Nursing Knowledge and Nurses’ Knowledge: A Reply to Mitchell and Bournes

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Reply by Pamela Reed

My appreciation for nursing theorizing as a way to advance knowledge for better patient care emerged during my undergraduate studies and propelled me into graduate school. My ideas have developed over time to bring me to an understanding of theory as a purposeful form of abstract thinking essential to a discipline and, by definition, as a characteristic of the professional nurse. Whereas I used to think of theorizing and practice, shifts in philosophy of science, healthcare systems, and in my own personal development have inspired new thinking about theorizing in practice, or as pragmatists explain, theorizing as practice. Five propositions about this idea, addressed in the previous column titled “The Practice Turn in Nursing Epistemology,” (Reed, 2006) are summarized below.

The Theory in Theory-Guided Practice Should be Practice-Based Theory

While nursing knowledge has been and may continue to be regarded as a product applied to practice as in theory-guided practice or theory-based practice, it is time to extend our thinking to consider another path to theory development, that of practice-guided theory or practice-based theory. While there is an abundance of articles describing how nursing theory directs practice, there also is need to better understand how practice directs nursing theory, and more basically to recognize the potential for practitioners to originate the theories they use in practice. As Ellis (1969) explained, for intelligent practice: “The professional practitioner must become not simply a user of given theory, but a developer [italics added], tester, and expander of theory” (p. 1436).

Professional Nurses, by Definition, are Knowledge Driven

Theory building is not the exclusive domain of people formally identified as theorists. All human beings, including patients and nurses, possess theories and theory building ability.

Theorizing has accompanied nursing practice over history, as expressed in various forms of theory: from Nightingale’s empirical generalizations; to Dickoff and James’ (1968) situation-producing theory; to micro, mid-range, and grand theory; and considered to be the most inclusive form, practice theory (Higgins & Moore, 2000). However, for various educational, political, and personal reasons, practicing nurses may not be aware of the theories they use much less develop in the context of their practice. Further, nurses’ conceptual thinking, values, and culture do not diminish practicing nurses’ potential to be theory-based knowledge producers. Since the publications of Kuhn and other scholars of the practice and processes of science, it is widely accepted that knowledge production is a social (including cultural and personal) construction.

Knowledge is Not Nursing Knowledge Until it is Transformed Into Theories Through Practice

Peplau (1992) described the transformation of knowledge into nursing knowledge by a process that included the peeling out of theories in the context of practice. This is not to say that other forms of knowledge are not useful in practice. But caring and healing processes that are most basically nursing (as opposed to medical, sociological or physiological for example) are best facilitated by nursing knowledge. Moreover, nursing knowledge is not applied knowledge. It is the basic knowledge of our discipline. Akin to Lobo’s (2005) editorial on bench research in nursing is my proposal that the practice setting is the bench in bench science for nursing. If nurses truly are to function with autonomy and to be an effective advocate for patients, nurses must knowingly participate in abstract thinking.

In his research, Abbott (1988) found abstract thinking to be particularly significant in influencing the level of jurisdiction a profession had over its practice. Physicians should not be the only professionals who possess a sense of agency in their knowledge production and therefore command full jurisdiction over their healthcare practice. What form this abstract thought and theory development in practice may take is a relevant concern, as is whether current and proposed...
changes in educational curricula and in practice environments support this new thinking about practice-based knowledge production.

Nursing is Poised to Envision and Enact a Broader Definition of Science That Embraces Multiple Approaches to Science and Theory Development

This broadened definition is supported by our expanding epistemological infrastructure and definitions of evidence, initiated with Carper’s (1978) seminal article on patterns of knowing, and advanced by others who have delineated these and other patterns of knowing as legitimate theory sources (Fawcett, Watson, Neuman, Walker, & Fitzpatrick, 2001). This thinking transcends the limits of method imposed by positivist views of science (Harrick, 2002) and instead ignites a science of practice that can dissolve the gap—still real for a majority of practicing nurses—between theory and practice.

Conclusion: Taking the Next Step

Despite my (and others’) vision about a new path of theory development for nursing, I am concerned that nurse educators may not exploit recent changes in education to design curricula that can prepare practitioners to be theorists and producers of nursing knowledge. Nevertheless, I propose that we work toward the movement to develop nursing knowledge—inspired by Peplau, Rogers, Newman, Watson, Parse and other iconoclasts in nursing theory—one step further, in creating and teaching unique methods to answer research questions, may we embrace practitioners in the process of knowledge production.

Reply by Gary Rolfe

While I welcome the critique of my paper from Mitchell and Bournemouth (2006), many of their specific points are based on misreadings and misinterpretations of my position. This response therefore attempts to restate some of my main contentions, and to point out where I believe that my position has been misunderstood. Due to limitations of space, I have restricted myself to five points.

Theory

Mitchell and Bournemouth (M&B) have misinterpreted and misrepresented my use of the term theory. While pointing out that the term is used in Canada and the United States to refer to “nursing and other theorists who have set forth ontological assumptions,” they claimed that “Rolfe used the word theorist when meaning researcher.” This implies that I was confusing my meanings, using one word when I really meant another, whereas I actually used the word theorist to include the meaning of researcher rather than to replace it. Thus, my use of the term theory is far broader than simply to refer to research and/or research findings, and encompasses all attempts at conceptualization. This includes grand theory (M&B’s ontological assumptions); mid-range theories, which are amenable to testing through research; micro theories; and practitioners’ own informal theories, which they formulate and test in practice. Furthermore, this misrepresentation of my views allows M&B to claim in the title of their paper that my position is atheoretical, whereas it simply takes the term theory at its wider and more usually accepted meaning. It is also rather disingenuous of M&B to assume that I reject or am unaware of the importance of the values, culture and conceptual thinking underpinning theory generation just because I did not specifically refer to them. I am not so naive that I imagine practitioners to formulate informal theories out of the blue without reference to their values, culture, and prior knowledge, including their knowledge of grand and mid-range theories.

Reflection-in-Action

M&B misunderstand and misrepresent the concept of reflection-in-action, which I proposed as a mechanism for formulating and testing informal theory. By conflating Schön’s concept of reflection-in-action with reflective practice (which is more usually employed in relation to reflection-on-action), M&B are able to reject it as merely descriptive. Thus, they claim that “if reflective practice becomes nurses’ primary mode of knowledge generation . . . then nursing theory will simply describe what is—that is, it will portray what nurses are currently doing.” However, as I have already outlined in my paper, and as any cursory reading of Schön (1983) will reveal, reflection-in-action is clearly not merely descriptive, but is a highly complex form of experimenting in practice, or praxis. Praxis encompasses description, theorizing, testing of hypotheses, and bringing about change in practice based on these experiments. In fact, as I pointed out in my paper, praxis mirrors the scientific method of hypothetico-deductivism.

Practice

M&B wrongly accuse me of failing to acknowledge theory-guided practice. I am certainly not denying that most practitioners use grand and mid-range theory to direct their practice, nor that many appear to be happy with the outcomes. Rather, I am suggesting that such a technical rationality model is neither the only way of practicing, nor necessarily the most effective. As M&B themselves point out, despite 40 years of theorists promoting theory-guided practice, “there is an abundance of evidence that healthcare systems worldwide are less than ideal places, and that nurses do not always practice in ways persons cared for consider helpful.” I am merely suggesting that perhaps practitioners are better placed than theorists to know which nursing interventions are considered helpful by individual persons cared for. In other words, while general theories might help us to know about the general needs of large groups of people, individual theories of the unique, formulated by individual nurses in response to individual patients, might be more appropriate to the unique needs of these singular persons. If nurses are still not practicing in ways considered helpful by patients despite 40 years of theorizing, then perhaps there is something wrong with that theorizing and the sort of theory that it produces. M&B counter this assumption, claiming that it is “inconsistent with our
realities and the realities of numerous scholars who have advanced the development of nursing knowledge within clearly articulated and coherent theoretical frameworks." However, it is nurses who are faced with the reality of translating these grand theories into specific practice, and M&B's endorsement of theory-guided practice might have sounded more convincing if it were made by practitioners rather than theorists.

Science

M&B have misinterpreted and misrepresented my position as advocating a single view of science which is "exclusive of others' ideas and ways of sciencing." They are correct in their assertion that I am advocating what they refer to as the study of proximal causes, although I prefer the terms local or contextual. However, such a position does not deny or exclude other views; all I do is to suggest a science of the unique as another, perhaps more relevant, approach for practitioners. As I explicitly claim: "That is not to say that the traditionalist model of science should be rejected, only that it should know its place" (Rolfe, 2006, p. 40), before going on to describe some situations in which the traditional model might be more appropriate.

Conclusion: Theory Knowing Its Place

This final point of theory knowing its place is the nub of my argument and the issue that never fails to generate a response from researchers and grand theorists. As Foucault (1980) pointed out, we cannot separate knowledge from power, and my claim that the informal theory generated by practitioners is perhaps of greater importance to practice than the writing of theorists is therefore as much a political point as it is an epistemological one. Technical rationality, the privileging of theory over practice, is also a privileging of nursing knowledge over nurses' knowledge. In contrast, an approach to science in which the most relevant knowledge for practice emerges from practice itself turns this power/knowledge hierarchy on its head. While I can see how such a turn to practice might be perceived as threatening to the power and status of some theorists (including myself), I nevertheless stand by my assertion that such a science of the unique offers a viable and valuable way forward for the practice of nursing.

References


A Counter Response to Reed and Rolfe

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It seems that the scholarly dialogue will continue far beyond this column. It is clear that the difference is not in misunderstandings or misinterpretations, but rather in our divergent worldviews and values. We have completely counter views from Reed and Rolfe about knowledge development, what constitutes nursing science, nursing theory, and the art of nursing as lived in research and practice. Divergent views, when clearly presented, offer scholars and students options and opportunities for debate and choice.