal knowledge and thus the previous discussion goes some way to answering questions regarding the origins of nursing knowledge. Much of the knowledge that we possess as nurses, however, is specific to the discipline and enhanced by personal knowledge, and so where does this nursing knowledge come from? According to one sample of practitioners (Le May *et al*., 1996), nursing knowledge comes from a variety of sources. Patients and clients provide us with a wealth of knowledge which informs our practice. Expert nurses and advanced practitioners enable us to develop our knowledge and skills and ‘make sense’ of our practice. During our initial training courses as student nurses, periods of continuing education and training following qualification and through our own personal and professional development, we acquire an abundance of nursing knowledge from a variety of sources including nurse teachers and lecturers, practitioners from a variety of clinical backgrounds, clinical placements, books and journals, clinical representatives from health care organizations and the media. These sources of knowledge have a direct influence upon our practice and upon the development of nursing knowledge.

Nursing knowledge, however, is also influenced by indirect sources. According to Habermas (1971), knowledge development is embedded in a social context which influences the knowledge produced. Development and construction of knowledge occur in a social context involving human interaction and its legitimacy tends to be dependent upon the values and beliefs of certain powerful groups in society such as doctors, managers and politicians. These groups of people are able to exert influence and control over our beliefs

about knowledge and its validity, often due to the basic fact that they control the finances required to develop knowledge through research and debate. Acceptance and credibility are necessary in order to move the boundaries of nursing knowledge forward (Chinn & Jacobs, 1987); however, difficulties often arise when holders of the purse-strings fail to be convinced of the merit of a particular research initiative, often because the method is not congruent with those used by the scientific community (Muller & Dzurec, 1993).

Gender has also been identified as being significant in the valuing or otherwise of different types of knowledge and ways of knowing. Scientific knowledge developed within the positivist paradigm is often seen to have male bias (Hagell, 1989). In contrast, knowledge related to relationships, caring and meanings is often interpreted from a female stance (Condon, 1992). Such devaluation of certain types of knowledge by society has been discussed in terms of patriarchy and the relationship between gender and knowledge. Pascall (1986) discusses the evidence of sexism in certain mainstream disciplines, observing the male bias and sexual stereotypes apparent in their interpretation of the world. Feminist critiques of knowledge and knowledge generation (Dunlop, 1986; Hagell, 1989) suggest that, in terms of thought and worth, the views of men are often seen as superior to those of women. Yet, despite the obvious steps forward made in terms of equal opportunities, many of us still question the disproportionate share of senior posts which are held by our male colleagues (Davies, 1995).

In order to redress the balance, Hagell (1989) promotes nursing education as the key area from which to effect change. She suggests that curriculum development should encompass a range of perspectives in its coverage of nursing theory and theory development. Historical debate should include political and social factors which have influenced and are still influencing the development of nursing. Employment of such strategies within nursing education would, in Hagell's view, strengthen and consolidate nursing and the women's movement.

In our search for sources of nursing knowledge and the development of such, we must include the continued drive for professionalization in nursing. Possession of a unique body of knowledge has been seen as central to the attainment of professional status and thus has implications for the types of knowledge that have been promoted and the ways in which such knowledge has been developed. As we have previously discussed, traditional scientific approaches with their emphasis upon fact, objectivity and reductionism, such as medical knowledge upon which nursing was rooted in the 1950s and 1960s, exerted a powerful effect upon the types of knowledge and methods of knowledge generation in nursing. Early conceptualizations of nursing concentrated upon the action or 'doing' of nursing in their attempts to examine the principles and traditions which were passed on through the apprenticeship form of education apparent in the twentieth century. Following the Second World War, with the advent of changes in social circumstances for women, women were able to enter higher education and nurses took this opportunity to examine the nature of nursing and disseminate their findings about nursing and the type of knowledge needed for practice. Traditional science had an obvious effect upon these early expositions and in turn influenced the authors in their methods and approaches (Hall, 1964; Levine, 1969).

More recently, nurses are approaching knowledge development from a more holistic perspective, acknowledging not only its value for nursing but also awareness of knowledge being context specific (Masterson, 1996). Having made this acknowledgement, nurses

are now challenging the tradition of professionalization, calling for the creation of new visions which break down the patriarchal and classbased expositions of nursing. Analysis of the professionalization debate highlights the range of views regarding what appears to be a highly emotive subject. Despite differences of opinion regarding the necessary requirements for a profession (Hugman, 1991), there appears to be some consensus in terms of the need for professionalization and a distinct knowledge base (Perry & Jolley, 1991); however, evidence of critical theorizing about the status of nursing is now apparent and, as Salvage (1985, p. 92) suggests, 'the question we should ask is not *Is nursing a profession?* but *Should we want nursing to be a profession, and if so what do we mean by it?*'.

In the drive for professionalization, nursing has attempted to distance itself from the medical profession by developing its own knowledge base and becoming relatively selfsufficient in terms of education, research and management. Nursing has also begun to draw away from the historical emphasis placed upon all things physical and has concentrated upon the psychological and subjective nature of the body. Whilst doing this, every effort has been made to ensure that the practical aspects of nursing are given due consideration and the presence of clinical nurse specialists and lecturer practitioners goes some way to addressing those needs.

It is hoped that this discussion has assisted in clarifying and debating the wealth of knowledge available for nursing and particularly the sources of this knowledge. Examples of the literature available regarding nursing knowledge and the sources and development of this knowledge have been examined, thus demonstrating that nursing practice draws upon several different ways of knowing. Our next consideration should therefore be what types of knowledge we need for practice and how this knowledge can enhance our practice.

What types of knowledge do we need for practice and how can these enhance our practice?

As we have discovered, nurses draw upon knowledge from a variety of sources, each approach having something to offer to holistic nursing practice. Having acknowledged this, it is important that we understand and value the knowledge gained from each of the paradigms concerned.

The relationship between nursing and scientific knowledge should never be underestimated: the natural sciences have and will continue to provide us with information which is useful and upon which we base our clinical judgement. For example, wound dressings we use have been subjected to clinical trials which provide us with information regarding their effectiveness and modes of use; however, a fundamental problem in this approach is that, whilst one may be able to prove that a particular hypothesis is false, one cannot prove beyond doubt that a hypothesis is true. In scientific terms it can only be suggested that there is a high probability according to the data gathered. Let us return to the example of wound dressings. Following testing and experimentation upon specific wound dressings one could suggest that the particular dressing has a beneficial effect upon a specific wound; however, one could not state with absolute certainty that one dressing is better than another, bearing in mind issues such as validity, reliability, manipulation and control.

Despite its obvious value to nursing practice, however, we must be mindful that there are some areas of knowing within nursing that do not readily lend themselves to scientific measurement. So, how does science enhance nursing practice? The positivist paradigm of

science attempts to present a view of the world which can be predicted and controlled. Nurses need knowledge and understanding of relationships and identified interventions in order to be able to predict and control human responses. Our understanding of anatomy and physiology is vital to practice (Gortner, 1993) and enables us to recognize disease processes, thus determining how a specific patient or client will be treated and how they will be nursed; however, we are increasingly recognizing that factors such as social support and personality also have a role to play in the development and treatment of disease, and that these areas of personal life are not easily measured. Schumacher & Gortner (1992) advocate scientific realism for nursing. Whilst accepting that certain theoretical entities can provide explanations for observable phenomena, scientific realists believe that, as they make discoveries about the world as it really is, they are drawing closer and closer to the truth and, regardless of observability, that what affects us is real. Such an approach to nursing knowledge development is supported by Schumacher & Gortner (1992) in that it values the subjective nature of human beings and enables us to develop knowledge which is realistic and useful for practice.

Enlarging upon the notion of realism and the acknowledgement of factors which impact upon human life, the interpretive/constructivist paradigm also recognizes the value of reality and interpretation of that reality in order to deepen our understanding of the world. The key philosophical assumptions of the interpretive/constructivist paradigm are very much in keeping with nursing's own understanding of the world. Its focus upon a context related and holistic approach to knowledge development which underpins practice is consistent with many of nursing's central values (Masterson, 1996). This perspective encourages us to work with patients and clients in their own environment in order to increase our understanding of the emotions and perceptions involved in a given situation. In a phenomenological study (Watson, 1991), I had the opportunity to examine the grief responses demonstrated by fathers following the loss of a child. This study not only described the bereavement process experienced by fathers following their loss, but also enabled nursing staff at the research site to acknowledge the findings and modify their practice to ensure that fathers were involved in the care of their dying child and that they were supported following the death. Thus it can be demonstrated that knowledge gained from this approach was used to enhance nursing practice.

Critical science arises out of the notion that theory is embedded in practice but that 'actual knowledge' is always limited to some degree by the sociohistorical context in which it arises (Allen, 1985). Deeper understanding of the things causing limitations on our own actions are said to lead to emancipation and praxis (Freire, 1972). In this way people may begin to understand themselves by being able to practise autonomy and initiate change, and change is seen as a creative process developed through reflection on action rather than being limited to deductive application of theory. Through action research, challenges can be made to current practice and on some occasions may even result in the transformation or alteration of practice (Stevens & Hall, 1992). Despite some obvious limitations (Fay, 1987) the critical paradigm can help nurses to see the world in a different light, from a global perspective in terms of the world of nursing and its development and also from a practical perspective in terms of multidisciplinary relationships. For example, nurses as a group have been oppressed for a number of reasons: gender issues, their relationship with medicine and their perceived role in society. Rather than a group of nurses who devalue the contributions that can be

made to nursing knowledge by medicine and the self-knowledge possessed by their patients, what we do want for nursing are people who are emancipated and can value their own contributions to practice and health care alongside other members of the multidisciplinary team (Smythe, 1986).

Acknowledging the development of action research through the development of critical scholarship, it is interesting to note further developments in nursing in terms of theory which is orientated towards action. Practice theory or 'praxiology' is proposed by Pearson (1992) as the emerging paradigm to uncover nursing knowledge. Practitioners solve many problems every day because professional practice is a continuous process of professional judgement (Benner, 1984), and:

> This view of practice as a world of action, where practitioners engage in both practical and theoretical endeavour, begins to open up a scene full of exciting opportunities (Pearson, 1992, p. 222).

Initially this new concept seems ideal: theory which generates practice knowledge. Pearson (1992), however, reminds us that, although practice theory can undoubtedly contribute to the development of nursing knowledge, we should not deny the richness of practice by concentrating upon any one view.

Developing one's knowledge of research and then keeping up to date is another way in which practice can be enhanced, and specifically the quality of that practice (Burrows & McLeish, 1995). Thus, research-based knowledge must feature in our discussion. Unfortunately, many practitioners still view research as irrelevant to their day-to-day nursing care delivery. Reasons for this include valuing practice which is ritualistic and based upon habit and myth (O'Conner, 1993), seeing research as being removed from practice (Greenwood, 1984) and finding research findings difficult to translate into practice (Luker & Kenrick, 1992). There is a range of strategies available, however, in order to enable nurses to use research based knowledge and thus enhance their practice. Research utilization can be achieved by improving knowledge, encouraging implementation of research findings and developing strategies for carrying out new research in clinical practice (Burrows & McLeish, 1995). This by no means implies that every nurse should become a researcher, but that every nurse should have an awareness of research and its implications for practice.

Conclusion

In this paper several different ways of knowing upon which our nursing practice is based have been examined. The literature regarding nursing knowledge outlines the existence of a variety of ways of knowing that have developed from a range of sources. We have discussed the types of knowledge which are necessary to enhance the quality of our practice, yet implicit throughout this is the difficulty that we encounter in attempting to explain what it is that nurses do. It is possible, however, to bring everyday practices to light and thus to reveal the *what* and *how* of nursing practice. It is, in fact, essential to do this if we wish to recognize and value nursing and the knowledge and skills embedded in its practice.

The knowledge inherent in everyday nursing practice is complex practical knowledge which, for the most part, is filled with theoretical knowledge; it is 'knowing in practice' (MacLeod, 1994). This knowledge is not captured particularly well by nursing textbooks and nursing theory, but can be more explicitly demonstrated through the exploration of everyday nursing.

During my career in nursing, one thing which I have noticed never appears to diminish is the ability, skill and enthusiasm with which we tell each other stories about patients. Through interpretation of such stories

(Darbyshire, 1994a) and observation and analysis of everyday nursing practice (MacLeod, 1994; Lamond *et al*., 1996), nurses can begin to embrace the wealth of knowledge and skills in nursing. In valuing the immensity and diversity of our knowledge and the ability to translate this knowledge into practice, we can take our place alongside our colleagues, working in partnership and collaboration, whilst demonstrating the invaluable contribution of nursing to health care.

References

Allen D. (1985) Nursing research and social control: alternative models of science that emphasize understanding and emancipation. *Image: The Journal of Nursing Scholarship* 17(2), 58–64.

Bendall E. (1975) *So you Passed Nurse. An Exploration of Some of the Assumptions on Which Written Examinations are Based*. Royal College of Nursing, London.

Benner P. (1982) From novice to expert. *American Journal of Nursing* 82(3), 402–407.

Benner P. (1984) *From Novice to Expert: Excellence and Power in Clinical Nursing Practice*. Addison Wesley, Menlo Park.

Benner P. & Tanner C. (1987) Clinical judgement: how expert nurses use intuition. *American Journal of Nursing* 87(1), 23–31.

Burrows D.A. & McLeish K. (1995) A model for research-based practice. *Journal of Clinical Nursing* 4, 243–247.

Carper B.A. (1978) Fundamental patterns of knowing in nursing. *Advances in Nursing Science* 1(1), 13–23.

Carr-Hill R. (1995) Welcome to the brave new world of evidence-based medicine. *Social Science and Medicine* 41(11), 1467–1468.

Carroll E. (1988) The role of tacit knowledge in problem solving in the clinical setting. *Nurse Education Today* 8, 140–147.

Central Office of Information (1995) *Towards Evidence Based*
Practice: A Clinical Effectiveness Initiative for Wales. Central Office of Information, London.

Chinn P.L. (1985) Debunking the myths in nursing theory and research. *Image: The Journal of Nursing Scholarship* 17(2), 45–49.

Chinn P.L. & Jacobs M.K. (1987) *Theory and Nursing*, 2nd edn.
CV Mosby, St Louis.

Clarke M. (1986) Action and reflection: practice and theory in nursing. *Journal of Advanced Nursing* 11(1), 3–11.

Clarke B., James C. & Kelly J. (1996) Reflective practice: reviewing the issues and refocusing the debate. *International Journal of Nursing Studies* 33(2), 171–180.

Collins (1990) *Dictionary and Thesaurus*. Collins and Sons, London.

Condon E.H. (1992) Nursing and the caring metaphor: gender and political influences on an ethics of care. *Nursing Outlook* 40(1), 14–19.

Darbyshire P. (1994a) Reality bites. *Nursing Times* 90(40), 31–33.

Darbyshire P. (1994b) Skilled expert practice: is it all in the mind? A response to English's critique of Benner's novice to expert model. *Journal of Advanced Nursing* 19(4), 755–761.

Davies C. (1995) *Gender and the Professional Predicament in Nursing*.
Open University Press, Milton Keynes.

Dewing J. (1990) Reflective practice. *Senior Nurse* 10(10), 26–28. Downie R.S. & Calman K.C. (1987) *Healthy Respect: Ethics in Health Care*. Faber and Faber, London.

Dunlop M. (1986) Is a science of caring possible? *Journal of Advanced Nursing* 11(6), 661–670.

English I. (1993) Intuition as a function of the expert nurse: a critique of Benner's novice to

expert model. *Journal of Advanced Nursing* 18(3), 387–393.

Fay B. (1987) *Critical Social Science*. Polity Press, Cambridge. Freire P. (1972) *Pedagogy of the Oppressed*. Penguin Books, Harmondsworth.

Fretwell J. (1982) *Ward Learning and Teaching: Sister and the Learning Environment*. Royal College of Nursing, London.

Goddard H.A. (1953) *The Work of Nurses in General Hospital Wards. Report of a Job Analysis*. Nuffield Provincial Hospital Trust, London.

Gortner S. (1993) Nursing syntax revisited: a critique of philosophies said to influence nursing theories. *International Journal of Nursing Studies* 30(6), 477–488.

Greenwood J. (1984) Nursing research: a position paper. *Journal of Advanced Nursing* 9, 77–82.

Habermas J. (1971) *Knowledge and Human Interests*. Beacon Press, Boston.

Hagell E. (1989) Nursing knowledge: women's knowledge. A sociological perspective. *Journal of Advanced Nursing* 14(3), 226–233.

Hall L. (1964) Nursing: what is it? *Canadian Nurse* 60, 150–154. Hugman R. (1991) *Power in the Caring Professions*. Macmillan, Basingstoke.

Jacox A. (1974) Theory construction in nursing: an overview. *Nursing Research* 23(1), 4–13.

Johnson J.L. (1994) A dialectical examination of nursing art. *Advances in Nursing Science* 17(1), 1–14.

Katims I. (1993) Nursing as aesthetic experience and the notion of practice. *Scholarly Enquiry for Nursing Practice* 7(4), 269–272. Kenny A. (ed.) (1994) *The Oxford Illustrated History of Western Philosophy*. Oxford University Press, Oxford.

Kerlinger F.N. (1973) *Foundations of Behavioral Research*, 2nd edn. Holt, Rinehart and Winston, New York.

Lamond D., Crow R., Chase J., Doggen K. & Swinkels M. (1996) Information sources used in decision making: considerations for simulation development. *International Journal of Nursing Studies* 33(1), 47–57.

Le May A., Mulhall A. & Alexander C. (1996) *Implementing Research into Practice The Research Culture: Myth or Reality?* Paper presented at the Royal College of Nursing Annual Research Conference, Newcastle.

Levine M.E. (1969) *Introduction to Clinical Nursing*. FA Davis, Philadelphia.

Luker K. & Kenrick M. (1992) An exploratory study of the sources of influence on the clinical decisions of community nurses. *Journal of Advanced Nursing* 17, 457–466.

MacLeod M. (1994) It's the little things that count: the hidden complexity of everyday clinical nursing practice. *Journal of Clinical Nursing* 3, 361–368.

Masterson A. (1996) *Clarifying Theory for Practice: Study Guide*. Distance Learning. Royal College of Nursing, London.

Meerabeau E. (1992) Tacit nursing knowledge: an untapped resource or methodological headache? *Journal of Advanced Nursing* 17, 108–112.

Minsky M. (1987) *The Society of the Mind*. Picador, London.

Mitchell G. (1994) Intuitive knowing: exposing a myth in theory development. *Nursing Science Quarterly* 7(1), 2–3.

Moch S.D. (1990) Personal knowing: evolving research and practice. *Scholarly Inquiry for Nursing Practice* 4(2), 155–165.

Muller M.E. & Dzurec L.C. (1993) The power of the name.

Advances in Nursing Science 15(3), 15–22.

O'Conner H. (1993) Bridging the gap. *Nursing Times* 89(2), 21–28.

Pascall G. (1986) Social policy: a feminist analysis. In *Clarifying Theory for Practice* (Masterson A., ed.). Distance Learning. Royal College of Nursing, London.

Pearson A. (1992) Knowing nursing: emerging paradigms in nursing. In *Knowledge for Nursing Practic*e (Robinson K. & Vaughan B., eds). Butterworth-Heinemann, Oxford, pp. 213–226. Perry A. & Jolley M. (eds) (1991) *Nursing: A Knowledge Base for Practice*. Edward Arnold, London.

Polyani M. (1958) Personal knowledge. In *Clarifying Theory for Practice* (Masterson A., ed.). Distance Learning. Royal College of Nursing, London.

Revans R.W. (1964) *Standards for Morale: Cause and Effect in Hospitals*. Oxford University Press, Oxford.

Rew L. (1989) Intuition: nursing knowledge and the spiritual dimensions of persons. *Holistic Nursing Practice* 3(3), 56–68.

Roper N. (1976) *Clinical Experience in Nurse Education*. Churchill Livingstone, Edinburgh.

Roper N., Logan W. & Tierney A. (1980) *The Elements of Nursing*. Churchill Livingstone, Edinburgh.

Royal College of Nursing (1996) *Clinical Effectiveness and Evidence Based Practice*. Royal College of Nursing, London.

Salvage J. (1985) *The Politics of Nursing*. Heinemann, London.

Schon D. (1983) *The Reflective Practitioner: How Professionals Think in Action*. Basic Books, New York.

Schon D. (1987) *Educating the Reflective Practitioner: Towards a New Design for Teaching and Learning in the Professions*. Josey-Bass, San Francisco.

Schultz P. & Meleis A. (1988) Nursing epistemology: traditions, insights, questions. *Journal of Nursing Scholarship* 20(4), 217–221.

Schumacher K. & Gortner S. (1992) (Mis) conceptions and reconceptions about traditional science. *Advances in Nursing Science* 14(4), 1–11.

Smith M.C. (1992) Is all knowing personal knowing? *Nursing Science Quarterly* 5(1), 2–3.

Smythe W.J. (1986) *Reflection in Action*. Deakin University Press, Victoria.

Stevens P.E. & Hall J.M. (1992) Applying critical theories to nursing in communities. *Public Health Nursing* 9(1), 2–9.

Taylor B.J. (1992) Relieving pain through ordinariness in nursing: a phenomenological account of a nurse-patient encounter. *Advances in Nursing Science* 25(1), 33–43.

UKCC (1992) *Code of Professional Conduct*. UKCC, London. Walsh M. & Ford P. (1990) *Nursing Rituals: Research and Rational Actions*. Heinemann, Oxford.

Watson E.A. (1991) *A descriptive study to identify grief responses displayed by fathers following the loss of a child*. Unpublished BN (Hons) dissertation, University of Wales College of Medicine, Cardiff.

Young C.E. (1987) Intuition and the nursing process. *Holistic Nursing Practice* 1(3), 52–62.

Younger J.B. (1990) Literary works as a mode of knowing. *Image: Journal of Nursing Scholarship* 22(1), 39–43.