

# Reflection and patterns of knowing in nursing

Helen Heath RN RM RNT BA(Hons) Msc

Senior Lecturer, Homerton School of Health Studies, Cambridge, England

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## Reflections and patterns of knowing in nursing

Over the last decade nursing has progressed from a reliance on empirical theory applied to practice to a recognition that experience develops knowledge that can guide the actions of practitioners. Reflection is a means of surfacing experiential knowledge, and students may begin to use reflection as their experience of nursing accumulates. As Carper was a key figure in widening that knowledge accepted as knowing in nursing beyond the empirical, it is both justified and recommended that her work should be incorporated into reflective practice. Johns has integrated Carper's work in his model of guided reflection and this paper briefly examines this combination. The main focus is on two further patterns of knowing: unknowing and sociopolitical knowing. These patterns are examined and the contribution they could make to reflective practice is discussed.

*Keywords:* reflective practice, knowing in nursing, expert practitioner, habitual practice, socio-political context

## INTRODUCTION

While the idea of learning from experience is not new, dating at least from the writings of John Dewey in the earlier years of this century, the use of reflecting on experience as a means of enhancing professional practice stems from the work of Schön (1983) who highlighted the weakness of the theory application approach that had dominated professions and those claiming professional status. Schön described a high hard ground where research-based theory may easily be used, but noted that the most important challenging problems generally occur in the swampy lowland of practice as confusing 'messes' that require the intuitive artistry of the expert practitioner.

Nursing had been one of those professions seeking recognition, with theory and research dominated by the abstract scientific approach seen as the pathway to academic and professional credibility. Carper's (1978) seminal article describing four patterns of knowing in nursing legitimized empirics, moral knowledge, personal knowing and aes-

thetics as valid, indeed essential, to the professional nurse. She noted that 'each pattern may be conceived as necessary for achieving mastery in the discipline but none of them could be considered sufficient' (Carper 1978 pp. 21–22).

The belief that scientific knowledge should be applied to practice if correct nursing actions were to result (Figure 1) was further weakened by the work of Benner (1984) who charted the progress from novice to expert. During this process reliance on theory or abstract principles and a need to focus on part of a situation to which theory and rules are applied by the detached observer is replaced by intuitive use of accumulated past experiences by the participating expert nurse who perceives 'wholes' and homes in on the heart of the problem. Benner does not dismiss theory, but while this form of knowledge enables the practitioner to ask the right questions and look

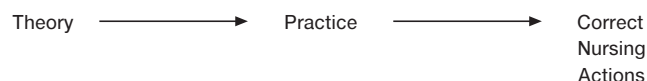
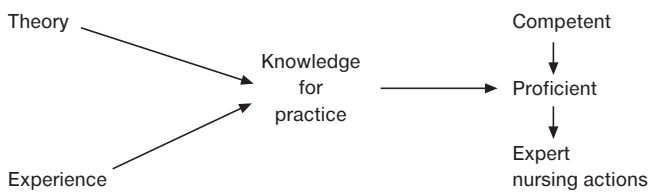
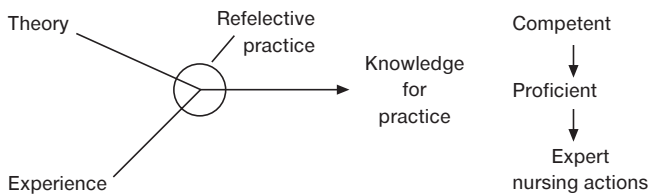


Figure 1 Theory application approach to nursing.

Correspondence: Helen Heath, 15 Monkswell, Trumpington, Cambridge CB2 2JU, England.



**Figure 2** Contribution of theory and experience to growth of the expert practitioner.



**Figure 3** Theory integration via reflective practice.

for problems that promote learning from practice, theory alone is insufficient to produce higher levels of performance. Indeed Benner (1984 p. 4) pointed out that 'not all of the knowledge embedded in expertise can be captured in theoretical propositions'.

Nursing actions can rarely be simply right or wrong and qualified nurses may perform at different levels with both formal theory and experience contributing to their decisions. This is represented in Figure 2 which nevertheless fails to capture Benner's idea that theory may point the way forward and provide invaluable knowledge in new settings but only experience will produce the expert.

Moch (1990) compared knowledge that evolves within practice with research and theory that might stem from practice, but is developed separately from it and, when applied to practice, may create a theory-practice gap. Reflection on practice enables the nurse to examine her decisions and surface the knowledge that has evolved within practice. Furthermore it is suggested that by examining where and how formal theory contributed or could contribute to actions, theory will be more deeply understood and integrated with practice in relevant situations and in relevant ways (Figure 3).

### THE ABILITY TO REFLECT ON PRACTICE

Schön (1983) described the benefits of reflective practice and challenged the belief that reflection-on-action (i.e. reviewing actions after the event) is doomed to failure as the artistry and intuitions of the expert practitioner are indescribable. He maintained that while intuitive knowing is always richer in information than any description of that knowing, reflection on practice will enable the criticism, testing and restructuring of understanding. He described the reflections of expert practitioners or less experienced and student practitioners being guided to

review their experience under close supervision and questioning from experts; thus the question remains who can use reflective practice effectively. Burrows (1995) posed a similar question noting that students lack a repertoire of practice-based examples and that, in line with Benner's (1984) description of novices and advanced beginners, they value the scientific approach for the rules and direction it supplies. However, Burrows maintains that students still need to develop skills of learning from practice and describes ways in which this might be achieved. This author suggests that the most junior students can be overwhelmed by a stream of new impressions and experiences which probably deny focusing on specific situations to examine in depth. While the advanced beginner might still achieve greatest benefit from a more generalized discussion of practice placements, they can be encouraged to identify key events and explore these with the guidance of practice-based mentors or nurse teachers. During branch studies more focused reflection should be encouraged, with the aim of encouraging life-long reflection on, and analysis of, their practice.

While limited experience may restrict the use of reflection or at least the ways in which it is used with the less experienced, the complexity of the skills involved should not be seen as a barrier. These skills have been identified by Atkins & Murphy (1993) as self-awareness, description, critical analysis, synthesis and evaluation; but while the competent nurse just beginning to utilize reflective practice is unlikely to be able to use all of these, this stems in part from the limitations of the level of performance which may be efficient and complex but is based on deliberate planning (Benner 1984). If skills of reflection are equated only with academic skills and not practical ability and reflection on practice is delayed the ability to reflect will lag behind the ability to nurse.

Benner (1984) suggested different instructional strategies for each discreet level of performance with the mentor ideally being close to the mentee's level of practice; this being seen as likely to enhance awareness of mentees' needs. The point would appear to be supported by Schön's (1983) examples from design and psychotherapy where an understanding gap existed between mentor and mentee which the mentor failed to breach. The need to match levels need not, however, create too great a problem. When Schön described the gap that exists between knowing-in-action and articulating that knowledge he pointed out that without excessive information the simplified picture may enable reflection; this could be especially true when reflections are shared in a group of practitioners whose experience varies. Polanyi (1969) presented an analogy of a letter describing what the writer has seen while on holiday; details are lost in writing but the reader interprets the letter based on his own experience of scenes similar to the one described which enable him to fill in the gaps. The result may not be an accurate representation, but the

reader understands another's experience within his own framework and knowledge. Polyani provided a further example of a student doctor learning to read chest X-rays. As his experience grows he can begin to understand the details of what he sees and hears about the X-ray; it may still be a fraction of what the expert sees, but he is beginning to understand the articulations of the expert and benefit from them.

Furthermore in one to one relationships the expert practitioner may need to develop expertise in facilitating the reflections of another. Schön (1983) attributed some of the failure of understanding in his psychotherapy example to a mystery and mastery approach of the supervisor and a complementary mystery and passivity approach of the resident (mentee). Reid (1994) identified the problem of mentors being carried away with the excitement of their own reflections and a presumption that the mentee could follow the analysis. She pointed out the need to recognize that the student's insights might be of equal value. Personal experience with groups of practitioners with varying experience and from diverse areas of nursing suggests that as confidence grows and involvement increases questions asked by nurses with limited knowledge of the situation described can both clarify details and deepen the level of thought. Thus mixed groups may possibly enhance the development of skills of reflection.

There is still a degree of controversy surrounding the use of guides to structured reflection, for example Burns (1994) found that while students wanted guidance, staff were unwilling to provide this, fearing that, however unique the original experience, guides would produce uniformity. However, Dewey (1938) suggested that education based on experience may require more not less guidance, and this holds true for reflective practice. Johns (1994) who himself noted that practitioners may use guides in a way that reduces experience to a series of questions that may splinter an encounter, identifies the need for reflection to start with a model to provide guidance and structure. This, of course, fits with Benner's (1984) concept of novices requiring rules and advanced beginners' guides; as practitioners develop the skill of reflection, guides can be used more appropriately for each case, adapting, combining or abandoning them as required.

## REFLECTION AND PATTERNS OF KNOWING IN NURSING

Johns' (1994) incorporated Carper's (1978) patterns of knowing into his ninth model of guided reflection by suggesting that when reviewing the learning resulting from reflection, practitioners ask which pattern of knowing has been changed: empirics, aesthetics, ethics and/or personal.

In his tenth model (Johns 1995) integrated the four patterns more clearly within the cue questions posed, and this could enhance the completeness of individual reflec-

tions on practice. However, Smith (1992) has expressed concern that the integrated, interdependent and overlapping nature of the patterns of knowing could be lost in convenient groupings for organizing them into discrete components. Johns' tenth model, by grouping and labelling cue questions, could encourage this when the expert supervision he may assume occurs even outside his direct influence is in fact missing. Practitioners may be unable to restore the unity of experience that transcends the multiple dimensions and sources of knowing (Smith 1992) and blame this on reflective practice, turning experience into an academic exercise.

Carper concluded that a philosophical discussion of patterns of knowing may appear to some as a somewhat idle, if not arbitrary and artificial, undertaking having little or no connection with the practical concern and difficulties encountered in the day-to-day doing and teaching of nursing. But it represents a personal conviction that there is a need to examine the kinds of knowing that provide the discipline with its particular perspectives and significance. Understanding four fundamental patterns of knowing makes possible an increased awareness of complexity and diversity of nursing knowledge.

Johns may have enhanced reflection by integrating Carper's patterns of knowing into his model and by developing questions to reflect this, but, it is suggested, practitioners need to have considerable nursing expertise and skills of reflection before they can appreciate the very real complexity and diversity of their practice and not see an examination and categorization of their knowledge as a mere academic exercise. A study of patterns of knowing may be introduced independently by examination of theory and research and identification of relevance to one's own practice and expertise. At this stage the reflective practitioner can recognize how reflections already ask questions about each pattern, both within a model of reflection and as extensions to it. Further reflections could naturally address the issue of patterns of knowing individually as well as integrated, interdependent and overlapping. Using John's tenth model but without labelling the questions and with the final question of his ninth model, would allow a more natural deepening of reflections and pleasure and pride in the ways of knowing identified.

## 'UNKNOWING' AND REFLECTIVE PRACTICE

Two further patterns of knowing have been identified and the inclusion of these within reflections could be beneficial. Munhall (1993) proposed that knowing may lead to closure based on confidence in one's own interpretation, and identified a fifth pattern of knowing which, paradoxically, is unknowing. This unknowing is an awareness that the nurse does not and cannot know or understand the client when they first meet and by recognizing this

unknowing, the nurse remains alert to the client's perspective of the situation. Assumptions based on the nurse's subjective view of reality are avoided, the nurse listens to the client and a true working together relationship can be established. Without a state of conscious unknowing conflict, or potentially more destructively, an apparent but unreal agreement may result.

Munhall described unknowing as an art, but the exploration appears to focus on a pattern linked to personal knowing. It is suggested that unknowing is related to all patterns. The nurse needs to be aware of his or her lack of empirical knowledge, and to avoid a belief that formal theory and research is to be applied or rejected without thought. Unknowing here could promote an alertness to learning how, when and where theory and research may be used to produce a desired outcome. Unknowing is clearly related to ethical knowing. Jacobs-Kramer & Chinn (1988) emphasized that while this pattern may be expressed through codes, standards and ethical theories, descriptions of real cases of ethical decision-making will identify important contextual aspects that influence the final judgement and reveal the reasoning process used. The centrality of real examples highlights how openness that results from unknowing will enable learning to continue. White (1995) cited Bishop & Scudder's (1990) point that some moral dilemmas cannot be solved, but must be lived with; an initial acceptance of unknowing may help accept not finding solutions and differentiate such situations from ones where the dilemma may be solved or ameliorated. Aesthetics above all is an important area of unknowing. While knowledge increases as expertise grows, a denial of unknowing and satisfaction with one's own level of performance may be the most potent block to the development of expert practice.

Greenwood & King (1995) commented on the two pictures of nursing presented in literature: that of the expert practitioner, e.g. Benner (1984), and that of nursing dominated by routine and coping, e.g. Cook (1991). The former could represent awareness of unknowing that permits progress, the latter early closure with confidence in one's own state of knowing, albeit at times resulting from external pressures to get through the work. Benner noted how the external pressures of poor staffing levels can affect practice and Schön discussed an internal process he calls 'selective inattention' where, as knowing in practice becomes spontaneous, those aspects of a situation that do not fit knowing-in-action are ignored; workable solutions may result but these will not be the best course of action. This concept of habitual practice has been examined by Jarvis (1992) who cited the work of Berger & Luckmann (1967) to make a case that habituation is more likely to develop as the practitioner moves towards expert levels of performance. However, while Berger and Luckmann describe stages of action that move from creative experimental actions in new situations, through repetitive and thoughtful acts

to presentation with minimal thought and then mindless ritual and alienation, they also claimed that habituation:

frees energy for such decisions as may be necessary on certain occasions. In other words, the background of habituated activity opens up a foreground for deliberation and innovation.

(Berger & Luckmann 1967 p. 71)

Two types of habituation could thus be described. In the first, as competence grows, the nurse enters a state of confidence in his or her knowing, closure follows and negative habituation results in routine and coping dominated practice. In contrast, the positive form of habituation means the nurse can focus on new learning opportunities and this may be especially helpful when transferring skills to new areas.

In fact, the real world of nursing is far more complex than described. Probably most practitioners experience days when despite working very hard and dealing with many problems, they leave work feeling dissatisfied because they are aware of what was left undone or not given sufficient time, i.e. they are aware of acting in a negative habitual manner. While not the focus of the author's current research, interview data suggest that practitioners are not only aware of habitual practice when working under external pressure but aware that the danger of habitual practice may increase as expertise grows. Comments related to awareness of habitual practice always arose spontaneously to contradict and challenge researchers' questions related to developing and improving practice with the passage of time. One practitioner spoke of occasionally losing compassion and needing to go back and retrieve it when working with patients whose medical condition was very familiar. Another discussed sometimes when busy not listening to patients fully and how it was important to retain this, especially when patients may not tell the nurse directly what the problem entailed. A third spoke of impatience with certain clients which must show even when the nurse tried to conceal it, this would damage the nurse-patient relationship. Interestingly, all examples related to the type of unknowing described by Munhall (1993) not the extensions suggested above; this could either support the completeness of her theorizing or indicate a need to reflect on other possible aspects of unknowing.

Greenwood & King (1995) compared the concurrent verbal reports and retrospective discussions of care given by novice and expert nurses to patients who had undergone routine total hip replacement 1–3 days previously. They found some 'surprising similarities' and concluded that the expert may not need to differ in mundane situations. While their definition of 'novice' could be criticized (3–18 month orthopaedic experiences), there were clear differences with the 4–11 years orthopaedic nursing experience of experts. However, it is suggested that the need is

not for the more experienced to differ from the less experienced but for them to remain alert to selective inattention in such situations, and to develop more fully the art of unknowing. Johns (1994) noted the need to reflect on the mundane as well as critical incidents, and it is probably within the mundane that habitual routinized practice is most likely to occur. Practitioners should be encouraged to follow Johns' advice and reflect on their everyday practice to surface habitual actions, examine their strengths and weaknesses and thus open up the possibilities of learning by developing the art of unknowing.

## **SOCIO-POLITICAL KNOWING AND REFLECTION**

There has been recent debate in the nursing literature regarding the place of sociology in nursing. Cooke (1993) holds that while nurses tend to have negative attitudes, claiming that nursing is about individuals, they do need to understand those individuals in the context of their pathology and society. She is also critical of those who advocate a focus on micro sociological aspects such as labelling and the family, claiming that an understanding of the sociology of nursing and organizations is also important. Sharpe's (1995) response can probably be discounted here, he is a non-nurse with, it appears, little knowledge of nursing; his views would certainly negate the need for reflective practice. He proposed that it is difficult to imagine what nursing would gain from sociology as different schools would imply the need for different approaches to client care and thus not meet nursing's need for recommended action in different situations. Possibly Sharpe sees nursing as a very advanced profession with a highly developed knowledge base and resulting certainty of approach to client care. Alternatively he may see nursing as a simple, straightforward, task-orientated occupation where clear instruction needs to be given and thought and reflection minimized. Porter & Ryan's (1996) article is far more helpful; they too note that different schools of sociology exist, some focusing on the individual and some on structures of society that are seen to influence individuals. They see both approaches are useful and believe that factors influencing nurse and client should not be ignored. These factors would form the socio-political pattern of knowing identified by White (1995) who contended that what was missing from earlier work was the context of nursing. Other patterns addressed the 'who, how and what' of nursing, but not the 'where in'. For White there is more involved than the organizational constraints stemming from limited resources created by government funding policy and the political economy within which the government operates that were identified by Porter & Ryan (1996). She believes issues of power are involved and the critical question of whose voice is heard and whose voice is silent needs to be raised.

Porter & Ryan (1996) demonstrated the need to consider the wider context when their investigation showed that the reason behind speedy assessment and care plans not being used was not a lack of awareness of the theory behind the nursing process or a rejection of its philosophy, but a lack of time and experienced staff. It has been advocated that reflections should consider this wider context (Goodman 1984, Kemmis 1985) and experience with reflective practice groups demonstrates that nurses are very aware of some of these constraints, but when surfaced during reflection they can produce a feeling of helplessness that the problem lies outside the practitioners' domain of influence. Nurses need to increase their socio-political knowing to understand when and how they might act in relation to the context of nursing.

One way forward might be based on Schön's suggestion that problem setting needs to precede problem solving as problematic situations are a complex mixture of issues that require practitioners to set boundaries and frame problems within an identified context. For nurses the boundaries could be: the individual practitioner's actions, the practice setting and nursing team, other health care professionals including doctors, the organization, e.g. NHS Trust, and wider social influences including government policy. By initially framing problems within boundaries of the individual practitioner or the practice setting and examining them at this level some potential actions to enhance practice may be identified. The context could then be widened to identify influencing factors that both help and hinder practice and to frame new problems. Where problems are difficult to resolve when the context widens, reflection may at least enable the formulation of reasoned arguments for change which can then be presented to managers; the socio-political restraints will still exist but an argument that acknowledges this and presents detailed analysed examples of the effect on client care may produce small and gradual change. Critical questions should therefore include 'Where is my voice heard?' and 'How can my voice be heard in the wider arena?'. The change process is never easy, but by considering each level separately and together, the practitioner can possibly identify ways of initiating change or, as with ethical dilemmas, identify which constraints can be eliminated, which ameliorated and which must be lived with.

## **CONCLUSION**

Part of the socio-political context is the constraints to reflection itself as well as the constraints to practice identified by reflection. Limited skills have been discussed, but perhaps the major issue is time to reflect. It is acknowledged that this can present considerable difficulties in today's market orientated health service where time spent must be justified, but the recommendation for implementation of clinical supervision (UKCC 1996) provides an

argument for time allocated to sharing reflections in either a one-to-one or group format. In depth reflection-in-action need not take place every day or even every week, indeed too frequent detailed analysis of practice may turn a beneficial experience into a chore to be completed and practitioners need time to be themselves doing their job and enjoying nursing their clients. However, while this may ease the pressures of time, the practitioner needs to avoid only using reflection when critical incidents highlight deficiencies in practice. Reflective practice should also be used to identify why a situation went well as this will identify the knowledge embedded in practice that will enrich nursing, enable the practitioners to assess their professional development and, by providing understanding of actions, be used to guide less experienced nurses.

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