Deconstructing reflective practice as a model of professional knowledge in nursing education

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Declaration and Word Count

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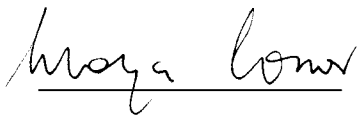

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Abstract

The knowledge needed for nursing practice has long been a contested and divisive issue among nursing scholars and nurse practitioners. Professional knowledge in nursing is recognised as complex and multifaceted, drawing on many different sources. Throughout the history of modern nursing, as the profession attempted to establish itself as a discipline in its own right, various movements in the development of nursing knowledge may be identified. From an earlier era of grand theories to evidence-based practice in more recent times, the nature, origins and scope of nursing knowledge remains a source of on-going debate and discussion. Reflective practice has proved to be a very popular model of professional knowledge in nursing since it first appeared in the literature in the 1980s. Its appeal for nursing may be understood in its valuing of practice knowledge and the possibility of generating knowledge from practice. However, despite the appeal of reflection as an epistemology of practice in nursing education, the term is understood in many different and sometimes contradictory ways.

This aim of this study is to examine the textual construction of reflective practice as a model of professional knowledge in nursing education. Since knowledge in many disciplines is textually mediated, a consideration of the language in which knowledge claims are made seems apposite when a concept is contested. Deconstruction consists in a close reading of texts, not with the aim of understanding the meaning of a text but with the aim of understanding how meaning is constructed, in particular, the resources of language that are used and the effects thereby created.

This deconstructive reading reveals a concept that never fully coincides with itself. Reflective practice as a model of professional knowledge in nursing education is never punctually present in the texts that strive to construct its identity. The identity of reflective practice appears deeply saturated by its so-called binary opposite. Such a reading does not claim to be the "truth" of reflective practice. It

does, however, permit the concept to be considered and understood in a different way and that, I should contend, is what reflective practice is all about.

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Chapter 1 Introduction

Like many issues in nursing generally, nursing knowledge – its nature, origins, and scope - has been the subject of on-going debate and discussion within the profession for decades. As a relatively new discipline, nursing has attempted to assert an identity distinct from other healthcare disciplines, in particular medicine, to which it has, historically, been most closely allied. The assertion of a unique identity is intimately connected with the development of a unique knowledge base. In developing a body of unique disciplinary knowledge, nursing strives to balance its strong attachment to practice with the requirement for advancements in theory and research. Reflective practice, as a model of professional knowledge in nursing education, appears to offer a means of achieving the required balance. Reflective practice has proved a popular theory of professional knowledge over the past three decades, particularly in nursing education. However, it is not without controversy in that field. While reflective practice appears to validate the art or practice of nursing, the science or theory of nursing seems to be less accredited. This apparent opposition between art and science lies at the core of many of the debates and disagreements concerning nursing knowledge. Is nursing an art or a science? Is it more art than science? Or is it both in equal measure? And what kind of knowledge for nursing does reflective practice afford? This study is an attempt to address these recurrent questions from the perspective of deconstruction. In this chapter, the main outlines of the study will be presented. Beginning with an historical overview of developments in nursing knowledge through the lens of nursing education, the chapter will include an account of my position and interest in this area. The study has strong resonances with my own lengthy career as a registered nurse, registered midwife, and nurse educator in both the UK and Irish contexts. To a certain extent, the study parallels and mimics my professional biography. In this chapter, also, the phenomenon that is reflective practice in nursing will be introduced. An outline of deconstruction as a research methodology and how I came to choose this approach for my investigation of reflective practice as a model of professional knowledge in nursing education will

be included. I begin by outlining developments in nursing education and how such developments influenced conceptions of nursing knowledge

1.1 Developments in nursing education

As 'modern' nursing developed in the late nineteenth and early twentieth centuries with the establishment of hospital-based training schools and the drive for professional registration, nursing competence was taken to be a combination of personal qualities, practical skill, and biomedical knowledge (Fealy, 2006). Nursing was considered a vocation and only those with the appropriate disposition were selected for training. Close supervision and strict discipline, enforced by ward sisters and hospital matrons, ensured the development of a nurse's moral character and correct attitude (Abel-Smith, 1960; Maggs, 1983; Scanlan, 1991). Formal instruction was provided in basic scientific knowledge, progressing, as the nurse advanced in training, to knowledge of patients' medical and surgical conditions. Clinical procedures relevant to the treatment of such conditions were also taught. Examinations for entry onto the register of nurses were set by the body with statutory responsibility for the training and regulation of the profession. Examination content reflected the syllabus of training and the medical model of care, that is, care based on medical diagnosis and treatment (Aggleton & Chalmers, 1986, 2000; Fealy, 2006). Practical skills were assessed in ward settings by senior nursing staff. Various formats were developed to assess practical skills; all were largely procedure-focused. Caring qualities and appropriate attitudes were not formally assessed. The knowledge base of nursing was derived from medical science coupled with practical knowledge of clinical tasks and procedures (Marriner Tomey & Alligood, 2006). Nursing knowledge served the needs of the hospital, and student nurses provided a workforce in return for a professional qualification (Baly, 1973; Scanlan, 1991).

This model of nursing education persisted with minor adjustments until the 1980s in the United Kingdom and the 1990s in Ireland. Throughout that time, a higher educational level preparation for nurses was advocated by nurse leaders (Marriner

Tomey & Alligood, 2006; Scanlan, 1991). Resistance to such a move from varied quarters was based in part on the idea that higher education was in some way inimical to the development of appropriate personal caring qualities in the nursing student. This was coupled with a belief that nursing did not require the scientific knowledge and theory that it was the role of universities to provide (Scanlan, 1991).

Nursing education in Britain and Ireland was influenced by developments abroad, particularly in the United States which had a long established history of higher educational preparation for nurses (Marriner Tomey & Alligood, 2006). Part of the mandate of higher education was the development of a knowledge base for the profession through research, scholarship and publications (Ryan, 2008). Nurse academics sought to develop a unique identity for nursing which would distinguish it from medicine and the medical model of care. This led to the development of various models and theories of nursing, frequently modifications of models and theories borrowed from other disciplines, such as sociology and psychology (Aggleton & Chalmers, 1986; Kershaw & Salvage, 1986; McKenna, 1997). Early nursing research was modelled on the scientific method reflecting the dominance of this approach in higher education at that time. As alternative research approaches, such as grounded theory and action research, were developed, many nursing scholars identified an inherent compatibility between the underlying philosophical principles of qualitative research approaches and nursing itself. A fierce debate ensued regarding the methodologies appropriate for the development of nursing theory and research with some nurse researchers rejecting the scientific method outright while others argued for a mix of scientific and qualitative approaches (Fawcett, 2005). At the core of this debate was the identity of nursing as art or science, more art than science, or both equally. To validate nursing as art would require that those less visible, less measurable aspects of practice, such as personal qualities and practical knowledge, be identified and accredited. This was unlikely to occur, particularly in the early years following nursing's entry into the milieu of higher education, as nursing attempted to establish itself as a discipline with a strong scientific base (Risjord,

2010). A more detailed account of these perspectives on professional knowledge in nursing will be considered in Chapter 2.

The latter decades of the twentieth century witnessed the most significant change in pre-registration nursing education in the United Kingdom and Ireland since its inception a century before, with the move from hospital-based, apprenticeship-style training to a university-based academic model. Many factors contributed to this change: the aforementioned drive for recognition of nursing as a profession in its own right with its own body of professional knowledge; recognition of the increasing complexity of the nursing role; societal changes bringing greater educational and career opportunities for young people, in particular, young women; increasing diversity of populations and health care needs requiring a wider knowledge base; developments in medical science leading to greater complexity of treatments and procedures; the influence of the health promotion movement and a re-orientation of health services from a focus on treating illness to disease prevention and promotion of wellness; the growth in consumerism leading to a more discriminating service user; the ever-increasing cost of health care services and the need to find more flexible modes of health care service delivery; the increasing professionalization of allied healthcare professions, such as occupational therapy, dietetics, social work, and others; and growth of the multi- and inter-disciplinary health care team approach. All of these developments contributed, to varying extents and at varying degrees of remoteness, to the most radical change in entry level nursing education for more than a century (Abel-Smith, 1960; Baly, 1973; Briggs, 1972; Fealy, 2005; Royal College of Nursing, 1985; Scanlan, 1991; United Kingdom Central Council for Nursing, Midwifery and Health Visiting, 1986).

'Project 2000', as the new pre-registration nursing programme was known in the United Kingdom, proposed a decoupling of education and service (UKCC, 1986)). Student nurses would no longer be considered part of the hospital or health care workforce. In addition to achieving a professional qualification at the end of three years, they would also receive a Diploma award from a higher education institution. The new programme would prepare the nurse to work with

'*uncertainty*', recognising that a training programme based largely on rituals and routines was inadequate to meet the needs of a rapidly changing healthcare system (UKCC, 1986, 20). Opportunities to develop creativity, '*thinking ability*', and problem-solving skills in clinical situations would be provided via new approaches to teaching and learning (UKCC, 1986, 20). The knowledge-transmission model, that is, learners as passive recipients of knowledge delivered by experts, would be supplemented by student-centred approaches to teaching and learning, enabling the student '*to question, as well as to obey, to discover as well as to be taught, to learn from those who have never been nurses as well as from those who have been excellent ones*' (RCN, 1985, 12). Students would not only learn what they needed to function as a nurse, but also learn how to learn. Lifelong learning and continuing professional development were strongly emphasised in the new programme, acknowledging that professionals are required to update their knowledge and skills, and that formal educational programmes must equip the learner with the skills to do so. One of the key concerns in the proposed changes to nursing education was to retain a strong focus on practical knowledge and competence, so that what emerged from the educational experience was a "'*knowledgeable doer*'" (UKCC, 1986, 40). Clinical competence had been an acknowledged strength and a highly valued attribute of the apprenticeship model of nursing education. With the move to an academic model, there was a risk that nurses exiting the programme would not be as proficient in clinical skills as their traditionally prepared predecessors. Under the new programme, much of the student nurse's time would be spent in a university setting far removed from clinical experience. Exposure in that milieu to academics with expertise in a variety of social and biological sciences posed a dual risk. One was that the abstract nature of the knowledge taught in university would not easily transfer to a clinical setting. The second risk was that the student nurse, as a supernumerary member of the clinical staffing complement, would have less time and fewer opportunities to practice and acquire clinical skills than had the student prepared under the traditional training system (Simons et al., 1998). So while the apprenticeship model was considered inadequate to meet the education needs of a nursing profession that would be required to practice in a rapidly evolving, complex healthcare system, potential weaknesses in the new model of nursing education were also recognised (RCN, 1985; UKCC, 1986).

1.2 Developments in nursing education in Ireland

Similar developments to those initiated in nursing education in the UK occurred in Ireland in the mid-1990s. The body with statutory and regulatory responsibility for the nursing profession in Ireland, until very recently known as 'An Bord Altranais' (The Irish Nursing Board), published a framework document proposing changes to nursing education modelled along the lines of Project 2000 in the UK (An Bord Altranais, 1994). Around the same time, a local initiative was undertaken at one hospital site in response to EU Directive 89/595/EEC (*EU Directive 89/595/eec*). Many of the changes in nursing education in Ireland were presaged by European Union legislation. An earlier Directive 77/453/EEC (*EU Directive 77/453/eec*) required that student nurses gain clinical experience in a variety of specialist settings such as mental health and maternity care. Hospitals that could not provide experience for student nurses in specialist clinical areas had to endure the loss of the student from their service to other settings where the required experience was available. This development was the first example of the educational needs of nursing students taking precedence over service needs (Fealy, 2005). The later European Directive - 89/595/EEC - specified a rebalancing of the time allocated to theoretical and clinical instruction in the nursing education programme. Time allocated to theoretical instruction was increased from 26 weeks to 40 weeks with a concomitant reduction in time allocated to clinical instruction. Implementation of the European directive of 1989 provided an opportunity to draft a new curriculum with a wider theoretical base and more focused clinical experience. This opportunity was taken by the School of Nursing in Galway in the West of Ireland. 'The Galway Model', as the new nursing education programme became known, represented formal collaboration between the nursing school, the local university, and the regulatory body, The Irish Nursing Board (Simons et al., 1998). University lecturers participated in drafting a new curriculum and also in teaching and assessing their subject areas on the new nursing studies programme. Department of Health and Nursing Board approval for the new programme was secured and the 'Galway Model' had its launch in 1994, extending to all Schools of Nursing in the Republic of Ireland by 1998.

Students entering under the new nursing education programme had supernumerary status. As well as becoming registered nurses on successful completion of the programme, they were awarded a Diploma in Nursing from a relevant third level institution. The new model also allowed for existing Registered Nurses with a Diploma award to attain a Baccalaureate Degree in Nursing by completing a full-time fourth year of study based entirely within the university.

The 'Galway Model' proved to be an interim measure in nursing education in Ireland. A major review of nursing, including pre-registration education, was undertaken in 1998 following industrial action by nursing unions (Commission on Nursing, 1998). The Commission on Nursing was charged with examining all aspects of nursing and with making recommendations for the future direction of the profession. Following a wide consultation process with a variety of stakeholders, the Commission recommended that pre-registration nursing education be fully integrated within higher education, with students gaining a professional qualification and a Bachelor of Science (Honours) degree at the end of four years (Commission on Nursing, 1998). While the changes proposed for pre-registration nursing education were quite radical, the Commission on Nursing (1998, 50), was anxious that what is '*most cherished*' in nurses be retained, '*namely enthusiasm, energy, commitment, integrity, responsiveness to change, sense of humour, and above all, a deep sense of caring*'. In framing a new nursing curriculum, cognisance needed to be taken of the traditions of the apprenticeship model, in particular, the personal qualities of the nurse and the artistic element of nursing, as the practice became a discipline.

1.3 Reflective practice in nursing education

The changes in nursing education in the United Kingdom and Ireland that occurred in the late 1980s and throughout the 1990s coincided with the publication of a number of texts in the field of education, the most important of which from a nursing education perspective, was Donald Schön's '*The Reflective Practitioner*',

published in 1983. Schön (1983) was critical of the educational model espoused by universities at that time for the preparation of practitioners of the professions. He described the dominant model of professional knowledge, which he called '*the model of Technical Rationality*' (Schön, 1984, 21), as consisting in the application of rigorous, scientific, context-independent, value-free knowledge and techniques to the instrumental problems of practice. However, practice situations are characterised by uncertainty, uniqueness, complexity, and conflicting values, and, therefore, call for a different kind of knowledge, what Schön (1983, 49) termed '*an epistemology of practice*'. An epistemology of practice would recognise the artistry and practical knowing that is central to the work of practitioners. This kind of knowing is embedded in practice and is ordinarily tacit, in the sense that practitioners are unable easily to articulate it. It sometimes, however, '*surfaces*' in situations of surprise when practitioners are prompted to engage in '*reflection-in-action*' (Schön, 1983, 50). By investigating these situations and paying close attention to what practitioners actually do, knowledge can be constructed from practice and, subsequently, validated and shared. Schön's (1983) ideas appeared to strike a chord with those responsible for framing and guiding the new model of nursing education. The terms '*reflection*', '*reflective practitioner*', and '*reflective practice*' became common currency in documents produced for the new nursing education programme.

Outlining the standards of proficiency for pre-registration nursing education, the Nursing and Midwifery Council (NMC), which succeeded the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) as the regulatory body for nursing and midwifery in the United Kingdom, states that: '*The level of learning must be such as to facilitate...the development of critical thinking, problem-solving and reflective capacities essential to complex professional practice*' (Nursing and Midwifery Council, 2004, 17). For registered nurses, a post-registration education and practice handbook, published by the NMC, was designed to encourage nurses to '*think and reflect*', and required them to maintain a '*personal professional profile*' of learning activities to include '*a personal view (reflection) of the way in which the learning has informed or influenced*' their practice (Nursing and Midwifery Council, 2006, 13). Clinical supervision was

identified as an integral part of nurses' lifelong learning. Among the aims of clinical supervision was '*to bring practitioners and skilled supervisors together to reflect on practice*' (Nursing and Midwifery Council, 2002, 7). Similarly, the Irish Nursing Board (An Bord Altranais), in formulating requirements and standards for pre-registration nursing education programmes, included the following learning outcome: '*Demonstrate development of skills of analysis, critical thinking, problem-solving and reflective practice*'(An Bord Altranais, 1999, 13). Guidelines published by the Irish Nursing Board on developing a quality clinical learning environment, state that '*Each registered nurse/midwife has a duty to provide students with clinical support to help them question, analyse, reflect upon their practice and develop autonomy in decision-making to enable them to become safe, caring competent nurses/midwives*' (An Bord Altranais, 2003, 1). In terms of post-registration education, reflective practice is included among examples of activities that may contribute to professional development for registered nurses and midwives (An Bord Altranais, 2000). From the perspective of the regulatory bodies responsible for nursing and midwifery, reflective practice is one among a number of skills necessary to ensure that learning from practice and learning appropriate to professional practice occurs.

1.4 A personal perspective

As indicated in the introductory remarks above, my interest in reflective practice as a model of professional knowledge arises from a long professional career in nursing, midwifery, and nursing education. My initial training as a registered nurse occurred under the apprenticeship system in Ireland. Periods of study 'blocks' were interspersed with working in a variety of clinical settings throughout a three year training period. A syllabus of training prepared by the regulatory body for nursing was followed. Didactic content was oriented to disease and illness. Very little content was devoted to social sciences. Clinical experience was random in response to the needs of the service. Placements within particular clinical areas were likely to be interrupted if a staff shortage occurred elsewhere. No formal learning structures were in place in the clinical setting. The focus was

very much on getting the daily tasks completed. I learned by following the example of other nursing students more senior than I and, to a lesser extent, qualified nursing staff. Lack of knowledge and mistakes, even minor ones, were poorly tolerated in a sometimes quite harsh, hierarchical learning environment. There seemed to be no time and little motivation to reflect upon, and learn from, experiences, even negative ones.

At times, I had what I now recognise as knowledge deficits, particularly in the area of the psychological care of patients. I subsequently undertook midwifery and neonatal care training in the UK where an exemplary apprenticeship model applied. Learning was integrated and structured throughout the training period. Clinical experience was specific and focused and, while there was still an emphasis on tasks and routines, experienced nurses and midwives ensured that learners had exposure to the necessary experience so that required competencies could be achieved. Competencies were largely confined to the domain of clinical skills. Other areas of competence such as supporting bereaved patients and communicating in difficult situations were generally taken for granted in the sense that specific training in those areas was not provided. My idea of a competent nurse was someone with highly developed clinical skills, and good communication and organisational ability. On registration, I worked in a variety of clinical settings for a number of years, mainly in maternity and neonatal care. When my interest turned to nursing education, the route to qualification as a nurse tutor/teacher was a three-year Bachelor degree programme in university in Ireland. This was my first exposure to nursing in a higher education setting. The Bachelor of Nursing Studies programme followed the model of technical rationality as articulated by Schön (1983). Biological and social sciences were combined with educational theories and curriculum studies. Teaching practice followed in the final year of the programme when students were expected to apply the knowledge acquired in university to a classroom setting in nursing schools.

As a qualified nurse teacher employed in a School of Nursing within the health service sector, I participated in developing the first Diploma/RN (Registered Nurse) programme in the Republic of Ireland in 1994. As outlined above, this

initiative was prompted by changes to nursing education at EU level. Working with academics from the higher education sector but not being part of that culture was at times an uneasy experience. A major concern among nurse teachers responsible for developing a new nursing curriculum was that the sciences, in particular the biological sciences, would dominate the curriculum at the expense of nursing subjects. This was, perhaps, a reaction to the dominance of the medical model in the traditional nursing education programme that I and my colleagues had experienced as student nurses. A decision was taken to 'frontload' the sciences in year one of the Diploma programme, with the remaining two years devoted to nursing studies. This was unpopular with both students and lecturers in the sciences, and was perceived as widening the so called 'theory-practice' gap. On the other hand, developing the nursing studies modules proved equally challenging. Articulating a philosophy of nursing and exploring nursing theories and models in depth was demanding, despite having had exposure to these ideas in university. The language in which nursing theory was framed was very often dense and it was difficult to imagine what relevance such content had to nursing practice. Supporting students in practice and my role in that arena was another source of confusion and unease. The role of the nurse teacher in the clinical setting and the issue of clinical credibility is something that has bedevilled nurse educators from the time they first deserted the real world of practice for the rarefied world of the classroom. A number of models have been tried, for example, joint appointments whereby a tutor divides their time between the clinical setting and the classroom, working as a clinician in the former and a lecturer in the latter (Kershaw & Salvage, 1986). No model has proved entirely satisfactory. With the integration of nursing education fully into the higher education setting and the transfer of nurse teachers to that setting also, the dilemma of a clinical role for the nurse lecturer continues. Nurse lecturers are now 'linked' to specific clinical areas but the nature of the link is open to a wide variety of interpretations. As part of the preparation for transferring to the higher education sector, nurse teachers were required to obtain a Master's degree in nursing or a cognate discipline. I chose to study for a Master's degree in Psychological Counselling in the UK.

My introduction to reflective practice as a concept and as a practice came when I studied for a Master's degree in Psychological Counselling. I had previously completed a Diploma in the Theory of Counselling which I found invaluable in teaching student nurses about therapeutic relationships and interpersonal skills. I was immediately attracted to reflective practice because I saw it as a formal method of capturing, analysing, validating, and learning from practical experience. I found the idea of knowledge derived from experience in a helping relationship which, in turn, enriched the repertoire of helping skills, compelling. I taught reflection and the reflective practice approach to many different groups of nursing students, always basing learning on real life clinical experiences and examples. The experiences students chose to reflect upon were always interesting, sometimes involving quite minor, seemingly insignificant incidents, while at other time, very moving or quite dramatic events were recounted. I found the experience of teaching reflective practice kept me very close to, and conversant with, the realities of the practice domain and I felt privileged to be able to facilitate learning in that way. Students' reactions to being asked to reflect on practice varied from bewilderment to scepticism, and, occasionally, enthusiasm.

Registered nurses taking Higher Diploma awards in various clinical specialities, such as peri-operative and orthopaedic nursing, were required to write reflective essays, and, very often, they would ask my advice about the content and structure of their work. I tried to orient them to deeper levels of reflection, beyond technical problem solving, perhaps as a result of my training in counselling. Students were always concerned about using a 'model' of reflection in their writing as they were required to do. I frequently saw how the students' attempts to use a model led to quite rigid adherence with the result that the story of their experiences became distorted. I encouraged them to write freely initially, and later to think about how they could apply a model of reflection. I enjoyed reading the students' essays and commenting where I felt it was appropriate. It gave me great insight into the realities of practice. Occasionally, there would be something akin to an 'aha' phenomenon as these experienced clinicians discovered something about themselves or their work that they didn't already know or see, or something they already knew but hadn't recognised as knowledge. That was very satisfying for

me. However, I sometimes conflicted with colleagues who had different ideas about reflection. Some took a more 'scientific' approach to reflective practice and expected a reflective essay to be formulated like any other piece of academic writing. Such events caused me to doubt my own understanding of reflective practice and I would go back to the literature to find reassurance for my point of view.

More recently, my work has involved continuing professional education with registered nurses who are supporting student learning in practice. As preceptors, these nurses are required to facilitate reflective practice with students, and my job is to ensure that they feel prepared to do so. Time is generally limited and I sometimes vary my teaching strategy between using a didactic approach and using a clinical scenario from a book. These are not the most rewarding teaching experiences. It is clear, from participants' evaluations of the classes, that, in the time available, nurses want factual material such as knowledge of competency frameworks, which they are required to complete in the context of assessing students' progress in the clinical arena. Reflective practice is viewed as something optional. Indeed, one of the most frequent comments made to me by preceptors is: '*Students go to the library to do reflection*'. And when I explain that this is not the only, nor necessarily the optimum, way to 'do reflection', some nurses are relieved to be given 'permission' to engage in reflection using material from students' diary entries in a dialogic mode while others are not so enthusiastic.

My role also includes educating and training support staff whose job specification is rapidly changing and developing as they assume duties and responsibilities previously undertaken by nurses. The education programme for support staff requires reflective writing. To help them to begin to think reflectively, I ask them to record some experience from their work in the clinical setting using written guidelines which I devise for them. We then discuss the experience in small groups and I encourage them by my questioning to analyse their experiences and identify what they may have learned. Reactions vary. Some learners 'get it' straight away while others struggle. My enthusiasm for the subject and the practice remains but I am now aware that not everyone shares this feeling. What I find most challenging

and thought-provoking is the wide disparity of views and understandings of reflective practice held by relatively homogeneous groups, to the extent that it can seem as if the same term is referring to very different practices. However, when I examine the literature, I find such disparity not unreasonable. Reflective practice seems to signify in many different, and at times, contradictory, ways. There is also something of a paradox discernible in the way that reflective practice was first adopted by the nursing discipline. In examining this event, some clues to the complicated identity of reflective practice as a model of professional knowledge in nursing education may be detected.

1.5 The paradox of reflective practice in nursing education

As acknowledged earlier, Schön's (1983) argument for a new epistemology of practice may be understood as addressing the concerns of those who feared that the new nursing education programme would result in a diminution in clinical competence and professional artistry, and a widening of the gap between nursing theory and nursing practice. Schön (1983), through his writing, gave recognition and credibility to practice knowledge or knowledge derived from practice. He also, however, proposed that this kind of knowledge was not that taught in, or valued by, universities. The model of technical rationality that underpins the education of professionals in universities is considered of questionable relevance to the needs of practitioners of the professions in their everyday work situations. Schön (1983) cites disillusionment with the professions by society in general at the time as part of the reason for his search for a new epistemology of practice. In the twenty or so years prior to the publication of his book, Schön (1983) argues that the professions had gone from being universally praised for their contribution to the advancement of all areas of society to being suspected of betraying the trust and regard vested in them by citizens. Schön (1983) attributes this shift in societal attitudes toward the professions as partly due to the model of professional education espoused by universities. The model of technical rationality is instrumental, focusing on finding the best means to achieving pre-established ends (Schön, 1983). However, this approach does not take account of the complexities obtaining in the real world of

practice where ends are not always clear and unambiguous. Schön (1983) cites engineering as one example to illustrate his argument. Engineers have knowledge of what kind of roads to build and they know how to build them, but in the process of building, they may create unexpected and unforeseen adverse effects on local communities. In medicine, to take another example, technological advancement, in the form of resuscitation techniques and equipment, allows people to survive who previously would have died. Survivorship may bring a poor quality of life and create many additional problems for the person concerned, the person's family and wider society that could not have been envisaged at the time of reanimation, and that medical expertise is unable subsequently to address. In other instances, technological advancements may outstrip healthcare budgets resulting in healthcare professionals being required to make difficult choices for which their formal education has left them ill-prepared. These situations occur, Schön (1983) argues, because the model of professional knowledge to which professional practitioners are exposed in tertiary education settings does not take the complexities, uncertainties and value conflicts that exist in the real world of practice into account. Reflective practice, on the other hand, recognises a kind of knowing that is inherent in the actions of competent practitioners which allows them to deal with the complexity and uncertainty of practice (Schön, 1983).

Shortly following the publication of Schön's (1983) text, nursing education in the UK was preparing to transfer to higher education settings where students would be educated according to the model of technical rationality. At the same time, reflective practice, which was developed because of the perceived limitations of the model of technical rationality, was included as a key component in the new nursing curriculum. Reflective practice thus entered the nursing lexicon at a time when nursing education was preparing to adopt the dominant technical rational model of professional knowledge with its move from apprenticeship style training to university based education. The changes in nursing education required knowledge derived from reflecting in, and on, practice to co-exist with rigorous, scientific, context-independent, value-free knowledge and techniques espoused by universities (Schön, 1983). A new nursing curriculum must, therefore, attempt successfully to contain and enact two apparently opposing epistemologies.

Reflective practice was posited as a challenge to the prevailing orthodoxy in higher education settings. Within that milieu, it might be difficult for reflective practice to remain heterogeneous to the model of technical rationality. As part of higher education, nursing aspired to become a research-based profession, developing its own unique body of knowledge (Ryan, 2008). Reflective practice knowledge might not be accredited as a legitimate kind of knowledge for nursing in a culture accustomed more to positivist and post-positivist approaches to knowledge generation. The tensions and paradoxes evident at the inception of reflective practice in nursing education may in part account for the variety of subsequent understandings and responses to reflective practice as a model of professional knowledge for nursing.

Differences in understanding may also have contributed to the lack of any stable or agreed definition of reflective practice. Moon (1999, vii) comments on the problem of identity and reflection:

> *The ramifications of the literature that refers to reflection and to what it seems to be could well lead you to doubt that it exists as a subject in its own right. You might well then doubt the case for the study of reflection. However, the rate of growth of literature on this subject, particularly in the last 20 years, and its apparent face value and broad practical application, provide due justification for its study, despite the difficulties that surround its identity...*

In the above quotation, reflection bears an identity as a textual construction. Although textual construction does not guarantee existence as a self-identical '*subject*', it does not prevent reflection from functioning. For instance, it does not prevent the study of reflection nor its application in practice. The existential problem is further signalled by the use of the term '*face value*', generally used to indicate nominal as opposed to real value. The term is frequently used in the context of currency. The coin or note may be worth very little in real terms but it bears a value in economic terms. The metaphors of writing and face-value are very interesting in the context of deconstruction. Deconstruction recognises writing as

part of a binary opposition: speech/writing. Speech is privileged as natural and normal whereas writing is considered a deviation from, or corruption of, the norm, to be used only when speech is not possible. Writing is considered suspect as it can function in the absence of a speaker. With no speaker present to guarantee correct meaning, a text may generate effects unimagined and unintended by its author. In a similar way, the gold bars contained in bank vaults that guarantee the value of a monetary note or coin do not need to be present in order for currency to function in financial transactions. That something might not exist in the present and yet produce effects connects Moon's description of reflection above with the practice of deconstruction. Other similarities between reflective practice and deconstruction as a practice will be identified later in the chapter. A more detailed exposition of deconstruction will be presented in Chapter 4.

The difficulties posed by words and what they might mean in the context of reflection are illustrated in the following quotation:

> *While in general there may be too many words and meanings floating around the idea of reflection, in some areas of its study there are distinct deficiencies in vocabulary and this is particularly the case in the study of reflection in learning. When words are missing, concepts tend to be missing and the absence of concepts may distort understandings* (Moon, 1999, viii).

The use of the term '*floating*' above suggests that the words and meanings used to give expression to the '*idea*' of reflection never quite 'hit the mark', or coincide with the thing itself. This again is a deeply deconstructive point of view. Words or signifiers are all there is, with no final signified concept that would arrest meaning. It is also clear in the above extract that there can be no signified without a signifier – '*When words are missing, concepts tend to be missing*'. The final line of the quotation suggests that if the missing words and concepts can be found or supplied then correct understandings of reflection in learning will follow. This is a deeply un-deconstructive point of view. And I hope to demonstrate, in the deconstructive readings which follow in later chapters, that univocal meaning is an impossible ideal.

1.6 Reflective practice and nursing knowledge

The problem of identity recognised by Moon (1999) is replicated in the nursing literature on reflective practice. The lack of a clear definition and an agreed understanding of the concepts of reflection and reflective practice are recognised as problematic for nursing education. Atkins and Murphy (1993, 1188) describe '*much of the literature on reflection as complex and abstract*'. They add that '*the lack of clarity of the concept of reflection and the failure of many of the empirical studies to define it, has made the concept difficult to operationalize*' (Atkins & Murphy, 1993, 1191). James & Clarke (1994, 84) agree that '*conceptualising reflective practice is problematic...and describing it adequately for all contexts presents difficulties*'. Carroll et al. (2002, 15) claim that '*The lack of a clear definition of reflection and reflective practice, together with the plethora of terms used interchangeably in the literature, make this phenomenon difficult to utilise within nursing education*'. Students' lives are affected by '*these multiple and tacit understandings of the concept*' in the sense of exposure to diverse teaching and learning strategies that are designed to '*foster reflective development*' (Pierson, 1998, 165). Attempts are made in the literature to 'demystify' reflection and reflective practice (Cooney, 1999; Richardson, 1995), echoing Moon's suggestion of an ethereal, other-worldly quality characteristic of reflection. While the concept of reflection in nursing education may appear somewhat vague, and while a clear, agreed definition is lacking, there appears to be general agreement that reflection is capable of producing effects in nursing, namely, the generation of professional knowledge. Cooney (1999, 1531) asserts that '*The value of reflection is mainly identified as developing professional expertise, competency and valid knowledge for nursing practice*'. Reflection is considered '*vital*' if learning from practice is to occur (Atkins & Murphy, 1993, 1191). The development of reflective practitioners enables the process of critical analysis of practice thereby creating '*new knowledge*' for practice (Carroll et al., 2002, 16). A similar consensus regarding the kind of knowledge for nursing made possible by reflective practice is not, however, evident in the nursing literature. Kinsella (2007) questions whether Schön (1983) has created or overcome a dichotomy between technical rationality and reflective practice. Some argue that reflective practice as a model of professional knowledge

is not compatible with the dominant technical rational model which regards professional knowledge as the application of scientific theory and technique to the problems of practice (Rolfe, 2002). As the following extract illustrates, reflective practice and technical rationality are regarded as two opposing epistemologies that cannot be reconciled:

> *...a genuine reflective epistemology requires to substitute the concept of ready-made knowledge with the liberating and illimitable possibility of creating knowledge. The aspiring objective is not to fill the heads of every student with identical, replicable and 'factual' knowledge, but to provide the means and mechanisms for every student to produce their own individual and personal knowledge* (Mantzoukas, 2007, 245).

For others, reflective practice encompasses knowledge from many sources, including scientific theory and research (Johns, 2009; Rycroft-Malone et al., 2004). Reflective practice, although it challenges a model of professional knowledge based solely on technical rationality, may be used to address concerns at the level of technical problem-solving (Brookfield, 1995; James & Clarke, 1994), in which case it may be difficult to distinguish one model of professional knowledge from the other. Reflection may also be used in such a way that it becomes another technology (Boud & Walker, 1998; Rolfe, 2002). Reflective practice as a model of professional knowledge is challenged by the evidence-based practice movement in healthcare (Rolfe & Gardner, 2005). The knowledge derived from reflecting in and on practice is considered inferior as a source of evidence for practice when compared to the evidence derived from scientific research studies. Reflective practice is also criticised for not having evidence of its effectiveness in nursing education and practice (Atkins & Murphy, 1993; Carroll et al., 2002; Nicholl & Higgins, 2004).

Many of the arguments and binary oppositions emanating from the nursing literature on reflective practice may be viewed as bearing on the identity of nursing as art or science, which was alluded to in the introductory comments of this chapter. Those who seek a clear, univocal definition of reflection and

reflective practice, who identify reflection as a cognitive skill relevant to the process of technical problem-solving, and as a competence that can be taught and assessed against measurable outcomes employing models and mechanisms, and researched using scientific method, may be considered advocates of nursing as science, interpreting reflective practice as a science of practice. They may be contrasted with those who reject this view of reflective practice, seeing it instead as representing the art of practice, indefinable, non-rational, non-linear, holistic, emancipatory, to be judged on its own merits and not against some pre-established criterion. In the case of reflective practice as a model of nursing knowledge, these '*warring forces of signification*'(Derrida, 2004a, xv, Translator's introduction) may be indicative of nursing's uncertain and divided identity as a discipline. But can such binary oppositions be sustained by a close reading of the texts wherein such arguments are constructed? This question will be addressed in the analysis chapters of the thesis.

1.7 Deconstruction

A number of features of reflective practice as a model of professional knowledge in nursing education recommend a deconstructive reading, namely, the instability of meaning and the binary oppositions identified in the nursing literature. When meaning is unclear or contested in respect of any concept, it prompts a consideration of how meaning is constructed. Meaning is a function of the language system. Knowledge in any domain is linguistically mediated (Peters & Biesta, 2009). By examining the language in which a knowledge claim is constructed, the possibility of new insights arises. Because language is a system of arbitrary and conventional signs, it is never fully within the control of the individual speaker or writer (Bally, Sechehaye, & Riedlinger, 1986). When the same word or signifier is used to signify in many different and contrary ways, something important may be at stake (Culler, 2008). Western thought is structured by binary oppositions (Derrida, 1997), which, as indicated above, privilege one term over its opposite by regarding the first term as standard or normal while its opposite is considered a corruption of, or deviation from, the

standard. Thought structured in this way has a long tradition. Plato, for example, privileged knowledge (episteme) over opinion (doxa); the former was considered good while the latter was regarded as suspect. Saussure, however, demonstrated that, in language, there are no positive terms; there are only differences. Each term, therefore, requires its binary opposite in order to produce meaning.

> *...signs signify not as independently meaningful units corresponding to external objects but as elements whose value is generated by their difference from neighbouring elements in the system. Saussure put forth a notion of* ***difference*** *(not identity) as the origin of meaning* (Johnson, in Lentricchia & McLaughlin, 1995, 41). (Johnson's emphasis).

How is reflective practice knowledge claimed as science or art or both in the texts that present such arguments? What resources of language - rhetorical, grammatical, syntactical, and so on – are deployed to construct the entity and persuade the reader of a particular meaning? To address such questions, a close reading of texts is required; a reading not for 'what' a text means in the sense of a single, univocal meaning discernible behind a surface structure, but for 'how' a text means (Johnson, 1980). Deconstruction is a strategy of close reading that facilitates this kind of analysis. Rather than look through or past language for and at meaning, deconstruction examines the language in which meaning is constructed and how meaning is thereby achieved. As Graff (in Lentricchia & McLaughlin, 1995, 171) remarks of literary texts: *' if the authority of the expressed "truths" depends not on their correspondence with some reality but only on the coercive power of language'*, then any claim to a truth that transcends language is rendered doubtful.

Since all texts are constructions it is possible for them to be de-constructed. *'...the word "de-construction" is closely related not to the word "destruction" but to the word "analysis", which etymologically means "to undo" – a virtual synonym for "to de-construct'"* (Derrida, 2004a, xv, Translator's introduction). It is also closely related to the word 'critique', not critique in the negative sense as criticism of a

text and suggestions as to how it could be improved, but critique as questioning the conditions of possibility for the existence of any system.

> *Every theory starts somewhere; every critique exposes what that starting point conceals, and thereby displaces all the ideas that follow from it. The critique does not ask "what does this statement* ***mean****?" but "where is it being made from? What does it presuppose? Are its presuppositions compatible with, independent of, and anterior to the statement that seems to follow from them, or do they already follow from it, contradict it, or stand in a relation of mutual dependence such that neither can exist without positing that the other is prior to it?"* (Derrida, 2004a, xvi, Translator's introduction) (Translator's emphasis).

To deconstruct is not to clear up the confusions and remove the paradoxes that a textual construction reveals. Rather, to deconstruct is to demonstrate the inability of an author to achieve their stated intentions within a text. A deconstructive reading illustrates how language used to convey meaning is, at least partially, beyond the ability of an author's intentions to control. Those who take a deconstructivist approach to text analysis focus upon '*the instability of linguistic meaning and the contradictions of conceptual thought...*' (McPheron, 1998, cited in Peters & Biesta, 2009, 50).

Johnson (1995) suggests that re-reading texts that have made a difference to some aspect of our world, and doing so in a deconstructive way, may make it possible to recognise contradictions, repressions, uncertainties, and ambiguities, even in those texts that appear most lucid. To do so is not to dismiss the texts or the values reflected in them but '*rather to see them in a more complex, more* ***constructed****, less idealised light*' (Johnson, 1987, xviii) (Johnson's emphasis). The inherent instability of language and meaning allows marginalised voices to enter a text at those points where the author tries to dominate and exclude, so that other claims can be made and other identities asserted (Johnson, in Lentricchia & McLaughlin, 1995). Deconstruction is not a method that is applied to a text from the outside, as it were. Deconstruction is always and already at work in a text (Weber, 1995).

The aim of a deconstructive reading is to reveal that process. Derrida (1977, 141) states that *'Deconstruction does not exist somewhere, pure, proper, self-identical, outside of its inscriptions in conflictual and differentiated contexts; it "is" only what it does and what is done with it, there where it takes place'*. Deconstruction may be described as a strategy of reading that produces rather than protects. The reader is not the passive decoder of an author's intention. Critical reading produces another text which contributes another perspective to the entity under consideration. *'The reader's task is to read what is written rather than simply attempt to intuit what might have been meant'* (Johnson, in Lentricchia & McLaughlin, 1995, 46).

1.8 Deconstruction and reflective practice

As touched upon earlier in the chapter, some resemblances or similarities may be noted between deconstruction and reflective practice. Reflective practice searches out and subjects to scrutiny all assumptions and presuppositions (Brookfield, 1995) that underpin any practice. At its most radical, reflective practice may precipitate a revolution in thinking and action, what Mezirow (1990, 7) denotes as perspective transformation or *'Transformative learning'*. Transformative learning occurs as we become aware not only of what we think and of what we think of what we think, but also aware of how we think and how thinking in that way has been made possible by our particular culture and socialisation. Reflection, and what some authors refer to as critical reflection, is directed at such perspective transformation (Mezirow, 1990). Both deconstruction and reflective practice are characterised by uncertainty and movement. Both activities are concerned to find new ways of envisioning existing realities, working with what is given without accepting that any situation is closed (Caputo, 1997). Deconstruction also aims at developing something new, a new determination of a given concept (Caputo, 1997). Deconstruction as critique shakes up or de-stabilises what we take for granted, thus making more things available to critical scrutiny (Peters & Biesta, 2009), enabling us to look at things and understand concepts differently. Howells (1998, 70) maintains that *'constant reviewing of the most seemingly unquestionable*

assumptions is vital to any healthy intellectual life'. Reflective practice, which demands that practitioners ask searching questions of themselves and their practice in pursuit of knowledge, cannot itself be exempted from the same kind of analysis.

Both reflective practice and deconstruction share an ethical dimension. Of deconstruction, Caputo (1997, 123) states:

> *The affirmation of "responsibility", "ethics", "decision" - ...- will never be a matter of knowledge* (Refs), *of a determinable program, a knowable plan, of planning ahead, but of a generosity, a gift that gives itself without return – whenever it is called for, whenever the occasion calls for it.*

In providing individualised care to service users, nurses frequently have to respond to unique situations which could not have been foreseen. Appropriate responses must be constructed from the elements of the unique situation. These are the kinds of situations, Schön (1983) claims, that cannot be responded to with a rule or procedural technique, as would be the case if practice were underpinned by the model of technical rationality. There may be conflicting values at play. Such situations require the practitioner to reflect-in-action, drawing upon and integrating particular contextual features, self-knowledge, knowledge of the patient and the patient's value system, as well as the ethical codes and guidelines that govern the profession. At the same time, the nurse must be able to account for her actions to the service user, her colleagues, and her professional body. She must be seen to be acting in the best interests of the client. Sometimes, however, it is not easy for nurses to explain the rationale for their actions and responses, in particular, the knowledge upon which such actions and responses are based.

An effort to know and understand reflective practice as a model of professional knowledge in nursing more fully, and to account for the variations in understanding and attitude that the concept appears to stimulate among nurses, and in the nursing literature, prompted me to consider a close reading of the texts in which meaning is constructed. Deconstruction is a method of close reading,

although the word "method" in the context of deconstruction requires some qualification. This issue will be explored more fully in Chapter 4.

I was intrigued by the underlying similarities between reflective practice and deconstruction. Deconstructing reflective practice would not only assist me to understand reflective practice as a model of professional knowledge in nursing education more fully, but might also help me to reflect better.

1.9 Conclusion

Reflective practice has been widely adopted within nursing education as a model of professional knowledge. Its appeal lies in the challenge it poses to the traditional dominant model of professional knowledge which tends to exclude or disregard phenomena of importance in practice disciplines. In the context of nursing, such phenomena include caring and therapeutic relating. Reflective practice raises the possibility of developing a body of knowledge that develops from practice and is unique to nursing. At the same time, reflective practice is a fuzzy concept with many different meanings articulated within the nursing literature. As a practice, it shares many similarities with deconstruction. Both defy stable definition and conceptual clarity. Both are aimed at breaking open existing totalities and uncovering hidden assumptions, enabling new possibilities for action. Both are responsible, ethical practices. The aim of this study is to engage in a deconstructive reading of texts that articulate reflective practice as a model of professional knowledge in nursing education.

The following chapter provides an account of the various movements in the development of professional knowledge in nursing education and how such knowledge has been conceptualised over time.

Chapter 2 Theoretical framework

2.1 Introduction

The knowledge needed for the practice of nursing has long been a contested and divisive issue in nursing education. Throughout its history, as nursing moved from an untrained occupation populated by women of dubious moral character (McKenna, 1997) through vocational training with a strong religious influence (Abel-Smith, 1960) to its current status as an all-graduate profession, the knowledge base appropriate to nursing practice has been a source of on-going debate and disagreement. As alluded to in the previous chapter, with the establishment of formal training for nurses in the mid to late nineteenth century, moral character and virtue were regarded as of equal, if not greater, importance as scientific knowledge and practical skills in the apprentice nurse. These elements still form the basis of the graduate nursing qualification, although scientific knowledge is arguably accorded greater significance and prominence in nursing curricula than moral character. However, debate still centres on the priority accorded to the various elements of professional knowledge, the methods appropriate to generating nursing knowledge, and what should constitute a knowledge base unique to nursing. The aim of this chapter is to explore the issue of professional knowledge in nursing and to examine the role and potential that has been attributed to reflective practice as a model of professional knowledge for the discipline. Professional knowledge in general is first outlined. This is followed by a discussion of professional knowledge in the context of nursing from a diachronic or historical perspective. Reflective practice as a model of professional knowledge is then addressed. The chapter concludes with a consideration of reflective practice as a model of professional knowledge in nursing education.

2.2 Professional knowledge

Professional knowledge is recognised as a complex issue. Attempts to characterise the knowledge base required for professional practices in general have been made. Broadly, professional knowledge is categorised as consisting of two kinds: propositional and practical knowledge (Eraut, 1994, Heilbronn, 2008). The former is also referred to as theoretical knowledge and the latter as procedural knowledge. Propositional knowledge is further distinguished by Heilbronn (2008) as consisting of theoretical and technical knowledge. In highly skilled professional practices, technical knowledge is '*essential to practice in an immediate way, whereas theoretical knowledge is not*' (Heilbronn, 2008, 71). Luntley (2010), however, argues that propositional and theoretical knowledge are not synonymous. Propositional knowledge consists not only of theoretical propositions which can be fully articulated in textbooks but also consists of propositions '*the content of which is intrinsically embedded in the knowing subject's engagement with her environment*' (Luntley, 2010, 23). Whereas the meaning of a theoretical proposition may be captured completely in language, the meaning of other propositions depends not only on the words used but also on '*perceptual engagement by which you focus on what is picked out by a demonstrative phrase*' (Luntley, 2010, 23). The conclusion drawn from Luntley's (2010, 22) theory of '*epistemic conservatism*' is that there is no need to posit different kinds of professional knowledge since all such knowledge may be understood as propositional.

Eraut (1994) describes propositional knowledge as knowledge that enables professional action, and practical knowledge as inherent in and inseparable from the action itself. Whether and how practical knowledge relates to theoretical knowledge in professional practice is the subject of much debate within professional education. In the context of philosophical argumentation, Ryle (1949, 28) draws a distinction between what he calls '*knowing how*' and '*knowing that*'. Arguing that skilful performances '*display qualities of mind yet are neither themselves intellectual operations nor yet effects of intellectual operations*', Ryle

(1949, 27) asserts: '*Intelligent practice is not a step-child of theory*'. One may have a great deal of propositional knowledge or '*knowing that*' about any number of practice areas, yet be unable to perform intelligently in those areas. Equally, Ryle (1949) contends, the exercise of skilful action does not require the presence in the mind of propositional knowledge, whether the activity in question is physical or mental. Ryle (1949) does not deny that propositional knowledge is required in order to practice intelligently; what he does dispute is that intelligent, skilful performance is dependent upon appropriate theorising:

> *A man knowing little or nothing of medical science could not be a good surgeon, but excellence at surgery is not the same thing as knowledge of medical science; nor is it a simple product of it. The surgeon must indeed have learned from instruction or by his own inductions and observations, a great number of truths; but he must also have learned by practice a great number of aptitudes. Even where efficient practice is the deliberate application of considered prescriptions, the intelligence involved in putting the prescriptions into practice is not identical with that involved in intellectually grasping the prescriptions* (Ryle, 1949, 48-49).

Ryle's (1949) thesis would suggest that, for practice disciplines, '*knowing how*' is of equal, if not greater significance, than '*knowing that*'. It also suggests that knowledge inherent in skilful action is of a different order to propositional knowledge; the former cannot simply be 'read off', nor is it reducible to, the latter. Given this difference in kind, it follows that the methods used to generate and acquire practical knowledge must also differ from methods used to generate and acquire propositional knowledge. Ryle's (1949) ideas lend support to the argument for the development of reflective practice as a model of professional knowledge which will be discussed later in this chapter.

Professional education in practice disciplines consists, generally, in the communication of a body of theoretical and scientific knowledge and techniques coupled with periods of supervised work experience in the relevant domain of practice, during which time formal learning is applied and the norms of the

discipline are acquired. This model of professional education is referred to as a 'technical rational' approach (Schön, 1983). It has given rise, in some professions, to what has become known as a theory-practice gap. A theory-practice gap refers to the disparity between the formal propositional knowledge of a discipline and the knowledge relevant to, and utilised in, practice. Heilbronn (2008) acknowledges that the relationship between these kinds of knowledge is complex. In terms of professional practice, it is recognised that theoretical ideas, even when they are relevant in practice, cannot simply be applied without considering their implications. Ideas, also, get reinterpreted in use, and may need to be used before they acquire meaning for the user (Eraut, 1994). This suggests that propositional knowledge is subject to some kind of transformation in practice and part of that transformation involves appropriation by the knowledge user. Referring to teacher knowledge, Heilbronn (2008, 73) states: *'In practice, how an individual teacher believes what she has read and is told is also influenced by her own personal experience, including her own observations and discussions with other teachers'.* Even technical knowledge, a kind of propositional knowledge with a more immediate relationship to practice, does not necessarily imply successful action based on such knowledge (Heilbronn, 2008).

Moon (1999), citing the work of Argyris and Schön (1974), suggests that propositional knowledge is bypassed in practice. Contrasting *'espoused theories'*, which describe the official theories that characterise a discipline publicly and are taught to aspiring practitioners, and *'theories-in-use'*, which refer to unofficial theories developed in practice, Moon (1999, 40) asserts that it is the latter *'that characterise the real behaviour of professionals'*. Citing Brookfield (1987), 'theories-in-use' are described *"as guiding the 'intuitively based activities' that are 'privately developed, proven ways of performing that are contextually specific, idiosyncratic and unmentioned in textbooks of professional practice'"* (Moon, 1999, 40). The development of theories-in-use signals a gap between formal propositional knowledge and professional practice. It also indicates the existence of a body of theory originating in practice.

The theory-practice gap may be understood in terms of particular features of professional practice that render problematic the use of propositional knowledge. A certain degree of unpredictability and uncertainty characterise most professional occupations (Eraut, 1994). As the aim of scientific theory and research is to accrue abstract, objective knowledge that seeks to explain, predict and control the domain of interest, it is inevitable, perhaps, that propositional knowledge will not always appear relevant in particular practice situations. Practice problems do not present neatly packaged and instantly recognisable (Schön, 1983; Eraut, 1994; King & Kitchener, 1994; Heilbronn, 2008). This indicates the limitations of purely applied scientific knowledge and techniques in making decisions about individual cases. Professional work is also characterised by the ability to handle cases quickly and effectively. Professional or practical judgement is acknowledged as important in these situations (Eraut, 1994; Heilbronn, 2008; King & Kitchener, 1994). Such judgement is assumed to be informed by personal experience of large numbers of cases. Much professional know-how is implicit in, and derives from, experience (Eraut, 1994; Heilbronn, 2008). Eraut (1994) contends that there are important aspects of professional competence and expertise that cannot be represented in propositional form and made publicly accessible. This has implications for professional education and for the development of disciplinary knowledge.

2.3 Professional knowledge in nursing

The question of what kind of knowledge is needed for nursing practice is described by Marriner Tomey & Alligood (2006, 5) as '*the pervading question*' that has occupied nursing theorists and scholars throughout the history of modern nursing. Nightingale, acknowledged as one of the earliest nursing theorists, emphasised the importance of the patient's environment in nursing practice (Carroll, 1992; van der Peet, 1995). Although she distinguished nursing from medical knowledge, asserting that the role of the physician is to cure disease while the role of nursing is to ensure that the patient's environment, in terms of cleanliness, lighting, ventilation, and so on, is such as to maximise the reparative powers of nature, she

also emphasised the importance of obedience to physicians' orders (Alligood & Marriner Tomey, 2006; Carroll, 1992; Maggs, 1983).

Under the apprenticeship system of training, which dominated in the UK and Ireland until the final decades of the 20th century, nursing education was hospital-based. As indicated in the introductory chapter, in hospitals, service needs took precedence over the education needs of nursing students. Nursing practice tended to follow a medical model of care which was oriented toward the diagnosis, treatment, and cure of bodily diseases (McKenna, 1997; Pearson, Vaughan, & FitzGerald, 2005). Student nurses acquired most of the knowledge that they needed to nurse from their experiences in practice. They were, therefore, equipped with considerable practical knowledge or 'know-how'. As nursing education progressed, practical experience was complemented by lectures in classroom settings frequently provided by medical practitioners. The goal was to ensure that nurses had the necessary knowledge to care for patients with medically diagnosed conditions.

As nursing began the process of establishing itself as a discipline and as a profession, the question of nursing knowledge became central. A discipline is defined by its domain of knowledge (Meleis, 2012), and one of the defining characteristics of a profession is the possession of a body of specialised knowledge and skill. Marriner Tomey & Alligood (2006, 5) remark of this period:

> *Although some nursing leaders aspired for nursing to develop as a profession and an academic discipline, nursing practice continued to reflect a vocational heritage more than a professional vision. The transition from vocation to profession included successive eras of history as nurses searched for a body of substantive knowledge on which to base nursing practice.*

The transition of nursing education from hospitals to tertiary education settings occurred in the United States of America in the early and middle decades of the 20th century. Research became a feature of graduate and post-graduate nursing

programmes. However, the search for a substantive body of nursing knowledge required more than just research.

> *With an increased understanding of research and knowledge development, it soon became obvious that research without theory produced isolated information, and it was research and theory together that produced nursing science* (Marriner Tomey & Alligood, 2006, 4-5).

The middle and later decades of the 20th century in the United States witnessed the growth of conceptual models in nursing education, with the aim of articulating the domain of nursing thus providing a focus for research and an overarching framework for knowledge development, and, ultimately, a guide to practice. This view of knowledge owes much to the traditional or '*received view*' of science current at that time: '*unique high-level concepts (conceptual models) are necessary to distinguish scientific domains*' (Risjord, 2010, 115). Four high-level concepts were identified as relevant in nursing science: person, environment, health, and nursing. These four concepts constituted the '*metaparadigm*' of nursing (Fawcett, 2005, 5), which Risjord (2010, 26) describes as '*the phenomena to be studied by any research and theory that was rightly considered part of the nursing discipline*'. The conceptual models developed in nursing consisted of sets of statements or propositions regarding each of the four metaparadigm concepts and the relationships between them. Nursing was conceptualised as a domain much broader than that envisaged by the medical model of care. The person receiving care rather than the disease process became central in nursing theory. The concept of holism, which acknowledges that the recipient of nursing care is more than a biological being but also a social, psychological, and spiritual being, was also an important dimension of nursing theory (McKenna, 1997). Nursing practice was described in terms of an interpersonal process with the relationship between the nurse and the patient of particular significance (Marriner Tomey & Alligood, 2006; McKenna, 1997).

Conceptual models were highly abstract and considered to be at the level of 'grand theory'. Less abstract levels of theory from which testable hypotheses could be generated were developed. It was recognised that these so-called 'middle range theories' (Fawcett, 2005) should be derivable from grand theory so that nursing knowledge did not become fragmented. By testing mid-range theories, it was possible to develop a cumulative body of knowledge unique to the discipline of nursing which could form the basis for nursing practice.

> *Mid-range theory tends to focus on concepts of interest to nurses. As well as pain, these include empathy, grief, self-esteem, hope, comfort, dignity, quality of life* (McKenna, 1997, 114).

The discipline of nursing would thereby advance along scientific lines. Nursing science would contribute propositional knowledge or 'knowing-that'.

> *Nurse scholars were encouraged to formulate their theories in terms distant from the contingencies of practice. There was no need to work directly with clinical concerns. Theory came first; application was left for the future. As a result, nurses at the bedside saw theory and research drift farther and farther apart from clinically accessible anchor points* (Risjord, 2010, 27).

By contrast, practice theory, which was oriented toward developing principles of practice or prescriptions for nursing action, was advocated by some nursing theorists at that time as an approach to knowledge development that would have its focus in the clinical concerns of nurses (McKenna, 1997). This approach was not widely accepted because of fears that developments in nursing knowledge would lack unity (Risjord, 2010). Borrowed theories, that is, theories borrowed from other disciplines such as, for instance, psychology, were considered for a time to be an appropriate knowledge base for nursing. Some borrowed theories proved helpful in understanding certain clinical phenomena (Chinn & Kramer, 2004). However, it was also recognised that theories developed in and for other disciplines, if adopted uncritically in nursing, could distort nursing's unique perspective. In terms of the development of a unique knowledge base, borrowed

theories were not adequate. Even though such theories could undergo some modifications to fit a nursing context, they could never provide a uniquely nursing focus (Fawcett, 2005).

The advancements in nursing theory that occurred in the United States influenced nursing education in the UK and Ireland to the extent that nursing models became part of curriculum content in the 1970s and 1980s. At this time, nursing education was still, largely, a hospital-based apprenticeship system of training. However, the Briggs Report (Briggs, 1972) and the Report of the Commission on Nursing Education (RCN, 1985) recommended fundamental changes to nursing education, including a decoupling of education and service, the development of nursing as a research-based profession, and the establishment of nursing education fully within tertiary education settings. While these changes did not begin to take effect until the late 1980s and early 1990s with the implementation of Project 2000 (UKCC, 1986), the deficiencies of the medical model as a framework for nursing knowledge and the inadequacy of task allocation as a model of care delivery to explain nursing practice were well recognised among nurse educators (Roper, Logan, & Tierney, 2003). However, theoretical developments in nursing in the United States did not transfer very successfully to the British system. The language in which theories were framed was frequently obscure and convoluted (McKenna, 1997; Risjord, 2010), and seemed to have little relevance to nursing as it was practised in the UK at that time. Even 'home grown' theories did not find favour with the majority of nurse practitioners. The development of nursing models and frameworks occurred in academic settings and were undertaken by nurses engaged primarily in nursing education (Meleis, 2012; Roper et al., 2003). Such developments were frequently regarded with scepticism by practising nurses and as an additional task imposed upon them by those who had little understanding of busy practice settings and the realities of clinical work.

> *For many nurses and students of nursing, nursing theory and the development of nursing models often seem to have little relevance to the complexities of the contemporary health system.*

> *...Nursing is essentially a practice; it is primarily concerned with the frontline delivery of health care to individuals and communities. Because of this practical imperative of nursing, its theoretical base is frequently, at worst, denied or, at best, forgotten. At its simplest level 'nursing theory' used to mean those things about nursing work which were taught in the classroom, and this meaning is still commonly held by many in nursing today* (Pearson et al., 2005, 2).

Alluding to more recent times, Risjord (2010, 3) remarks:

> *Working nurses do not seek out the most recent research results or use nursing theories to analyse their responses to the patient. Indeed, the mention of "theory" is likely to elicit groans from a practicing nurse. Nursing theory and research are not supporting the professional practice of nursing in the way that nurses expect it to.*

The above assertions testify to the long standing issue of a theory-practice gap in nursing. Developments in nursing knowledge, like all disciplines, are influenced by developments in philosophy of science. The challenge to the positivist view of science by philosophers such as Popper and Kuhn, and the development of alternative approaches to research affected how nursing as a discipline was viewed. Traditional scientific approaches to knowledge development - the methods appropriate to investigating the natural sciences - stressed objectivity and detachment on the part of the researcher. These methods were not considered appropriate for the study of the human sciences. Nursing, as a human science, was concerned with the individual person and with the nurse-patient relationship as the vehicle of nursing care. Qualitative research methodologies, in particular interpretivist approaches, in which theory was inductively developed and which enabled the investigation of phenomena considered central to nursing, seemed much more compatible with nursing than traditional scientific method.

> *To many nursing researchers in the late 1970s and early 1980s, qualitative research seemed to be exactly the new form of science for which Watson*

(nursing theorist) *was calling. One of the earliest and most important inspirations for methodological reflection on qualitative methods was phenomenology (Bogdan & Taylor, 1975; Paterson and Zderad, 1976). Nursing discussions of this early twentieth-century school centred on the work of Edmund Husserl, Martin Heidegger, Jean-Paul Sartre, and Maurice Merleau-Ponty. They emphasized both the subjective character of experience and the importance of appreciating subjective experience when understanding other people. Qualitative research was thus said to be subjective, rather than objective, value-laden rather than value-free, engaged rather than detached, and so on. The nice fit between qualitative methodology and nursing practice promised a form of nursing theory that would be more congruent with the goals and practices of nursing than the previously dominant forms of research (Lenninger, 1985; Duffy, 1986, 1987b; Moccia, 1988)* (Risjord, 2010, 190).

Despite its congruence with nursing and the above assertion of qualitative research as a new science, it was not considered scientific in the sense of the cumulative development of a body of disciplinary knowledge. The so-called 'paradigm wars' ensued in nursing between those who regarded nursing as a scientific enterprise and those who argued that scientific method was incommensurable with nursing as a unique discipline (Parahoo, 2006).

The publication of a paper by Barbara Carper in the inaugural issue of a journal entitled '*Advances in Nursing Science*' in 1978 is considered a seminal event in terms of clarifying the knowledge base of nursing. Carper (1978, 13) identified four '*fundamental patterns of knowing*' in nursing. Introducing the four patterns, Carper (1978, 13) stated:

It is the general conception of any field of inquiry that ultimately determines the kind of knowledge the field aims to develop as well as the manner in which that knowledge is to be organized, tested, and applied. The body of knowledge that serves as the rationale for nursing practice has patterns, forms and structure that serve as horizons of expectations and exemplify

> *characteristic ways of thinking about phenomena. Understanding these patterns is essential for the teaching and learning of nursing. Such an understanding does not extend the range of knowledge, but rather involves critical attention to the question of what it means to know and what kinds of knowledge are held to be of most value in the discipline of nursing.*

The four patterns identified by Carper (1978) were empirics, aesthetics, ethical, and personal knowing. Empirical knowing refers to the scientific basis of nursing, and included the conceptual models already developed and developing at that time. Carper (1978, 14) acknowledged that there was '*a critical need for knowledge about the empirical world, knowledge that is systematically organised into general laws and theories for the purpose of describing, explaining and predicting phenomena of special concern to the discipline of nursing*'. For Carper (1978), the extant conceptual models and theories provided new ways of looking at phenomena of interest in nursing, and new perspectives from which to conduct research. The empirical pattern of knowing in nursing is summarised by Carper (1978, 15) as follows:

> *...the first fundamental pattern of knowing in nursing is empirical, factual, descriptive and ultimately aimed at developing abstract and theoretical explanations. It is exemplary, discursively formulated and publicly verifiable.*

It might appear that the above extract could have described the sum total of nursing knowledge. Carper (1978, 16) acknowledges as much when she states:

> *Few, if indeed any, familiar with the professional literature would deny that primary emphasis is placed on the development of the science of nursing. One is almost led to believe that the only valid and reliable knowledge is that which is empirical, factual, objectively descriptive and generalizable. There seems to be a self-conscious reluctance to extend the term knowledge to include those aspects of knowing in nursing that are not the result of empirical investigation.*

Carper's (1978) identification of three other equally valid patterns of knowing marked her paper as ground-breaking and seminal for nursing. The aesthetic pattern of knowing describes the art of nursing which is not equivalent to technical and psychomotor skills. Indeed, Carper (1978) attributes the failure to articulate the art of nursing as a pattern of knowing to efforts to distance nursing from its origins in apprenticeship training, where practice consisted of rituals and routines not linked to any knowledge base. Unlike empirics, the art of nursing cannot easily be discursively formulated. The aesthetic pattern of knowing includes flexibility in the design of nursing care, creativity in the helping relationship, the ability to relate to the care recipient as a unique human being, and the perception and appreciation of wholeness.

> *The esthetic* (sic) *pattern of knowing in nursing involves the perception of abstracted particulars as distinguished from the recognition of abstracted universals. It is the knowing of a unique particular rather than an exemplary class* (Carper, 1978, 18).

Personal knowing is the third pattern identified by Carper (1978, 17) and is, she maintains, '*the most problematic*' to articulate and teach. It is concerned with self-knowledge and the development of therapeutic relationships. It involves commitment and risk on the part of the nurse, the risk of being fully human and authentic in the encounter with a patient. Personal knowing requires '*willingness to accept ambiguity, vagueness and discrepancy of oneself and others*' (Carper, 1978, 19). Reconciling the potential conflict between the empirical pattern of knowing, which deals in generalisations and predictions, and the personal pattern, which stresses authenticity and subjectivity, Carper (1978, 19-20) states:

> *Certainly empirical knowledge is essential to the purposes of nursing. But nursing also requires that we be alert to the fact that models of human nature and their abstract and generalized categories refer to and describe behaviours and traits that groups have in common. However, none of these categories can ever encompass or express the uniqueness of the individual encountered as a person, as a "self". These and many other similar considerations are involved in the realm of personal knowledge, which can be*

broadly characterized as subjective, concrete and existential. It is concerned with the kind of knowing that promotes wholeness and integrity in the personal encounter, the achievement of engagement rather than detachment; and it denies the manipulative, impersonal orientation.

Ethical knowing is the fourth and final pattern of knowing in nursing identified by Carper (1978). Ethical knowing encompasses more than knowledge of ethical theories and codes of professional conduct; it also includes matters of obligation and concern regarding the choice of morally appropriate action in particular situations, especially where a conflict of values may pertain.

Although each pattern of knowing is separate, Carper (1978, 22) considers all four to be '*interrelated and interdependent*'. For example, she maintains: '*Personal knowledge is essential for ethical choices in that moral action presupposes personal maturity and freedom*'. Each pattern is '*necessary for achieving mastery in the discipline, but none of them alone should be considered sufficient*', (Carper , 1978, 21-22). It was recommended that each pattern of knowing '*should be taught and understood according to its distinctive logic, the restricted circumstances in which it is valid, the kinds of data it subsumes and the methods by which each particular kind of truth is distinguished and warranted*' (Carper, 1978, 22). Carper did not elaborate any further on these matters. Although the logic, data and methods of empirical knowing were quite well established, there was less clarity regarding the logic, data and methods by which warrantable knowledge in the three other patterns of knowing might be generated. From the descriptions given of aesthetic, personal and ethical patterns of knowing, it is clear that experience is a prerequisite of knowledge generation. These patterns cannot be acquired and expressed apart from practice experience. Knowing in the personal domain, for example, is predicated on the notion of 'encounter', and interpersonal contact. Likewise, aesthetic knowing requires engagement in a specific clinical situation. Although Carper (1978) appears to use the terms 'knowing' and 'knowledge' interchangeably, Chinn & Kramer (2004, 2) later distinguished between these two terms:

> *The term **knowing** refers to ways of perceiving and understanding the self and the world. Knowing is an ontologic, dynamic, changing process. The term **knowledge** refers to knowing that is in a form that can be shared or communicated with others.* (Chinn & Kramer's emphases).

This way of distinguishing 'knowing' and 'knowledge' resonates with the differentiation Schön (1983) draws between 'knowing-in-action' and 'knowledge-in-action', which will be discussed later in the thesis. The pursuit of knowledge using Carper's (1978) fundamental patterns '*leads nursing away from "a quest for structural truth and towards a search for dynamic meaning'*" (White, 1995, 79, citing Jacobs-Kramer & Chinn). The 'being' of knowing is movement and change. 'Knowing' and a perceiving, understanding self in the world are inextricable.

Like Schön's (1983) work in the following decade, Carper's (1978) patterns of knowing were highly influential in how nursing knowledge was conceptualised and understood. Her ideas have been widely developed and accepted by nursing scholars as illustrative of a comprehensive knowledge base necessary for holistic nursing practice (Bonis, 2009; Chinn & Kramer, 2004; Heath, 1998; Hunter, 2008; Johns, 1995a). Carper's (1978) original model has been expanded to include two new patterns. White (1995) considered that the wider context in which nursing is practiced constitutes an important pattern of knowing. While Carper's (1978) patterns focused on the interpersonal context of nursing – the relationship between the patient and the nurse, and the immediate context of care – socio-political knowing:

> *...lifts the gaze of the nurse from the introspective nurse-patient relationship and situates it within the broader context in which nursing and health care take place. It causes the nurse to question the taken-for-granted assumptions about practice, the profession, and health policies* (White, 1995, 82).

Knowledge in this domain requires that nurses become politically engaged, recognising and challenging health inequalities, and those social and economic structures that adversely affect the wellbeing of citizens. It also requires nurses to

become active and influential in policy formulation and strategic decision-making in health-related matters. Socio-political knowing enables a change in the public perception of nurses and nursing, so that the caring role is seen to encompass political activism as well as the more traditional view of nursing as caring in an interpersonal context (White, 1995). Knowledge in this pattern cannot be described or developed apart from a context.

Unknowing is another pattern that extends Carper's (1978) original four fundamental patterns of knowing in nursing. Unknowing is described as '*a condition of openness*' (Munhall, 1993, 125), meaning that a nurse retains a readiness to be continually surprised and informed. Knowledge is never considered final. The nurse is aware of and recognises that her perspective is but one way of seeing a situation and is willing to consider different views on the same situation. Balancing and integrating the various patterns of knowing in the context of care requires skill and judgement on the part of the nurse. It was recognised that such skill and judgment is deployed by nurses in their professional role (Chinn & Kramer, 2004; Risjord, 2010). It was also recognised that this kind of knowledge was not explicit nor was it acquired by the usual transmission methods. Practice once again became an area of interest in the context of professional knowledge in nursing.

The next ground-breaking and seminal development in nursing knowledge came in 1984 with the publication of Patricia Benner's textbook '*From Novice to Expert. Excellence and Power in Clinical Nursing Practice*'. The book was the outcome of a substantial research study undertaken by Benner (1984) with the aim of investigating the perceived theory-practice gap in nursing. The study occurred at a time when the focus in nursing education in the United States and elsewhere was on technical competence which, it may be recalled from the earlier part of this chapter, is a kind of propositional knowledge applied to practice situations. Benner (2001, ix) describes the technical competence approach to nursing education as:

> *... designed to prespecify learning outcomes in well-defined behavioural objectives. The assumption was that both learning and nursing practice could be reduced to a collection of techniques. A technical understanding of nursing was rampant within both nursing education and practice. The phrase* ***technical understanding*** *refers to an assumption that all action can be determined through explicitly stated theories and directives. The original goal behind this research was to address the theory-practice gap. Instead, this research revealed many gaps between excellent practice and extant theoretical accounts of nursing practice. Nursing practice is far more complex than what most formal nursing theories predict.* (Benner's emphasis).

Benner (1984) made nursing practice the focus of her investigations, and the kinds of knowledge used by nurse practitioners at different stages of their professional development. In the foreword to the commemorative edition of her book published in 2001, Benner (2001, v) describes the aim and reception of her research as follows:

> *The goals of the work were to study experiential learning in nursing practice, examine skill acquisition based on clinical learning, and articulate knowledge embedded in nursing practice...Readers comment that this work 'puts into words what they have always known but not been able to express about nursing practice' – a perfect compliment since this work seeks to give public, accessible language to a hidden or marginalised practice (i.e., articulation research).*

Using an interpretative hermeneutic approach with data drawn from nurses' detailed narrative accounts of actual experiences and events in practice situations and minimally-participant observations, Benner (1984) demonstrated that nursing knowledge is complex and multifaceted, evolving and transforming as nurses become more experienced in practice. She theorised that new learners, for example, first year student nurses, bring formal knowledge and theory to the clinical setting and they rely on this kind of knowledge as they gain practical

experience. As students or novice practitioners become more experienced, the knowledge they bring to situations, both formal knowledge and prior experience, is tested, challenged, and modified. Benner (1984, 8) gives the name "experience" to knowledge that has been so affected: *'As a nurse gains "experience", clinical knowledge that is a hybrid between naive practical knowledge and unrefined theoretical knowledge develops'*.

Benner (1984, 4) identified six areas of practical knowledge which she categorised as follows:

1) *graded qualitative distinctions;*
2) *common meanings;*
3) *assumptions, expectations, and sets;*
4) *paradigm cases and personal knowledge;*
5) *maxims; and*
6) *unplanned practices.*

'Graded qualitative distinctions' refer to a nurse's ability to recognise subtle changes in a patient's condition before objective evidence emerges. This kind of knowledge is context dependent in that nurses' ability to recognise subtle changes occurs in the context of knowing the individual patient, his/her past history, and current status. 'Common meanings' is a second area of practical knowledge which refers to general understandings that nurses acquire about health, illness, coping, and so on. These develop as a result of interacting with a variety of individuals and families in a variety of health and illness contexts over time. Common meanings that are shared among nurses become part of nursing tradition. 'Assumptions, expectations, and sets' describe the knowledge that arises from observing the trajectory of illnesses and recovery in many patients. This kind of knowledge predisposes nurses to act in certain ways in certain situations. 'Paradigm cases' are learning experiences of such significance that they act as exemplars for future similar cases. Paradigm cases provide knowledge that allows the practitioner to

grasp similar situations as perceptual totalities, which, in turn, guide action and allow for rapid responses. Personal knowledge, which consists of prior knowledge and individual attributes and dispositions, may be implicated in paradigm cases, which renders the knowledge complex and not easily identifiable. Benner (1984, 10) describes 'maxims' as *'cryptic instructions that make sense only if the person already has a deep understanding of the situation'*. She also identifies maxims as clues to *'particularly perceptual knowledge'* which, she claims, *'is cloaked in maxims'*. 'Unplanned practices' constitute the final area of practical knowledge. This kind of knowledge accrues from interventions or treatments delegated to nurses by physicians or other members of the healthcare team. As nurses observe, monitor, or otherwise manage the patient's care and treatment, experiential knowledge is gained.

Benner (1984) argued that much of the experiential knowledge outlined above is not recognised or publicly acknowledged. Consequently, it remains undervalued and under-researched with consequences for the development of nursing knowledge and theory. Part of the reason for its lack of visibility is that the nature and complexity of practical knowledge is difficult to formulate in terms of principles and procedures. Descriptions of subtle distinctions and holistic perceptual appreciations are more nuanced than any textbook account of illness or recovery can represent. Benner (2001, vi) also adds:

> (Nursing) *Practices cannot be completely objectified or formalized because they must ever be worked out anew in particular relationships and in real time.*

Collecting and comparing detailed narrative accounts of nurses' caring practices is suggested as a means of capturing complex, localised, practical knowledge.

> *In developing a narrative account of experiential learning, the storyteller learns from telling the story. Teaching reflection allows clinicians to identify concerns that organise the story; identify notions of good embedded in the*

story; identify relational, communicative, and collaborative skills; and articulate newly developing clinical knowledge (Benner, 2001, vii-viii).

Benner (2001) regarded her research as the basis of a movement in the direction of developing a body of practical knowledge in nursing. She encouraged nurses '*to collect their* ***own*** *exemplars and to pursue the lines of inquiry and research questions raised by their* ***own*** *clinical knowledge*' (Benner, 2001, xxvi) (Benner's emphases), which very much exemplifies Schön's (1983) notion of practitioners as researchers in their own practice contexts.

Benner's (1984) research identified the role of the nurse as consisting of seven domains of practice, and, in each domain, a variety of competencies were identifiable. Examples of the different domains of practice include '*The Helping Role*'; '*The Teaching-Coaching Function*'; and '*Effective Management of Rapidly Changing Situations*' (Benner, 1984, 46). The complexity of the helping role is evident in the following description:

> *Patients look to nurses for different kinds of help than they expect or receive from other helping professionals. Help seeking and help receiving are two different issues. A person can receive help without asking for it and can ask for it without being able to receive it. Even "help" sometimes does not help; some individuals with a strong need for personal control may not be able to acknowledge that they need help or even that they are being helped.*
> *Many of the nurses we interviewed seemed to be aware of the personal issues of receiving and seeking help. Sometimes they covered their help and concern for their patients with humor* (sic) *or an air of nonchalance* (Benner, 1984, 47).

In terms of Carper's (1978) and others' patterns of knowing in nursing, fulfilment of the helping role as articulated above would require knowing in all patterns, with, perhaps, greater demand in the areas of personal knowing and unknowing. Competencies, identifiable within the helping role of the nurse, include '*Presencing: Being with a Patient*', '*Maximising the Patient's Participation and Control in His or*

Her Own Recovery', '*Interpreting Kinds of Pain and Selecting Appropriate Strategies for Pain Management and Control*' (Benner. 1984, 50). These kinds of competencies cannot be adequately represented in technical terms nor fully specified in behavioural objectives. Benner (1984, 40) stresses the importance of '*exemplars*' in conveying the competencies of nursing practice. Exemplars are the narrative accounts of experienced nurses that serve to illustrate competencies. Practice knowledge cannot be adequately described without them. She urged nurses to record their practice, in particular those occasions where nurses believe their actions make a significant difference to patient outcomes. Scientific knowledge is not ignored in this process of knowledge generation. Benner (2001) argues that practical knowledge and 'know-how' is not reducible to acting on gut feeling or by trial and error. Nor is it reducible to psychomotor skills. Learning from experience is more effective and efficient when it is based on what Benner (2001, xxiii) calls '*...a sound educational base*'. Her work attempts to demonstrate the limits of that base and to indicate a body of knowledge that lies beyond and transforms it.

> *Attending to the particular contingencies of a situation does not warrant the conclusion that the general principles governing that situation can be generally ignored. My position is not a careless recommendation for the abandonment of rules. Instead, I am claiming that a more skilled, advanced understanding of the situation allows orderly behaviour without rigid rule following.*
>
> *Once the situation is described, the actions taken can be understood as orderly, reasonable behaviour that responds to the demands of a given situation rather than rigid principles and rules. More descriptive rules could be generated to allow for multiple exceptions, but the expert would still function flexibly in other new situations requiring new exceptions* (Benner, 2001, xxiii).

The above quotation also indicates that while rules may be formulated for many diverse clinical situations, there will always be a requirement for knowledge and competence that exceeds such formulations.

Nursing, in general, was very receptive to Benner's ideas. Both she and Carper seem to have articulated a conceptualisation of nursing knowledge with which many nurses identified. As McFarlane (in Kershaw & Salvage, 1986, 1) observes:

> *Nursing is a practice discipline and if its innovative ideas do not spring from practice then there will inevitably be an unreality about them and a lack of utility. By the same token, practice which is shorn of any theoretical basis and which does not allow its theoretical foundations to grow is not a practice discipline. It is a ritualised performance unrelated to the health care needs of individuals and society.*

2.4 Reflection and Reflective Practice

Benner (2001) identified narrative and reflection on narrative accounts of practice as a method of uncovering practice knowledge in nursing. Narrative accounts capture the experience of nurses in clinical situations. Experience is recognised as integral to aesthetic, ethical, personal, socio-political, and unknowing patterns of knowing in nursing (Heath, 1998). These patterns, along with empirics, are considered to represent a comprehensive view of knowledge relevant to nursing practice. Chinn and Kramer (2004, 2-3) summarise this view of professional knowledge in nursing and how it might be developed:

> *In a discipline, knowledge represents what is collectively taken to be a reasonably accurate understanding of the world as it is known by the members of the discipline. The "knowledge of the discipline" is that which has been collectively judged by standards and criteria shared by members of the disciplinary community...As nurses practice, they know more than they can communicate and use insights and understandings that they often take for granted. Much of what is known is expressed through actions, movements, or sounds. These are the everyday actions or nondiscursive expressions of knowing that reflect the whole. What is expressed in a nurse's actions conveys a simultaneous wholeness that textbooks and theories can never portray.*

> *However, what happens in practice can only be shared in the moment and typically is not available to a broader audience.*
> *We believe that much of what nurses know has the potential to be more fully expressed and communicated than it has been in the past and that this can happen when all forms of knowing are integrated and valued. Language and other symbols that are used to convey empiric knowledge will only partially reflect the whole, but when we move beyond the traditional limits of empirics, it will be possible to convey a more complete picture of what is known within the discipline as a whole.*
> *Sharing knowledge is important because it creates a disciplinary community, beyond the isolation of individual experience.*

The possibility of articulating, sharing, and judging the knowing expressed in nursing actions and in the taken-for-granted understandings and insights that characterise nursing practice was given a fillip with the publication of Donald Schön's (1983) textbook '*The Reflective Practitioner. How Professionals Think in Action*'. Schön (1983) was not the first philosopher in modern times to write about reflection. Some fifty years earlier, Dewey (1933) had published his ideas on reflection in the context of pedagogy. What made Schön's (1983) ideas interesting for nursing was that his research involved professionals in practice disciplines. Kinsella (2007, 106) suggests that:

> *In a sense, Schön does for professional practice what Dewey did for education; he draws attention to the experiential world of the practitioner in the way that Dewey drew attention to the experiential world of the child, pointing to the relevance of such worlds for knowledge development.*

What was ground-breaking and seminal for nursing knowledge was Schön's (1983, 21) questioning of the appropriateness of '*technical rationality*' as a model of professional knowledge in practice disciplines. The model of technical rationality, which Schön (1983) described as the dominant model of professional knowledge, consists of a hierarchy, with scientific theory and knowledge occupying the highest level. Below that comes applied science which yields techniques and procedures

that are, in turn, applied to practice problems. Professional practice is viewed as a process of technical problem solving using specialised, preferably scientific, knowledge.

The model of technical rationality also posits a hierarchical relationship between knowledge and practice: knowledge is generated by academics and consumed by practitioners. High status is accorded scientific knowledge and its producers. Professional education reflects the model of technical rationality: students first learn the basic and applied sciences followed by experience in practice when the relevant skills and attitudinal elements of the programme are acquired. Knowledge is unidirectional: problems of practice form the raw material for research within the academy; the academy, in turn, provides the knowledge needed to solve the problems of practice. Schön (1983) asserts that those professions with a high degree of scientific and technical knowledge, such as medicine and engineering – the so-called major professions - are paradigm examples of the model of technical rationality both in their education and in their practice. Other professions with less well developed scientific knowledge bases, such as nursing, teaching, and social work – the so-called minor professions - cannot operate in the same way and so the gap between theory and practice is quite substantial. The minor professions attempt to mimic the major ones so that the former may enjoy the prestige and rewards that accompany a strong base in scientific knowledge.

The problem with technical rationality as a model of professional knowledge, and the reason why Schön (1983) is critical of it, is that, in practice, problems do not always present neatly circumscribed and yielding to solutions by the application of scientific theory and technique. Practice situations are characterised by uncertainty, instability, uniqueness, and value conflict (Schön, 1983). The model of technical rationality is neither appropriate nor helpful in such circumstances. However, Schön (1983) observed that some practitioners do manage quite well to solve the complex, ill-defined problems they face every day. They do so by deploying another kind of knowledge, which Schön (1983, 50) calls '*knowing-in-action*'. Knowing-in-action, as the term suggests, is knowledge that is embedded

in, and which cannot be separated from, action, whether that action be a physical or a mental process. Knowing-in-action is tacit, intuitive, and expressed in skilful, spontaneous performance. It constitutes the '*art of practice*' or practical knowledge (Schön, 1983, 69). Because practitioners have not learned this kind of knowledge in a formal manner, they are not conscious of having acquired it and may not even recognise it in themselves. Consequently, such knowledge is not recognised as legitimate either by professional schools or indeed by practitioners who use it. Schön (1983, 54) advances a new epistemology of practice which he calls '*reflection-in-action*'. This model of professional knowledge permits knowing-in-action to be surfaced, articulated and theorised. As practitioners practice, they sometimes experience surprise (Schön, 1983). Surprise is frequently a stimulus to reflect-in-action. The practitioner becomes consciously aware of the knowing that is implicit in their actions. Knowing that is articulated may be criticised and restructured via a process of 'on-the-spot' experimenting (Schön, 1983). It may then be tested in action in an on-going process of action and reflection.

As well as reflection-in-action, Schön (1983) also described a process of reflection-on-action. The latter occurs retrospectively and is concerned with reviewing and learning from experience. Kinsella (2009) regards reflective practice as an umbrella term that encompasses reflection-in-action and reflection-on-action. Many of the theories and models of experiential learning that were developed in the field of adult education in the 1980s are predicated on the notion of reflecting on experience (Boud, Keogh, & Walker, 1985; Boyd & Fales, 1983; Kolb, 1984). Experiential learning is defined as '*a process whereby knowledge is created through the transformation of experience*' (Kolb, 1984, 38). Kolb (1984) represented experiential learning as a cycle which begins with concrete experience. Experience prompts observations and reflections. From reflection on experience, abstract concepts and generalisations form. These are then tested out in new situations which lead, in turn, to new experiences (Kolb, 1984). Experiential learning is understood as a holistic process, involving emotion as well as cognition. Experience is conceived broadly as the total response of a person to a situation. In experiential learning, scientific or 'subject-matter' knowledge is appropriated and integrated in a manner personal to the individual learner based on their prior

experiences and current motivations (Boud et al., 1985). Knowledge derived from reflecting on experience is personal knowledge. It is, in general, oriented towards action. In that sense, it may be described as personal practical knowledge (Ghaye & Lillyman, 2000; Johns, 2001). Personal practical knowledge is not simply knowledge for knowledge's sake but knowledge for the sake of doing something; changing an unsatisfactory situation into something more desirable.

Reflection may be used to serve knowledge interests at many levels from instrumental changes to changing how individuals view themselves and their place in society. Mezirow (1990, 12) used the term *'critical reflection'* to describe reflection that addresses broader societal issues. Reflection at this level serves emancipatory interests and involves becoming aware of and challenging established, habitual assumptions and patterns of expectation. Critical reflection has two functions: to understand the operation of power in social processes, such as, for example, in health and education, and to recognise and analyse hegemonic practices (Brookfield, 1995). The activity of critically reflecting on experience leads to the uncovering of paradigmatic assumptions, which challenge what appears to be the natural order of things. Critical reflection permits the transformation of an individual's meaning structures so that they become more inclusive, discriminating, and open. Such structures allow for better understanding and integration of experience which in turn guides further action (Mezirow, 1990). The resulting knowledge generates '*perspective transformation*' and greater empowerment on the part of practitioners (Mezirow, 1981, 6). In the context of education, Brookfield (1995) identifies a number of reasons why learning from critical reflection is important, for example, actions are more informed; it helps to develop a rationale for practice; self-blame is avoided; emotions become grounded; the classroom is enlivened, and democratic trust is increased. Reflection is recognised as a key element in learning from experience. The process of reflection is the core difference between whether a person repeats the same experience several times or learns from experience in such a way that they are changed cognitively or affectively. Such changes involve change to a person's meaning structures (Boyd & Fales, 1983). Critical reflection affords a means of uncovering knowing in the socio-political domain (White, 1995).

Many of the ideas touched upon above were appealing in an era when nursing was attempting to develop a body of unique disciplinary knowledge. The epistemological assumptions underpinning reflective practice and experiential learning were consistent with the ethos of a discipline that valued individual experience and the meaning of experience for the individual (Moon, 1999). Reflective practice, as an epistemology, would ensure that knowledge development was oriented towards practice, and practice, in turn, would shape disciplinary knowledge. The historical gap between theory and practice would no longer obtrude. Moon (1999, 56) comments:

> *A justification for the interest in reflective practice in nursing...concerns the rapid development of nursing theory to justify the new place of nursing in higher education. Those who have developed this theory are nurses, and not generally those who have moved into nursing from other disciplines, and they are nurses who have often recently been in practice. They are therefore keenly aware of the need to relate theory to practice. In this development there may also have been conscious or unconscious reasons for ensuring that nursing theory differs markedly from its partner, medicine, which has traditionally been male dominated and, until recently, has displayed a strong instrumental orientation.*

Referring to professional knowledge in disciplines such as teaching, nursing and social work, Moon (1999, 55) considers their '*subject matter*' to be:

> *...interpretive and not rooted in fact to the same extent that scientific disciplines are. The methods used in nursing and teaching, for example, involve review, interpretation and reconstruction of ideas and reflection is employed in these processes.*

Reflective practice is an appealing epistemology in such disciplines, Moon (1999, 55) maintains, because '*...practice in these professions is often based on rapid action... Because it is action that counts, these professions display a characteristic difficulty in relating theory to practice*'.

2. 5 Reflective practice as a model of professional knowledge in nursing education

Adopting reflective practice as a model of professional knowledge *'has the potential to alter paradigmatically the way professional groups consider what material and processes belong with conceptions of professional knowledge, and also within the curriculums of professional schools'* (Kinsella, 2009, 7). Meleis (2012) describes nursing as a human science or science of caring, and, as such, it is concerned with humans as holistic beings, their life experiences, and the meanings that experience of health and illness has for them. As a practice-oriented discipline, the goal of knowledge development in nursing is to *'understand the nursing needs of people and to learn how to better care for them; therefore, the caring activities that nurses are involved in on a daily basis may be the focus for knowledge development'* (Meleis, 2012, 90). The ontology of nursing has moved from a focus on '*empiricism*' to a focus on '*subjective reality*' (Bonis, 2009, 1329). Epistemology must move accordingly. Reflective practice challenges the dominance and appropriateness of scientific theory and technique as the basis for practice and knowledge development in practice disciplines. It recognises the validity and relevance of the personal practical knowledge of practitioners.

Kinsella(2007, 105) claims that:

> *Professional practitioners, caught in a gap between their lived experience of practice and the limitations of the discourse of scientism as the dominant way to grapple with problems, are perhaps relieved to discover the language of 'reflective practice'. This discourse questions the dominant paradigm and re-frames issues in a manner that is accessible, that acknowledges the complexity of practice, and considers the experiences of practitioners.*

Carper's (1978) four fundamental patterns of knowing, extended to six by White (1995) and Munhall (1993), identified the variety and scope of nursing knowledge. Benner (1984) contributed narrative as an approach to accessing the knowledge

embedded in nursing practice. Schön's (1983) reflection-in-action provided an epistemology of practice. These disparate strands formed a rich intertextual tapestry affording the potential to develop a unique body of nursing knowledge and to eliminate the so-called theory practice gap.

Carper's (1978) patterns of knowing are integrated in a model of reflective inquiry developed by Johns (1995a). The model is reproduced in Figure 2.1

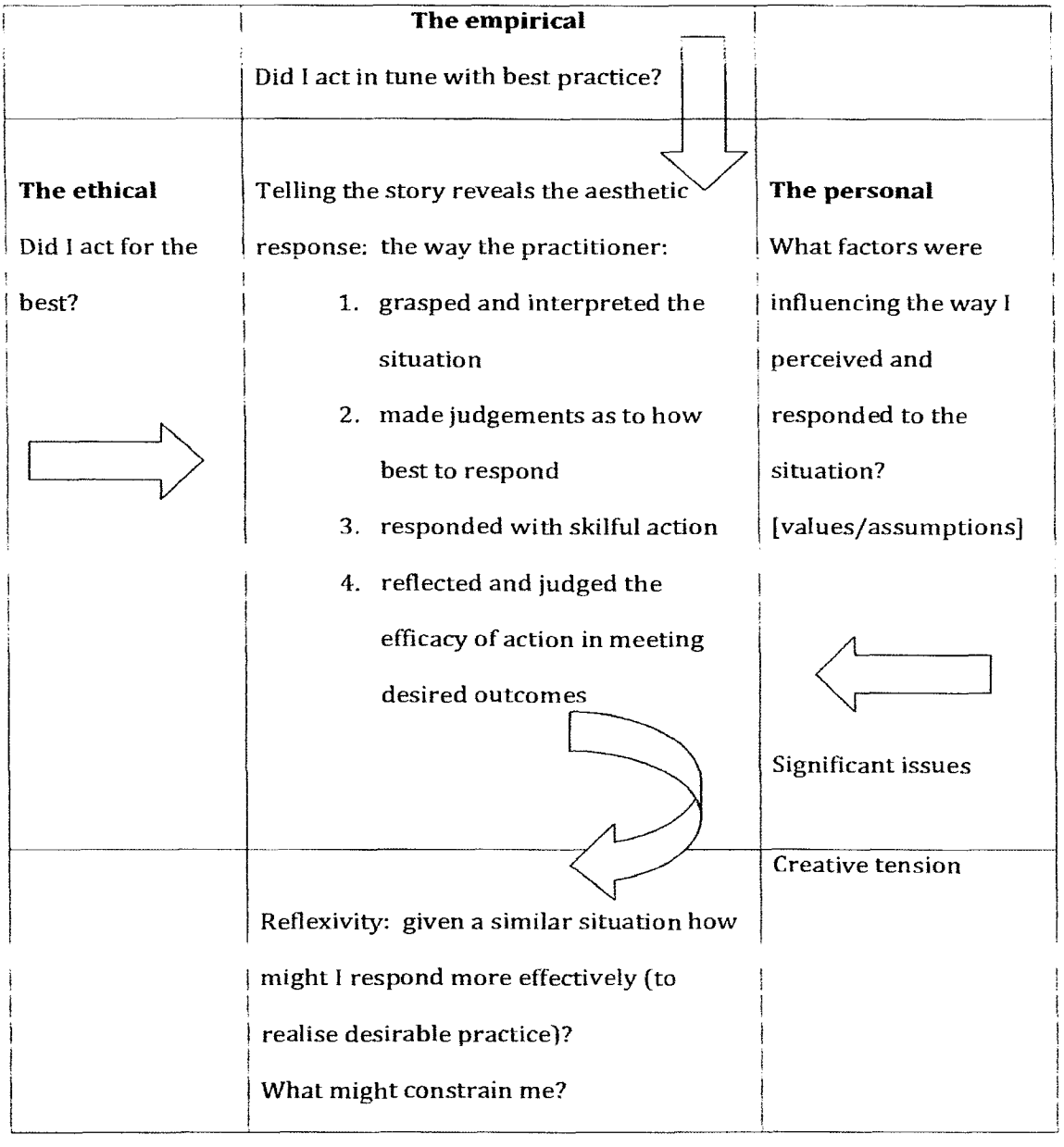

Figure 2.1: Model for Reflective Inquiry (Source: Johns, 2009, 61).

At the centre of the model is the aesthetic pattern of knowing in which the narrative of practice is revealed. The narrative represents the practitioner's holistic response to a clinical situation including their evaluation of actions taken. Influencing and helping to formulate the aesthetic response is knowledge from empirical, ethical and personal patterns of knowing. 'Reflexivity' in the model above is future or action oriented. Arising from reflection on experience, a tension may be identified between what actually happened in practice and the practitioner's sense of what should have happened if there were no impediments to realising 'desirable practice'. Any potential dissatisfaction drives the practitioner to identify those impediments and learn how they may be removed or overcome in future similar clinical situations.

Johns (1995b, 25) describes the knowledge made possible by reflection, how it is constructed, how it relates to propositional knowledge, and its value for nursing practice as follows:

> *...reflection is the method to access, make sense of and learn through experience. In this process of reflection, personal knowledge becomes visible and communicable...Unlike the universal, static, and context-free nature of positivist or instrumental knowledge, the knowledge that results from reflection – reflective knowledge – is particular, dynamic and context-bound. Although it is particular and context-bound it is also of immediate and valuable use to other practitioners. This assertion can be justified on two key points.*
>
> - *That although practice may be grounded in personal knowledge, many of the values, norms, and contexts of practice will be similar and hence enable sensible practitioners to make judgements about the value of one practitioner's experience in the context of their own experiences.*
> - *That the focus of reflection on everyday messy problems leads to the sort of knowledge that other practitioners would find most beneficial to use in their own practice.*
>
> *From an epistemology of professional practice viewpoint, it becomes evident that reflective personal knowledge is the most substantive form of knowledge*

and should properly constitute the body of knowledge of a practice discipline. Basic and applied sciences are merely sources of information that reflective practitioners can draw upon to assimilate into their personal knowledge as appropriate. In doing so, such knowledge becomes particular and transformed through reflection on its appropriateness within the particular situation.

Reflecting in and on practice, and sharing the knowledge gained from these processes, represents the most appropriate knowledge base for nursing. Basic and applied sciences, which form the foundation of the model of technical rationality, are but sources of information in the reflective model. Knowledge contributed by the sciences is not simply applied in practice but is mediated via the practitioner's personal pattern of knowing. Johns (2009) distinguishes between 'doing' reflection and 'being' reflective. The former associates reflection with technique and the dominant model of professional knowledge whereas the latter denotes a way of being. The mode of being of a reflective practitioner is reflective. It is not something the practitioner **does**; it is something the practitioner **is**. Johns (2009, 3) describes the reflective practitioner as '*someone who lives reflection as a way of being*'.

Rolfe, Freshwater, & Jasper (2001) develop and expand upon Benner's (1984) ideas to create a model of professional knowledge that is reproduced in Figure 2.2 below. The model includes Ryle's (1948) distinction between 'knowing how' and 'knowing that' alluded to earlier in the chapter, although the distinction is not conceptualised in the same way.

	Scientific knowledge	Experiental knowledge
Theoretical knowing that	scientific theoretical knowledge	experiental theoretical knowledge
Practical knowing how	scientific practical knowledge	experiental practical knowledge

Figure 2.2: A model of practitioner knowledge (Source: Rofle et al., 2001, 11)

Rolfe et al. (2001) draw upon Benner's (1984) research into nursing expertise and Schön's (1983) concepts of reflection-in-action and reflection-on-action to chart a pathway towards the potential development of a body of knowledge for nursing which is grounded in practice. The model of practitioner knowledge above also indicates the relationship between theoretical and practical knowledge, and between scientific and experiential knowledge. Scientific theoretical knowledge is the starting point of knowledge acquisition. The model of technical rationality could be said to occupy the left hand column of the model above and reflective practice the right hand column. Rolfe et al. (2001, 11) acknowledge that in nursing and other health care disciplines allied to medicine:

> *Both models of practice are important and have their place: the technical rationality model in which scientific theory determines research-based practice* ***and*** *the post-technical model in which the knowledge gained directly from practice informs and builds experiential theoretical knowledge.* (Rolfe et al.'s emphasis).

The novice nurse begins to practice using knowledge derived from scientific knowledge and theory. As scientific knowledge is implemented in practice in the form of procedures and techniques, scientific practical knowledge is acquired. There is an order of dependence between the latter and the former. The nurse's scientific practical 'knowing how' derives from scientific knowledge and theory. To quote Rolfe et al. (2001, 12) the nurse *'knows* ***how*** *because she knows* ***that'.*** (Rolfe et al.'s emphases). This suggests a relatively unproblematic application or translation of theoretical knowledge to practice. Following a lot of experience in

practice, knowledge begins to develop '*directly from experience*' (Rolfe et al., 2001, 12). Although this knowledge is a kind of practical 'knowing how', as indicated by its placement in the model above, it is distinguished from scientific practical knowledge. No arrow connects these two categories which might have suggested an order of dependence. In fact, the very experienced practitioner '*almost totally rejects*' scientific practical knowledge as they acquire experiential 'know how' (Rolfe et al., 2001, 20). The kind of knowledge arising directly from practice experience is referred to as '*experiential practical knowledge*' (Rolfe et al., 2001, 12). It is tacit, intuitive, and '*organismic*', that is, contained in muscles and reflexes of the body (Rolfe et al., 2001, 20). It manifests itself in skilful, fluid actions. This kind of knowledge does not, however, have to remain tacit. By reflecting in and on practice:

> *...the expert nurse eventually begins to recognise, understand and articulate the processes underpinning her expertise. She realises that there is a rational process underpinning intuitive grasp. She eventually begins to build a body of experiential theoretical knowledge out of her experiential practical knowledge. This knowledge is not the abstract content-based knowledge of the novice or beginner, nor is it the concrete content-based knowledge of the expert. Rather, it is process-based knowledge, and is concerned with* ***how*** *she practices rather than* ***what*** *she practices. Furthermore, it can be shared between practitioners...*(Rolfe et al., 2001, 20). (Rolfe et al.'s emphases).

In this way, Benner's (1984) model is extended to include expertise that is articulated and shared. The nurse may now be said to 'know that' because she 'knows how'. This is an important point as nurses are expected '*to be able to justify their clinical decisions according to some form of evidence*' (Rolfe et al., 2001, 15). Unlike Benner's expert nurse, who is operating at an intuitive level and whose operations bypass rational processes, in the manner of Ryle's 'knowing how', the reflective practitioner is able to provide an account of their professional actions and decisions in theoretical terms. Experiential theoretical knowledge, which originates in practice and is developed by processes of reflection in, and particularly, on action, constitutes the evidence base for nursing practice. This

kind of theoretical knowledge seems to be not as concerned with '*the scientific ambition to master and define a conceptual field*' (Selden, 1995, 1) as were the grand theories discussed earlier.

2.6 Evidence-Based Practice

The above conceptualisation of evidence-based practice was challenged by a movement in medicine which became known as Evidence-Based Medicine (EBM). Evidence-based medicine originated in the work of Dr. Archie Cochrane, a medical doctor and researcher, active in the post-World War II era in Britain. Cochrane was concerned that the results of research were not being applied in medical practice, with potentially deleterious consequences for patients. He called for the results of good quality research, in particular, randomised controlled trials (RCTs), to be systematically reviewed, synthesised, and made available to physicians to guide their clinical decision making (Melnyk & Fineout-Overholt, 2011). Dr. Cochrane inspired the evidence-based practice movement in medicine which developed in the early 1990s. The Cochrane Library, which publishes and disseminates the results of systematic reviews and meta-analyses, was named for him and is a key resource in the practice of evidence-based medicine. Porter (2010, 5) describes evidence-based practice as '*one of the most significant developments in healthcare in the last 2 decades*'. The evidence-based practice movement in medicine recommended the integration of the best available external evidence with patient choice and clinician expertise when making decisions in medical practice. External evidence was to be derived from:

> *...clinically relevant research, often from the basic sciences of medicine, but especially from patient-centred clinical research into the accuracy and precision of diagnostic tools (including the clinical examination), the power of prognostic markers, and the efficacy and safety of therapeutic, rehabilitative and preventive regimens* (Sackett, Rosenberg, Muir Gray, Haynes, & Richardson, 1996, 71).

The type of research evidence to be used would depend on the presenting clinical problem, and could include findings from cross-sectional or longitudinal research design studies. Randomised trials and meta-analyses of the results of several clinical trials were deemed the most valid and reliable sources of evidence when prescribing therapy (Sackett et al., 1996). Use of evidence from research would be subject to the judgement of the medical practitioner:

> *External clinical evidence can inform, but can never replace, individual clinical expertise, and it is this expertise that decides whether the external evidence applies to the individual patient at all, and if so, how it should be integrated in the clinical decision* (Sackett et al., 1996, 72).

In making decisions about medical care and treatment, clinical expertise would ensure that cognisance was taken of the individual patient's situation and the latter's preferred options (Sackett et al., 1996). Evidence-based medical practice was intended to preserve the concept of physician expertise and patient choice, with the latter two elements constituting forms of 'internal' evidence. However, in the so-called 'hierarchy of evidence' that developed subsequently, systematic research is accorded the highest value, with other sources of knowledge occupying lower levels (Cullum, Ciliska, Haynes, & Marks, 2008). Systematic research is synonymous with large scale randomised controlled trials, or large scale surveys. Systematic reviews and meta-analyses, such as those undertaken by the Cochrane Collaboration, collate and integrate results from numerous studies, and these results subsequently form the basis for the development of protocols and guidelines to be implemented in practice (Hyde, 2009). The farther away from systematic research the evidence is deemed to be, the lower down the hierarchy it appears. Evidence from qualitative research studies, which include grounded theory, phenomenology, hermeneutic inquiry, and action research, occupies a level below that of all scientific research on the hierarchy of evidence. These approaches are much favoured in nursing research, in particular, phenomenological approaches, as the aim of such studies is to gain an understanding of the meaning of the experience of health and illness for individual patients. Such understanding sensitises nurses to the patients' experiences and

assists them in providing individualised, holistic care. Expert opinion and clinical experience occupy the lowest level in the hierarchy of evidence. Knowledge generated from reflecting in and on practice is, thereby, devalued.

Evidence-based practice, initiated in medicine, and not without its own debates within that field, extended to other healthcare disciplines, including nursing. This occurred at a time when nursing was:

> *...attempting to register its difference as a caring endeavour with a separate knowledge base from biomedicine...reflective practice offered intellectual respectability to the 'softer' areas of healing and facilitated nursing in define* (sic) *itself as a discipline* (Hyde, 2009, 118).

Commenting on the risks for nursing of following medicine's lead, Smith, James, Lorentzon & Pope (2004, 68) warned:

> *If nursing chooses to solely utilise RCTs* (Randomised Controlled Trials) *to examine the effectiveness of practice, questions which are concerned with the meaning events have for both patients and practitioners are more likely to be overlooked.*
>
> *...The RCT is limited in its ability to reveal the different dimensions of human experience and how patients and nurses relate to each other. The importance of emotions and ethical reasoning needs to be made apparent in the decision-making process and valued as evidence alongside the use of systematic reviews of clinical trials. It is essential therefore that ways are sought to capture some of the missing elements of evidence such as emotional labour, practitioners' knowledge and lay knowledge in order to incorporate them into the debate about effective health care and what underpins it.*

As health service provision becomes increasingly policy-driven and demands ever greater accountability from healthcare professionals, evidence-based practice assumes ever greater significance. Referring to Carper's (1978) fundamental patterns of knowing in nursing, Porter (2010, 12) suggests that:

> *...claims that esthetic,* (sic) *ethical and personal knowing are, to greater or lesser degrees, unamenable to scrutiny, means that they fall foul of public expectations for transparent and accountable healthcare. This is an increasingly untenable position for nursing to adopt.*

Evidence-based practice, therefore, poses a dilemma for nursing knowledge, namely, to retain multiple ways of knowing and reflective practice as an epistemology while at the same time fulfil the demand for evidence and accountability in clinical decisions. Porter (2010, 5) asserts:

> *With EBP* (Evidence-based practice), *not only does empirics enjoy a total hegemony, either displacing (as in the case of esthetics and personal knowledge) or incorporating (as in the case of ethics) alternative modes of knowing, it is also itself reduced to a very circumscribed and mechanistic interpretation of empirical knowledge.*

Porter (2010, 6) adds that '*EBP fails to pay even lip service to either the other patterns of knowing or the organizing function of theory*'. Not only does evidence-based practice diminish and devalue knowledge patterns considered fundamental in nursing, but its narrow interpretation of empirics deprives nursing of a theoretical base. Consequently, if evidence-based practice becomes dominant, the development of nursing as a discipline with its own unique body of knowledge is delayed or arrested.

Nursing's response to the challenges posed by evidence-based practice is to argue for making non-empirical patterns of knowing visible and warrantable as evidence (Rycroft-Malone et al., 2004). Indeed, Avis & Freshwater (2006, 217) maintain that all sources of knowledge used in practice should be subject to critical reflection:

> *...a misleading distinction between hard, external, scientific evidence and the softer, value-laden stuff of personal experience can obscure an underlying*

logic which requires critical reflection on all the evidence in order to determine how we ***ought to*** *practice.* (Avis & Freshwater's emphasis).

The above approach to basing practice on evidence appears to readjust the hierarchy of evidence to ensure greater equity between empirical and personal practical knowledge. The failure adequately to articulate experiential practical knowledge and the rational processes that underpin expert nursing actions, thereby creating a body of experiential theoretical knowledge, leaves nursing vulnerable to 'colonisation' by more powerful disciplines, namely, medicine (Porter & O'Halloran, 2009). The desire of nursing to register its difference as a discipline from medicine may have led to an undue emphasis on intuition as a basis for clinical decisions with a concomitant diminution of the relevance of empirical knowledge. Referring to '*the question of contested knowledge in nursing*' Nelson (2012, 204) argues that '*Nursing knowledge includes biomedical knowledge, pharmacology, psychology, math, anthropology, and so forth*'. The evidence-based practice movement in healthcare has perhaps required nursing to acknowledge more overtly the contribution of empirical research to its knowledge base while at the same time articulating and verifying other sources of knowledge, in recognition of the fact that the discipline and disciplinary knowledge is defined by more than empirics.

2.7 Conclusion

Professional knowledge generally comprises a mixture of theoretical and practical knowledge. The relationship between these two types of knowledge and how they blend is a matter of debate and disagreement. In nursing, efforts to formulate a unique knowledge base included recognition of the inadequacies of the medical model to represent nursing and a move toward a more holistic conceptualisation of care. The construction of conceptual models reflected a stage in the evolution of nursing theory. Problems of relevance and application of theory to practice bedevilled the widespread adoption of nursing models. The articulation of different patterns of knowing in nursing, and the recognition of expertise arising in

and from practice, oriented the search for a disciplinary knowledge base toward practice. Reflective practice formally acknowledged the limitations of scientific knowledge and the model of technical rationality for practice disciplines. It made possible the generation of knowledge from clinical experience. Its appeal as a model of professional knowledge for nursing was challenged by the evidence-based practice movement in healthcare. Reflective practice, however, remains an important element in the conceptualisation of nursing knowledge.

Many of the concepts that have formed the content of this chapter will be revisited in the context of a deconstructive reading in later chapters. Prior to that, an overview of the nursing literature as it relates to reflective practice and nursing knowledge will be presented.

Chapter 3 A diachronic perspective on reflective practice in nursing education

3.1 Introduction

An exploration of how reflective practice as a model of professional knowledge has been presented in the nursing literature over time is the focus of this chapter. Unlike the analysis chapters that follow later in the thesis and which consist of a close, fine-grained reading of a limited number of texts, the present chapter encompasses a broad sweep of literature on reflective practice in nursing education. Few of the papers included in this review have as their primary or sole theme the topic of professional knowledge *per se*. However, in the course of the discussions and debates articulated, a perspective on professional knowledge may be discerned. It is the purpose of the chapter to identify these various perspectives and the presuppositions upon which they rely. A temporal dimension also underpins the organisation of the material, beginning when reflective practice first entered the nursing literature in the late 1980s and continuing to more recent times. The years in question are divided into three periods. The first decade – from the late 1980s to the late 1990s - witnessed a proliferation of publications on reflective practice in nursing education and, for that reason, is divided into an early and middle phase. The second decade – from 2000 onwards – constitutes the later period in the review which follows. An attempt is made to trace the trajectory of reflective practice as a model of professional knowledge in nursing education as it is represented in the literature and to capture the preoccupations obtaining amidst the temporal flux.

3.2 The Early Years

The 1980s marks the first appearance of the terms 'reflection' and 'reflective practice' in the nursing literature. One of the earliest papers located in the literature search describes a research study. The researcher/author investigated clinical decision-making among a group of experienced nurses (Powell, 1989). The aim of the study was to identify if nurses used reflection-in-action as part of their decision-making process. Schön's (1983) theory was used as a framework for the study. Also used was a modified version of Mezirow's (1981, 12) seven '*levels of reflectivity*'. The researcher wished to find out not only if reflection was used when making clinical decisions but also at what level it was occurring. As briefly alluded to in Chapter 2, Mezirow (1981) distinguished different levels of reflection or reflectivity. Critical reflection refers to the process of becoming aware of and challenging established and habitual patterns of expectation, patterns that have been assimilated uncritically by means of socialisation. Such a process accounts for '*perspective transformation*' in learning and is referred to as '*psychic*' and '*theoretical reflectivity*' in Mezirow's (1981, 13) framework. Powell's (1989) study appears to represent an optimistic take on reflective practice as a model of professional knowledge in nursing. Reflection-in-action is still a quite new concept in nursing at this time. The researcher acknowledges that the nurses who participated in the study did not know very much about reflective practice as a concept. Nor did they have any prior relevant instruction. It was, however, evident in their practice, which seems to bear out Schön's (1983) contention of a distinction between formal propositional knowledge and practice knowledge. Powell (1989) found that among the small group of nurses who participated in the research study, all used reflection, with those practicing in areas where there was greater autonomy engaging in critical reflection, that is, becoming aware of and challenging habitual patterns of expectation. As Powell's (1989) paper marks one of the earliest references to reflective practice in nursing and as it builds on Schon's (1983) epistemology of reflection-in-action in search of practice knowledge, it will be subjected to a closer reading in Chapter 8 of the thesis.

By the early 1990s, reflection is recognised as an important development in nursing education, and described as *'a cornerstone of nursing professionalism'* (Newell, 1992, 1326). It is also claimed that reflection is *'essential for competency'* (Saylor, 1990, 9); *'a learning tool'* (Atkins & Murphy, 1993, 1188) that can facilitate the integration of theory and practice; *'a necessary process in professional education'*; and *'vital'* if learning from practice is to occur (Atkins & Murphy, 1993, 1191). Reflection has become *'increasingly prominent in nursing and nurse education...promoted enthusiastically by practitioners and educators alike'* (James & Clarke, 1994, 82); and *'a focus of educators aspiring to a better understanding of how a professional thinks and, therefore, how a professional should learn to think'* (Saylor, 1990, 8).

However, difficulties with reflection were also beginning to be recognised. The literature on reflection is described as *'complex and abstract'* (Atkins & Murphy, 1993, 1188). Reflective practice is poorly defined (Atkins & Murphy, 1993; Jarvis, 1992), with a wide variety of terms used interchangeably (Carroll et al., 2002). It is *'difficult to conceptualise'* (Clarke, James, & Kelly, 1996, 171) which makes it *'difficult to operationalise'* (Atkins & Murphy, 1993, 1191). There is, also, *'little critical examination of either theoretical or practical problems of reflection about nursing'*, and descriptions of how to improve reflective practice are *'characterised by vagueness'* (Newell, 1992, 1326). Reflection could even be described as *'a bandwagon upon which many professionals have jumped because it provides a rationale for their practice'* but it has *'not really helped to solve the problem of the relationship between theory and practice'* (Jarvis, 1992, 174). Describing reflection *'adequately for all contexts presents difficulties'* (James & Clarke, 1994, 82).

Reid (1993) reports hostility among some nurses with whom she was facilitating reflection, with nurses believing that there was nothing new in the idea for them. Contrary to Powell's (1989) study, Reid's (1993) experience may be an indication that if reflective practice is made into an 'academic' subject and presented as such, it may provoke a negative reaction. I have experienced this kind of reaction also when presenting the 'theory' of reflective practice to experienced nurses.

Definitions of reflection began to appear in the nursing literature in the early 1990s. Drawing on educational philosophy and theory, Dewey's (1933) definition is frequently cited as is the following definition by Boyd & Fales (1983, 100):

> *Reflective learning is the process of internally examining and exploring an issue of concern, triggered by an experience, which creates and clarifies meaning in terms of self, and which results in a changed conceptual perspective.*

Definitions are appealing when the concept referred to is unclear, although, as Eraut (1994) remarks , definitions have a way of making things appear more certain than they, in fact, are. Boyd & Fales (1983) identified a key characteristic of reflective learning, and one that distinguishes it from other types of mental activity, such as for example, problem-solving, and that is that the problem or issue of concern is conceptualised in relation to the self (Boyd & Fales, 1983). The popularity of their definition in the nursing literature may be attributable to this personal dimension of reflective knowledge.

A focus on 'doing' reflective practice becomes a dominant theme in the nursing literature in this early period. As well as adopting models from the education domain, nurses themselves begin to develop models and frameworks with a view to making the processes involved in reflection more tangible. Atkins and Murphy (1993) present a model distilled from a review of the literature on reflective practice. The authors identify a common 3-stage process which consists of the following: awareness of uncomfortable thoughts and feelings, critical analysis of feelings and knowledge, and new perspective (Atkins & Murphy, 1993). The skills needed to engage in reflection are also identified and enumerated as: self-awareness, description, critical analysis, synthesis, and evaluation (Atkins & Murphy, 1993). Suggestions for improving the methods used to investigate reflection are proposed, for example, the use of reflective diaries in addition to observation and interview approaches. A better understanding of the process of reflection, it is argued, is likely to enhance the practice of reflection (Atkins & Murphy, 1993).

While understanding and implementing reflective practice is a dominant theme in the nursing literature at this time, concern is also expressed regarding the nature of the knowledge derived from reflecting in, and on, practice (James & Clarke, 1994). The rituals and routines that characterised the knowledge base of nursing in earlier decades are not to be relied upon (James & Clarke, 1994). In a reflective curriculum, applied science no longer provides the sole source of knowledge for practitioners. However, reflective practice knowledge is regarded as an immensely complex, unstable, practical kind of knowledge (James & Clarke, 1994). This creates problems in the arena of nursing education as there is a lack of control over learning outcomes and consequent difficulties in the assessment of learning from reflection (James & Clarke, 1994). There is also little guidance on the teaching strategies that promote reflective practice (James & Clarke, 1994). The difficulties identified by James & Clarke (1994) appear to reflect a nursing curriculum that is oriented towards the dominant model of technical rationality, with the teacher as expert and the body of knowledge consisting of formal propositional knowledge. Their paper gives an indication of the degree of change required to move from a technical rational model to a reflective curriculum. Meerabeau (1992), on the other hand, takes a more optimistic view of the task of identifying the nature of reflective knowledge, asserting that, with appropriate research methods, practitioners' tacit knowledge may be captured. Meerabeau's (1992) argument will be considered in greater detail in Chapter 8.

Greenwood (1993) is critical of reflective practice being removed from the practice setting and transferred to a classroom context. Drawing on theories in cognitive psychology, particularly, concept formation and utilisation, Greenwood (1993) argues that practice and feedback must occur in real-life clinical settings so that appropriate cues are triggered and activated in subsequent situations. If reflection occurs in a classroom setting, different concepts are activated, for example, what the teacher expects, assessment requirements, and so on (Greenwood, 1993). Reflection should precede action as well as follow it; otherwise inappropriate concepts may be activated and reinforced. Again the focus of Greenwood's (1993) paper is on 'doing' reflection, and the theory used to support the argument being

presented appears to reflect a rational, linear approach to learning more reminiscent of the model of technical rationality than reflection-in-action.

3.3 The Middle Years

'Doing' reflective practice remains a dominant theme in the nursing literature throughout the latter half of the 1990s. As an indication, perhaps, of the presence of reflective practice in new nursing curricula, and the presence of nursing education in tertiary education settings, reports of research studies that investigated reflective practice from a variety of perspectives begin to appear during this time (Durgahee, 1996; Platzer, Blake, & Snelling, 1997; Reece Jones, 1995; Richardson & Maltby, 1995; Wong, Kember, Chung, & Yan, 1995). Reflective practice is by now an established part of nursing education programmes. The need for valid and reliable assessment methods prompted a study by Wong et al. (1995). The reflective assignments of 45 registered nurses undertaking a 30-hour unit of study as part of a BSc degree in nursing were analysed for evidence of reflection using Boud et al.'s (1985) framework. Like Boyd & Fales (1983), Boud et al.'s (1985) definition of reflection is frequently cited in the nursing literature. They define reflection as:

> *...a generic term for those intellectual and affective activities in which individuals engage to explore their experiences in order to lead to new understandings and appreciations* (Boud et al., 1985, 19).

Experience is conceived holistically as the total response of the person to the situation. Reflection may be triggered by internal states, such as loss of confidence or disillusionment with an existing situation, or by external events. Acknowledging the difficulty of being precise about the nature of the reflective process, Boud et al. (1985) offer a model of reflection which consists of three elements: the experience itself, the reflective processes which include attending to feelings, and re-evaluating experience by means of association, integration,

validation, and appropriation. The final component of the model is the outcome of reflection.

Wong et al. (1995) took great care when using Boud et al.'s (1985) model to ensure the validity and reliability of the tool with criteria established for each coding category, for example., attending to feelings, association, integration, and so on. Principles of coding were developed during a pilot study of the tool. Cases, that is, paragraphs of text, were coded separately by a number of coders and a mathematical formula used to test agreement (Wong et al., 1995). With the analytic procedures in place, the students' assignments were examined for evidence of reflection and assigned to one of six categories depending on to which element of the reflective process the case was deemed to belong. 100 reflective elements were coded from 45 scripts. Most of these belonged to the categories of attending to feelings, association, and integration, with fewer coded as belonging to the latter three categories: validation, appropriation and outcome of reflection. Examples of each category from the textual data are provided in the report of the study (Wong et al., 1995). Based on the initial analysis, students were then assigned to one of three categories: non-reflectors, reflectors, and critical reflectors (Mezirow, 1981). The unit of coding in this case was the student. A majority (n=34) were assigned to the middle category, that is, reflectors. An in-depth interview with one 'non-reflector' and one 'critical reflector' student followed with the aim of illuminating the thought processes of each. Analysis and findings of the interview data are not reported (Wong et al., 1995). The researchers acknowledge their difficulty in differentiating the fine distinctions between the elements of Boud et al.'s (1985) framework and the fact that the data being coded do not refer directly to reflective processes. They acknowledge also that assignment work may not be the most suitable medium for reflection. As part of an assessment, students may censor what they write (Wong et al., 1995). Wong et al.'s (1995) study may be considered another example of a technical rational curriculum in nursing education and the dominance of empirical methods in nursing research. Although the authors acknowledge the limitations of the approach for the subject matter of their investigation, they nevertheless adhere to recognised, accepted research methods. The study may also be seen as part of a process of legitimizing reflective

practice by the standards of the time and place: rigorous empirical inquiry in an academic setting.

Other authors, during this period, express concern that reflective practice may be 'colonised' by the dominant model of professional knowledge. In the absence of a shared understanding, Richardson(1995) warns that reflective practice could become identified with the methods and techniques of natural science and ignore the social context of nursing practice. Nursing requires many sources of knowledge, and theories will emerge from understanding experience gained in practice (Richardson, 1995). By adopting a broader perspective, reflection will not be limited to the technical level but will also include ethical and political considerations (Richardson, 1995). The outcome will be not simply better techniques and procedures but "*the development of person-centred, 'morally appropriate' action*" (Richardson, 1995, 1049). The latter is particularly pertinent in nursing practice as illustrated by Carper's (1978) fundamental patterns of knowing in nursing and the importance accorded to the concept of caring in nursing theory, as discussed in Chapter 2.

Acknowledging that reflection is used differently depending on the perspective of the user, Boud & Walker (1998) register their concerns regarding the fate of reflective practice in professional education programmes in higher education settings. Misinterpretations of the reflection literature and examples of poor educational practice are reported (Boud & Walker, 1998). The authors re-assert the radical nature of reflection, for example, respect for uncertainty and doubt, the distrust of easy solutions, the influence of context, and questioning the notion of the teacher as 'the' authority (Boud & Walker, 1998). Practices which are incompatible with this view of reflective practice are identified; these include: recipe-following, reluctance to question experience, traditional assessment methods, misuse of teacher power, and non-recognition of, or mismanaging, context (Boud & Walker, 1998).

Clarke et al. (1996) recognise that nursing practice requires a broad knowledge base, and that reflection is important for the development of nurses' personal practical knowledge. Such knowledge is derived from many sources: it is created in practice situations; it is personal and shared; recent and long-standing; dynamic and living; and at odds with the notion of competence-based practice (Clarke et al., 1996). Based on their experiences as reflective practitioners, Clarke et al. (1996) recommend broadening the scope of what they refer to as holistic reflection to include not just direct analysis of experience which can easily become a technical problem solving activity, but also other forms, such as art, sculpture, and so on. The setting in which reflective practice takes place is also recognised as important; it must, among other things, be open, collaborative, and not focused on outcomes (Clarke et al., 1996). Reflective practice as a model of professional knowledge appears quite distinct from the technical rational model in Clarke et al.'s (1996) account, although the latter is not excluded. According to Pierson (1998), deliberate attempts must be made to encourage reflective thinking. If appropriate teaching strategies are not developed and used, then rational thinking predominates (Pierson, 1998). In terms of generating a knowledge base for nursing, reflective approaches must be used alongside systematic and interpretive approaches Both Clarke et al's (1996) and Pierson's (1998) attempts to define reflective practice and to distinguish it from the model of technical rationality will be revisited and analysed in more detail later in the analysis chapters.

'*Reflexive practice*' describes practice that generates new theory and is, in turn, modified by that theory (Rolfe, 1997, 96). Informal theories, which refer to personal theories about individual patients in specific situations, are constructed, tested, modified and retested in the process of reflection-in-action. Informal theory construction, Rolfe (1997, 96) argues, requires a comprehensive knowledge of the patient, '*mindful attention*' or intense concentration on the task at hand, and the ability to combine knowledge from different sources in the practice situation.

This middle phase in the nursing literature marks the appearance of early versions of Johns's (1995a) model of structured reflection. As illustrated in Chapter 2, Carper's (1978) four fundamental patterns of knowing in nursing - the personal,

aesthetic, empirical, and ethical – were incorporated into the model developed by Johns (1995a). In utilising this model of structured reflection, knowledge is developed in all four domains. Such knowledge is described as '*the most significant form of disciplinary knowledge*' as it is the knowledge used to practice (Johns, 1995a, 233). 'Reflexivity', as another pattern of knowing, is included in Johns' (1995a) model, acknowledging the assimilation of new with existing knowledge, and the on-going development of personal, practical knowledge (Johns, 1995a, 1995b). Like Boud & Walker (1998), Johns (1999) recognises that models of structured reflection may be used inappropriately as a 'technology', telling the practitioner how to reflect and limiting reflection to a cognitive activity. To avoid this and the potential of traditional nursing culture to limit the emancipatory and empowering effects of reflective practice, guided reflection is recommended (Johns, 1999). The guide is non-judgemental, affirmative, highly challenging and supportive, and, preferably, not too closely associated with organisational values (Johns, 1999).

By the mid to late 1990s, reflective practice as a model of professional knowledge is established in the nursing literature. The main emphasis at this time is on the practical issues involved in teaching, assessing, and researching reflection. While theories, definitions, and frameworks have been borrowed from the education domain, these have not been assimilated uncritically into nursing education. New models originating in nursing are also developed. The potential for reflective practice to become like the dominant model of technical rationality is recognised and ways of avoiding such an outcome are identified and explored.

3.4 The Later Years

A major preoccupation in the nursing literature of the early 2000s concerns the challenge to reflective practice posed by the evidence–based practice movement in health care. The impact and consequences upon nursing knowledge of this movement, and the response of nursing to the challenge, have been highlighted in Chapter 2. Texts in which the relationship between reflective practice and

evidence-based practice, as models of professional knowledge in nursing education, is explored and debated will be the subject of a deconstructive reading in Chapter 9.

The influence of postmodernism on perceptions of reflective practice as a model of professional knowledge becomes evident in the nursing literature of the later years. Reflective knowledge is presented as marginalised by the dominance of evidence-based practice (Rolfe & Gardner, 2005). It is also presented as a dominant or hegemonic discourse in its own right (Cotton, 2001; Gilbert, 2001). If conceived of as the latter, reflective practice may be misused as a form of surveillance and '*thought control*' (Cotton, 2001, 515). The micro-techniques of reflection commonly used in nursing education programmes, such as making previously private thoughts public and thus subject to control, is recognised as a particular risk in higher education settings where reflection forms part of assessment and nursing research (Cotton, 2001). If analysed from a micro-sociological perspective, Taylor (2003) claims that reflective practice is a no more faithful or truthful representation of professional knowledge in nursing than is the model of technical rationality. Both approaches are textual constructions that create certain versions of 'reality'. The particular rhetorical devices employed in reflective accounts, such as the use of first person pronouns and narrative approaches appear to bring practice closer giving it a more authentic feel (Taylor, 2003).

Adopting a Foucauldian perspective, Nelson (2012, 204) argues that reflective practice as a model of professional knowledge has emphasised what she terms the '*virtue script*' at the expense of scientific knowledge needed for competence.

> *...nursing discourse, and most particularly nursing pedagogy, is almost entirely focused on the subjective and relational dimensions of practice...*(The virtue script) *worked to overshadow the skilled and knowledgeable dimensions of nursing work, reinforcing nursing as good work undertaken by good, for the most part, women.*

Calls for conceptual clarity and research into the nature of reflective thinking persist into the first decade of the new millennium. Clarity and research are needed if the debate on reflective practice as a model of professional knowledge for nursing is to '*resist degenerating into polemic*' (Teekman, 2000, 1126). Research studies focusing on how nurses use reflection in practice found that reflection is used mainly for action, that is, to keep going in situations of doubt. It is used less often to evaluate or create understanding of the total situation, and rarely to question the wider context of practice. These findings seem to support Schön's (1983) theory of reflection-in-action as outlined in Chapter 2. In a qualitative research study by Gustafsson and Fagerberg (2004), nurses reported tending to reflect on situations of poor nursing care and on what they had said and done in such instances and if their actions were correct. Ethical issues and situations that require courage were also subject to reflection (Gustafsson & Fagerberg, 2004). These findings suggest that reflection functions in situations where, perhaps, knowledge is less certain. Again, this is consistent with Schön's (1983) theory.

Nurses' ability to practice reflectively and to use reflective knowledge may be limited by the wider social context in which they work. An interpretive ethnographic methodology was used to capture '*daily ward reality*' for four nurses from different wards in two hospitals (Mantzoukas & Jasper, 2004). Interviews followed observation of practice to explore the decision-making processes of the nurses involved and how they perceived reflection was used. Participants completed a written reflection of the practice situations. A second interview three weeks later followed up on issues arising from the first and any changes in perspective that had occurred (Mantzoukas & Jasper, 2004). Participants felt constrained in using reflective practice because ward culture was dominated by the hard scientific knowledge of doctors and managers (Mantzoukas & Jasper, 2004). Linking knowledge and power, the researchers assert that using reflection and learning from practice was diminished due to power imbalances (Mantzoukas & Jasper, 2004).

Research studies in the later years also continue to investigate the development of reflective skills in nurses (Duke & Appleton, 2000; Glaze, 2001; Liimatainen, Poskiparta, Karhila, & Sjogren, 2001; Paget, 2001). In a qualitative study of 14 Advanced Nurse Practitioner students from one cohort who had completed a pre-entry degree level reflective practice module and a reflective component on a Master's degree practice module, Glaze (2001) found that the majority perceived themselves as having gone through a process of transformation. This included becoming more aware of how personal biography shaped actions, developing a greater appreciation of what nursing can be, and becoming more realistic, open and confident (Glaze, 2001). Whether this process is attributable solely to the reflective components of the programme or to the level of academic preparation and practice these students had experienced is not debated. The latter issue does form part of Paget's (2001) retrospective survey of 200 students who had undertaken a variety of pre- and post-registration courses at both undergraduate and post-graduate levels, all of which had included a formal and measurable preparation for reflective practice. A majority of the 35% who responded to the questionnaire reported that their practice had changed not only in the specific area reflected on for the course but also in other areas, and that these changes had persisted beyond the course and become integrated into their practice (Paget, 2001). These changes were not associated with level of academic preparation. A telephone interview one year later with ten randomly selected respondents who had volunteered contact details re-enforced the results of the questionnaires (Paget, 2001). These studies point to the impact of reflective learning on the development of personal knowledge.

Attempts to measure reflective skills using quantitative methodologies is also evident in the literature of the later period (Duke & Appleton, 2000). A research study reported similar problems with measuring reflective skills to those reported by Wong et al. (1995) in the previous decade. In the later study, a marking grid was developed from the theoretical literature with criteria to denote reflective skills, for example: an ability to describe practice, analyse feelings, action planning, and so on. As well as reflective skills, the grid used in the data analysis included traditional academic skills such as clarity of presentation, referencing, and so on.

Grades awarded included marks in the latter skills. The problem of markers being able to differentiate reliably between reflective skills, together with the artificial fragmentation of reflection using discrete skills are acknowledged as limitations of the study (Duke & Appleton, 2000). This research study could be considered illustrative of the tensions involved in trying to assimilate two quite different models of professional knowledge in a nursing curriculum.

Teaching strategies and the effectiveness of different approaches to facilitating reflection are also investigated and reported in the nursing literature (Nicholl & Higgins, 2004; Platzer, Blake, & Ashford, 2000;Scanlan, Care, & Udod, 2002). The main theme to emerge from Scanlan et al.'s (2002, 140) study of teaching reflection was '*making connections*'. This theme described the teachers' efforts to assist students in connecting taught content to personal and professional experience, their own and the students', in order to attain a deeper understanding of theory. Reflection was found to be more easily facilitated when the teacher had mastery of content as well as teaching expertise, and when the teacher was not emotionally drained (Scanlan et al., 2002). Personal and emotional investment is required not only on the part of the reflective practitioner but also on the part of those who facilitate reflection. 'Mastery of content' suggests a point of contact between reflective and technical models of professional knowledge, with technical knowledge subsumed, but none the less relevant, within reflective practice.

Nicholl & Higgins's (2004) description of an investigation into how reflection is taught in Schools of Nursing that offer Diploma/Pre-registration nursing programmes is an interesting example of the dominance of a technical rational approach to researching reflective practice. A questionnaire was employed as the data-gathering instrument in the research study. Questions related to teachers' experience in terms of time teaching reflection, time allocated to the subject, learning outcomes, and teaching strategies employed. The researchers report that learning outcomes used by teachers related mainly to the cognitive domain (Nicholl & Higgins, 2004). In the examples provided in the report, learning outcomes were oriented towards the 'theory' of reflection rather than the practice of reflection. Learning outcomes in the cognitive domain included, for example,

'*Define reflection*', '*Describe a model of reflection*', and so on. If these outcomes are achieved, the learner will know a lot about reflection but not necessarily very much about reflective practice. Teacher preparation for facilitating learning about reflective practice was reported as including reading about reflection or getting information as part of an academic course (Nicholl & Higgins, 2004). A distinct theory-practice gap appears evident in the teaching of a practice designed to overcome a gap between theory and practice.

Assessing reflection is an issue explored in some detail by Hargreaves (2003). The influence of reflection on professional education coupled with the increasing emphasis in higher education on developing effective assessment strategies clearly linked to student learning creates problems with assessment (Hannigan, 2001). One of the problems is the lack of control over learning outcomes which is characteristic of reflective learning. Another is the requirement to mark reflective material, which may induce students to produce work that is acceptable to the teacher and the profession rather than an accurate account of experience (Hargreaves, 2004). The alignment of learning and formal assessment in the reflective practice model of professional education is therefore rendered questionable.

Further signs of tension between two differing epistemologies of practice is evident in Carroll et al.'s (2002) demand for rigorous research evidence for the effectiveness of reflective practice in enhancing student learning and improving nursing practice. Working in an environment of evidence-based practice poses difficulties for the nurse educator, as research on teaching reflection is sparse as is research on how assessment of reflection via journals and diaries is to be carried out (Carroll et al., 2002). Carroll et al. (2002) echo James & Clarke's (1996) concern at the lack of clarity on specific teaching methods designed to facilitate reflective practice and the lack of a clear definition of reflection and reflective practice. An added concern for these authors is that an increased focus on reflection could lead to certain core skills that are essential to the development of a dynamic, responsive nurse, for example, critical thinking, problem-solving, and self-awareness, being lost (Carroll et al., 2002). The view of professional

knowledge presupposed in the concerns expressed above seems oriented towards a behavioural competence model and appears indicative of a more positivist than reflective view of nursing knowledge.

Many of the issues first highlighted with the introduction of reflective practice into the nursing literature remain evident almost quarter of a century later. Efforts at clarifying and defining the concept continue (Duffy, 2007; Kinsella, 2007). New or refinements of existing models and frameworks are presented (Fowler, 2006; Nielsen, Stragnell, & Jester, 2007). Research studies are reported (O'Connor & Hyde, 2005). The debate regarding evidence-based practice as a model appropriate for the discipline of nursing endures. Approaches to integrating evidence-based practice and reflective practice are proposed. Describing recent changes in healthcare in the USA and the potential they offer for a sea change in nurse education and practice, Picard & Henneman (2007) advocate valuing theory-guided, evidence-based, reflective practice in a Clinical Nurse Leader Masters-level curriculum (Picard & Henneman, 2007). Reflection and dialogue on disciplinary knowledge as it is 'lived out' in everyday nursing practice will be required. Nurses, Picard & Henneman (2007) claim, can shape conversations about choosing from evidence in practice, and ensure that evidence is not restricted to research-based findings but includes the patient and family experiences, as well as context and environment in clinical decision-making (Picard & Henneman, 2007).

3.5 Conclusion

This diachronic view of reflective practice as a model of professional knowledge in nursing education reveals it to be an enduring feature in the nursing literature. The problem of definition and consistency of understanding is evident and remains a focus of concern over time. Tension between reflective practice as a technology and reflective practice as an emancipatory process is revealed though not always declared. The influence of higher education is perceptible in the strong focus on researching reflective practice, although some of the methodologies chosen seem

more consonant with a technical rational model of professional knowledge than a reflective one.

In the following chapter, deconstruction as the research methodology is presented and discussed.

Chapter 4 Methodology

4.1 Introduction

> *Deconstruction is often thought of as a dismantling, or undoing. Certainly, Derrida thought that an argument, an individual or an institution's account of itself was not necessarily the most reliable authority. The moment we are confronted with self-representations, Derrida thought we should hone our listening and critical faculties, a little like a highly attentive therapist or psychoanalyst. Deconstruction suggests that texts and arguments with which we are most familiar contain hidden and unexpected reserves, points of inner resistance, dialogues and alternatives. Attending to these, Derrida converted our understanding of the available resources of the familiar* (Deutscher, 2005, xii).

The method of deconstruction is most closely associated with the French philosopher, Jacques Derrida. As indicated above, deconstruction is a critical approach to text analysis. In general, authoritative texts are consulted when one wishes to understand a particular issue or domain. When I want to know, for example, what reflective practice as a model of professional knowledge in nursing education is, I consult texts that refer to that subject. This I did in order to write much of the content contained in previous chapters of the thesis. I read the texts of those renowned in the field of reflective practice and nursing education with care and attention in order to understand and re-present their ideas using a combination of my own words and the authors' words. There is, however, as the above extract indicates, another way of reading those same texts; a reading that is alert to the '*hidden reserves*', the '*points of inner resistance*', and so on, that the texts contain. This reading 'otherwise' of texts that elaborate reflective practice as a model of professional knowledge in nursing education is the aim of the thesis. Presenting the arguments for why and how such a reading should be accomplished is the purpose of this chapter. Deconstruction has not always enjoyed a positive

response in the world of the academy. Derrida himself and his ideas have been subjected to quite vitriolic comment by fellow professional philosophers and other academics in his lifetime. He was not particularly enamoured of the word 'deconstruction' and how it came to be used subsequently (Derrida, 2004b). However, I believe his ideas have value for research and scholarship and, in the following pages, I hope to make a case to that end that persuades the disinterested reader. Many of the introductory comments that follow are presented to counter some of the misconceptions that pertain regarding deconstruction.

Deconstruction offers the researcher an approach to text analysis that opens the possibility of an alternative reading. As indicated in Chapter 1, re-reading texts that have made a difference to some aspect of our lives and reading them in a deconstructive way allows us *'...to see them in a more complex, more* ***constructed****, less idealised light'* (Johnson, 1987, xviii) (Johnson's emphasis).

A deconstructive reading does not claim to be a better, truer, or more accurate reading of a text. The goal of analysis is not to arrive at a new set of themes or to generate a new theory. On the contrary, deconstruction is oriented towards loosening or unsettling any totalizing system (Caputo, 1997). Because part of the method of deconstruction is to question 'conceptuality', it is sometimes mistaken as attempting to do away with concepts with the result that either nothing has any meaning or, alternatively, the extreme relativist position, that any meaning is possible. Deconstruction does not sanction an 'anything goes' relativism in respect of the question of knowledge (Caputo, 1997). The possibility of meaning is not eliminated in a deconstructive reading. Without some sense of stable meaning, there would be no knowledge in many disciplines. Howells (1998, 154) contends that *'deconstruction is not in any way a nihilistic undermining of truth, but rather an exploration of the prejudices and preconceptions that underlie much of what we generally accept without question'*. Deconstruction recognises the necessity of using concepts such as 'truth' and 'knowledge' while refusing them any particular privilege. At the same time, as Norris (2002, 220) makes clear: *'no case can be argued, no proposition stated – however radical its intent – without falling back on the conceptual resources vested in natural language'*.

As indicated in the introductory chapter, my reading of the texts of reflective practice in the context of nursing education prompted many questions. Teaching reflective practice and facilitating reflection also presented challenges of understanding and clarity. Discussions with colleagues revealed multiple perspectives on the same topic. One of my main questions was how so many interpretations and sometimes quite diverse interpretations of the same concept and activity are possible. I began to believe that the answer to that question must lie in the textual constructions of reflective practice. In my reading of deconstruction as a research methodology, I noted some similarities between reflective practice and deconstruction. Both begin from a stance of uncertainty. Reflection is prompted by practice situations where propositional knowledge is not entirely apposite or available, and the practitioner must draw on alternative forms of knowledge which are not readily recognisable. Deconstruction is oriented to finding new openings in entities that seem fixed and stable. Both reflective practice and deconstruction seek out and challenge taken-for-granted assumptions and presuppositions inherent in any knowledge claim. *'the defining attribute of the reflective practitioner is precisely the inquisitive attitude of taking nothing as given'* (Rolfe et al., 2001, 1). Both are practices that respect the materials with which they work. A deconstructive reading and reflecting on practice in search of knowledge begin with an openness to what may be revealed. Caputo (1997, 73-74) remarks of deconstruction in relation to scientific knowledge:

> *The sneaking suspicions that something may be wrong with what we currently believe, while keeping a watchful eye that current paradigms not be taken dogmatically, that something else, something other, still to come, is being missed – that deeply deconstructive frame of mind goes to the heart of hardball science, if it has a heart!*

Similarly, reflecting in, and on, practice is a response to perplexity and doubt. Reflective practice requires that one steps outside the mainstream and questions dominant frames of reference.

Both reflective practice and deconstruction are concerned with changing existing actualities, seeing things in new ways, and generating new possibilities of action. In situations of uncertainty in nursing practice, where the application of a rule or procedure is inappropriate, the search for new knowledge and the envisioning of new possibilities is guided by certain ethical principles, chief of which are respect for persons and respect for individual autonomy. These principles are at the core of an ethic of caring which characterises the discipline of nursing (Meleis, 2012).

As outlined in Chapter 2, reflective practice as a model of professional knowledge is frequently opposed to the dominant model of technical rationality (Schön, 1983). The latter sets the standard for professional knowledge and anything different, such as reflective practice, is regarded as a corruption of that standard. This is especially evident in the so-called hierarchy of professional knowledge and the hierarchy of evidence in evidence-based practice. Scientific knowledge dominates over other sources of knowledge in professional practice. Promoting reflective practice as a more appropriate model of professional knowledge for nursing than the model of technical rationality could be read as an attempt to reverse the hierarchy, with reflective practice now dominant and technical rationality considered deviant. Deconstruction is very much concerned with analysing these sorts of hierarchized oppositions. The aim is to destabilise or dislodge the opposition revealing it to be a construct rather than anything necessary or inevitable. In so doing, other understandings are made possible.

> *If each text is seen as presenting a major claim that attempts to dominate, erase, or distort various "other" claims (whose traces nevertheless remain detectable to a reader who goes against the grain of the dominant claim), then "reading" in its extended sense is deeply involved with questions of authority and power* (Johnson, in Lentricchia and McLaughlin, 1995, 46).

Just as reflective practice retains the right to question all knowledge claims, it surely follows, in the spirit of true reflexivity, that the knowledge claims attributed

to reflective practice must be analysed in the texts wherein such claims are constructed.

4.2 Background to the methodology

Deconstruction is part of the post-structuralist movement in philosophy and the social sciences which arose as a reaction to, and critique of, phenomenology with its privileging of the subject or consciousness as centre and source of knowledge and meaning. Post-structuralism also critiqued structuralism, which had 'decentred' the subject, and attributed meaning to systems as opposed to individuals (Sturrock, 2003). Systems are composed of elements. No single element in a system has meaning in and of itself, be it a word in a language system, an individual in an organisation, or an artefact within a culture (Sturrock, 1979). Meaning is a function of the relationship between elements that make up the system or structure. Stability is attributed to the structure (Sturrock, 2003), thereby presupposing the possibility of stable meaning. Post-structuralism challenges this presupposition.

> *Structures for Derrida have no centre, because they are structures. It can make no sense to speak of the 'centre' of a language or of any other such system. These systems are in constant 'play'. Because this is a realization unpopular with many, who crave 'centres' and 'essences', it has been 'neutralized' by a false centring of structures round a fixed point* (Sturrock, 2003, 132).

There are varied approaches to text analysis within post-structuralism. As indicated in Chapter 3, reflective practice has been analysed using Foucauldian (Cotton, 2001; Gilbert, 2001; Nelson, 2012; Wellard & Bethune, 1996) and social constructionist methods (Taylor, 2003). While deconstruction shares with these approaches a general scepticism with respect to truth and knowledge, it does not dispense with these concepts.

> *...deconstruction in no way rejects or renounces the values of truth and falsehood, but "reinscribes" them - together with referential function of language - in a more complex differential "economy" which is there to be analysed in the texts of (among others) Marx and Engels. No doubt deconstruction entails a questioning of what Derrida calls "logocentrism", that is to say, the deep-laid metaphysical prejudice whereby the values of truth and reason are equated with a privileged epistemic access to thoughts "in the mind" of those presumed or authorised to know* (Derrida, 2004b, xix) (Introduction second English edition, 2002).

Structuralism made use of Saussure's theory of language as a framework for research in a wide range of disciplines, from psychoanalysis to anthropology. Deconstruction continued the interest in Saussure's theory of language and went further, identifying in it possibilities that Saussure himself had recognised but, perhaps unconsciously, suppressed. Since Saussure's theory of language is central to an understanding of deconstruction as a research methodology, it is necessary briefly to outline its main points.

Saussure theorised that language is a system of signs. He referred to the sign system as 'langue' and the language event or instance of language use as 'parole'. The system is necessary for the event to occur, and the event in turn makes the system what it is. Saussure focused his attention on examining the system rather than the events of language use. The sign system is not a nomenclature; it does not name things: '*A linguistic sign is not a link between a thing and a name but between a concept and a sound pattern*' (Bally et al., 1986, 66). A sign is therefore not unitary. It consists of a sensible or material aspect and an intelligible or conceptual aspect. The material aspect of the sign, that is, the sound pattern or graphic image, Saussure called the 'signifier' and the intelligible or conceptual aspect he called the 'signified'. Saussure also advanced the thesis of the arbitrariness of the sign, that is, that no natural connection or resemblance exists between the phonic or graphic pattern and the concept. There is nothing about the word 'cat', either written or spoken, that links it to a four legged furry domestic pet or a graceful fleet-footed panther. The word 'cat' signifies or conveys meaning

because it can be distinguished aurally and visually from the words 'bat', or 'cot'. Both signifiers and signifieds are arbitrary. The idea of a cat is distinguished in 'the mind's eye' from the idea of a dog or a baby. Meaning depends not on any thinking subject but on the sign system.

> *No word has a value that can be identified independently of what else there is in its vicinity.*
> *... what we find, instead of* ***ideas*** *given in advance, are* ***values*** *emanating from a linguistic system. If we say that these values correspond to certain concepts, it must be understood that the concepts in question are purely differential. That is to say they are concepts defined not positively, in terms of their content, but negatively by contrast with other items in the same system. What characterises each most exactly is being whatever the others are not* (Bally et al., 1986, 114-115) (Bally et al.'s emphases).

The idea that there are no positive terms in language, that meaning is a function of difference, is very significant for deconstruction. No thing or entity exists in and of itself. '*No word can acquire meaning in the way in which philosophers from Aristotle to Bertrand Russell have hoped it might - by being the unmediated expression of something non-linguistic (e.g., an emotion, a sense-datum, a physical object, an idea, a Platonic form)*' (Rorty, in Selden, 1995, 173). It is not possible, as phenomenology asserts, to return to 'the things themselves', that is, to things present to consciousness or 'intended' without the mediation of language. '***The thing itself is a sign***' (Derrida, 1997, 49) (Derrida's emphasis).

> *The sign is usually said to be put in the place of the thing itself, the present thing, "thing" here standing equally for meaning or referent. The sign represents the present in its absence. It takes the place of the present. When we cannot grasp or show the thing, state the present, the being-present, when the present cannot be presented, we signify, we go through the detour of the sign. We take or give signs. We signal. The sign, in this sense, is deferred presence. Whether we are concerned with the verbal or the written sign, with the monetary sign, or with electoral delegation and political representation, the circulation of signs defers the moment in which we can encounter the*

thing itself, make it ours, consume or expend it, touch it, see it, intuit its presence (Derrida, 1982, 9).

The identity of the sign is constituted by its difference from other signs. '*From the moment that there is meaning, there are nothing but signs. We* ***think only in signs***' (Derrida, 1997, 50) (Derrida's emphasis). But the sign itself is divided and takes its meaning from that which it is not. Derrida (1973, 129) coined the term '*différance*' to illustrate how meaning is made possible in the language system. For Caputo (1997, 96), '***différance*** *is what deconstruction is all about*' (Caputo's emphasis). An elaboration of this term is therefore required for an understanding of deconstruction as a research methodology.

4.3 Différance

The French verb 'différer' combines two meanings: to differ and to defer. *Différance* combines the sense of difference as the state of being different from or other than, and also the sense of deferment or delay. It is, as Derrida notes, '*the condition for the possibility and functioning of every sign*' (Derrida, 1982, 5). Signs only take their meaning from their differences from other signs. That difference (between two phonemes or graphemes) is not itself heard or seen. So the difference that makes meaning possible is nowhere ever 'punctually' present. Neither is it totally absent; otherwise there would be no meaning. Every sign contains the 'trace' of other signs, of what the sign is not, and that (the trace) is what makes the sign mean what it does. To mean, therefore, is not to be (present in the present). Meaning is different (not that) and deferred (not here, not now) (Caputo, 1997). *Différance* is neither a word nor a concept. It belongs neither to the realm of sensibility nor intelligibility. A word that conveys meaning is apprehended by the senses; it is either seen or heard. The word must also be distinguishable from other words in order to signify as it does. For example, a reader must be able to distinguish the letter 't' from the letter 'l' and, similarly, the word 'tot' from the word 'lot' in order to grasp the meaning of a text which contains those signs. Similarly in speech, the sound 't' must be distinguished from

the sound 'd' and the word 'tot' distinguished from the word 'dot'. But the difference that allows such distinctions is not a third letter or word or sound. The difference is an interval or spacing between two letters or signs. Referring to speech, Glendinning (2001, 2-4) explains:

> *4: The difference between two phonemes is not itself a sound – not some third sound, not an audible 'something'.*
> *5: Therefore the difference which establishes speech and lets it be heard is inaudible ('in every sense of the word').*
> *6: But since meaningful speech is possible the difference between two phonemes must still be discriminable.*
> *7: Therefore one ought to reject the idea that such discrimination belongs to sensibility.*
> *According to this argument, what is discriminated when one hears an identifiable phoneme* ***cannot*** *be reduced to a sound which is simply present in the present. And that is because, as Derrida puts it...its 'identity can only determine or delimit itself through differential relations to other elements'. Or again, as Saussure puts it, the basic elements of speech are not substantial positive terms or sound atoms, but only emerge out of, or issue from, a system of phonic differences.* (Glendinning's emphasis).

Neither is the difference between two phonemes or two graphemes, and which permits meaning, present in the mind or to a consciousness.

> *...this 'discrimination of differences' cannot belong to an 'order of intelligibility' either. We cannot conclude, as for example Descartes might have concluded, that the perception of phonemes entails that something is present not to the senses but is ('seen' or 'heard' by) the mind, or the mind's eye or ear* (Glendinning, 2001, 4).

Meaning is instituted or conventional; the speaker or author cannot choose what signs mean. Meaning therefore cannot arise in the mind of the thinking subject. It

is the language system rather than the mind that provides the concepts that make meaning possible (Stocker, 2006).

Différance is the condition of possibility of meaning. A 'condition of possibility' is a necessary condition for the appearance of an entity to be possible. For example, space is a condition of possibility for the appearance of three dimensional objects. It does not cause the object to appear nor is it part of the appearing object's identity (Peters & Biesta, 2009). Meaning is not caused or made to appear because of an intention, that is, because of something present to the mind or to consciousness. Meaning or conceptuality may be described as an effect of the differential play of language, an effect without a cause, or both cause and effect (Peters & Biesta, 2009). *Différance* thus disrupts the notion of origin. *Différance* is prior to, in a nontemporal way, but cannot serve as, the source or origin of meaning because it is not itself a single point or a 'now' moment. While *différance* is the condition of possibility for the functioning of every sign, it is also the condition of impossibility of pure meaning, that is, a meaning identical with itself, fully present to itself. Every sign is inhabited or contaminated by a non-present element and that makes the idea of pure meaning impossible. Every sign bears within it the trace of what it is not. *Différance*, therefore, prevents conceptual closure (Norris, 2002).

> *The role of difference/**différance** is to establish the conditions within which discourse functions. It founds (and un-founds, undermines) languages, vocabularies, showing how they are both possible and impossible, that is, incapable of a closure which would give them self-sufficiency and a feeling of success in nailing things down* (Caputo, in Silverman, 1989, 28). (Caputo's emphasis).

The sound that first signified 'food', for example, had to be distinguished from other sounds around it, so that when the sound signifying food was heard, it bore the trace of those other sounds which it was not. There is nothing intrinsic to the sound itself that makes it mean food. *'differences of sound and sense are the only markers of meaning'* (Norris, 2002, 24).

> *Difference (radicalised by Derrida's neologism* ***différance*** *to bring out both spatial and temporal resonances, identity being an effect of differences from other elements* ***and*** *between events of repetition) is the* ***milieu*** *in which identities are sketched but never quite achieved (any element being defined only in terms of all the others and all its repetitions, the* ***trace*** *of which remains as a sort of constitutive contamination), but never quite lost (****différance*** *can be thought of as a dispersion, but never an* ***absolute*** *dispersion). Identities depend on traces of other identities: but the trace 'itself', now the logically prior term, is not answerable to any metaphysical characterisation (it is, for example, neither present nor absent, and, as the condition of identity in general, is not itself* ***identifiable***) (Bennington, 2000, 12). (Bennington's emphases).

Bennington's reference to 'events of repetition' in the above citation signals the importance of context in the construction of meaning. Meaning is context bound, for example, the word 'food' will signify in different ways depending on the context in which the sign is deployed. 'Food for thought' will have a different meaning to food harvested in a tillage field and to food itemised on a shopping list. Reference to a 'tot' may signify a small child or a tot of whiskey or the addition of a set of numbers as in 'to tot up the bill'. A 'lot' may signify quantity or items in an auction sale, or it may denote a biblical reference such as in the reference 'They drew lots for his clothes'. When a signifier with many different significations is used, one looks to context to determine its meaning. Whenever any sign is used, it is used in a context. There is no 'outside' context (Derrida, 2004b). Meaning is therefore context-dependent. At the same time, no context can ever be determined so completely that it arrests the 'play' of the signifier (Derrida, 1977). Using the word 'food for thought' may signify food that enhances cognitive capacity, memory, and so on, rather than signifying something to think about.

Language cannot be understood solely in terms of the transfer of a signified or semantic content without a consideration of the vehicle of transfer. '*...the threat posed by writing is that the operations of what should be merely a means of expression might affect or infect the meaning it is supposed to represent*' (Culler,

2008, 91). The same threat is also attributable to speech. Meaning that cannot be fixed, that is never anywhere punctually present is intolerable especially when clarity of concepts and perspicuity is required. Stocker (2006, 185) asserts:

> *...if there is no totality with a centre to determine interpretation and meaning, then interpretation and meaning emerge from the equivocations and contextuality of signs within discourse. Discourse itself does not reflect a world of fixity and determinism; it emerges from the 'playful' equivocation and contextuality of the sign. Again this means that we are faced with madness, anxiety and unintelligibility. There is no way in which we can fix meanings absolutely, or find completely stable structures to contextualise them in a deterministic manner.*

The response to this anxiety has been to create a system of thought that attempts to nail things down. What cannot be logically determined as clear and precise will be rendered so by force. The construction of hierarchized oppositions is a way of achieving stability of concepts. Terms are arranged in binary oppositions with the first term of the opposition privileged as the normal, the standard, while its opposite is regarded as derivative, parasitic, a corruption. Binary oppositions rely on the principle of non-contradiction whereby something cannot be both A and not A at the same time. Johnson (1987, 14) claims that what is most radical in deconstruction is that it questions the basic logic of binary oppositions, and not in a simple way: '*While traditionalists say that a thing cannot be both A and not-A, deconstructors open up ways in which A is necessarily but unpredictably already different from A*'. It is the repression of differences within, for example, a word or an individual, that creates unity and identity, and this allows binary oppositions to function (Johnson, 1994). A deconstructive reading will be alert to how reflective practice as a model of professional knowledge differs from itself in the texts that attempt to construct its identity.

> (Certain) *theoretical constructs do not fit easily into the categories of conventional logic, which requires clear unambiguous definitions, consistency of argument and a commonsensical view of time and space, cause and effect* (Britton, in Selden, 1995, 198).

4.4 Binary oppositions

In an attempt to fix meaning, the tradition of Western thought has established binary oppositions. Examples of such oppositions include: nature/culture, good/evil, presence/absence, mind/body, male/female, true/false, original/copy, literal/metaphorical, theory/practice, ideal/empirical, essential/contingent, speech/writing. The first term is given priority both temporally and qualitatively (Derrida, 2004a, Translator's introduction). Plato's ideal world, for example, is the world of 'forms': timeless and immutable, present to the mind but not perceptible to the senses. The empirical, contingent world, the sensible world, on the other hand, represents a corruption of that ideal. An original painting, to take another example, is considered superior to a copy of the same painting. Derrida describes these oppositions as violent hierarchies (Derrida, 1997). The reason for the violence is that the second term threatens the purity and self-identical meaning of the first term. It must therefore be suppressed or excluded by force. What deconstruction demonstrates is that the so-called derivative term is a positive condition of possibility of the privileged term. For example, could Plato's ideal world be imagined were it not for the existence of the empirical world? Is the ideal world not a modification or abstraction of the empirical world? (Derrida, 1973, Translator's introduction). If an original painting could not be copied, how would its originality be determined? It is by way of a copy that original features may be identified (Culler, 2008). At the same time, the possibility of copying threatens the purity of the original. A copy may be mistaken for an original, and occupy the place of the original. Doubts may be expressed about the identity of the copy. It may not be possible to establish definitively that the copy is not, in fact, the original. It may be an 'undecidable'. Whether there is any such thing as an 'original' painting is also questionable as artists are influenced by other artists, trained in certain techniques, and so on. Culler (2008, 88) claims that deconstruction destabilizes hierarchical oppositions '*by producing an exchange of properties*'. Two opposing forces playing against each other constitute the so-called identity of a phenomenon (Derrida, 1997).

The opposition presence/absence is particularly significant in deconstruction. Meaning as present in the mind, the subject present to her/his thought, the presence of the present moment, are all examples of what Derrida (1997, 49) terms '*the metaphysics of presence*'. Presence is posited as the ultimate foundation and origin of meaning because there is nothing that divides it, no prior thing from which it could be constituted. To mean is to be, to exist in the 'now' moment. Bennington & Derrida (1993, 16-18) offer the following comment on the metaphysics of presence:

> *The metaphysics of presence thinks in two (logical and often historical) moments: presence first, of the world to a gaze, of a consciousness to its own inspection, of a meaning to a mind, of life to itself, of a breast to a mouth; absence next – the world veiled, consciousness astray, non-sense, death, debauchery, language, weaning. By thinking the second moment as derived with respect to the first, one returns, if only in thought, the complex to the simple, the secondary to the primary, the contingent to the necessary. This is the very order of reason and meaning, of the* ***logos****...*(Bennington & Derrida's emphasis).

However, as the discussion of *différance* illustrates, the present is constituted by that which it tries to exclude, that is, absence. When one refers to the present moment, it is already past. Without the concepts of past and future, it is difficult to imagine how the present moment could be constituted. It is not possible to recover the simple, the primary moment as that moment is already divided. The present is always and already inhabited by absence. While it does not appear as such, the trace of the non-present remains detectable. The system of hierarchized oppositions strives to suppress this difference 'within'. Referring to philosophical concepts, Gasché (1986, 128-129) contends:

> *They exist precisely on a disregard for their own bipolar opposite, to which they deny a value similar to their own. Philosophical concepts would be entirely homogeneous if they possessed a nucleus of meaning that they owed exclusively to themselves – if they were, in other words, conceptual atoms. Yet since concepts are produced within a discursive network of differences, they*

not only are what they are by virtue of other concepts, but they also, in a fundamental way inscribe that Otherness within themselves...
No concept... can be thought rigorously without including the trace of its difference from its Other within itself.

A deconstructive analysis is alert to what is excluded or suppressed within the concept of interest to the researcher. Reflective practice, as a model of professional knowledge, is sometimes posited as the binary opposite of the model of technical rationality, with the latter occupying the dominant position. At other times, reflective practice is asserted as the normal or standard model of nursing knowledge, with technical rationality 'cast out', as it were. These oppositions will be examined in more detail in the texts analysed in later chapters.

4.5. Deconstruction's other conceptual resources

Différance and binary oppositions are described by Stocker (2006) as the conceptual resources of deconstructive practice. Other terms, such as 'iterability', 'undecidable', 'supplement', and so on, function in the same way. Commenting on these so-called *'"key"'* terms in Derrida's writing, Johnson (in Derrida, 2004, xvii)(Translator's introduction) argues that such terms must not be used as a *'static lexicon'* but rather, as in Derrida's text, *'as a moving chain or network, it* (the text) *constantly frustrates the desire to "get to the point"'*.

As indicated above, deconstruction is sensitive to the contexts in which signs are used. No sign can function outside a context and yet no context can ever fully determine the meaning of any sign (Derrida, 1977). Although the same sign may be used, the meaning it conveys may be different depending on the context in which it is used. The term *'iterability'* designates this sense of repetition (sameness) and alterity (otherness) (Derrida, 1977, 7), and this feature of language has significance for a deconstructive analysis. In order for a sign to function and convey meaning, it must be repeatable and reproducible. This is because of the arbitrary and conventional nature of the sign system. The system

exists and functions by virtue of agreement among a particular community of language users. Any sign must be recognisable as the same sign despite variations in speech and writing among individuals.

> *A sign is never an event, if by event we mean an irreplaceable and irreversible empirical particular. A sign which would take place but "once" would not be a sign; a purely idiomatic sign would not be a sign. A signifier (in general) must be formally recognisable in spite of, and through, the diversity of empirical characteristics which may modify it. It must remain the* ***same****, and be able to be repeated as such, despite and across the deformations which the empirical event necessarily makes it undergo. A phoneme or grapheme is necessarily always to some extent different each time that it is presented in an operation or a perception. But, it can function as a sign, and in general as language, only if a formal identity enables it to be issued again and to be recognized* (Derrida, 1973, 50) (Derrida's emphasis).

This feature of language, to be recognised as the same despite variation, also enables a sign or sequence of signs to be detached from any particular instance of use and cited in other contexts. The sign does not require a particular signifying intention or consciousness to animate it. It will function and convey meaning even if the person using the sign or sign sequence has 'nothing in mind' at the time of the utterance. To say, for example, 'Happy Birthday' to someone whose birthday it is does not guarantee that the speaker really means or has in mind a wish for happiness for the person on their birthday. 'Happy Birthday' *means* because it repeats, and is recognised as, a conventional form of words. The speaker may, in fact, have quite the opposite in mind at the time of the utterance. Because the sign can function independently of any signifying intention, because language has what Derrida calls '*this structural unconsciousness*' (Derrida, 1977, 18), it can be cited in new and different contexts and still signify or convey meaning.

> *Every sign, linguistic or nonlinguistic, spoken or written (in the current sense of this opposition), in a small or large unit, can be* ***cited****, put between quotation marks; in so doing it can break with every given context, engendering an infinity of new contexts in a manner which is absolutely*

> *illimitable. This does not imply that the mark is valid outside of a context, but on the contrary that there are only contexts without any center or absolute anchoring* (Derrida, 1977, 12) (Derrida's emphasis).

This thesis is a series of citations. The citations signify differently in the context of this work than they do in the texts from which they were obtained. The academic conventions surrounding citations may be understood as an attempt to tie meaning to a source or origin and ensure that words are used in their correct sense, as their author intended. Copyright law has a similar goal (Derrida, 1977). The current debate concerning the writings of Shakespeare is an illustration of the influence of contextual factors on meaning. Would the meaning of the works attributed to the author William Shakespeare be the same if it could be established that he was not in fact the author? However, the attempt to fix context does not guarantee univocal meaning. While context is necessary for signs to function, no context can ever determine the meaning of a sign unequivocally. It is always possible for new contextual features to be identified which would allow for other possibilities of meaning. For example, the word 'reflection' will have a different meaning when used in a physics classroom to the meaning it will have in the context of a spiritual retreat. Its meaning will be different still in the context of a fairy tale, such as in, for example, 'Snow White'. Schön (1983) identified at least two different meanings of the word 'practice'. It may signify an occupation, such as nursing or medical practice. It may also refer to the process of developing a new skill, such as when one practices a musical instrument or a golf swing, with the aim of improving one's performance. The word may also signify a habit or custom, for example, 'He has a practice of getting up early in the morning'. At the same time, the use of a word in a particular context does not exhaust its meaning. The physics teacher may be preparing for an assessment before a group of peers. The musical instrument may be being practiced by an actor for a film role. Iterability denies the sign univocal meaning. '*The*' meaning of the word 'reflection' or the word 'practice' would necessarily have to include all of the above possibilities (Glendinning, 2001). It would also have to include the meanings attributed to these terms throughout the history of their use.

> *But the sign possesses the characteristic of being readable even if the moment of its production is irrevocably lost and even if I do not know what its alleged author-scriptor consciously intended to say at the moment he wrote it, i.e. abandoned it to its essential drift...by virtue of its essential iterability, a written syntagma can always be detached from the chain in which it is inserted or given without causing it to lose all possibility of functioning, if not all possibility of "communicating", precisely* (Derrida, 1977, 9).

The essential instability and autonomy of language, and the dissemination of meaning that such characteristics enable, ensures that an author can never be fully in control of the language that they use. Nor can an author control how texts that bear their name will be interpreted. *'Language can fulfil the condition of self-present meaning only if it offers a* ***total and immediate*** *access to the thoughts that occasioned its utterance. But this is an impossible requirement'* (Norris, 2002, 45). (Norris's emphasis). It is not necessary, Derrida (1973) argues, for example, that one perceives in order to understand a statement about perception, just as:

> *...the signifying function of the* ***I*** *does not depend on the life of the speaking subject. Whether or not perception accompanies the statement about perception, whether or not life as self-presence accompanies the uttering of the* ***I****, is quite indifferent with regard to the functioning of meaning* (Derrida, 1973, 96) (Derrida's emphases).

Another term that forms part of the lexicon of deconstruction is 'undecidable'. This refers to a word whose meaning is suspended between both poles of a binary opposition. A deconstructive analysis will be alert to terms that function in this way. The word 'reflective practice' may be used to signify in more than one way in the texts analysed. This may be an indication of the instability of the concept.

Just as the meaning of a sign can vary in different contexts, the same sign can signify in more than one way in a so- called unified text or work. Derrida (1997, 270) uses the terms *'supplement'* to designate this characteristic of the sign. The

word supplement has two meanings in French: it can mean to 'add' and to 'replace'. In a text by Rousseau which Derrida (1997) deconstructs, the word supplement is used in the context of education, among other things. According to Rousseau's text, education is required to supplement nature. At the same time, Rousseau asserts that nature is complete and culture is a corruption of nature. Education is a cultural construct. So education is something that both improves and corrupts nature. It has therefore the status of an undecidable. If an entity is already complete, why does it require an addition? And if something is already complete, how is a deficiency recognised? Similarly, writing is considered by Plato as both a remedy and a poison for memory (Derrida, 2004a). It is a remedy because it makes up for the deficiencies of memory. But writing also makes memory less effective. It is both remedy and poison and makes both possible. Johnson (1980, 8) remarks of undecidables: '*Undecidables set to work within a text that can no longer be included within binary oppositions, resisting and disorganising it without every constituting a third term*'.

The above terms – supplement, iterability, and so on, resist any settled or definitive meaning (Norris, 2002). The deconstructed or deconstructing text '*...mimes the movement of desire rather than its fulfilment, refusing to stop and totalise itself*' (Johnson, 1980, 11). The researcher cannot therefore treat these resources as tools or techniques to be applied in a deconstructive analysis. Rather they help to orient the researcher towards a deconstructive way of thinking and understanding. It is impossible to indicate in advance of a deconstructive reading how the various conceptual resources described above will be used or indeed where in the text the openings that enable a reading otherwise occur. However, it is possible to provide some detail of deconstructive reading strategies which guide the reader engaging in analysis.

4.6 Strategies of deconstructive reading

The "strategy" of deconstruction may be summarised as a slow, patient, close, fine-grained reading of already existing texts. Caputo (in Silverman, 1989, 30) reminds the reader that:

> *...deconstruction is a parasitic practice. For deconstruction can make a living only inasmuch as there is already someone who wants to say something about something to someone. Deconstruction requires a prior hermeneutics, the anterior work of addressing one another about the matter at hand. Deconstruction lies in wait for 'discourse' to stake its claims and then it pounces on it, showing how much trouble this discourse has bought for itself by its boldness. Were no one bold enough to launch the hermeneutic project, were no one willing to make such claims in the first place, then deconstruction would never get off the ground. This is another way of saying that deconstruction itself has nothing to say, or better that there is no deconstruction 'itself', that it is a parasitic practice, not a substantive position. In classical terms, the Being of deconstruction always exists* in alio, *by inhabiting the discourse of others, never* in se, *as something present in itself, as some form of* ousia.
>
> *In short, deconstruction is first of all a practice – it is what is does – not a body of theories, and secondly a parasitic practice – what it does is to inhabit the discourse of those who have something to say...*

It is claimed that deconstruction is 'always and already' at work in texts; all texts are potentially self-deconstructing. The reader therefore brings nothing new to a deconstructive reading. Deconstruction is *'not characterised by any exteriority to its object'* (Gasché, 1986, 121). It is not something that the researcher *does* to the text (Bennington, 2000). Everything that is needed for a reading otherwise is contained in the text precisely as the material signs appear to the reader. Derrida (1997, 141) states: '*It* (deconstruction) *"is" only what it does and what is done with it, there where it takes place*'. A deconstructive reading is not a search for a unified meaning or an attempt to discern what the author of a text might have wished to

convey: *'deconstruction does not elucidate texts in the traditional sense of attempting to grasp a unifying content or theme'* (Culler, 2008, 109). A deconstructive reading has been described as a reading 'otherwise'. Bennington (2000, 11) remarks of texts that they:

> *...**already** tend to read themselves, to offer up a preferred or 'official' reading (often the one assumed by subsequent readers to coincide with the author's intention): so Plato, Rousseau, Husserl, Saussure and many others (demonstrably) **declare** their preference for speech over writing; but they also manage (demonstrably) to **say** the very opposite too. Derrida's work consists essentially in bringing out the textual resources that question the 'official' version. These resources are demonstrably put forward, however discreetly, by the texts being read, and are not imported...*(Bennington's emphases).

The textual resources used to construct an argument are noted and their signifying function analysed. Deconstruction holds that language as logic or logos is an impossible ideal. Language as rhetoric, therefore, becomes the focus of attention. The rhetorical structure and strategies of a text are examined: how an argument is constructed; how a reader is persuaded to a particular point of view. The words used, their sedimented meanings, where words are positioned in a sentence, figures of speech, linguistic redundancies, and so on, are examples of the resources that may be deployed in the construction of a text. Tropes or figures of speech, such as metaphor, metonymy, personification, simile, and so on, are of particular interest in a deconstructive reading. These linguistic resources bring out possibilities of meaning which pre-exist the text in language (McLaughlin, in Lentricchia & McLaughlin, 1995). Metaphorical meaning is often contrasted to literal meaning. Metaphorical language is associated with the literary genre whereas literal language tends to be associated with scientific and other more so-called 'serious' discourses.

> *It is not difficult to see why a tradition ordered around the value of presence would be wary of metaphor, which speaks obliquely, exploits lateral*

> *connotations, insinuates things without really saying them, suggests ideas without making them explicit* (Bennington and Derrida, 1993, 119).

Metaphorical language is accepted as part of literary texts where it may be considered as ornamentation which obscures meaning and makes several different readings possible. In non-literary texts, however,:

> *...the literary qualities of style, tone and rhetoric tend to be regarded at best as decoration, at worst as encumbrances befuddling the purity of thought. Deconstruction, by contrast, insists that the meaning of these texts cannot be abstracted from the rhetorical ploys by which they both elicit and frustrate the wish for meaning* (Ellmann, in Royle, 2000, 213).

Drawing attention to the presence and function of metaphor in non-literary texts generates complexity in terms of meaning. Already, in identifying a text as belonging to a particular genre, an expectation is created of how a text is to be read and understood. A reader is oriented toward a particular understanding, for instance, whether there will be a straightforward one-to-one connection between signifier and signified or whether meaning will be more ambiguous, more open to the reader's interpretation. It could be argued that all language, as an arbitrary and conventional sign system, is metaphorical. The signifier stands in place of the signified concept or the referent to which it has no natural relationship, just as metaphor involves '*the perception of a similarity between two otherwise strikingly distinct semantic attributes, such that the sense of distance is preserved in the act of imaginatively leaping across it*' (Norris, 2002, 100-101). Indeed, a signifier is sometimes all there is; a signifier without a signified concept or a referent but not without meaning in some context, as Derrida demonstrates with his example of '*agrammaticality*' (Derrida, 1977, 12) in his book '*Limited Inc*'. An argument presented in what appears to be the most lucid and straightforward language may strain to suppress metaphorical possibilities. '*The use of metaphor in theoretical texts may work to subvert the premises on which the text relies*' (Culler, 2008, 23). At other times, metaphor may be used quite consciously and deliberately as a

detour from, or to, literal meaning, and it is in that space between literal and metaphorical that other possibilities of meaning may be disclosed. Norris (2002, 100) claims that metaphor and metonymy are '*the two most pervasive and powerful devices of rhetorical language*'. Metonymy substitutes part for whole, using a particular attribute of an entity to signify the entire entity, for example, 'the top floor' or 'head office' standing for management in an organisation.

The resources of a text that are used to construct an argument are also those that may be used to subvert what might be described as the official, orthodox or standard reading of the text in question. Using the text's resources in this way is '*the very condition of finding a foothold in the discourse to be deconstructed*' (Gasché, 1986, 168). A deconstructive reading attempts to demonstrate how a text achieves its effects. At the same time, it also demonstrates how the textual resources used to advance a claim or assert a position may also be used to undermine the argument being presented (Culler, 2008). A first reading aims at getting a sense of what a text is about, carefully following the text's logic. The reader is alert to those places in a text where a counter logic may be identified. Derrida uses the word 'aporia' to signify this sense of a text's difference from itself. Aporia literally means 'without passage'. In the context of deconstruction, an aporia refers to '*...a seemingly insoluble logical difficulty*' (Derrida, 2001, xviii, Translator's Introduction). An aporia is not an error that might have been avoided. When any claim is made or any authoritative position asserted, a writer draws on the system of binary logic and the inherited conceptual oppositions that characterise Western thought.

> *Every totality... can be* ***totally shaken****, that is, can be shown to be founded on that which it excludes, that which would be in* ***excess*** *for a reductive analysis of any kind...*
> *This excess is often posed as an* ***aporia****, the Greek word for a seemingly insoluble logical difficulty: once a system has been "shaken" by following its totalising logic to its final consequences, one finds an excess which cannot be construed within the rules of logic, for the excess can only be conceived as* ***neither*** *this* ***nor*** *that, or both at the same time – a departure from all rules of*

> *logic* (Derrida, 2001, xviii, Translator's Introduction) (Translator's emphases).

The same word used to signify in more than one way in a text that purports to present a unified meaning may signal the emergence of a counter logic, like, for example, the word 'supplement' in Rousseau. A reader is attentive to so-called 'blind spots' in an argument where the text produces effects that undermine its manifest sense (Norris, 2002). Things may be going on in a text behind the author's back, so to speak (Caputo, 1997). The text may unconsciously present what the author appears expressly to wish to deny (Norris, 2002). An underlying incompatibility may be discerned between what an author asserts and what the text reveals.

> *...the writer writes **in** a language and **in** a logic whose proper system, laws, and life his discourse by definition cannot dominate absolutely. He uses them only by letting himself, after a fashion and up to a point, be governed by the system. And the reading must always aim at a certain relationship, unperceived by the writer, between what he commands and what he does not command of the patterns of the language that he uses. This relationship is not a certain quantitative distribution of shadow and light, of weakness or of force, but a signifying structure that critical reading should **produce***
> (Derrida, 1997, 158) (Derrida's emphases).

It is not simply isolated incidences of paradox or ambiguity that are of interest in a deconstructive reading; rather it is the entire logic and coherence of a text. All texts consist of multiple layers, '*an ensemble*' of theses, themes and claims which correspond to a dominant reproductive reading (Caputo, 1997, 83). Deconstruction is an attempt to unfold the various layers that make up a text's argumentation, to '*disentangle what has been conflated*' (Howells, 1998, 2). It consists in '*the careful teasing out of warring forces of signification **within the text itself***' (Derrida, 2004a, xv, Translator's introduction) (Translator's emphasis). The discrepancies, tensions, contradictions, inconsistencies, repetitions, digressions,

and discontinuities that inevitably inhabit a discourse are brought into view in a deconstructive reading (Gasché, 1986). .

> *If in the process of deciphering a text in the traditional way, we come across a word that seems to harbour an unresolvable contradiction, and by virtue of being* ***one*** *word is made sometimes to work in one way and sometimes in another, and thus is made to point away from the absence of a unified meaning, we shall catch at that word. If a metaphor seems to suppress its implications, we shall catch at that metaphor. We shall follow its adventures through the text and see the text coming undone as a structure of concealment, revealing its self-transgression, its undecidability. It must be emphasised that I am not speaking simply of locating a moment of ambiguity or irony ultimately incorporated into the text's system of unified meaning but rather a moment that genuinely threatens to collapse that system* (Derrida, 1997, lxxv, Translator's Preface) (Translator's emphasis).

Sometimes it is the small details in a text that may be very revealing in terms of striving for univocal meaning, for example, what has been put between brackets, what seems to have been passed over or waved aside quite casually, the blanks, the spacing, the marginalia (Caputo, 1997). It is often by way of such seemingly insignificant and frequently overlooked details that anything that runs counter to an orthodox interpretation of a text may be identified. The metaphysical tendency of language may be exposed '*by fixing on accidental features of the text to subvert its essential message and by playing off its rhetorical elements against its grammatical structure*' (Peters & Biesta, 2009, 44). A deconstructive reading of theoretical texts often demonstrates the return in a disguised form of a procedure that the work claimed to criticise in others. In this way a text 'differs' from itself, and deconstruction is attentive to such practices.

> *Whatever themes, arguments, or patterns are cited in defining the identity of a particular work, there will be ways in which it differs from the self so defined, systematically or obliquely putting in question the decisions at work in that definition* (Culler, 2008, 214).

The fissures and fault lines that prevent conceptual closure are not sited in a text simply waiting to be discovered. Rather, they are 'produced ' by a deconstructive reading (Derrida, 1997). Two well-known examples of deconstruction will now be presented in order to provide an appreciation of the processes involved. The methodological approach developed and used to analyse selected texts in this study will then be outlined. .

4.7 Speech/Writing

Derrida's famous deconstruction of the speech/writing opposition provides an illustration of the approach and also the wider implications of deconstructive reading. Derrida, in his reading of the history of occidental philosophy, recognised the persistent privileging of speech over writing. Socrates used speech and oral dialogue to teach and promote secure foundations for knowledge. The ancient Greeks refused the gift of writing from the Egyptians. Rousseau regarded speech as natural and the use of speech as the correct approach to governing. He considered writing a corruption of natural presence. Husserl attempted to '*reduce*' the sign, that is, to put it out of play, in his analysis of the structures of consciousness. Saussure described writing as a distortion of speech. Derrida recognised in each of these examples, where speech is opposed to writing in a violent hierarchy, 'the metaphysics of presence'. Speech is privileged because it appears closest to thought. The speaker is present to their thoughts and to the listener. If any misunderstanding arises, it may be corrected at once. The speaker is in control of the meaning of the message. The pervasiveness of this conception of language and meaning is identifiable in many practices and domains of activity to the present day. For example, in courts of law, oral evidence is required despite a book of evidence having been assembled. Oral examinations are considered necessary in some domains of learning in addition to written work. Reference to the contents of a book or letter is signalled frequently in terms of speech, as in, 'the book *says*...' or 'the letter *says*...'. When information is exchanged in writing, it is often formulated as spoken language, for example, when responding to a missive, one writes: 'I was sorry to *hear* that you were ill'. Sturrock (2003, 129) remarks:

'...how often do we not read (or do I mean 'hear'?) of a writer writing for a particular 'audience', instead of a readership...' It is as if only in speech is true meaning revealed: *'...the voice is 'naturally' privileged over writing as the place where, to use the terminology of Saussure, the signifier seems most transparent or subservient to its signified, which it exists only to relay'* (Bennington, 2000, 9). The primacy of concept over language, signified over signifier, is reflected in the privileging of speech. In speech, the signifier disappears as soon as it delivers up its meaning.

> ***Voice*** *becomes a metaphor of truth and authenticity, a source of self-present 'living' speech as opposed to the secondary lifeless emanations of writing. In speaking one is able to experience (supposedly) an intimate link between sound and sense, an inward and immediate realisation of meaning which yields itself up without reserve to perfect, transparent understanding. Writing, on the contrary, destroys this ideal of pure self-presence. It obtrudes an alien; depersonalized medium, a deceiving shadow which falls between intent and meaning, between utterance and understanding. It occupies a promiscuous public realm where authority is sacrificed to the vagaries and whims of textual 'dissemination'. Writing, in short, is a threat to the deeply traditional view that associates truth with self-presence and the 'natural' language wherein it finds expression* (Norris, 2002, 28). (Norris's emphasis).

Writing is condemned because it can function in the absence of a speaker or an author. Writing functions across space and time. It is distanced from its origin. No 'voice' is required to animate the written sign. The danger of writing and the reason why it must be suppressed is that meaning is independent of any so-called source or origin. *'Writing is the endless displacement of meaning which both governs language and places it for ever beyond the reach of a stable, self-authenticating knowledge'* (Norris, 2002, 28). And, as Derrida demonstrates, writing cannot be merely a representation of speech, the so-called 'sign of a sign'. There are many features of writing such as spacing, punctuation, and so on, that are not part of speech. Spoken signs are subject to the same vagaries of meaning as written signs. At the moment of utterance, the presence of the speaker is not required in the sense of a signified content present in the mind. Derrida points to

the paradoxes inherent in the texts that privilege speech over writing, one of those being that the condemnation of writing is made in writing. Johnson (in Lentricchia and McLaughlin, 1995, 39) identifies the paradox of writing about writing which she describes as '*an attempt to comprehend that which it is comprehended by*'. Rousseau identifies writing as the medium that allows him to express himself as he truly is, something he is unable to do in the company of others. 'Truth' for him requires that he be absent. Saussure uses the example of writing, which he denigrates as the corruption of speech, to demonstrate his theory of the sign. Derrida recognises that what is repressed along with writing in its common or restricted sense of graphic notation on a page is the idea of language as a signifying system which exceeds all bounds of individual presence and speech.

> *Privileging speech by treating writing as a parasitic and imperfect representation of it is a way of setting aside certain features of language or aspects of its functioning. If distance, absence, misunderstanding, insincerity, and ambiguity are features of writing, then by distinguishing writing from speech one can construct a model of communication that takes as its norm an ideal associated with speech – where the words bear a meaning and the listener can in principle grasp precisely what the speaker has in mind* (Culler, 2008, 100-101).

Derrida (1997, 56) gives the name '*arche-writing*' to designate what precedes both speech and writing, in its narrow sense. In using this term, he is not arguing that writing should displace speech as the privileged term but that what is criticised in writing is also part of the structure of speech. Therefore, privileging speech is the outcome of an "...*'ethico-theoretical decision'*..." (Bennington, 2000, 8), rather than founded on any logical analysis of speech and writing.

4.8 Serious/Non serious

Derrida's deconstruction of Austin's speech act theory focused on the distinction Austin drew between serious speech acts and those same speech acts effectuated

in a non-serious context. Speech acts are those statements whereby something is accomplished by the utterance. Austin used the word 'performatives' to designate such statements and included among his examples the conventions used to name a ship, open a meeting, make a bet or a promise, and perform a marriage ceremony. '*It* (the performative) *does not describe something that exists outside of language and prior to it. It produces or transforms a situation; it effects*' (Derrida, 1977, 13). In this way, the performative statement seems free from notions such as true or false. '*The performative is a "communication" which is not limited strictly to the transference of a semantic content that is already constituted and dominated by an orientation towards truth*' (Derrida, 1977, 13-14). However, Derrida identifies, in Austin's analysis of speech acts, a return of the true/false opposition. Austin acknowledges that all acts of a ritual or conventional type can occur in a wide variety of circumstances and that some circumstances may result in the 'failure' of the performative. I may promise to do something for someone and use the appropriate form of words but I may not keep my promise. A bride may say '*I do*' but she may, at that moment, be already married to someone else (Culler, 2008). Rather than acknowledge that failure or 'infelicity' is always a possibility and therefore a necessary or structural possibility of every speech act, and must be accounted for in a theory of speech acts (Derrida, 1977), Austin seeks to exclude such infelicities as accidental features. He attempts to fix the conditions or context of the performative in a way that allows for '*...no "dissemination" escaping the horizon of the unity of meaning*' (Derrida, 1977, 14). For example, in the case of a marriage, Austin lists the circumstances or conditions that must pertain in order for the speech act to be successfully accomplished, namely, it must be conducted by an authorised person in an authorised location; the couple marrying must be free and consenting adult individuals, and so on. Austin also excludes from his analysis of speech acts performatives not done in so-called 'ordinary' circumstances. A bet that is made as a joke or a marriage ceremony that occurs as part of a rehearsal are examples of such exclusions as they do not occur in normal circumstances. The serious speech act, where the speaker intends the utterance, is posited as the normal, and the non serious – jokes, citations, and so on - is labelled as parasitic on the normal by Austin. Derrida challenges this distinction demonstrating that speech acts, because they adhere to a form of words that is

conventional and iterable (that is, as explained above, detachable from a particular context of use and cited in another context), are all examples of a general '*citationality*' (Derrida, 1977, 18). The serious speech act is but one citation among many others. If this were not the case, it would be difficult to imagine how a marriage ceremony that occurred in the context of a novel, for example, would be recognised as such. Derrida (1977, 18) poses the following question:

> *Could a performative utterance succeed if its formulation did not repeat a "coded" or iterable utterance, or in other words, if the formula I pronounce in order to open a meeting, launch a ship or a marriage were not identifiable as* ***conforming*** *with an iterable model, if it were not then identifiable in some way as a "citation"?* (Derrida's emphasis).

Derrida is not arguing that serious speech acts are not possible. He acknowledges that meetings are opened, ships are named, and people marry in ordinary circumstances all the time (Derrida, 1977). However, what he does contest is the positing of such occurrences as the norm or standard without which their repetition in other (non serious) contexts would be impossible. In other words, if there were not meetings called to order, ships named, and marriages conducted in 'real life', they could not occur in novels or as jokes (Culler, 2008).

> *...it is assumed without question that meaning is logically prior, and ontologically superior, to its linguistic expression, or that serious literal speech is logically prior, and ontologically superior, to jokes or fiction* (Bennington, 2000, 8).

In the exclusion of infelicities and the non-serious from a theory of speech acts, Derrida (1977, 14) recognises the metaphysics of presence at work, that is, intention as the centre or organising principle:

> *...the conscious presence of the intention of the speaking subject in the totality of his speech act. As a result, performative communication becomes once*

more the communication of an intentional meaning, even if that meaning has no referent in the form of a thing or of a prior or exterior state of things.

As the two examples of deconstruction illustrate, purity of origin and meaning in any domain is an impossible ideal (Deutscher, 2005). Reading like Derrida enables a deeper appreciation of the concept of interest which, in the case of this study, is reflective practice as a model of professional knowledge in nursing education.

4.9 Methodological process developed for text analysis

The general approach presented in the foregoing sections of this chapter guides the deconstructive reading of the texts selected for analysis. A number of non-discrete, non-linear activities may be identified as constituting the analytic process. Depending on the particular text being analysed, some or all of the activities outlined below will be discernible in the readings which follow in Chapters 5-9.

- The text in question is read and re-read to gain an appreciation of the main themes and arguments or what may be called 'authorial intention'.

- The text is examined for the language used to construct the argument. All aspects of language are considered, including for example, the material structure of the text on a page, the words used, their size and placement, any emphases used, where it is deployed and with what effect, text that appears in brackets, diagrams and graphics, and their consistency or otherwise with the accompanying text.

- Words that appear or may be seen to convey more than one meaning in a text – so-called 'undecidible' terms - are noted, and the implications of their use for the argument which contains them identified.

- Instances of simile, metaphor, metonymy, and personification, are identified and the meaning thereby created is analysed.

- Binary oppositions that form the ground of the arguments presented are identified as well as those points where the opposition does not hold and the consequences for the thesis being advanced.

- The logic of the argument presented is scrutinised. The reader is alert to any points of tension, paradox, irony, ambiguity, and so on that may undermine or destabilise the manifest argument or orthodox interpretation of the text in question. This requires re-reading the text many times, going back and forth to check one statement or set of statements against another. A sense of the whole is retained as the parts are analysed.

- Any point of argument that appears to have been passed over, discontinued, a conclusion overlooked, or a statement not followed through in terms of its implications is identified along with the possible consequences of that omission or discontinuity for the matter under consideration.

- An attempt is made to reveal the presuppositions that the text in question contains and if these are consistent with, contradict, or otherwise conflict with the overt theme.

- The implications of the particular deconstructive reading for the issue of reflective practice as a model of professional knowledge in nursing education are drawn.

4.10 Text selection

As indicated in Chapters 2 and 3, there is an abundance of texts that refer to reflective practice in nursing education. Since deconstruction requires close

attention to even the most seemingly inconsequential textual detail, the amount of material selected for analysis is small relative to the quantity available. Schön's (1983) text '*The Reflective Practitioner*' has been extremely influential in the domain of nursing knowledge. His work is considered seminal in the context of the debate regarding professional knowledge in nursing. Indeed, it could be argued that, had Schön's (1983) book not been published, reflective practice would not have become a recognisable feature in nursing education. Schön's (1983) text supplied the lexicon, the concepts, and the theoretical justification for the adoption of reflective practice as a model of professional knowledge in nursing education. Few texts that refer to reflective practice in nursing education fail to cite Schön's (1983) ideas and his arguments. The influence of his ideas on professional knowledge in nursing education has been profound and significant. Any consideration of reflective practice in nursing education, therefore, must include reference to Schön and his work. For these reasons, '*The Reflective Practitioner*' forms part of the textual material that is subject to a deconstructive reading. Three chapters from Schön's (1983) text are analysed: the first one addresses the rationale for an epistemology of practice and provides an outline of a new epistemology. The second chapter gives an example of reflective practice applied in the domain of psychotherapy. Schön (1983) uses several examples of practice disciplines to illustrate a reflective practice approach. The example of psychotherapy is chosen as it is one of the health care disciplines and therefore shares some similarities with nursing. The final chapter from Schön (1983) selected for analysis is a detailed account of the structure of reflection-in-action. Since, as indicated in the earlier discussion of this methodology, isolated incidences of irony and paradox are not the main concern of a deconstructive reading, the full text of each chapter is examined. This permits the more long-range logico-semantic arguments to be analysed (Derrida, 2004b).

4.10.1 Justification for the selection of nursing texts

Six full nursing papers and two fragments are included in the sample of texts for analysis. Several criteria guided the selection of the particular papers and they are enumerated as follows:

Firstly, the aim of the study, which is to engage in a deconstructive reading of texts that have something to say regarding the issue of reflective practice as a model of professional knowledge in nursing education;

Secondly, the debates identified in the theoretical framework chapter of the thesis, in particular, the problem of defining reflective practice and distinguishing it from the model of technical rationality, the arguments advanced concerning the scope and kinds of knowledge relevant to nursing practice, the role of the universities in the production of nursing knowledge, and the challenge of evidence-based practice;

Thirdly, the desire to retain a diachronic perspective – to include material from the early, middle and later years similar to the organizing principle adopted in Chapter 3;

Fourthly, each full paper selected had to have as its sole theme a detailed, specific and focused argument on the issue reflective practice as a model of professional knowledge in nursing education;

Finally, only texts that expressed a positive view of reflective practice as a model of professional knowledge were considered for inclusion.

The following papers were chosen as they approximated most closely the above inclusion criteria:

- *The Reflective Practitioner in Nursing* by Powell, 1989 – the first full paper located in the search of the literature, it describes a research study aimed at identifying reflection-in-action in nursing practice among a group of experienced nurses undertaking further study.

- *Tacit nursing knowledge: an untapped resource of a methodological headache?* by Meerabeau,1992 – the paper describes how tacit knowledge

or knowing-in-action may be identified among nurses and the role of the university in that regard.

- *Critical reflective inquiry for knowledge development in nursing practice* by Kim, 1999 – discusses the kinds of knowledge needed in nursing and how reflective knowledge may be generated. The role of the academic nurse researcher is also explored in this paper.

- *Reflective Practice: where now?* by Rolfe, 2002 – charts the fate of reflective practice as a model of professional knowledge in nursing education over time and debates its difference from, but possible colonisation by, the model of technical rationality.

- *What counts as evidence in evidence-based practice?* by Rycroft-Malone et al., 2004 – identifies the kinds and sources of knowledge needed in nursing and the role of reflective practice in creating evidence based knowledge for practice.

- *Towards a nursing science of the unique. Evidence, reflexivity and the study of persons* by Rolfe & Gardner, 2005 - describes how a nursing science based on reflective practice can be developed and debates the misunderstanding of the meaning of true evidence-based practice.

The journal fragments selected were drawn from the following two papers:

- *Reflective Practice: reviewing the issues and refocusing the debate* by Clarke et al., 1996 – a short extract illustrates the attempt to distinguish reflective practice from technical rationality

- *Reflection and nursing education* by Pierson, 1998- offers another take on the distinction between reflective practice and technical rationality in nursing education.

Full reference details of all of the above papers are included at the beginning of Chapters 8 and 9.

4.11 Rigour

As indicated in the introduction to this chapter, one of the dangers with a deconstructive approach is that it might be seen to authorise an 'anything goes' approach in terms of meaning. Since there is no 'outside text' in the sense of a non-linguistic referent or final signified that the analysed text may be compared with, and since deconstruction contests the notion of unified meaning, exploiting the resources of language in order to read otherwise, it might be assumed that one reading is as valid as another. However, Bennington (2000, 36) cautions the researcher embarking on a deconstructive approach to text analysis:

> *No text can make any particular reading of itself* ***necessary****..., but equally no text can open itself up to just any reading (no text is* ***absolutely indeterminate*** *with respect to its reading). Texts appeal to reading,* ***cry out for reading****, and not just for any reading, but leave open an essential latitude or freedom which just is what constitutes reading* ***as*** *reading rather than as passive decipherment...It follows that reading has a duty to respect not only the text's 'wishes' (the reading of itself most obviously programmed into itself) but also the opening that opens a margin of freedom with respect to any such wishes, and without which those wishes could not even be registered or*

recognised. It (a text) can always be read ***differently*** *with respect to the way it would wish to be read.* (Bennington's emphases).

The text's wishes in terms of a preferred reading are conveyed in the rhetorical features and other textual resources alluded to in the strategies of deconstructive reading outlined earlier in the chapter. Deconstruction is a careful balancing of freedom and responsibility: responsibility to the preferred or manifest meaning of a text and freedom to depart from that meaning in search of other possibilities inscribed within the text itself.

> *The absence of a unitary horizon of meaning for the process of reading does not commit Derrida to the* ***recommendation*** *of meaninglessness, nor does it entail the equivalence in value of all different readings (rather the singularity of each), and indeed demands the most rigorous textual evidence for the readings proposed: but it does argue that no one reading will ever be able to claim to have exhausted the textual resources available in the text being read* (Bennington, 2000, 11). (Bennington's emphasis).

To meet the demand for '*the most rigorous textual evidence*' for the readings proposed, extensive quotations are used in the deconstructive analyses which follow. Reproducing verbatim extracts from the original text should enable an appreciation both of the authorised reading as well as provide evidence for the proposed deconstructive reading. The material presented from the original text should make it possible for the reader to verify a reading otherwise. As Norris (2002, 150-151) asserts of deconstruction in the context of literary criticism:

> *...an approach that may indeed produce many instances of heterodox or counter intuitive argument... but which none the less refers back* ***at every point*** *to specific details of the text in hand, and which never takes refuge in a generalised appeal to the non-availability of truth values in criticism, the bankruptcy of classical reason, or the idea of rhetoric as an omnipresent dimension of language that makes it simply futile to invoke standards of argumentative rigour and consistency.* (Norris's emphasis).

Although deconstruction does not accept the dominant or orthodox interpretation as **the** meaning of a text, at the same time, the orthodox or dominant interpretation remains an *'indispensable guardrail'* (Derrida, 1997, 158) to which the deconstructive reading remains closely tied. It provides an anchor in the horizon of unstable meaning (Derrida, 1997, Translator's preface). It is only by observing the dominant reading that an alternative reading or a 'reading otherwise' becomes possible. *'A deconstructive reading is meticulously faithful to the details of the text'* (Norris, 2002, 149).

4.12 Conclusion

This chapter has presented an account of deconstruction as a research approach together with an argument for its deployment in the context of the study of reflective practice as a model of professional knowledge in nursing education. The particular strategies that guide the deconstructive readings that follow have been outlined together with the rationale for text selection. The reader is reminded that to deconstruct a discourse is to show how it undermines the philosophy it asserts or the hierarchical oppositions on which it relies. By identifying in the text the supposed ground of argument, the key concept or premise, does not mean, however, that the principle or premise is illegitimate or should be scrapped. To deconstruct a concept one must operate with the concept, asserting its indispensability while denying it any rigorous justification (Culler, 2008). In no case is deconstruction a discourse against truth or science.

A deconstructive reading is never final or definitive. It remains always possible to reread a deconstructed text and find some unexamined assumption or logical contradiction. Each reading is itself another writing with all of the contradictions and instabilities that inhere in a linguistic system of meaning. To re-iterate Bennington's (2000, 11) remark above: *'no one reading will ever be able to claim to have exhausted the textual resources available in the text being read'*. Caputo (in Silverman, 1989, 29) adds that difference, or deconstruction, "is":

> *...not aimed at locking us inside a play of signs but at making us think twice about claiming that our discourse has accomplished what it sets out to do. It*

> *throws a scare into our discourse, destroys a bit of the prestige and self-importance of 'reference', and ends up creating a salutary distrust in the power of language to do what it sets out to do (along with providing an account of how language accomplishes what it does manage to do).*

Deconstruction is not an opening into an inexhaustible wealth of meaning or the transcendence of semantic excess. It is rather '*a question of following through those repeated moments of "indetermination" or "undecidability" that signal the emergence of a counter logic, a logic of logical anomalies, whose effect it to subvert or greatly complicate the manifest meaning of the text*' (Derrida, 2004b, xxvii-xxviii). Undecidable terms radically unsettle a text, making a decision as to final meaning or a '*transcendental signified*' impossible (Derrida, 1997, 49). A deconstructive reading demonstrates that a text may mean both one thing and its opposite, and also, neither one thing nor its opposite. Deconstruction projects no unifying goal, but rather sketches a dispersive, pluralizing, scattering movement (Bennington, 2000).

> *Dissemination...foils the attempt to progress in an orderly way toward meaning or knowledge... (*Derrida, 2004a, xxxiii, Translator's Introduction*)*

The following chapters 5-9 present a deconstructive reading of the texts selected for analysis. Chapters 5-7 focus on Schön's (1983) text. Details of the chapters chosen are provided at the outset.

Chapter 5 Deconstructing Schön's text 1

Donald Schön's book '*The Reflective Practitioner*' published in 1983 is a very influential text in the context of reflective practice as a model of professional knowledge in nursing education. His work is cited in almost every text that refers to reflective practice in the nursing literature. Schön (1983) supplied the language, the concepts, the logic, and the theoretical justification for the adoption of reflective practice in nursing education. As references to Schön (1983) are so pervasive in the nursing literature that treats of reflective practice as a model of professional knowledge, it seems appropriate and necessary to begin a deconstructive analysis of this subject with his writings. This chapter presents a close reading of the central thesis of Schön's (1983) original text. How he constructs the argument for reflective practice as a new epistemology is examined. The structure of that epistemology and its application in practice are also analysed from a deconstructive perspective. In order to provide my reader with a general orientation to what Schön's book is about, extracts from the preface are presented below. Schön (1983, vii-ix) describes his purpose in writing the text as follows:

> *This exploration of professional knowledge stems directly from my working life as an industrial consultant, technology manager, urban planner, policy analyst, and teacher in a professional school. Because of these experiences, the question of the relationship between the kinds of knowledge honored* (sic) *in academia and the kinds of competence valued in professional practice has emerged for me not only as an intellectual puzzle but as the object of a personal quest. I have become convinced that universities are not devoted to the production and distribution of fundamental knowledge in general. They are institutions committed, for the most part, to a* ***particular*** *epistemology, a view of knowledge that fosters selective inattention to practical competence and professional artistry.*

> *...In this book I offer an approach to epistemology of practice based on a close examination of what some practitioners – architects, psychotherapists, engineers, planners, and managers – actually do.*
>
> *...The heart of this study is an analysis of the distinctive structure of reflection-in-action* (Schön's emphasis).

The first paragraph of the above extracts could be read as a metaphor for reflective practice. Experience in the real world of practice serves as the starting point for Schön's (1983) inquiry. Something puzzling occurred in the course of Schön's experiences in diverse work situations. The puzzle stimulated reflection. Knowledge derived from reflecting on the puzzling experience of practice is the book itself. The knowledge thus created is both personal and shared. A number of rhetorical features may be noted in the extracts quoted above. The preface begins with a personal account of experience. The list of occupations included at the outset warrants Schön's authority to address the subject matter of the book. His use of the term '*working life*' and his preference for referring to himself in the first person singular create a sense that the book is about ordinary real life experience as opposed to an esoteric academic text, which again reflects the central argument of the book. Schön (1983) assures the reader that the new epistemology he presents will be derived solely from the world of practice. The use of the word '*heart*' to refer to the essential message of the book could be read as a metaphor for the text as a living, dynamic entity which contrasts with the lifeless emanations from universities. A dichotomy between academia and professional practice is created in the introductory paragraph with the use of different signifiers to designate the kinds of knowledge relevant in each setting: '*knowledge*' in academia and '*competence*' in practice. The verbs used to describe how the different kinds of knowledge are regarded in each setting give an indication of the purpose which these kinds of knowledge serve. Knowledge is '*honored*' in academia which suggests that it is produced for its own sake to be admired and revered. Competence, on the other hand, is '*valued*' in practice, an indication that it is the kind of knowledge that enables the knower to do something useful and important.

Schön (1983) sets out his argument for a new epistemology of practice in Chapter 2 of his book. The chapter is entitled: '*From Technical Rationality to Reflection-in-Action*' (Schön, 1983, 21). The rhetorical structure of the chapter will first be considered followed by a detailed analysis of the logic of the argument advanced. Chapter 2 of Schön's text is structured in roughly three parts. The first part explains what is meant by technical rationality, and how it became the dominant epistemology in professional schools. The middle third of the chapter sets out the problem with technical rationality as the dominant model of professional knowledge, and the final third articulates an alternative epistemology of practice, which Schön (1983, 49) names '*reflection-in-action*'. Schön's Chapter 2 may be viewed an enactment of the message it conveys. That message, from the perspective of a conventional reading, may be summarised as follows: professional knowledge is dominated by a particular epistemology, which Schön (1983, 21) calls '*the model of Technical Rationality*'. This model consists in the application of scientific knowledge and techniques to the problems of professional practice and is based on a positivist epistemology. The greater the degree of scientific knowledge possessed by the profession, the higher the status of that profession in society. Medicine is cited as a paradigm example of the model of technical rationality both in terms of its scientific knowledge base and its prestige in society. Practical knowledge is introduced as '*a puzzling anomaly*' (Schön, 1983, 33) in the context of the origins of the model of technical rationality. How this anomaly was dealt with by the positivist tradition in such a way as to preserve the model is explained. The success of the model and its adoption by various occupations aspiring to be classified as professions is outlined.

A problem is then identified which is described as '*the flaws and limitations of the professions...a crisis of legitimacy rooted both in their perceived failure to live up to their own norms and in their perceived incapacity to help society achieve its objectives and solve its problems*' (Schön, 1983, 39). This is followed by the statement: '*Increasingly we have become aware of the importance to actual practice of phenomena – complexity, uncertainty, instability, uniqueness, and value-conflict – which do not fit the model of Technical Rationality. Now, in the light of the Positivist origins of Technical Rationality, we can more readily see why these phenomena are*

so troublesome' (Schön, 1983, 39). The text goes on to explain why this is so, arguing that the model views professional practice as a process that emphasises problem '*solving*' whilst ignoring problem '*setting*' (Schön, 1983, 40). Problem setting and its non-technical nature is then elaborated. Professionals are presented with a choice: do they continue to adhere to technical expertise and ignore important problems that do not fit the model of technical rationality or do they set aside the model and address problems of significance that fall outside it? (Schön, 1983).

How various professional groups have addressed the dilemma of either adhering to the model, and ignoring important problems, or setting aside the model in order to address significant problems of practice is debated. All approaches, Schön (1983) claims, remain attached to the model of technical rationality. Brief reference is made to the discrediting of the positivist epistemology in philosophy of science. A distinction is drawn between '*science per se*' and the '*Positivist view of science*' (Schön, 1983, 48). Science *per se* may be viewed as a process that is similar in many respects to the process of problem-solving in practice while the Positivist view of science cannot be regarded in the same light. Schön (1983, 49) concludes that the model of technical rationality is incomplete because it does not '*account for practical competence in "divergent" situations*'. The reader is then invited by Schön (1983, 49) to join him in a search '*for an epistemology of practice implicit in the artistic, intuitive processes which some practitioners do bring to situations of uncertainty, instability, uniqueness, and value conflict*'. A new epistemology of practice - '*Reflection-in-action*'- is described; its processes and constituents presented by way of examples from a wide variety of activities and occupational practices. If investigated carefully, this new epistemology will become '*a legitimate form of professional knowing*' (Schön, 1983, 69).

In terms of the textual construction of the argument, the title of the chapter '*From Technical Rationality to Reflection-in-Action*' (Schön, 1983, 21) dominates the page spatially, and in terms of font size and colour. Below the title, the first subheading reads '*The Dominant Epistemology of Practice*' (Schön, 1983, 21). The reader is thus oriented immediately to the main point of the first part of the chapter.

Dominance is asserted in the open sentence of the first paragraph. The model of technical rationality is said to be *'the view of professional knowledge which has* ***most powerfully shaped*** *both our thinking about the professions and the institutional relations of research, education, and practice'* (Schön, 1983, 21). (My emphasis). Force is conveyed in the language used. Freedom of thought regarding professional knowledge is impossible. The model determines how we think in this regard. It is not only individual thinking that is thus constrained. The model also exerts power over how institutions engaged in research, education, and practice relate to one another. Its influence pervades the literature on the professions, both positive reports and those that are critical of the professions: *'The model of Technical Rationality has exerted as great an influence on scholarly writing about the professions as on critical exposés of the role of the professions in the larger society'* (Schön, 1983, 22). Even those who exercise academic freedom and assert the right to question any construct must, it appears, do so within the frame of reference of the dominant model. The scope of the model extends to the curriculum of professional schools where it has created a *'dominant curricular pattern'* (Schön, 1983, 27) and *'an unquestioned belief'* (Schön, 1983, 30) in its appropriateness by senior academics.

Dominance is also reflected in the kind of language used to describe the model of technical rationality. Terms such as *'"disciplined by an unambiguous end..."', 'stable institutional contexts', 'grounded in systematic, fundamental knowledge', 'instrumental activity' 'firmly bounded'* (Schön, 1983, 23) connote strength and endurance. No doubt or equivocation is admitted. Structural metaphors such as *'knowledge* ***base***'; *'substantive* ***field***'; *'****hierarchy***'; *'"****concrete*** *problem solving"'; '****embedded*** *in the institutional context of professional life'* (Schön, 1983, 22-26); *'****built*** *into the very tissue of the universities'* (Schön, 1983, 36) (My emphases) create the effect of an edifice or physical structure. Objective language is used to describe the model conveying a sense of distance between author and entity in the text, which accentuates the notion of the model as a structure that may be independently observed and inspected.

Dominance also derives from the scope and variety of references deployed to certify the model's hegemony. References to philosophers, scientists, lawyers, and prestigious universities are interwoven with the description of the model. Direct quotations are used liberally and placed strategically throughout the section of the chapter that explicates the model of technical rationality. They serve to reiterate the main claims for the model's dominance.

The dominance of the view of professional knowledge in the form of the model of technical rationality is not confined to individual minds, texts, professional institutions and schools, and how they operate. It extends to other occupations and to society as a whole. Those professions that adhere to and reflect most accurately the model of technical rationality dominate in terms of the status, prestige and authority they command within wider society (Schön, 1983). Other occupations adopt the model in their own spheres as they strive for similar advancement. Any doubts that might remain regarding the power of the model are mitigated as '*three hundred years of the history of Western ideas and institutions*' (Schön, 1983, 31) is cited, contributing temporal dominance to the already established spatial dominance.

A subheading titled '*The Origins of Technical Rationality*' (Schön, 1983, 30) marks the significance of history in the dominance of the model. A variety of events, movements, individuals, and institutions, all powerful in their own right, are presented to account for the model's dominance through time. '*Technical Rationality is the heritage of Positivism, the powerful philosophical doctrine that grew up in the nineteenth century...*' (Schön, 1983, 31). The evolution of science and technology, the industrial movement, the rise of the professions, the philosophical theory of logical positivism, World War II, the development of the modern university and research institutions, the successes of medicine and engineering, and the space race, are cited as progenitors of the model of technical rationality (Schön, 1983). Such lineage serves to warrant the model's power and continuity. It is also made to account for the '*unquestioned belief*' (Schön, 1983, 30) in the model by its adherents and as an explanation for the fact that '*the dominant model of professional knowledge seems to its proponents to require very little*

justification' (Schön, 1983, 30). The message of power continues to be reflected in powerful language and structural metaphors with the use of such terms as, '*firmly established as a* ***pillar*** *of conventional wisdom*'; '***harnessing*** *science to create technology*' (Schön, 1983, 31) (My emphases). A nature metaphor is introduced in the concluding sentence of the section of the chapter that addresses the origins of the model of technical rationality: '*Thus were planted the* ***seeds*** *of the Positivist curriculum...and the* ***roots*** *of the now-familiar split between research and practice*' (Schön, 1983, 37) (My emphases). Dominance is thereby doubly guaranteed as the model is represented as both a constructed and a natural entity.

How is the movement indicated in the title of the chapter: '***From*** *Technical Rationality* ***to*** *Reflection-in-Action*' (Schön, 1983, 21) (My emphases) to be accomplished given the model's hegemony reinforced over the centuries and pervading so many aspects of society? There are few indicators to suggest any weaknesses in the model of technical rationality as the dominant view of professional knowledge and the dominant epistemology of practice. Any difficulties with the model seem insufficiently powerful to challenge its dominance. For example, Schön (1983, 33) refers to the recognition of the existence of '*Practical knowledge*' which was considered '*a puzzling anomaly*' from the perspective of the technical rational model of professional knowledge. This anomaly was quickly resolved by categorising practical knowledge as '*knowledge of the relationship of means to ends*' (Schön, 1983, 33). There is also reference to '*critical exposés of the role of the professions*' in society (Schön, 1983, 22). Professional expertise has also been criticised as '*a..." preoccupation with a specialized skill premised on an underlying theory*"' (Schön, 1983, 22). Those who question the dominant model include '*practitioners, educators, and researchers*' (Schön, 1983, 26). Despite the criticism, they remain '*party to institutions that perpetuate it*' (Schön, 1983, 26). So although the model has its critics, they have not been sufficiently powerful in challenging or changing it.

Movement '*From Technical Rationality to Reflection-in-Action*' (Schön, 1983, 21) is signalled in a subheading that follows the account of the origins of technical rationality. Entitled: '*Emerging Awareness of the Limits of Technical Rationality*'

(Schön, 1083, 37), the language of the subheading indicates that the transition from technical rationality to reflection-in-action will be gradually accomplished. It will not be a direct challenge from an equally powerful alternative but rather an inevitable occurrence borne of the model's own inherent shortcomings. But first there is a reiteration of the model's dominance and how it came to dominate the professions. From the great successes of the use of scientific research and technology during World War II came the following '*lesson*':

> *If a great social objective could be clearly defined, if a national commitment to it could be mustered, if unlimited resources could be poured into the necessary research and development, then any such objective could be achieved* (Schön, 1983, 37-38).

Research and development institutions were to benefit most substantially from such thinking (Schön, 1983). '*But as a side-effect, there was also a reinforcement of the idea of scientific research as a basis for professional practice*' (Schön, 1983, 38). The '*But*' at the beginning of the previous sentence introduces a contrast, the first small sign of cleavage in the monolith that is the dominant model of professional knowledge. The word '*side-effect*' is generally understood as an unwanted effect of a drug that is otherwise therapeutic. What was beneficial for research institutions was harmful to professional practice. Medicine, not surprisingly perhaps, is cited as the paradigm example of the model of technical rationality.

> *Nowhere was the rate of increase in research spending more dramatic, and nowhere were the results of that spending more visible, than in the field of medicine. The great centers* (sic) *of medical research and teaching were expanded, and new ones were created. The medical research center, with its medical school and its teaching hospital, became the institutional model to which other professions aspired.*

> *Here was a solid base of fundamental science, an equally solid body of applied clinical science, and a profession which had geared itself to implement the ever-changing products of research. Other professions, hoping to achieve some of medicine's effectiveness and prestige, sought to emulate its linkage of research and teaching institutions, its hierarchy of research and clinical roles, and its system for connecting basic and applied research to practice* (Schön, 1983, 38).

The above extract could be read as an endorsement of the model of technical rationality: great centres, great science, great effectiveness, so impressive that others aspire to be like it. Such a reading, however, would not advance the thesis of the chapter which is constructing an argument for replacing the model of technical rationality as the dominant model of professional knowledge. There are some clues in the above quotation, however, to indicate an alternative reading. In what, for example, does medicine's effectiveness consist? Does it consist in attracting large sums of money that are then spent on impressive buildings? The '*solid base of fundamental science*' and the '*equally solid body of applied clinical science*' contrast with the '*ever-changing products of research*'. Serious knowledge, one imagines, should be deployed in serious situations, and human illness would generally be regarded as constituting a serious situation. '*Ever-changing*' suggests a quite superficial approach to research, and the word '*products*' is associated more with the world of manufacturing than human health and wellbeing. The profession of medicine is represented as passively playing its part in this commercial enterprise. And, in imitating medicine, is the effectiveness that other professions hope to achieve that of commercial success and social recognition? The side-effect of taking the model's medicine has been to contaminate the profession of medicine. Like a drug that is harmful yet highly addictive:

> *The prestige and apparent success of the medical and engineering models* ***exerted a great attraction*** *for the social sciences. In such fields as education, social work, planning, and policy making, social scientists attempted to do research, to apply it, and to educate practitioners, all according to their perceptions of the models of medicine and engineering. Indeed, the very language of social scientists, rich in references to measurement, controlled experiment, applied science, laboratories, and clinics, was striking in its* ***reverence*** *for these models (*Schön, 1983, 38-39) (My emphases).

Again the above extract could be read as a positive account of the model of technical rationality and its appeal to other occupations beyond medicine and engineering. A struggle appears to be in play between the dominance of the model and the need to demonstrate its limits. The word '*apparent*' in the first sentence of the above quotation connotes something that, while manifest may not be real. And in the word '*reverence*', there is a religious metaphor, suggesting an adherence born of blind faith. At the same time, the religious metaphor also attests to the model's dominance: science as the new religion. An irony is detectable in the use of the words '*sciences*' and '*scientists*' given the argument being advanced. That these terms could be used in such an apparently easeful manner in this context is an indication that the language of science dominates not only the social scientists, but also those who wish to argue against its power. Exposing the limits of technical rationality will require other resources.

A temporal element is introduced into the argument which creates a sense of the gradual awareness of the model's limits: '*both the general public and the professionals,*' over a period of almost twenty years, '*have become increasingly aware of flaws and limitations of the professions*' (Schön, 1983, 39). It may be assumed that if lay people as well as professionals begin to recognise a problem, then the problem must be of a quite serious and obvious nature. The problem is stated as the professions' '*perceived failure to live up to their own norms and ...perceived incapacity to help society achieve its objectives and solve its problems*'

(Schön, 1983, 39). But how do these major concerns bear on the dominant model of professional knowledge? The link is made in the following way:

> *Increasingly we have become aware of the importance to actual practice of phenomena – complexity, uncertainty, instability, uniqueness, and value-conflict – which do not fit the model of Technical Rationality. Now, in the light of the Positivist origins of Technical Rationality, we can more readily see why these phenomena are so troublesome* (Schön, 1983, 39).

The challenge to the model comes not from eminent individuals or institutions, nor from major events or national programmes. It comes from the 'bottom-up', so to speak; from the localised, real-world, sphere of practice. It is recognised by individual practitioners with whom the writer/author identifies as indicated by his use of the first person plural pronoun. With a change in language comes a change in perspective. The phenomena of importance to practice are identified as '*complexity, instability, uniqueness, and value-conflict*' (Schön, 1983, 39), all signifying quite vague entities in contrast to the definite language of '*pillar*', '*base*', '*hierarchy*', and so on, that characterised the model of technical rationality. Problems of practice are described as '*puzzling, troubling, and uncertain*' (Schön, 1983, 40). Such problems '*may escape the categories of applied science*' or '*an unstable situation slips out from under them*' (Schön, 1983, 41). This description of practice contrasts with the strong, enduring edifice that is the model of technical rationality. The structural metaphor is continued but in place of a stable structure are '*problems*' in '*real-world practice*' that '*must be constructed from the materials of problematic situations which are puzzling, troubling, and uncertain*' (Schön, 1983, 40). No plan or map is available to guide the construction: '*when ends are confused and conflicting, there is as yet no "problem" to solve*' (Schön, 1983, 41). This does not mean, however, that the model of technical rationality has been replaced. Reverting again to a spatial and geographical metaphor, the model of technical rationality is said to occupy '*a high, hard ground*' in what is termed '*the varied topography of professional practice*' (Schön, 1983, 42), while its implied alternative, still vague, diffuse, and unnamed, occupies '*a swampy lowland.*' (Schön, 1983, 42). The contrast could not be more starkly drawn: a high hard ground from where the

model can dominate the landscape and where one can move about quite sure-footedly, with a swamp whose depth is indeterminable and where one risks disappearing into murky waters should one venture onto its surface. But does this metaphorical description not reassert rather than undermine the dominance of the model? How can anything be constructed on a swamp? Nothing can, of course, so another way must be found to challenge the model's dominance. If the structures cannot be modified, then a distinction must be created between what they contain.

> *...the problems of the high ground, however great their technical interest, are often relatively unimportant to clients or to the larger society, while in the swamp are the problems of greatest human concern* (Schön, 1983, 42).

Although the model of technical rationality remains dominant, its power is spurious, limited as it is to solving relatively trivial problems. The unlikely setting of the swamp is where the problems of greatest significance for humanity are located and, presumably, where their solutions are to be found.

Schön (1983, 42) provides an account of how professionals respond to what he calls '*This dilemma of "rigor or relevance"...*', that is, choosing between the high hard ground and the swampy lowland. Some professionals, he claims, opt for rigour and some choose relevance. Those who choose rigour will notice only what fits the model of technical rationality. Failures in practice will be attributed to external factors. Problem situations may therefore be misread or manipulated with serious consequences particularly if the recipients of professional services are human beings (Schön, 1983). Such a response, Schön (1983) claims, is motivated by fear or pride on the part of the practitioner. The power of the dominant model is such that not only does it determine what counts as professional knowledge but it may also be seen to influence the character of the practitioner, and not in a positive way, as Schön's (1983) observations above attest.

'*Some students of the professions*' are cited as having recognised a '*gap*' between professional knowledge and professional practice (Schön, 1983, 45). Although each explains the gap and how it might be addressed in different ways, their

accounts are identified as preserving the model of technical rationality (Schön, 1983). This indicates that even those at a remove from professional practice and whose role requires critical and objective analysis of the professions, appear to be as bound by the model's dominance as are professional practitioners themselves. Despite attempts from various quarters - professionals, the general public, assigning to it insignificant problems, and so on - the model still seems to dominate thinking. In fact, Schön (1983) himself appears to have difficulty escaping the model's dominance even as he attempts to criticise it. If the model cannot be removed or displaced, the only option that remains seems to be abandonment. This comes about first in a rejection of it by its parentage: the model '*has fallen into disrepute in its original home, the philosophy of science*' (Schön, 1983, 48). Finally, the author attempts to abandon it, urging his readers to do likewise.

> *Let us then reconsider the question of professional knowledge; let us stand the question on its head. If the model of Technical Rationality is incomplete, in that it fails to account for practical competence in "divergent" situations, so much the worse for the model. Let us search,* ***instead****, for an epistemology of practice implicit in the artistic, intuitive processes which some practitioners do bring to situations of uncertainty, instability, uniqueness, and value conflict* (Schön, 1983, 49) (My emphasis).

Some ambiguity attaches to the process of abandonment as it is described above. The word '*instead*' suggests that '*practical competence*' cannot be accommodated within the dominant model and therefore a new epistemology is required. On the other hand, the model of technical rationality is not described as irrelevant or outmoded, merely '*incomplete*'. Will a new epistemology produce effects similar to Rousseau's '*supplement*' referred to earlier in the methodology chapter? Will it complete or replace the dominant model of professional knowledge? A possibility is created, within Schön's text, that reflection-in-action may do both at the same time.

A break is signalled in the blank space preceding the next subheading of the chapter, and in the title of the subheading itself: '*Reflection-in-Action*' (Schön,

1983, 49). Even before the search referred to in the last paragraph of the preceding section gets underway, a new destination has been identified. It is a very different terrain to the one occupied by the model of technical rationality. Quite abruptly the reader leaves behind the world of philosophy and history, science and computing, and enters a much smaller and more local domain. The first signpost is a familiar one that everyone may recognise.

> *When we go about the spontaneous, intuitive performance of the actions of everyday life, we show ourselves to be knowledgeable in a special way. Often we cannot say what it is that we know. When we try to describe it we find ourselves at a loss, or we produce descriptions that are obviously inappropriate. Our knowing is ordinarily tacit, implicit in our patterns of action and in our feel for the stuff with which we are dealing. It seems right to say that our knowing is* ***in*** *our action* (Schön, 1983, 49) (Schön's emphasis).

The kind of knowledge described in the above extract requires no elaborate structures, language or antecedents. It is ordinary, familiar, and near-at-hand. From the '*everyday life*' of the average person, it is but a short step to '*the workaday life*' (Schön, 1983, 49) of the professional practitioner, who, Schön (1983) claims, depends upon this kind of knowledge. The *'hierarchy of kinds of knowledge'*, characteristic of the model of technical rationality with scientific theory occupying the highest level, had earlier been described as '*also a ladder of status*' (Schön, 1983, 37). That is now removed and both lay person and professional are on an equal footing. And the professional practitioner is no more adept at articulating tacit knowing than the average person which serves to nullify any notion of superiority on the practitioner's part.

> *Every competent practitioner can recognise phenomena - families of symptoms associated with a particular disease, peculiarities of a certain kind of building site, irregularities of materials or structures - for which he cannot give a reasonably accurate or complete description* (Schön, 1983, 49).

Despite its ubiquity, and unlike the model of technical rationality whose contours are vivid and easily identifiable, this new epistemology is occulted and elusive. The difficulty of articulating this kind of knowledge is evident in the following descriptions of it: *'we cannot say what it is that we know'*; *'cannot give a reasonably accurate or complete description'* (Schön, 1983, 49); *'cannot state the rules and procedures'* (Schön, 1983, 50); *'not capable of being expressed in words or as reasoning'* (Schön, 1983, 51); *'need not suppose that they* (jazz musicians) *reflect-in-action in the medium of words'* (Schön, 1983, 56). The remainder of the chapter is devoted to elucidating reflection-in-action. Unlike earlier sections of Schön's (1983) Chapter 2, no subheadings mark divisions or breaks in the part that deals with reflection-in-action. Any heading that is used forms part of a sentence and is distinguished only by the use of italics. Like knowing-in-action, such headings are easily overlooked. While references to the model of technical rationality attract capital letters wherever the term appears in the text, reflection-in-action is represented in lower case letters. Throughout the section that describes reflection-in-action, personal pronouns are used quite frequently, and illustrative examples are drawn from varied yet unremarkable spheres of activity. This maintains the theme of ordinariness which characterises the new epistemology. No scientific knowledge or techniques are required to validate this kind of knowledge. Rather, '*common sense*' is called upon to warrant its authenticity and, at the same time, common sense attests to its ordinariness.

> *Once we put aside the model of Technical Rationality, which leads us to think of intelligent practice as an* ***application*** *of knowledge to instrumental decisions, there is nothing strange about the idea that a kind of knowing is inherent in intelligent action. Common sense admits the category of know-how, and it does not stretch common sense very much to say that the know-how is* ***in*** *the action...*
>
> *There is nothing in common sense to make us say that know-how consists in rules or plans which we entertain in the mind prior to action* (Schön, 1983, 50-51) (Schön's emphasis).

Despite, or perhaps because of, its familiarity, it will take much patience and painstaking explication to articulate this new epistemology of practice. A brief summary of the '*entire process of reflection-in-action*' (Schön, 1983, 50) is provided initially. All of us - author, reader, and practitioner - have a kind of knowing that is '*tacit*', '*implicit*', but reveals itself in our actions (Schön, 1983, 49). If our actions cause surprise, we are prompted to think about the knowing that is implicit in the action. Reflection brings this knowing to light. It becomes accessible and thus manageable in various ways (Schön, 1983). As knowing-in-action is key to the process of reflection-in-action, and as it is that which cannot be described in words, its identity must be carefully worked out. First, however, as indicated in the extract above, the reader is reminded to '*put aside the model of Technical Rationality*' (Schön, 1983, 50). Otherwise, the idea of knowing-in-action will appear '*strange*' (Schön, 1983, 50). To ensure that '*knowing*' is not separated from '*action*', the words are joined together by hyphens. Examples are provided that illustrate the idea of a knowing that is in an action as opposed to a knowing that occurs prior to action (Schön, 1983). Tightrope walking, baseball pitching, solving maths problems, and learning to use a tool are some of the examples offered to illustrate this kind of knowing (Schön, 1983). What characterises each of the examples is the fact that they are spontaneous, skilful actions and the knowing that is in the actions cannot be described in words. The average person is not excluded from the examples of knowing-in-action: skilful use of language and skills in social interactions are both actions which ordinary people know how to do but are unable to explain how they do them. Schön (1983, 53) comments on these examples:

> *Psycholinguists have noted that we speak in conformity with rules of phonology and syntax which most of us cannot describe.* (Ref) *Alfred Schultz and his intellectual descendants have analyzed the tacit, everyday know-how that we bring to social interactions such as the rituals of greeting, ending a meeting, or standing in a crowded elevator.*

Schön (1983) appears to overlook any irony in the above comments: scientist/researchers, such as psycholinguists and ethnomethodologists and their

methods of investigation, are needed to describe, explain and predict the knowing-in-action of ordinary people engaged in everyday activities. Without those kinds of methods and investigations applied by others from outside, it may be assumed that the knowing-in-action of ordinary folk would remain tacit.

The properties of knowing-in-action are identified and may be summarised as follows: spontaneous and ineffable. Knowing-in-action is described as '*the characteristic mode of ordinary practical knowledge*' (Schön, 1983, 54). Reflecting-in-action, which is described as to '*think about doing something while doing it*' (Schön, 1983, 54), is explored in a manner similar to knowing-in-action. Schön (1983) provides examples of the process of reflecting-in-action as engaged in by baseball players and jazz musicians, among others. Schön (1983, 59) also refers to a research experiment involving children balancing blocks as '*a beautiful example of reflection-in-action*'. Use of these ordinary, everyday examples, could be understood as creating a reassuring effect on the reader. Although reflection-in-action is difficult to put into words, it is not difficult to recognise. What is lacking in explicit definition and description is compensated for by a sense of familiarity and omnipresence.

The search in which Schön (1983) is engaged, however, is for an epistemology of *practice* (my emphasis) and, therefore, the processes of knowing-in-action and reflecting-in-action must be capable of transferring from the ordinary, everyday world to the world of practice. '*Reflecting-in-practice*' (Schön, 1983, 59), appearing in italics at the beginning of a sentence, signposts a move in that direction. '*Knowing-in-action*' and '*reflecting-in-action*' become '*knowing-in-practice*' and '*reflecting-in-practice*', minimising any rupture with the sense of the familiar already established. Again Schön (1983) begins simply by exploring two different meanings of the word '*practice*' and notes how different understandings may have the effect of either enhancing or limiting a practitioner's knowing-in-action. The value of reflection as a way of addressing the limitations of knowing-in-action is then explored, although the reference to limitations is not treated with the same sense of concern as were the limits of the model of technical rationality. How and when a practitioner may reflect-in-action is outlined, and examples provided range

from banking to medicine to education. An argument for the potential of reflection-in-action, as a research methodology and as a solution to the previously identified dilemma of rigour or relevance in professional practice, concludes Schön's (1983) Chapter 2.

Some commonalities may be discerned between the model of technical rationality and what is intended to replace or supplement it. Just as the model of technical rationality has an impact on the emotions and behaviour of professional practitioners, so also does reflection-in-action. Again, the impact is not a positive one. Practitioners who reflect-in-action '*feel profoundly uneasy because they cannot say what they know how to do, cannot justify its quality or rigor*' (Schön, 1983, 69). Although '*for some reflective practitioners it is the core of practice...reflection-in-action is not generally accepted – even by those who do it - as a legitimate form of professional knowing*' (Schön, 1983, 69). The '*crisis of legitimacy*' (Schön, 1983, 39) suffered by the professions and attributed to the model of technical rationality is also, it seems, an issue for the reflective practitioner. There is another characteristic shared by both followers of the dominant model and reflective practitioners, and that is exclusivity. Greatest social prestige and authority attaches to a few top professions whose practice reflects most closely the model of technical rationality. Reflective practitioners are a rare group also. Once reflection-in-action migrates to the world of the professional practitioner, it appears to become scarcer: '*reflection-in-action...is central to the "art" by which practitioners* ***sometimes*** *deal well with situations of uncertainty, instability, uniqueness, and value conflict*' (Schön, 1983, 50); '*he* (the practitioner) ***may*** *respond by reflecting on the appreciations which he and others have brought to the situation*' (Schön, 1983, 63); '*for* ***some*** *reflective practitioners it* (reflection-in-action) *is the core of their practice*' (Schön, 1983, 69) (My emphases). The dominant model brings social acknowledgement to the few while its alternative, practiced by the few, cannot be acknowledged.

Schön (1983, 69) concludes his argument with the following appeal:

> *...the study of reflection-in-action is critically important. The dilemma of rigor or relevance may be dissolved if we can develop an epistemology of practice which places technical problem solving within a broader context of reflective inquiry, shows how reflection-in-action may be rigorous in its own right, and links the art of practice in uncertainty and uniqueness to the scientist's art of research. We may thereby increase the legitimacy of reflection-in-action and encourage its broader, deeper, and more rigorous use.*

It might have appeared that Schön (1983) and his readers had been engaged in a search for a new epistemology of practice and had identified an alternative to the model of technical rationality in the form of reflection-in-action. However the concluding lines of the chapter suggest that this process is just beginning. Despite all of the problems and difficulties attaching to the model of technical rationality – its failure to accommodate phenomena important to practice and address problems of greatest human interest, its inability to account for practical competence in divergent situations of practice, even its implication in the flaws and limitations of the professions – it will have a place in a new epistemology of practice. Granted it will not dominate but then reflection-in-action will be fashioned in such a way as to look like the model of technical rationality, with its rigour and similarity to scientists' activities. Reflection-in-action will also dominate spatially - '*broader and deeper*' - as the technical rational model had done heretofore.

Chapter 2 of Schön's (1983) book provides a textual construction of reflective practice. This chapter has analysed how that construction has been accomplished by identifying the rhetorical structure and strategies employed in the text. Powerful rhetorical devices drawing on ethos, pathos, and logos have been deployed in order to destabilise the dominant model and create a space for an alternative. However, the dominant model has not been completely removed or replaced. It remains implicated in the new epistemology and its remains may be shown to complicate the identity of reflective practice. A deconstructive analysis

of the logic of Schön's (1983) argument for reflective practice as a new epistemology is the subject of the following chapter.

Chapter 6 Deconstructing Schön's text 2

The aim of this chapter is to analyse the logic of Schön's (1983) argument as presented in Chapter 2 of his text. A deconstructive reading is attentive to any contradiction or inconsistency in the argument advanced. As indicated in the preceding chapter, Schön (1983) is concerned to elaborate a new epistemology of practice that will take account of the realities faced by practitioners of the professions in their everyday practice situations. A new epistemology is needed as the existing dominant model of professional knowledge, the so-called model of technical rationality, is unable to accommodate the uncertain, unique, unstable, conflicting aspects of professional practice. Schön (1983) argues that there is a kind of knowing inherent in the actions of skilled practitioners that, if articulated, may provide a new epistemology, thereby legitimising the knowledge embedded in practice.

Knowing-in-action is posited as a precursor to reflection-in-action. Knowing-in-action is the tacit, intuitive, spontaneous knowing that is 'surfaced' by reflection-in-action (Schön, 1983). Reflection-in-action becomes the means to achieving the end of identifying knowing-in-action. This knowing-in-action is represented as something that goes on all the time without conscious awareness on the part of the actor. Schön (1983, 54) describes the characteristics of this kind of knowing as follows:

- *There are actions, recognitions, and judgements which we know how to carry out spontaneously; we do not have to think about them prior to or during their performance.*
- *We are often unaware of having learned to do these things; we simply find ourselves doing them.*

- *In some cases, we were once aware of the understandings which were subsequently internalized in our feeling for the stuff of action. In other cases, we may never have been aware of them. In both cases, however, we are usually unable to describe the knowing which our action reveals.*

The only time the actor's attention is drawn to the knowing that is implicit in action is when a situation presents as uncertain, unique, unstable or involves a conflict of values (Schön, 1983). On those occasions, there is an element of surprise which prompts reflection-in-action (Schön, 1983). Otherwise it may be assumed that knowing-in-action remains tacit and is the key to skilful, competent actions and practice, illustrated by such examples as tightrope walking, baseball pitching, face recognition, and solving mathematical problems (Schön, 1983). Referring to professional practice, Schön (1983) states:

> *As a practitioner experiences many variations of a small number of types of cases, he is able to "practice" his practice. He develops a repertoire of expectations, images, and techniques. He learns what to look out for and how to respond to what he finds. As long as his practice is stable, in the sense that it brings him the same types of cases, he becomes less and less subject to surprise. His knowing-in-practice tends to become increasingly tacit, spontaneous, and automatic, thereby conferring upon him and his clients the benefits of specialization* (Schön, 1983, 60).

Practice needs to be stable in order for the practitioner to acquire the knowing-in-action that is the basis of skilled performance. If practice is unstable, the opportunity to develop '*a repertoire of expectations, images and techniques*', upon which skilled performance relies, does not occur. However, increasing knowing-in-action through stable practice does not guarantee increasingly skilful performance.

> *Further, as a practice becomes more repetitive and routine, and as knowing-in-practice becomes increasingly tacit and spontaneous, the practitioner may miss important opportunities to think about what he is doing.*
>
> *...And if he learns, as often happens, to be* ***selectively inattentive to phenomena that do not fit the categories*** *of his knowing-in-action, then he may suffer from boredom or "burn-out" and afflict his clients with the consequences of his narrowness and rigidity* (Schön, 1983, 61) (My emphasis*).*

The signifier 'knowing-in-action' appears to signify in two contrasting ways – as tacit knowledge that underpins skilled practice and, also, as the basis for rigid harmful action. Rather than becoming more skilled and competent as knowing-in-action becomes more tacit and spontaneous, it appears the practitioner may become less skilled. Knowing-in-action was posited as a kind of knowing that enabled practitioners to cope well with important phenomena of practice, namely, uncertainty, instability, uniqueness, and value conflict. It was the observed inability of the dominant model of professional knowledge to deal with such phenomena that prompted the search for a new epistemology. However, it seems that practitioners of this new epistemology or reflective practitioners may be equally capable of ignoring phenomena that do not fit the categories of their knowing-in-action. In this respect, they could be said to resemble practitioners of the model of technical rationality, who, Schön (1983, 44-45) claims, may respond to the dilemma of rigor or relevance by:

> *...cutting the practice situation to fit professional knowledge. This they do in several ways. They may become* ***selectively inattentive to data that fall outside their categories****.*
>
> *...Or they may try to force the situation into a mold* (sic) *which lends itself to the use of available techniques.*

> *...All such strategies carry a danger of misreading situations, or manipulating them, to serve the practitioner's interest in maintaining his confidence in his standard models and techniques. When people are involved in the situation, the practitioner may preserve his sense of expertise at his clients' expense.* (My emphasis).

In the case of both models of professional knowledge, the outcome seems to be the same: a negative impact on the client. Could the logic of these two models be more similar to one another than was suggested by their rhetorical structure? A close reading of what Schön (1983, 59) terms '*a beautiful example of reflection-in-action.*' may help to address this question. The example involves Schön's (1983) commentary on a report of a research experiment involving young children's attempts at balancing wooden blocks of varying weights on a metal bar. Some of the blocks are plain wooden blocks and some are weighted at different ends, conspicuously so in some instances, inconspicuously so in others (Schön, 1983). The researchers report their observations and describe the children's efforts.

All of the children initially try to balance the blocks at what the researchers call their '*geometric centers,*'; referring to this action, one child is quoted as saying: '"*things always balance in the middle*"' (Schön, 1983, 57). When this action fails with the counterweighted blocks, some of the children persist in trying to balance the blocks in the same way with just small adjustments around the centre. When those attempts prove unsuccessful, the children abandon all effort declaring the task to be impossible (Schön, 1983). Other children, faced with the same problem, begin to decentre the blocks, first the conspicuously weighted ones and later the inconspicuously weighted ones, leading the researchers to comment that the children were now balancing the blocks at their '*centers of gravity*' or, in the language of the children,: '"*you have to be careful, sometimes it's just as heavy on each side, sometimes it's heavier on one side*"' (Schön, 1983, 58).

The children seem capable of articulating the knowing that is in their actions, not of course, in the language of the researcher/observer but in a language sufficiently

lucid to enable the researcher/observer to recognise in it theories of physics and mathematics. In the latter stages of the experiment, the '"*children paused* ***before*** *each item, roughly assessed the weight distribution of the block by lifting it..., inferred the probable point of balance and then placed the object immediately very close to it, without making any attempts at first balancing at the geometric center*"' (Schön, 1983, 58) (Researchers' emphasis). This description of the children's actions could be read as a process of thinking and deductive reasoning prior to action, which is similar to the model of technical rationality.

How the knowing implicit in the children's actions becomes expressed in words is explained by Schön (1983, 59) in the following way:

> *It is interesting to note that as the authors* (of the research report) *observe and describe this process, they are compelled to invent a language. They describe theories-in-action which the children themselves cannot describe.*
>
> *...Knowing-in-action which the child may represent to himself in terms of a "feel for the blocks", the observers redescribe in terms of "theories". I shall say that they convert the child's know****ing****-in-action to know****ledge****-in-action.*
>
> *A conversion of this kind seems inevitable in any attempt to talk about reflection-in-action. One must use words to describe a kind of knowing, and a change of knowing, which are probably not originally represented in words at all.* (Schön's emphases).

Contrary to Schön's (1983) declaration, and as already indicated, the children seem quite capable of describing their 'knowing-in-action' and of using words to do so, just as the researcher/observers use an already existing lexicon to re-present the children's utterances in terms of theories. The ordinary language used by the children to describe what they are doing is converted by the observers into the language of science: '*These are the authors' theories about the children's knowing-in-action*' (Schön, 1983, 59). How does this example compare to the knowing-in-action that is a necessary precondition for reflection-in-action? Knowing-in-action, which Schön (1983, 54) describes as *'the characteristic mode of*

ordinary practical knowledge', is characterised as spontaneous and intuitive, the outcome of repeated practice. The children engaged in the research experiment have evidently some experience of balancing blocks, but no experience of balancing counterweighted blocks. In this sense, their knowing cannot be categorised as knowing-in-action. Also, they approach the task with some prior knowledge, namely, that '*things always balance in the middle*'. In fact, their actions could be read in terms of the model of technical rationality, which considers '*intelligent practice as an* ***application*** *of knowledge to instrumental decisions*' (Schön, 1983, 50) (Schön's emphasis). The task given to the children is an instrumental one: to balance the blocks. The end is clear and unambiguous. And they apply their propositional knowledge to the task. If knowing was implicit in their actions, they would be unable to offer any verbal description. So, in two key aspects, the report of the block balancing experiment differs from Schön's (1983) explication of knowing-in-action. Even in the descriptions offered by the researchers, how can someone other than the 'doer' of the action describe knowing-in-action? The researcher/observers are unable to have a *'feel for the stuff'* (Schön, 1983, 49) of action in the way the actors have since the former are not engaged in the practical activity. And, in describing the knowing implicit in action, even if it were to be done by the actors themselves, is that not separating knowing from action, and consequently, distorting a key 'property' or characteristic of that knowing? Another key property of knowing-in-action is that it is '*ordinarily tacit*' (Schön, 1983, 49). There are many references to this feature in Schön's (1983) text as indicated below:

> *Often we cannot say what it is that we know* (Schön, 1983, 49)*; skilful action often reveals a "knowing more than we can say"* (Schön, 1983, 51)*;*
> *..."thinking processes"* (are distinguished) *from "non-logical processes" which are not capable of being expressed in words or as reasoning* (Schön, 1983, 51)*; non-logical processes which are omnipresent in effective practice* (Schön, 1983, 52)*; we are usually unable to describe the knowing which our action reveals* (Schön, 1983, 54).

If that which cannot be expressed in words is expressed in words, is it still the same kind of knowing? In the case of the experiment conducted with the children, the example chosen to illustrate reflection-in-action involved block-balancing. In this example, the knowing is literally in the '*feel for the stuff with which* (the children) *are dealing*' (Schön, 1983, 49); '*the stuff* (literally) *at hand*' (Schön, 1983, 50). Knowledge of how the blocks are weighted and where the weight is distributed may be determined by handling the blocks. The literality of the example may be indicative of Schön's (perhaps unconscious) desire to ensure that knowing and action remain inextricable. In the block-balancing example, the identity of reflection-in-action as a new epistemology of practice appears complicated or contaminated by the dominant model of technical rationality.

Schön (1983) presents another illustration of the processes of reflection-in-action. A close reading of the text of this second example provides further insight into the logical basis of reflective practice. The example is taken from an in-service education programme for teachers undertaken by researchers. The education programme was '*organised around the idea of on-the-spot reflection and experiment*' (Schön, 1983, 66), and designed to encourage the teachers taking part '*to explore their own intuitive thinking about apparently simple tasks...*' (Schön, 1983, 66). What Schön (1983, 67) describes as 'a *critical event*' occurred early in the research project/in-service programme. The teachers were asked to view a video recording of two boys seated on either side of an opaque screen (Schön, 1983). Each child had a number of different coloured shapes on a table in front of him. In the case of one of the boys the shapes were arranged in a pattern, and in the case of the other boy, the shapes were scattered. The boy with the patterned shapes was requested to instruct the other boy to create a similar pattern. After a short time, the boy receiving the instructions appeared to have '*gone astray*' (Schön, 1983, 67), although neither boy was aware of a problem. The teacher/viewers gave their responses to the tape which is quoted in the extract which follows:

In their initial reactions to the videotape, the teachers spoke of a "communications problem". They said that the instruction giver had "well-developed verbal skills" and that the receiver was "unable to follow directions". Then one of the researchers pointed out that, although the blocks contained no green squares - all squares were orange and only triangles were green - she had heard the first boy tell the second to "take a green square". When the teachers watched the videotape again, they were astonished. That small mistake had set off a chain of false moves.

...At this point, the teachers reversed their picture of the situation. They could see why the second boy behaved as he did. He no longer seemed stupid; he had, indeed, "followed instructions". As one teacher put it, they were now "giving him reason". They saw reasons for his behaviour; and his errors, which they had previously seen as an inability to follow directions, they now found reasonable (Schön, 1983, 67-68).

Previously Schön (1983, 50) described the process of reflection-in-action in the following way:

Stimulated by surprise, they (professional practitioners) *turn thought back on action and on the knowing which is implicit in action. They may ask themselves, for example, "What features do I notice when I recognise this thing? What are the criteria by which I make this judgement? What procedures am I enacting when I perform this skill? How am I framing the problem that I am trying to solve?" Usually reflection on knowing-in-action goes together with reflection on the stuff at hand. There is some puzzling, or troubling, or interesting phenomenon with which the individual is trying to deal. As he tries to make sense of it, he also reflects on the understandings which have been implicit in his action, understandings which he surfaces, criticizes, restructures, and embodies in further action.*

How does the intuitive thinking of the teachers in the videotape incident approximate the above description of reflection-in-action? The teachers respond

with surprise, but not to their initial interpretation of the meaning of the boys' behaviour on first viewing the tape recording. At that stage, they attribute the error observed to the 'second' boy's inability to follow clear verbal instructions due to some intellectual difficulty on his part. The teachers' surprise comes when an alternative explanation is given to account for the second boy's actions. They '*turn thought back on action*' – but it is not on their own action in failing to listen carefully to the tape recording and hear accurately the instructions given by the 'first' boy. Nor do they turn thought back on their intuitive judgement of the boys as verbally skilled in respect of the 'first' boy and intellectually challenged in respect of the 'second'. They do not appear to allow themselves to be puzzled or troubled by what they have observed. Their intuitive response is to explain their observations in terms of cause and effect without referring in any way to themselves or their role in this particular construction of meaning. The '*interesting phenomenon*' that they try to deal with appears to be the '*small mistake that set off a chain of false moves*', not their mistake in mishearing, but the first boy's mistake in the instruction he gave. The '*criteria*' by which they made their judgement seem to derive from rational principles: behaviour is explained in terms of cause and effect. What changed for the teachers was being informed of the reason for the second boy's behaviour. Being apprised of the correct cause of boy's behaviour by a third party caused the teachers to change their understanding. While it is clear from the above example that the teachers involved in the research/in-service programme saw and understood the situation differently following reflection on their experience, the knowing that was surfaced could be understood as having its origins in a technical rational model of professional knowledge.

Returning to the block balancing experiment, Schön (1983, 59) concedes that that particular example of reflection-in-action is '*very far removed from our usual images of professional practice*', and he offers the teachers' in-service/research programme as one of a number of '*brief examples of the kinds of reflection-in-action which I shall illustrate and discuss at greater length later on*' (Schön, 1983, 63).

Psychotherapy is one of the professional practices selected by Schön (1983) for a more detailed illustration of reflection-in-action. The chapter that describes

reflection-in-action in the context of psychotherapy practice is entitled: '*Psychotherapy: The Patient as a Universe of One*' (Schön, 1983, 105), and it occupies Chapter 4 of Schön's text '*The Reflective Practitioner*'. That chapter appears to fulfil Schön's promise in the preface of his book to offer '*an approach to epistemology of practice based on a close examination of what some practitioners... actually do*' (Schön, 1983, viii). The following deconstructive reading will focus once again on the logic of the argument presented. As indicated in the methodology chapter, psychotherapy practice was chosen for a deconstructive reading because it comes within the general remit of health care disciplines. It also shares some similarities with nursing. Both practices involve a helping role. Nursing is concerned not only with the physical wellbeing of patients and clients but also with their emotional and psychological wellbeing. Psychotherapy and nursing are both predicated on the formation and maintenance of therapeutic relationships with service users. This is particularly the case in mental health nursing. My previous experience as a student of psychological counselling also influenced the choice of this piece of text for analysis.

Schön's (1983, viii) Chapter 4 presents, as anticipated also in the preface of his book, one of the '*vignettes of practice, concentrating on episodes in which a senior practitioner tries to help a junior one learn to do something*'. Excerpts from a verbatim transcript of a tape recorded interaction between a psychiatric Resident (a student undertaking professional training in psychotherapy) and his Supervisor (a qualified experienced psychotherapist) form the focal point for Schön's (1983) analysis of reflection-in-action. Several ambiguities and complexities may be noted at the outset. The practices of teaching and therapy appear to be conflated in the chapter. Psychotherapy practice receives a great deal of attention in the discussion and commentary on the transcript even though it is not the practice being engaged in at the time of the recording. The actions and interventions of the Supervisor are the focus of Schön's (1983) interest, although the Supervisor, in this instance, is not the actual practitioner. Some background information regarding the supervisory session is provided:

> *The therapist is a third-year Resident in psychiatry. His current Supervisor, a psychoanalyst, is one of some sixty supervisors with whom he has met in the course of his three-year training program. The Resident sees his current Supervisor for one half-hour every week, averaging one supervisory session for every seven or eight sessions with the patient. Because the Resident has been troubled by his relations with this Supervisor, he has agreed to tape-record the session and then to discuss the resulting protocol, hoping to learn from reflection on the record of the meeting* (Schön, 1983, 109).

Various layers of experience are interwoven in this example: the Resident's practice of therapy with his client; the Resident's relationship with his Supervisor; the Resident's experience of other supervisors; the supervisor's relationship with the Resident; the Supervisor's experience as a therapist; the Supervisor's role as a teacher; Schön's relationship with the Resident, the Resident's relationship with Schön; and Schön's interest in illustrating reflection-in-action. The situation might be described as complex. However, the contextual factors alluded to above do not form any part of Schön's (1983) subsequent analysis and description of reflection-in-action. This appears paradoxical as reflection-in-action is posited as an epistemology that takes account of unique contextual factors that pertain in practice situations. Presenting reflection-in-action as an a-contextual, static entity appears to mimic the dominant model of professional knowledge and is reminiscent of what Derrida (1997) refers to as the '*metaphysics of presence*'.

Schön justifies his selection of an incident from professional education rather than professional practice to illustrate a new epistemology by stating that, in the context of professional education, '*a practitioner's reflection-in-action is more likely to be made public than it is in ordinary practice*' (Schön, 1983, 108). An expectation is thereby created that the practitioner's tacit, intuitive knowing-in-action will be surfaced by the process of reflection-in-action. The reader may also have an expectation that the processes involved in this endeavour, for example, addressing such questions as "What are the criteria by which I make this judgement?" and '"How am I framing the problem I am trying to solve?"' will be made explicit.

Schön's (1983) Chapter 4 begins by outlining the history of psychotherapy from its origins in medicine and psychiatry and its treatment of the insane to the development of various schools of therapy; the entry into the field of new professions, such as clinical psychology and social work; and the extension of therapy services to the general public. Schön (1983, 108) isolates the issue of therapeutic pluralism early on in the chapter and the various responses to the '*predicament*' posed by this phenomenon.

> *Some practitioners, for example, share a disposition to regard the patient as a unique case – in Erik Erikson's words, "a universe of one". These practitioners, however much they may differ from one another in language and technique, share an approach to therapy that distinguishes them from those who regard patients as examples of standard diagnostic categories. The practitioners of the unique case are of special interest from the point of view of the study of reflection-in-action.*

Previously, Schön (1983, 41-42) had identified '*conflicting paradigms of professional practice, such as we find in the pluralism of psychiatry*' as a problem for the model of technical rationality in that:

> *...there is no clearly established context for the use of technique. There is contention over multiple ways of framing the practice role, each of which entrains a distinctive approach to problem setting and solving. And when practitioners do resolve conflicting role frames, it is through a kind of inquiry which falls outside the model of Technical Rationality'.*

Psychotherapy should therefore provide an example of the kind of inquiry that falls outside the dominant epistemology of practice, which views professional knowledge as the application of scientific theory and technique to real life problems of practice. Schön (1983, 108) makes the following comment prior to his presentation and analysis of the interaction between the Supervisor and the Resident:

> *I have chosen a practitioner who takes a psychoanalytic point of view, while recognizing that a protocol drawn from the work of Carl Rogers, Fritz Perls, or Salvador Minuchin might have produced a very different set of materials for analysis. It seems to me, nevertheless, that therapists, who are in other respects very different from one another must still frame the problem of the particular patient, construct and test interpretations of his behaviour, and design interventions aimed at helping him. The supervisor, in the case that follows, goes about his business in a manner peculiar to his underlying model of therapy, but the generality of his tasks links his inquiry to other therapies of the unique case.*

The above remarks seem to provide an indication of how particular theories and theoretical frameworks may be accommodated within a reflective practice epistemology. Schön (1983) suggests that there is a process common to all therapies that transcends theoretical approaches and may be discerned in the actions of the therapist. In the transcribed conversation included in the text, the Resident reports on his work with a particular client. As the transcript is presented and analysed it becomes clear that the 'generality' of the therapist's tasks cannot be separated from, or transcend, his underlying model of therapy. The Supervisor frames the client's problem, constructs interpretations, and designs interventions in terms consistent with psychoanalytic theory. At one point, he asks the Resident: '"How would you characterize her (the client's) problems in your own mind, psychodynamically?"' (Schön, 1983, 120). It also becomes clear that the Resident does not appreciate or identify with the generality of the tasks performed by the Supervisor. Reflecting on the tape recording, Schön (1983, 125) remarks that:

> *...he* (the Resident) *seeks to explain his troubles with the Supervisor in terms of conflicting approaches to psychotherapy: "He is more psychoanalytic, while I deal more with conscious phenomena". Yet he displays in the protocol an eagerness to join, indeed, to compete with, the Supervisor's psychoanalytic inquiry.*

It may be that the Supervisor, when he '*brushes aside*' (Schön, 1983, 120) the Resident's attempts at an explanation and when he '*refrains from joining the Resident's excursion into the patient's history*' (Schön, 1983, 114) is being selectively inattentive to phenomena that do not fit the psychoanalytic model of therapy. The '*repertoire of meanings and psychodynamic patterns accessible to the Supervisor, but apparently not to the Resident*' (Schön, 1983, 119) may be read more as a function of the differing theoretical approaches of the two practitioners rather than as a function of the Supervisor's knowing-in-action.

Immediately following the transcript and prior to its analysis, a section entitled '*Therapeutic Knowledge-in-Practice*' is presented (Schön, 1983, 116). Knowledge-in-practice, it may be recalled from the block-balancing experiment, is derived from converting the 'knowing' that is implicit in action to 'knowledge'. This is effected by a process of articulation and theorisation (Schön, 1983). The therapeutic knowledge-in-practice that is presented is that of psychotherapist Erik Erikson, whom Schön (1983) had previously referenced in respect of the former's approach to the predicament of therapeutic pluralism. Erikson's response to the pluralism of psychotherapy is to regard the patient as a unique case (Schön, 1983). Schön (1983, 116-118) outlines this approach as follows:

> *Erik Erikson has described the psychotherapist's task as one of listening to the patient's complaint, eliciting its history, and making, testing, and delivering interpretations of the patient's data. The main questions of therapy have to do with the reliability of interpretation:...*
>
> *...to discover the patient's unconscious and refrain from imposing unconscious assumptions of his own...*
>
> *...The* (patient's) *material ought not to be subsumed under existing categories. The patient is "a 'series of one' who must be understood in terms of the unique experiences of his life".*
>
> *...In the testing of interpretations and, indeed, in the entire interpretive inquiry, Erikson gives a special place to the phenomenon of transference.*

Schön (1983, 118) adds: '*In the protocol we have examined, the Supervisor lives out the main lines of Erikson's description of therapeutic practice*'. Using a pre-existing theory to map onto and explain the practice situation seems to be at odds with the concepts of knowing-in-practice and reflection-in-action. Foregrounding the uniqueness and individuality of the patient and her life experiences may be understood as a way of obscuring the psychoanalytic theory that is being used to describe and explain the person and her difficulties. By sleight of text, as it were, the patient's difference from other patients in terms of her history and personal circumstances seems to be being used metonymically for the therapeutic approach as a whole.

The above deconstructive reading may help to account for Schön's (1983) remarks towards the conclusion of the chapter. Referring to the Supervisor, he states:

> *He* (the Supervisor) *does not reveal the thoughts and feelings which guide him in his shifts from one phase of inquiry to the next. He reflects-in-action but he does not reflect on his reflection-in-action.*
>
> *...Nor has the Supervisor tried to discover what the Resident makes of his demonstration. His approach to instruction consists in demonstrating and advocating a kind of therapeutic reflection-in-action, but it is also an approach of mystery and mastery.* (Ref) *He demonstrates his mastery of the material, but he keeps the sources of his performance mysterious* (Schön, 1983, 126).

At the outset, the expectation had been created that analysing an incident from education rather than professional practice was more likely to result in reflection-in-action being made public. It seems clear from the above remarks that this has not occurred. Could the lack of publicity be attributable to the absence of reflection-in-action as a new epistemology of professional knowledge in this example? Schön (1983) does not entertain such a possibility because that would undermine his argument. Instead, he asserts that the Supervisor reflected-in-action but did not share this knowledge with the Resident (Schön, 1983). If that is

the case, and the application of Erikson's 'theory of practice' or 'practice of theory' as a way of explaining the Supervisor's actions is overlooked, Schön's role could be regarded as that of 'analyst' to the interlocutors, with an ability to see and read meaning that has been disguised behind surface appearances. This might suggest that the application of theory (in this case psychoanalytic theory), which Schön (1983) has been attempting to suppress, turns out to dominate not just the interaction between the Supervisor and the Resident, but also the way that the interaction between the Supervisor and the Resident is interpreted and understood by the 'Auditor'.

Towards the conclusion of Schön's (1983) Chapter 4, there is an account of what appears to be 'reflection-on-practice', not the practice of psychotherapy in this instance but the practice of teaching. Schön and the Resident listen to the tape recording of the supervision session (Schön, 1983). The Resident's thoughts and feelings about his experience are reported, for example:

> *...he* (the Resident) *complains that the Supervisor was not telling him what he wanted to hear. Then, upon reflection, he adds that he was not asking for what he wanted to know. He doubts that the Supervisor is an effective role model for him. He wants more help than he is getting, but feels angry when he asks for it. He senses that the Supervisor has formed a negative judgement about him which has never been expressed, and he seeks to explain his troubles with the Supervisor in terms of conflicting approaches to psychotherapy:...*(Schön, 1983, 125).

Schön (1983, 125-126) adds his perspective on the interaction between the Resident and the Supervisor:

> *It is clear, both from the protocol and from private interviews, that the Resident discerns in the Supervisor's performance a knowing-in-practice that he values, but he is frustrated in his attempts to grasp it.*

> *...The Resident does not know whether the Supervisor would be unwilling, or perhaps unable, to make more of his knowing-in-practice explicit. The Resident has not asked for this, and the Supervisor has not offered it.*

Schön (1983) then formulates the problem from his analysis of the data of the teaching situation. He attributes the difficulty experienced by the Resident to the failure of the Supervisor to make his thinking and analytic processes explicit. He also identifies the Resident's passivity in his approach to learning as contributing to the problem (Schön, 1983). Rather than seek to clarify what he does not understand, the Resident keeps his negative feelings towards the Supervisor to himself and simply goes along with the Supervisor's approach (Schön, 1983). In the reflection on, and analysis of, the Resident's teaching/learning experience, Schön (1983) does not identify his own activity as an instance of reflection-on-action. The primary reason for making the recording was the Resident's troubled relationship with his Supervisor and his wish '*to learn from reflection on the record of the meeting*' (Schön, 1983, 109). While the main thesis of Schön's (1983) book is to elucidate 'reflection-in-action' as a supplement or alternative to the dominant model of professional knowledge, he acknowledges that 'reflection-on-action' is also possible.

> *Practitioners do reflect* ***on*** *their knowing-in-practice. Sometimes, in the relative tranquility* (sic) *of a postmortem, they think back on a project they have undertaken, a situation they have lived through, and they explore the understandings they have brought to their handling of the case. They may do this in a mood of idle speculation, or in a deliberate effort to prepare themselves for future cases* (Schön, 1983, 61) (Schön's emphasis).

It seems paradoxical, therefore, that in the case of the supervision session, reflection-in-action could be identified even though it was not made explicit, yet in the case of the analysis of the supervision session, reflection-on-action is explicit yet not identified as such.

The knowledge that derives from reflection-on-action for the Resident is quite dramatically illustrated in the following quotation:

> *It is very striking that the two therapists do not make their own interaction into an object of mutual reflection. In one of his interviews* (with Schön), *the Resident discovers this point. Excitedly, he shows how his relationship with the Supervisor resembles the patient's relationship to her therapist, especially in the matter of control and cooperation. Like his patient, the Resident feels stuck in his relationship to the person who is supposed to help him, wanting more from him than he feels he is getting, yet angry at himself for wanting more. But these issues do not come up for discussion in the clinical supervision itself. Had they done so, the boundaries of reflection might have been stretched to include the meaning of the Supervisor's demonstration, the Supervisor might have begun to reflect on his own reflection-in-action, and the Resident might have begun to gain access to the mysterious sources of the Supervisor's performance* (Schön, 1983, 126-127).

Perhaps the source of the Resident's excitement is the recognition that he has learned to see and think psychodynamically. The Supervisor had urged the Resident to see in the client's relationship with him (her therapist) a reflection of her relationships outside therapy. Now the Resident has learned to see his relationship with the Supervisor as a reflection of the client's relationship with him (the Resident). And he has learned that he has learned to do this via the process of reflection-on-action. It is also paradoxical to note that what would have made the process of reflection-in-action explicit - what would have surfaced the Supervisor's knowing-in-action – that is, making the two therapists' own interaction into an object of mutual reflection, lay outside '*the boundaries of reflection*' as represented in this vignette. Reflection-in-action seems to be never punctually present in the text that strives to demonstrate its identity. Its presence is endlessly deferred.

Chapter 7 Deconstructing Schön's text 3

Having identified the limitations of technical rationality as a model of professional knowledge and made a case for a new epistemology of practice, Schön (1983) provides an example of the new epistemology, which he names 'refection-in-action', using an instance from psychotherapy (Schön, 1983). Deconstructing the text in which the above argument is presented could be seen to produce the following reading. The limitations of the dominant model of professional knowledge create a space that enables a new epistemology of practice to be articulated. However, the model of technical rationality casts a shadow over that space that is difficult to escape. The dominant model remains implicated in the new epistemology which making it difficult to separate the latter from the former. Every effort to do so seems to result in a reassertion of the dominant model. Reflection-in-action, in consequence, acquires a spectral quality; it is never fully present in the present. Chapter 5 of Schön's (1983) textbook '*The Reflective Practitioner*' appears to address this issue of non-presence. The chapter is titled '*The Structure of Reflection-in-Action*' (Schön, 1983, 128), and it is the culmination and synthesis of Schön's (1983) investigations of reflection-in-action in both psychotherapy and architecture practice. The reader may, therefore, expect to find a quite detailed and explicit description of reflection-in-action and, perhaps, a clearer understanding of its unique identity.

This chapter presents a deconstructive reading of Schön's (1983) Chapter 5. It is the final chapter of Schön's (1983) work to be considered in the context of this thesis. Rhetorically, the word 'structure' in the title of Schön's (1983) Chapter 5 coming before the word(s) 'reflection-in-action' creates an expectation of the latter as a tangible, definable entity. Although mining for a new epistemology in the '*swampy lowland*' (Schön, 1983, 42) of practice, where practitioners must abandon technical rigor in order to involve themselves in problems of greatest human concern, and where their '*methods of inquiry*' consist of '*experience, trial and error, intuition, and muddling through*' (Schön, 1983, 43), a structure is proposed which

may confer stability on a previously vague and elusive phenomenon. The structural metaphor continues as the aim of the chapter is outlined: '*I propose that by attending to the practitioner's reflection-in-action in both cases* (architecture and psychotherapy practice) *it is possible to discover a fundamental structure of professional inquiry which underlies the many varieties of design or therapy advocated by the contending schools of practice*' (Schön, 1983, 130). The word '*fundamental*' connotes a ground or base, something that remains constant and unchanging in unstable situations of practice. The metaphor of structure is similar to that used to describe the model of technical rationality. However, the word '*inquiry*' suggests that the structure in question is a dynamic rather than a static entity, which is unlike the hierarchical, dominant model of professional knowledge. The process by which competent practitioners surface and articulate the tacit intuitive, knowing-in-action that they use to deal with unique and uncertain situations of practice will, it seems, be provided with a structure.

The practices that Schön (1983) has analysed and synthesised to create the structure of reflection-in-action are both instances where an experienced practitioner attempts to teach a junior colleague how to do something. As indicted in the previous chapter, in the context of psychotherapy, the practice being engaged in at the time of Schön's (1983) investigation is the practice of teaching rather than the practice of therapy. The same holds for the example of architecture. In neither case is the practice selected the actual practice of the experienced practitioner. Both are mediated via the students' experiences. Although the student therapist has engaged in the practice of therapy as therapist to a real client, in the architecture case, the 'practice' in question is an assignment given to all students by their teacher at the beginning of a college term. The student architects are required to design an elementary school using a given '*set of design specifications... and a graphic description of the site on which the school is to be built*' (Schön, 1983, 80). In neither case is the interaction between the teacher and the student intended as a demonstration of reflection-in-action. In the architecture case, the interaction occurs in the context of a review of one student's progress with the assignment, something that occurs at intervals throughout the term (Schön, 1983). At the end of term, the student's completed assignment is

presented before a group of critical reviewers (Schön, 1983). In the case of the psychotherapist, as outlined in the preceding chapter, the interaction occurs in the context of a supervision session in which the student discusses the work he has been engaged in as part of his professional training. In neither case is the author himself a witness to, or a participant in, the interactions he analyses. Schön (1983, 81) develops the structure of reflection-in-action from protocols of the interactions, acknowledging, in the architecture case, that while the student can interpret the teacher's '*dychtic utterances – "here", "this", "that" ...only by observing his* (the teacher's) *movements*', Schön's (1983) interpretation '*must reconstruct Quist's* (the teacher's) *pointing and drawing, referring to the sketches which accompany the transcript and, on occasion, making new sketches which clarify Quist's meanings*'. These several degrees of separation have the effect of distancing the author from the object of his study. Reflection-in-action is already an image (Schön's reading) of an image (the protocols) of an object (reflection-in-action). Schön (1983) asserts that, in the examples he has chosen to fashion a structure of reflection-in-action, each senior practitioner reflects-in-action, although neither articulates this process in a manner that would be perceptible to other participants or onlookers. Of the architect teacher's performance, Schön, (1983, 104) states:

> *This underlying process might emerge with greater clarity if Quist's demonstration were not so masterful. In his unfailing virtuosity, he gives no hint of detecting and correcting errors in his own performance.*
>
> *...But Quist reflects very little on his own reflection-in-action, and it would be easy for a student or observer to miss the fundamental structure of inquiry which underlies his virtuoso performance.*

Such an admission points to yet another layer of obscurity. The object itself (reflection-in-action) never appears, as such.

The structure of reflection-in-action or professional inquiry as articulated by Schön (1983) may be summarised in the following way: a problem is presented - the problem as presented is unsatisfactory - the problem is reframed – the reframed

problem is tested – the processes of reframing and testing conclude when satisfactory change is produced or the problem is understood in a new way. References to 'knowing-in-action' or 'knowledge-in-practice' do not feature in Schön's (1983) account of the structure of reflection-in-action. So how is the issue of knowledge accommodated within the structure?

A reference to professional knowledge occurs in the introduction to Schön's (1983) Chapter 5. Schön (1983, 128) begins his elaboration of the structure of reflection-in-action by drawing attention to the differences between the two professional practices under consideration.

> *The differences between architecture and psychotherapy are so very striking that at first glance there seems to be very little point in searching for resemblances. To begin with, the goals of the two professions have almost nothing to do with one another. The one aims at designing good buildings on a site; the other, at curing mental illness or helping people cope with the problems they encounter in their lives. One uses the media of sketchpad, delineations, scale models; the other, talk. The architect works in his studio; the therapist, in a clinic or office. And the two professions draw on very different bodies of professional knowledge.*

The difference contributed by '*bodies of professional knowledge*' appears as the last item on a 'list' format as evident in the above extract. By the time the reader gets to '*professional knowledge*', the impact of the very striking difference contributed by it is somewhat diluted. '*Goals*' are elaborated to some degree in the above extract, as are '*media*' and '*work locations*'. However, there are no explanatory examples of professional knowledge. It could be assumed, given the context in which the reference occurs and the use of the verb 'draw on' with its 'banking' connotations, that the professional knowledge referred to is the scientific theories and techniques characteristic of the model of technical rationality. As attention is drawn to differences **between** the professions, differences **within** are somewhat obscured. An example of the latter appears in the extract above but in a way that makes it easy to overlook. Among the aims of therapy, Schön (1983, 128) cites

'*curing mental illness* ***or*** *helping people cope with the problems they encounter in their lives*'. (My emphasis). Whether a therapist is curing mental illness or helping people cope with problems in everyday life points to differences within the field of psychotherapy. The former suggests a medical model and medically qualified personnel with curative intent, whereas the latter indicates an orientation towards non-medically qualified professionals and a clientele who may be described as the 'worried well'. Differences within the field of psychotherapy are further reinforced by reference to the location in which therapy is practiced: '*The architect works in his studio; the therapist, in a clinic* ***or*** *office*' (Schön, 1983, 128). (My emphasis). A 'clinic' has medical connotations whereas an 'office' is associated with business transactions and the provision of services to the general public.

The presentation of differences in a list format creates an impression of separate entities with little or no connection between them. The spatial separation created by placing '*goals*' at the beginning of the description of differences and '*bodies of knowledge*' at the end serves to accentuate the lack of any connection or interrelatedness between these two elements. If connections were made or allowed to be inferred between the various differences listed, that would inevitably involve a reference to different bodies of professional knowledge. In the domain of psychotherapy, for example, a psychoanalyst will draw on a body of professional knowledge quite different from a therapist who follows an existential model. Therapeutic goals and methods will, likewise, be influenced and shaped by the specific theoretical approach being adopted. It is not fortuitous, perhaps, that the reference to '*different bodies of professional knowledge*' in the above extract appears as the final item on the list. If the influence of the technical rational model of professional knowledge is greater than Schön (1983) might wish to acknowledge, where better to place a reference to it than at the end of a list prefaced by an '*And*', and without additional explanatory remarks?

Differences between the professions, which might, if analysed in detail, reassert the dominance of the technical rational model of professional knowledge, are given quite cursory attention. The focus of Schön's (1983) text moves to a consideration of the similarities between the two practices, as these '*create the conditions for*

reflection-in-action' (Schön, 1983, 129). Among the similarities identified are that both practitioners approach the student's problem as unique, and, because of that, they do not try to apply '*standard theories or techniques*' (Schön, 1983, 129). As similarities are described, the dominant model of professional knowledge appears to surface but in a disguised form.

> *In both examples, the practitioner approaches the practice problem as a unique case. He does not act as though he had no relevant prior experiences; on the contrary. But he attends to the peculiarities of the situation at hand* (Schön, 1983, 129).

In what does '*relevant prior experience*' consist? The reference to it is placed between '*a unique case*' and '*the peculiarities of the situation*', both emphasising something that has not happened or been seen before. The reference is brief and abruptly terminated: the '*contrary*' of acting '*as though he had no relevant prior experience*' is not presented. Some clues to its identity, however, are provided when Schön (1983) explains the concept of '*reframing*'. The process of reflection-in-action begins when the student or junior colleague presents a problem that the senior practitioner rejects. Schön (1983, 129) states:

> *In the half hour or so that he* (the senior practitioner) *spends with the student, he must construct an understanding of the situation as he finds it. And because he finds the situation problematic, he must reframe it.*

Reframing is explained as follows:

> *...the practitioner tries nevertheless to set a problem he can solve. If (the senior practitioners) failed to do this, they would be stuck as their students are stuck. Hence they step into the situation with a framing of the problem for which they feel they can find a solution.*

> *Quist* (the Architect) *chooses a geometry of parallels which can be made to work slightly with the contours of the slope; at the same time, he sets a threshold standard of fit which enables him to say that "slightly" is enough. The Supervisor* (Psychotherapist) *frames the patient's problem in terms of the transference which lends itself both to a strategy of inquiry and a strategy of intervention. Neither practitioner can know, at the moment of reframing, what the solution to the problem will be, nor can he be sure that the new problem will be soluble at all. But the frame he has imposed on the situation is one that lends itself to a method of inquiry in which he has confidence* (Schön, 1983, 134).

The problems presented by the students are rejected, perhaps, because they are not framed in a way consistent with the teacher's theoretical framework. In the case of the Supervisor, reframing appears to be a matter of converting the presented problem into a form consistent with psychoanalytic theory: concepts such as '*guilt*', '*conflict*' and '*transference*' are key elements of psychoanalytic theory.

> *The Supervisor builds gradually from his perception of the patient's dilemma toward an interpretive synthesis congruent with his fundamental values and theories. He reaches for partial interpretations which stay close to the data of the thematic stories he has elicited from the resident. He guides his search for explanations by reference to the psychoanalytic themes of "inner conflict" and "guilt". By the time he has fully surfaced his interpretive synthesis, he has...made it congruent with psychoanalytic theory* (Schön, 1983, 136).

Although Schön (1983, 133) maintains that the senior practitioners *'act as though they were judging their reframing of the students' problems in terms of these questions* (which include): *Have I made it* (the presented problem) *congruent with my fundamental values and theories?*', he does not, in the context of the discussion of the structure of reflection-in-action, elaborate on the meaning of the term '*fundamental values and theories*'. Nor does he explain how the senior practitioners come to hold their fundamental values and theories. However, he

refers to the Supervisor valuing *'self assertion, independence, and the ability to free oneself from dead ends; the story* (as relayed by the student), *which reveals the absence of these qualities in the patient, gives him a direction in which to seek interpretive understanding'* (Schön, 1983, 135). The values identified above could be explained as deriving from a particular theory or model of mental health. It is possible to argue that it is the absence of sameness rather than the presence of difference in the problem presented by the student that guides the senior practitioner's actions, actions that will terminate with the student's adoption of the Supervisor's theoretical model which will be applied subsequently in his therapeutic work with the patient.

The issue of prior experience is the subject of a separate section of Schön's (1983) Chapter 5 entitled: '*Bringing Past Experience to Bear on a Unique Situation*' (Schön, 1983, 137). The discussion which follows the above title addresses one of the questions posed by Schön (1983, 133) which, he maintains, points '*to a further elaboration of reflection-in-action as an epistemology of practice*'. Schön (1983, 132) asks:

> *When the practitioner takes seriously the uniqueness of the present situation, how does he make use of the experience he has accumulated in his earlier practice? When he cannot apply familiar categories of theory or technique, how does he bring prior knowledge to bear on the invention of new frames, theories, and strategies of action?*

This question seems to bear directly on the issue of how the dominant model of professional knowledge relates to the new epistemology of practice. In explaining the relationship, Schön (1983, 137) does not refer to the model of technical rationality by name. Instead, he acknowledges that:

> *Quist (the Architect) recognizes many familiar things in Petra's (the Student's) situation, and he places them within familiar, named categories such as "parallels", "classrooms", "slope", and "wall".*

> *Similarly, the Supervisor recognizes and names examples of "self-assertion", "dependence", and "guilt". But when it comes to the situation as a whole, each practitioner does not subsume it under a familiar category but treats it as a unique entity for which he must invent a uniquely appropriate description* (Schön, 1983, 137).

How familiar parts are made to constitute a unique whole is not explained. It is not fortuitous, perhaps, that the professions selected for analysis are those whose object of study - building sites and human beings - is likely to vary from one instance to the next. It is possible that this inherent variation may be being used metonymically for the situation as a whole: '*The notions of guilt and self-frustration guide his* (the Supervisor's) *attempts to discover what is* ***different*** *about this patient's experience*' (Schön, 1983, 137) (Schön's emphasis).

Schön (1983) acknowledges as puzzling how a practitioner can make use of prior experience in a situation that he approaches as a unique case. He states in this regard: '*It is clear that* (both practitioners) *use a great deal of their experience and knowledge*' (Schön, 1983, 138-139), and goes on to propose the following solution to the puzzle:

> *What I want to propose is this: The practitioner has built up a* ***repertoire*** *of examples, images, understandings, and actions. Quist's repertoire ranges across the design domains. It includes sites he has seen, buildings he has known, design problems he has encountered, and solutions he has devised for them. The Supervisor's repertoire includes patients he has seen or read about, types of stories he has heard and psychodynamic patterns associated with them, interventions he has tried, and patients' responses to them. A practitioner's repertoire includes the whole of his experience insofar as it is accessible to him for understanding and action.* (Schön's emphasis).

> *When a practitioner makes sense of a situation he perceives to be unique, he* ***sees*** *it* ***as*** *something already present in his repertoire.*(Ref) *To see* ***this*** *site as* ***that*** *one is not to subsume the first under a familiar category or rule. It is, rather, to see the unfamiliar, unique situation as both similar to and different from the familiar one, without at first being able to say similar or different with respect to what.* (Schön's emphases).
>
> *...Seeing* ***this*** *situation as* ***that*** *one, one may also* ***do*** *in this situation* ***as*** *in that one.* (Schön's emphases).
>
> *...Indeed, the whole process of* ***seeing-as*** *and* ***doing-as*** *may proceed without conscious articulation.* (Schön's emphases).

How can something which is taken to be unique, at the same time, be seen as something already present in the practitioner's repertoire? Is such an approach not an indication that the practitioner is not, in fact, seeing the situation as unique? Schön (1983, 138) cites Thomas Kuhn's idea of an '*exemplar*' in the context of scientific problem solving to illustrate the former's case for 'seeing-as'. Schön (1983, 139) quotes Kuhn as follows: '"*confronted with a problem, [one] seeks to see it as like one or more of the exemplary problems he has encountered before...his basic criterion is a perception of similarity that is both logically and psychologically prior to any of the numerous criteria by which that same identification might have been made...*"' . No reference is made, in the more extended quotation from Kuhn, to unique features or differences. When Schön (1983, 139-140) applies the argument for 'seeing-as' to the practitioners whose reflection-in-action he is analysing, he states:

> *When Quist immediately calls Petra's site "screwy" and says that she must impose a discipline on it, which she can always break open later, I believe he is seeing her situation as one or more others with which he is familiar and carrying over to her problem variations of strategies he has employed before. And when the Supervisor asks how the woman is stuck in her relation with her boyfriend as she is stuck in her relation to the therapist, I believe he is doing very much the same sort of thing.*

> *...It is our capacity to see unfamiliar situations as familiar ones, and to do in the former as we have done in the latter, that enables us to bring our past experience to bear on the unique case.*

No reference is made in the above extract to any unique features of the situation or how these may be accommodated within the familiar. Nor is any reference made to how an already existing familiar situation is thereby changed. Difference falls away and any unique features are dissolved in an effort, perhaps, to make the strange familiar. It appears also that the new epistemology of practice must itself be subsumed under existing (Kuhnian) familiar categories in order that its identity may be asserted.

Practitioners' prior knowledge and experience constitutes a '*repertoire*' which permits them to see the unique case as familiar. A list format is once again used to present the sources of the practitioner's prior knowledge and experience. In the case of the Supervisor, his repertoire is developed from '*patients he has seen or read about, types of stories heard and psychodynamic patterns associated with them, interventions he has tried and patients' responses to them'.* (Schön, 1983, 138). The source of these sources is not explored. It may be assumed, however, that before the Supervisor began to see patients, he had completed or was undertaking concurrently some formal training in psychotherapy, and that the model of professional knowledge and education to which he was exposed approximated the model of technical rationality. Similarly with patients read about, it is likely that the sources of his reading were academic and professional journals reporting on research studies or other empirical investigations. Stories heard would be told, as the above quotation indicates, from a psychodynamic perspective. Interventions and responses would likewise be filtered via the same viewpoint. If the repertoire is what enables the practitioner to see unfamiliar situations as familiar ones, and to do in the former as he has done in the latter, he may be doing little more than applying relevant scientific theory and technique to the practice situation. Such an interpretation is supported by the lack of any reference to tacit, intuitive, knowing-in-action in the account of how a practitioner's repertoire is developed. All sources may be explained as consciously acquired and cognitively mediated.

The section of Schön's (1983) Chapter 5 that follows the account of past experience as an element of the structure of reflection-in-action is entitled: '*Rigor in On-the-Spot Experiment*' (Schön, 1983, 141). It begins:

> *Seeing-as is not enough, however. When a practitioner sees a new situation as some element of his repertoire, he gets a new way of seeing it and a new possibility for action in it, but the adequacy and utility of his new view must still be discovered in action. Reflection-in-action necessarily involves experiment* (Schön, 1983, 141).

The limitations of the practitioner's repertoire are signalled in the opening sentence of the above extract. Repertoire alone does not describe adequately the structure of reflection-in-action. In the title of this section of Schön's (1983) text, the words '*rigor*' and '*experiment*' have connotations of scientific endeavour. At the same time, describing experiment as '*on-the-spot*', which connotes urgency and immediate action, serves to distinguish the experimenting of reflection-in-action from the more planned and controlled experiments that characterise scientific method. By exploring the 'experimenting' of reflection-in-action, and by comparing and contrasting it with experiments conducted as part of scientific method, the structure of reflection-in-action as a new epistemology of practice is likely to be further clarified. An unstated assumption of Schön's (1983) account of the experimenting involved in reflection-in-action is that it yields knowledge-in-practice, just as scientific experiments yield scientific knowledge. Scientific experiment serves as the point of reference or norm of experimenting against which the '*on-the-spot*' experimenting of reflection-in-action will be described (Schön, 1983, 141). The dominant model of professional knowledge, with its basic science component, could, therefore, be regarded as a condition of possibility of reflection-in-action. In the absence of the model of technical rationality, is it possible that the identity of reflection-in-action could be asserted? Several pages of text are devoted to outlining the method of hypotheses-testing in traditional scientific experiments (Schön, 1983). The drawbacks and limitations of this kind of experimenting in practice situations are then outlined by Schön (1983, 144) as follows:

> *Under conditions of everyday professional practice the norms of controlled experiment are achievable only in a very limited way. The practitioner is usually unable to shield his experiments from the effects of confounding changes in the environment. The practice situation often changes rapidly, and may change out from under the experiment. Variables are often locked into one another, so that the inquirer cannot separate them. The practice situation is often uncertain, in the sense that one doesn't know what the variables are. And the very act of experimenting is often risky.*

The differences between hypothesis-testing in the practice context and the context of research are also outlined.

> *...hypothesis-testing experiment has a more limited function in practice than in research. And because of this, constraints on controlled experiment in the practice situation are less disruptive of inquiry than they would otherwise be.*
>
> *... the practice context places demands on hypothesis testing which are not present in the context of research* (Schön, 1983, 152).

Throughout Schön's (1983) description of the experimenting that is characteristic of reflection-in-action, there is constant reference to practice: '***In practice**, the hypothesis subjected to experiment may be one that has been implicit in the pattern of one's moves...*' (Schön, 1983, 147); '*What is it, then, that is distinctive about the experimenting that goes on **in practice**?*' (Schön, 1983, 147); '*And from this fact follows the distinctive character of experimenting **in practice***' (Schön, 1983, 147); '*But **in practice situations**...hypothesis testing is bounded by appreciations*' (Schön, 1983, 151) (My emphases).

Practice is contrasted with research as illustrated in the following quotation:

> *Hence, according to the model of Technical Rationality, emphasis is placed on the separation of research from practice. On this view, practice should be based on scientific theory achievable only through controlled experiment, which cannot be conducted rigorously in practice* (Schön, 1983, 144).

The rigour that is an essential part of scientific research cannot be identical with the rigour of 'on-the-spot' experimenting in practice situations that is characteristic of reflection-in-action.

However, it becomes clear in the part of Schön's (1983) chapter that follows the account of on-the-spot experimenting that it is not practice *per se* that is being discussed but rather '*a virtual world*' of practice. Schön (1983, 157-158) remarks:

> *The situations of Quist* (the Architect) *and the Supervisor are, in important ways, not the real thing. Quist is not moving dirt on the site. The Supervisor is not talking to the patient. Each is operating in a virtual world, a constructed representation of the real world of practice.*
>
> *This fact is significant for the question of rigor in experimenting. In his virtual world, the practitioner can manage some of the constraints to hypothesis-testing experiment which are inherent in the world of his practice. Hence his ability to construct and manipulate virtual worlds is a crucial component of his ability not only to perform artistically but to experiment rigorously.*
>
> *...Constraints which would prevent or inhibit experiment in the built world* (referring to the architect's practice) *are greatly reduced in the virtual world of the drawing.*
>
> *...The pace of action can be varied at will. The designer can slow down, to think about what he is doing. On the other hand, events that would take a long time in the built world – the carving of a slope, the shaving of the trees – can be made to "happen" immediately in the drawing.*

No move is irreversible. The designer can try, look, and by shifting to another sheet of paper, try again...Moves that would be costly in the built world can be tried at little or no risk in the world of the drawing.

It is possible to eliminate changes in the environment which would disrupt or confound experiment. In the drawing, there are no work stoppages, breakdowns of equipment, or soil conditions which would make it impossible to sink a foundation.

Some variables which are interlocking in the built world can be separated from one another in the world of the drawing.

It is not just the worlds of research and practice that are distinguished in the above account. The world of practice is itself divided into a 'virtual' and a 'real' one. However, from the description given of the virtual world, it appears more similar to the world of research than the real world of practice. The issue of rigour would seem to necessitate the construction of a virtual world of practice: '*Virtual worlds are contexts for experiment within which practitioners can suspend or control some of the everyday impediments to rigorous reflection-in-action*' (Schön, 1983, 162). Just as controlled experiments, which yield scientific knowledge, '*cannot be conducted rigorously in practice*' (Schön, 1983, 144), neither, it seems, can the '*on-the-spot*' experimenting of reflection-in-action. The desire that the experimenting of reflection-in-action be rigorous, a value closely associated with scientific investigation, could be understood as necessitating the creation of a world more similar to the world of research than the real world of practice. The phrase '*on-the-spot*' appears to be redundant as a description of the kind of experimenting characteristic of reflection-in-action. In addition, it could be argued that other kinds of research, in particular, non-quantitative methodologies, might be closer to the real world of practice than is the virtual world as envisioned by Schön (1983).

Bearing in mind that the purpose of developing a new epistemology of practice is to accommodate phenomena important to '*actual practice*' (Schön, 1983, 39), for example, uniqueness, instability, uncertainty and value conflict, it seems

paradoxical to detour via a virtual world. Given the manipulations imposed therein, there is no guarantee that knowledge derived by experimenting in a virtual world will transfer successfully to the real world of practice. Relevance may again be sacrificed on the altar of rigour. Referring to the architect's practice, Schön (1983, 159) acknowledges the issue of the transfer of knowledge but not the paradox upon which his account is founded:

> *But the virtual world of the drawing can function reliably as a context for experiment only insofar as the results of experiment can be transferred to the built world. The validity of the transfer depends on the reliability with which the drawn world represents the built one.*
>
> *...Drawing functions as a context for experiment precisely because it enables the designer to* ***eliminate features of the real world situation which might confound or disrupt his experiments****, but when he comes to interpret the results of his experiments, he must remember the factors that have been eliminated.* (My emphasis).

Reflection-in-action was presented as an epistemology of practice that would surface and articulate knowing-in-practice. For that reason, the issue of the 'application' of knowledge to practice did not arise. How knowledge derived from experimenting in a virtual world will transfer to the situations of instability, uniqueness, uncertainty and value conflict that a practitioner must deal with in the real world of practice is not addressed beyond the final cursory remark in the above extract. But the above account could be read as requiring that knowledge created in one domain be utilised in another that differs from the former '*in important ways*' (Schön, 1983, 157). This would impose limits on reflection-in-action as a model of professional knowledge not unlike those that apply to, and have been criticised in, the model of technical rationality.

Experimenting in reflection-in-action is described as '*exploratory*', '*move-testing*', and '*hypothesis testing*' (Schön, 1983, 145-146). Exploratory experiment involves taking action '*only to see what follows, without accompanying predictions or*

expectations' (Schön, 1983, 145); move-testing experiments describe '*Any deliberate action undertaken with an end in mind*' (Schön, 1983, 146); and hypothesis testing experiments are designed to confirm or refute particular hypotheses that are proposed to explain particular observations. Schön (1983, 151) explains the relationship between the different kinds of experiment in the following way:

> *...the action by which he* (the practitioner) *tests his hypothesis is also a move by which he tries to effect a desired change in the situation, and a probe by which he explores it.*

Various outcomes may follow experimenting in reflection-in-action (Schön, 1983). The discussion of outcomes sheds light on the relationship between theory and action in the new epistemology of practice. Schön (1983, 153) describes the following outcome as '*a typical case for reflection-in-action*':

> *When a move fails to do what is intended and produces consequences considered on the whole to be undesirable, the inquirer surfaces the theory implicit in the move, criticizes it, restructures it, and tests the new theory by inventing a move consistent with it* (Schön, 1983, 155).

While reflection-in-action typically attends unexpected and undesirable results, there are other outcomes which do not prompt a similar response. In such cases, '*the inquirer's expectation is disappointed but the consequences* (of the action) *taken as a whole are considered desirable. The associated theory is refuted but the move is affirmed*' (Schön, 1983, 155). Referring to the architecture student, Schön (1983, 156) states:

> *Petra need not reflect on the theory which underlay her move. According to the logic of affirmation, the move has succeeded. Petra may wonder why her gallery failed to work as expected. But she need not reflect on it unless she wishes to consider the present case as a preparation for future cases where problems of circulation are also likely to arise.*

It might be imagined that the above outcome should also be a typical case of reflection-in-action. As the theory associated with the move has been refuted, it is probable that there is some other theory implicit in the successful move. Would the practitioner not wish to identify the theory implicit in the move which led to its being successful? Could the above situation not be read as an instance of the tacit intuitive knowing that is revealed in the skilful actions of competent practitioners as they deal with complexity and uncertainty in practice situations? Is it not the purpose of reflection-in-action to surface and articulate such knowledge so that it may be used in future similar cases as indicated in the final remark of the above quotation? By remaining equivocal about the necessity for reflection in the above situation, Schön (1983) may be attempting to protect reflection-in-action as an alternative epistemology of practice. If theory can be isolated and separated from action in the process of reflecting-in-action, and if the theory that is thereby identified can be used in future similar situations of practice, it might become difficult to distinguish the new epistemology from the dominant model of professional knowledge.

Chapter 8 Deconstructing reflective practice in nursing texts 1

As indicated in the historical overview presented in Chapter 3, reflective practice, as it relates to nursing education and practice, has been debated, theorised and researched in a range of academic and professional nursing journals. Publications were particularly numerous during the period when pre-registration nursing education was making the transition from hospital-based apprenticeship-style training to a tertiary education model. This occurred in the UK in the late 1980s/early 1990s, and in Ireland, in two stages, from the mid-1990s to the early 2000s. A number of nursing texts from this period have been chosen for a deconstructive reading in this chapter. The complete text of 3 journal articles as well as fragments from a further two forms the material for analysis. The criteria for text selection have been outlined in Chapter 4 (Section 4.10.1, p149). In addition to the criteria enumerated there, all of the texts that will be analysed in the following pages are ones that I have read before, in another context and for another purpose. They are resources that I have looked to in order to gain a greater understanding and appreciation of reflective practice, and its role and potential in nursing education and practice. The appreciations gained via my encounter with these texts provided a source of guidance in facilitating learning about reflection. All of the texts included in this chapter provoked questions and deliberations on my part, and lively discussion with learners in the classroom context. In that sense, they are texts that have made a difference to a particular aspect of my life. As indicated in the methodology chapter, Johnson (1987, xvii) recommends that such texts be re-read in a deconstructive way so that they may be viewed in '*a more complex, more constructed, less idealised light*'. The following table contains full reference details of the papers selected for analysis in this chapter:

Title of Paper	Title of Publication	Author	Year of Publication
The Reflective Practitioner in Nursing	Journal of Advanced Nursing	Jean H. Powell	1989
Tacit nursing knowledge: an untapped resource of a methodological headache?	Journal of Advanced Nursing	Liz Meerabeau	1992
Reflective Practice: where now?	Nurse Education in Practice	Gary Rolfe	2002

Table 8.1 Details of journal articles A

Shorter extracts are drawn from the following two sources:

Title of Paper	Title of Publication	Author(s)	Year of Publication
Reflective Practice: reviewing the issues and refocusing the debate	International Journal of Nursing Studies	Brenda Clarke Chris James Jan Kelly	1996
Reflection and nursing education	Journal of Advanced Nursing	Wanda Pierson	1998

Table 8.2 Details of journal fragments

The two shorter extracts outlined above are considered first. These fragments are included as I consider them illustrative of the tensions involved in attempting to identify reflective practice knowledge and to distinguish reflective practice from technical rationality. In an article that covers a wide range of issues bearing on reflective practice and nursing, Clarke, James, & Kelly (1996, 177) argue *'for separating out two kinds of reflection'* which they term *'deliberative reflection and deep reflection'*. Deliberative reflection is described in the following way:

> *Deliberative reflection allows professionals to practice thoughtfully, intelligently and carefully. This kind of reflection involves higher order processes of reflection such as planning, preparing, analysing, synthesizing, predicting and evaluating. These important reflective processes require practitioners to draw on both their knowledge of the context in which they are working and their non-contextualised professional knowledge. They do this in order to make decisions about appropriate courses of action and to solve the myriad of problems that confront them in their professional work. The outcome is the professional judgement, and such judgements take place before, during and after practice* (Clarke et al., 1996, 177).

The authors appear to sense the possibility that their description of deliberative reflection could be (mis)read as a description of technical problem solving. The word 'reflection' or 'reflective' appears in each of the first three sentences that describe the process, and twice in the second sentence. What might be (mis)interpreted as a rational linear process is countered, to some extent, by the description given of the context in which deliberative reflection is used. Reference to '*the myriad of problems that confront* (practitioners) *in their professional work*' connotes a sense of the unpredictability and pressures that characterise the real life world of clinical practice. Clarke et al. (1996) explicitly acknowledge the problem of (mis)interpretation. They follow their explication of deliberative reflection above with the commentary below:

> *The process of arriving at a professional judgement in this way may appear to be grounded in a positivist form of logic, but the nature of the form of knowledge on which the practitioner draws means that it cannot be truly positivist in nature. The knowledge of the practitioner is grounded in interpretive judgements of a dialectical form, constructed by the reflections of the practitioner, rather than in "facts" that can be externally verified. The process may appear positivist because in the practical life of the professional, the true complexity must go unnoticed...* (Clarke et al., 1996, 177).

In the above extract, the identity of deliberative reflection is further divided between its truth or 'reality' and how it appears. This state of affairs is reminiscent of Schön's (1983) comments regarding practitioner expertise which tends to mystify the process of reflection-in-action. This aspect of Schön's (1983) argument has been outlined in a previous chapter in the context of psychotherapy and architecture practice. Deep reflection, on the other hand, as described by Clarke et al. (1996), does not attract any clarifying statements. It is presented as a more overarching concept which includes the '*...processes of deliberative reflection*' (Clarke et al., 1996, 177), and is oriented to a consideration of how knowledge is acquired.

In a similarly wide ranging article entitled simply '*Reflection and nursing education*', Pierson (1998,169) proposes that reflection requires '*the employment of both calculative and contemplative thinking*'. The former is directed towards analysis and problem-solving while the latter involves exploring meanings. Calculative thought is encompassed within contemplative reflection. These descriptions are not unlike Clarke et al.'s (1996) '*deliberative*' and '*deep*' reflection. However, unlike Clarke et al. (1996), there is no attempt to suppress the association between calculative thinking and positivism.

> *Calculative thinking represents the spirit of positivistic thinking.*
>
> *...Within this perspective, the substance of reflection resides in instrumental problem-solving directed by the strict application of theory and technique...*
>
> *It is a superficial level of reflection*...(that)... *primarily serves to reinforce positivistic and behaviourist educational traditions* (Pierson, 1998, 166).
>
> *The technique of reflection may be taught as a discrete skill. Students may be encouraged to examine their thoughts, feelings and understanding of situations via written and verbal reflective processes. As educators, however, we must be aware that some of the techniques and strategies implemented to facilitate reflection, may actually strengthen calculative thinking* (Pierson, 1998, 169).

If calculative thinking, which is a kind of reflection, is strengthened, so Pierson's (1998) description above would suggest, then this kind of reflection becomes more like, and perhaps indistinguishable from, the model of technical rationality. Clarke et al.'s (1996) concern to distinguish their 'deliberative' reflection from any positivist connotations may be understood as an attempt to ensure that the boundary between reflection and technical rationality is sharply drawn, and that no inadvertent blurring occurs. Both of the above fragments appear to illustrate the difficulty involved in attempting to disentangle reflective practice from the dominant model of professional knowledge. The authors' desire to create distance and difference between reflective practice and technical rationality appears, paradoxically, to produce an effect of sameness.

The first full text article that is the subject of a deconstructive reading is a report of a research study. Entitled '*The reflective practitioner in nursing*', by Jean Powell, it was published in the '*Journal of Advanced Nursing*' in 1989. I chose this paper as it was one of the first published on reflective practice in nursing and its publication coincided with a period of enormous change and transition in nursing education referred to earlier in the introduction to this chapter. The title of the paper conveys a confident assertion that the reflective practitioner is (locatable) in nursing. Powell (1989, 824), identified in the text as a Principal Lecturer in Nursing in a School of Humanities, Education and Social Science, describes her research as '*a study of eight practising registered nurses and their use of reflection-in-action in their everyday work*'. Given its relative novelty at the time the paper was published, the language of Schön's (1983) new epistemology seems to have been easily adopted in the context of Powell's (1989) study. The aim of the research was to investigate the kind of knowledge used by experienced nurses in practice, and to establish if this knowledge included reflection-in-action (Powell, 1989). Motivated by the anticipated '*radical change*' (Powell, 1989, 824) in nursing education in the United Kingdom with the introduction of Project 2000 at that time, and, also, by reductions in funding for post-registration nursing education that would result in fewer formal education programmes, learning from reflection on experience was identified as a possible means of providing a less costly approach to continuing professional development. However, reflection

should not, in Powell's (1989, 824-825) view, replace formal education courses but rather complement them as explained below:

> *The development of reflective techniques, particularly of reflection-in-action, seems possibly to provide a partial solution to this problem, although it is not suggested here that they could or should replace current formal programmes of study, at either basic or post-basic level, merely that they would be complementary to these As the time spent on courses is very short in relation to an entire nursing career, it would also be of great benefit if reflective techniques were used to deliberately promote learning from experience throughout the nursing career*

Schön's (1983) work is credited with giving a new dimension to the role of reflection in learning (Powell, 1989). Reflection-in-action is recognised as having a sound conceptual basis, providing '*the foundation of reflective practice*' (Powell, 1989, 825). In the above introductory remarks, Powell (1989) appears to view reflection-in-action from the perspective of the dominant model of professional knowledge. Schön (1989) may be understood as having developed a conceptual framework or theory from which '*techniques*' can be derived to be applied to the process of learning in practice contexts. Reflection-in-action cannot, and, even if it could, it should not replace the formal learning approach of technical rationality. Reflection-in-action is to be '*complementary*' to the dominant model. The use of the adverb '*merely*' in the above extract serves to reinforce the diminished role of reflection-in-action in professional education relative to formal programmes of study. At the same time, it seems paradoxical to attribute such a limited role to reflection-in-action given that Powell (1989) recognises its potential to contribute to learning over a professional career lifetime, while formal programmes occupy relatively brief episodes within that same career lifetime.

Powell (1989) speculates that reflection-in-action and reflective practice may explain the difference in clinical effectiveness that exists between ward sisters - some being highly effective and others ineffective – despite similar years of professional experience. If this were shown to be the case, then learning derived

from reflection-in-action might be understood as being of far greater significance than any formal learning programme. One of the reasons, Powell (1989, 826) suggests, that learning from experience may not occur is that such learning may not be regarded as valuable by nurses and others:

> *A reason for not learning from practice may be that they* (experienced nurses) *believe the technical-rationality type of knowledge is of the greatest, or only, importance, and therefore they do not attempt to learn from experience because this is not valued by them as knowledge The emphasis during initial training and in post-basic courses is on a technical-rationality approach, as can be seen in such reports as that of Briggs (1972), and the multiplicity of references in nursing literature to the nursing process, which, with its emphasis on measurable goals, promotes this type of knowledge generation*

As indicated in Chapter 2, the nursing process was a dominant theme in nursing education at the time of Powell's (1989) study. To recapitulate, the nursing process describes a systematic approach to care provision, consisting of a number of sequential steps. A comprehensive assessment of the patient is the first step, followed by analysis of the information gathered, the identification of actual and potential patient problems, the setting of goals, the design and implementation of appropriate nursing interventions, and evaluation of care outcomes against predetermined goals (Aggleton & Chalmers, 1986). The nursing process was introduced as a way of making nursing practice more scientific, replacing the rituals and routines upon which practice had been based, hence its affinity with the model of technical rationality. This rational linear model of care may be contrasted with the concept of Model II learning (Schön, 1983), which Powell (1989, 825) identifies '*as the foundation of reflective practice*'.

> *Model II learning...promotes a view of the professional as one with specialized knowledge and experience, who may be helpful and who will work with the client/patient towards finding an individual solution or amelioration for his individual problem*

...the type of problem most requiring of professional help is usually so complex as to be totally individual, with little in espoused theory of use in the solving of it

...Several features emerge to define reflection-in-action and give direction to its application and development The first is flexibility and experimentation in problem solving in order that a solution may be found, although accepting fully that it may not

'*Espoused theory*' refers to formal, propositional, codified knowledge that is recognised as forming the knowledge base of a discipline. It is contrasted with '*theories-in-use*' which refers to theories implicit in the practitioner's action, or tacit knowledge. Powell (1989, 825) identifies the relevance of '*tacit knowledge*' for professional practice as follows:

These theories-in-use are important as they are rarely, if ever, explicated yet these guide practice in a more significant way than the explicated espoused theory

...many practitioners not only have theories-in-use different to their professed theories but also are often unaware of these and therefore unable to describe them This is why observation of behaviour is important, it is the major way in which theories-in-use can be recognized.

Observing the behaviour of competent practitioners is proposed as a way of identifying tacit knowledge or knowing-in-action. Similar to Schön's (1989) method, the observer seems able to reveal what appears to be imperceptible to the practitioner. The research method used by Powell (1989) to explore reflection-in-action consisted in observing a small number of experienced nurses as they engaged in patient care. These care episodes were followed by open-ended, one-to-one interviews with the aim of trying to determine the thinking behind the observed nurses' actions and decisions. Interview data were analysed and categorised in terms of levels of reflectivity using a modified form of Mezirow's (1981) seven levels of reflectivity, as explained in Chapters 2 and 3 of this thesis.

An additional framework that sought to distinguish the basis for nurses' actions and decisions was also used in the analysis of Powell's (1989) research data. Included in this framework were categories such as '*Law*', '*Norm*', '*Belief*', and so on (Powell, 1989, 827). So, for example, if nurses based their decisions or actions on scientific knowledge, such a decision would come under the category of 'law'. Powell (1989, 829) explains the 'belief' category as follows:

> *The use of the belief category enables an identification to be made of the times the nurse uses her own judgement, expressing her feelings and opinions The judgement here may be based on experience, in which case he or she may be acting as a researcher in action, using Schön's view of practice and research, or alternatively it may simply reflect a lack of knowledge of nursing practice, research and theory from nursing and other disciplines.*

From the description given above, it appears that the 'belief' category is an ambiguous one. Nursing judgements encompassed within the belief category, it seems, may be based either on knowledge derived from reflecting in and on the experiences of practice or they may have no basis in any kind of knowledge, either practical or theoretical. In the interviews conducted with the research participants following the period of observation, Powell (1989) attempts to distinguish between nursing judgements based on experiential knowledge and those based on lack of knowledge. The aim of the interviews was, as stated previously, to try to determine the thinking and reasoning behind the nurses' observed behaviours. Powell (1989, 829) reports:

> *The (interview) questions produced many answers which seem to support the latter explanation (that is, nursing judgements based on a lack of knowledge of nursing practice, research and theory from nursing and other disciplines), with a resulting 'hit or miss' type of nursing care*

The nurse would try various methods of assisting the patient, often producing a helpful result, but in a time-consuming and essentially unthinking way A careful assessment of the problem, and relating of the theoretical knowledge from a variety of disciplines to this, would in several instances have led to effective solutions being produced more quickly

When Powell's (1989) description of the observed behaviour of the nurse in the above extract is examined closely, it appears very similar to her description of Model II learning which she previously identified as the foundation of reflective practice. The textual evidence supports a reading of the nurse's behaviour as an example of reflection-in-action. The nurse's actions could be explained as helping the patient to find a solution to an individual problem. Reflection-in-action involves on-the-spot experimentation (Schön, 1983), which may account for the nurse trying different ways of helping the patient. Nor is such a reading contradicted by the interview data. What Powell (1989) interprets as a lack of knowledge may instead be an indication of the difficulty involved in surfacing and articulating the knowledge generated by reflecting-in-action. The nurse may have been unable at interview to articulate the knowledge revealed in her actions. That Powell (1989) does not interpret the nurse's behaviour as an example of reflection-in-action could be explained by her unacknowledged, and perhaps unconscious, bias toward the model of technical rationality. This bias is evident in her early remarks regarding the role of reflection-in-action in nursing education. Despite her assertions to the contrary, Powell's (1989) analysis of the research data seems to indicate not just a devaluing of reflection-in-action as an epistemology of practice but a clear suppression of this kind of knowledge. When Powell (1989) suggests, in the above extract, that the nurse might have made a '*careful assessment of the problem*' and applied relevant disciplinary knowledge to it, she is articulating a technical rational approach to professional knowledge. The desired outcomes of effectiveness and efficiency, indicated in the final line of the above quotation, reflect a rational, linear approach to care which is exemplified by the nursing process, a process whose dominance the researcher herself formerly criticised as contributing to a devaluation of reflective practice knowledge.

Powell (1989, 826) expresses admiration for Benner's (1984) research into nursing expertise, describing the latter's book '*From Novice to Expert*' as an '*excellent study*' and identifying her own research interests as similar to those of Benner. It may be recalled, from the discussion of Benner's (1984) work presented in Chapter 2, that nurses who participated in her study were unable to articulate the tacit intuitive knowledge upon which their expertise depended. However, it seems that, in Powell's (1989) study, if nursing judgement cannot be articulated in terms of disciplinary knowledge, then it is likely to be categorised as lack of knowledge.

While Powell's (1989) espoused theory appears to value reflective practice as a model of professional knowledge, her theories-in-use, which may be read in the account of her research study, seem to illustrate more affinity with the model of technical rationality. Powell (1989) argues for an in-depth knowledge base for effective nursing practice which is focused on the application of theory to practice.

> *A higher and deeper understanding of nursing and its contributing disciplines is necessary in nurse education, but it also seems to be apparent that the applications of this knowledge should be given more emphasis, and monitored more closely, throughout nurse training and education, rather than left to the individual nurse* (Powell, 1989, 830).

As a Principal Lecturer in Nursing in a tertiary education setting, Powell's (1989) theories-in-use may be shaped more by the values prevalent in that setting at that time rather than by the values pertaining in nursing practice. Schön (1983) identified the model of technical rationality as the dominant model of professional knowledge in higher education. The model determines how professional knowledge is conceptualised and taught. Its dominance is such that it is difficult even for those critical of it to escape its influence. While Powell (1989) acknowledges that higher education may predispose professionals towards a technical rational approach to practice, she also contends that reflective practice and the development of '*new knowledge*' are unlikely to occur in the absence of a

sound knowledge base such as that which the model of technical rationality provides (Powell, 1989, 830).

The role of higher education in the generation of practice knowledge is more overtly referenced in the second full paper chosen for a deconstructive reading in this chapter (Meerabeau, 1992). Writing also at a time when reflective practice in nursing education was relatively new, the author is, like Powell (1989), a senior lecturer in a higher education setting. Meerabeau (1992) focuses her discussion specifically on the role of the university in the generation of tacit knowledge in nursing. This focus continues a theme identified by Schön (1983), who argued that the kind of knowledge produced by universities was of limited relevance to practitioners of the professions in their everyday work situations. Schön (1983), however, did not suggest that the university become involved in the generation of knowledge from practice. Instead, he argued for a new epistemology of practice: one that would articulate and legitimise the knowing-in-action of skilled practitioners. Meerabeau's (1992, 108) paper is entitled '*Tacit nursing knowledge: an untapped resource or a methodological headache?*' A binary opposition seems implied in the title: either tacit nursing knowledge is an untapped resource or it is a methodological headache. Indecision as to which pole of the opposition such knowledge belongs is designated by the question mark which completes the title. The geological metaphor used – an untapped resource – is more reminiscent of Schön's (1983) high hard ground of technical rationality than of the swampy lowland of practice where tacit knowledge is required and deployed. Meerabeau (1992, 108) does acknowledge the work of Schön (1983) and Benner (1984), claiming that "*expert knowledge or 'artistry'*" is an important yet *'neglected resource in nursing education'*, a claim which seems tacitly to acknowledge the dominance of the model of technical rationality in nursing education. The difficulty involved in articulating the expert knowledge of practitioners is conceded. Summarising extracts from the literature on expert knowledge or artistry, Meerabeau (1992, 110) states:

The consensus is that practitioners' knowledge is a largely untapped resource, and that research has been too narrowly defined by the academic community, who question why practitioners do not use research-based knowledge. If a broader framework is used, it is seen that practitioners also create new knowledge, but it is often not codified or published, nor is reflection and discussion often possible in the work environment

The dominance of the academic community in matters relating to professional knowledge is readable in the above extract. The academic community defines what counts as research and, thereby, also, what counts as knowledge. It is within the gift of that same community to redefine/extend the scope of what may be called knowledge. And it is also within their gift to contribute the literary skills and knowledge needed to shape the practitioners' creation into something more refined. It is not fortuitous, perhaps, that a geological metaphor is used to describe practitioners' knowledge. The academic community could be viewed as bringing their sophisticated and advanced knowledge-producing skills to the 'primitive' arena of practice. Cultural differences between the academic community and the community of practitioners are evident in Meerabeau's (1992, 110) discussion of the methods appropriate to researching tacit knowledge.

The technique of observing participants and then interviewing them about their perceptions of the observed event is proving fruitful (Redfern et al 1991, Lawler 1991) Lawler argues that this requires an 'insider' to appreciate the nuances of what is being discussed, although paradoxically tacit knowledge may also mean that there are many features of our practice which may require an outsider to research, since we are unable to make them 'anthropologically strange' (Dingwall 1977)

It is, of course, one of the perennial pitfalls of anthropologists that if they stay too long in one setting they may acquire tacit knowledge of the society, and therefore 'go native' and be unable to continue their analysis of the culture

Since identifying the tacit knowledge of practitioners is the goal of research, it might be assumed that to 'go native' would, in such circumstances, be not only advantageous, but obligatory. However, the researcher is required to distance themselves from the practitioner so that the knowledge identified can be rendered different from itself. The university may be perceived as 'colonising' the life world of the practitioner, not, however, with the goal of creating knowledge that advantages practice. Referring to the different ways that professional knowledge is used by practitioners and academics, Meerabeau (1992, 109) explains:

> *...the way that knowledge is used by an academic, who may wish to explore its problematic nature, will be different from the way it is used by the practising professional, who as a pragmatist wishes to find some sort of pointer for practice*

Power dynamics may be detected in Meerabeau's (1992, 111) account of how '*collaborative research projects*' between higher education and the professions could be enacted. Such projects are proposed as one of several ways of accessing professional knowledge. Change is required of higher education.

> *Higher education needs to extend its role from being the creator and transmitter of generalizable knowledge, to that of enhancing the knowledge-creating capacities of individuals and professional communities* (Meerabeau, 1992, 111)

The university, therefore, rather than ceding the power of knowledge creation to the professionals, becomes influential in yet more areas of knowledge creation. No longer limited to creating and transmitting scientific knowledge, knowledge that Schön (1983) identified as associated with the highest status for its producers, the university's role in knowledge creation now lays claim to partial ownership of the knowledge generated by practitioners. It is for the researcher to resolve the '*methodological headache*' (Meerabeau, 1992, 110) of researching tacit knowledge while practitioners become '*partners*' (Meerabeau, 1992, 111) in the research endeavour. The issue of whether and to what degree the methodology employed

shapes the knowledge created is not commented upon by Meerabeau (1992). It could be argued that, as in Powell's (1989) study, the theories-in-use of the academic researcher may have a substantial yet unacknowledged impact on the knowledge-creation process. While Meerabeau (1992) suggests collaborative roles for practitioner and researcher, they remain separate roles. This is contrary to Schön's (1983) vision of a practitioner who reflects-in-action on their tacit knowing thereby becoming researchers of their own practice: '*When someone reflects-in-action, he becomes a researcher in the practice context*' (Schön, 1983, 68). The hierarchical relationship of theory and practice, researcher and practitioner, which Schön (1983) identified and criticised as contributing to the problem of legitimacy of practitioner knowledge, appears to be retained in Meerabeau's (1992) account of knowledge creation. Constituting a role for the academic in the creation of professional knowledge could be read as a way of legitimising, not the knowledge thereby created, but the continuing involvement of the university in professional education.

While both Powell (1989) and Meerabeau (1992) declare their approval of reflective practice as a model of professional knowledge for nursing, the texts that encode that message also permit a reading in which the model of technical rationality remains dominant.

In the third and final paper that is subject to a deconstructive reading in this chapter, the dominance of the model of technical rationality in nursing is conceded (Rolfe, 2002). However, an argument is advanced which illustrates how the dominance of the technical rational model may be reduced and reflective practice given precedence as a model of professional knowledge in nursing. The title of the paper: '*Reflective practice: where now?*' (Rolfe, 2002, 21) has a resonance with the 'journey' metaphor employed by Schön (1983) in his exposition of reflective practice as a new epistemology of practice. As discussed previously in the analysis of Schön's (1983) text in Chapter 5, the search for a new epistemology was prompted by recognition of the limitations of the model of technical rationality as a model of professional knowledge. The journey involved moving across a high hard ground where little of significance in professional work occurred to a swampy

lowland where professionals engaged in problems of greatest human concern (Schön, 1983). Rolfe's (2002) title '*Reflective practice: where now?*' might be an indication that, although a new epistemology has been arrived at, that is not the end of the journey. The question in the title is suggestive of a crossroads having been reached. Having achieved the goal or destination of a new epistemology, '*now*', a choice must be made as to the direction in which to take this new model of professional knowledge. One option is to disregard or underplay the radical origins and potential of reflective practice for the generation of nursing knowledge and to treat it as '*just another technical tool*' (Rolfe, 2002, 24). The alternative is to effect a paradigm change wherein current conceptualisations of the knowledge base for nursing are completely overturned (Rolfe, 2002). While the former option appears to be the road taken during the decade or so that reflective practice has been part of nursing education, Rolfe (2002) presents an argument for a change of direction which will have the effect of restoring the true identity and potential of reflective practice as a model of professional knowledge in nursing.

Rhetorically, Rolfe's (2002) paper could be regarded as an enactment of the metaphorical journey of reflective practice in nursing. Reflective practice '*...entered the discipline of nursing as a radical alternative to technical rationality, with the promise of revolutionizing the way in which nursing knowledge was conceptualized, generated, taught and applied to practice*' (Rolfe, 2002, 24). Due to the dominance of the model of technical rationality, however, reflective practice '*...has gradually become immersed into mainstream practice*', and '*...become just another technical tool*'..., '*The radical promise of reflective practice therefore became neutralized...*' (Rolfe, 2002, 24). In order to restore the potential of reflective practice as a model of professional knowledge for nursing, it is necessary to step outside the dominant paradigm of technical rationality. Rolfe (2002, 21), in the introduction to his paper, attempts to step outside the dominant conventions that apply when writing for publication in an academic peer review journal; he states: *'...in keeping with its subject matter, this paper is written in a reflective style rather than in a 'traditional' academic form'.* The strictures involved in following '*the usual academic format*' of 'Introduction', 'Literature review', balanced arguments and conclusions (Rolfe, 2002, 21) are not conducive to the subject matter which is

about valuing personal experience as a source of knowledge. However, it is not easy to step outside dominant conventions and the difficulties involved are reflected in peer reviewers' comments on Rolfe's (2002) paper, which criticise the departure from customary procedures. Rolfe (2002, 21-22) continues to resist the pressure, and in another departure from convention but quite characteristic of reflective practice, shares his dilemmatic experience with the reader.

> *I feel that it would be plainly contradictory to the spirit in which this paper is written to add an up-to-date and critical review of the literature, to rewrite the paper as a 'balanced' argument for and against reflection, and to support my arguments with 'objective' research-based evidence.*

It is obvious that Rolfe's (2002) paper was obliged to conform to certain rules of the genre of academic publications. The title of the paper is followed by the author's name and an abstract. And it is also clear from the author's remarks that he was obliged to include an introduction in the paper which was not originally intended (Rolfe, 2002). However, the text of the introduction may be read as an attempt to resist or subvert the usual academic format for introductions. The title '*A reluctant introduction*' (Rolfe, 2002, 21) signals something new and different. As if to emphasise the reluctance with which the introduction is written, the first line of it reads: '*This introduction is written reluctantly....*' the unfinished sentence perhaps signifying hesitancy and delay in complying with the rules of the genre (Rolfe, 2002, 21). The first line above is written in italics, which, when used throughout the remainder of the paper, signal emphasis. Reluctance is therefore signified by all possible literary and lexical means. Although the obligatory introduction is written, rather than being an introduction in the conventional sense, it is instead a commentary on the requirement of writing a conventional introduction. In complying with the academic norm of writing an introduction, the author has, at the same time, undermined that same norm. However, the dominance of the norm may still be detected in the final sentence of the introduction which is quoted below:

> *I have reluctantly written this introduction to explain why the paper does not conform to certain academic norms, which in an ideal world would be no more necessary than writing an introduction to justify* ***conformity*** *to those same norms* (Rolfe, 2002, 22). (Rolfe's emphasis).

Even in an ideal world, academic norms still appear to constitute the point of reference or centre from which textual conformity or non-conformity is to be recognised and judged.

Rolfe (2002) violates another canon of academic writing in the introduction to his article by relating a personal anecdote. The experience described could serve as a microcosm of the larger debate: the dominance of the model of technical rationality and the concomitant marginalisation of reflective practice. Recounting a recent experience, Rolfe (2002, 21) states:

> *I recently attended a meeting where, as often happens, the discussion turned to evidence-based practice. When I (rather timidly) suggested that perhaps it is not always wise to base our decisions on the evidence from research, I was challenged to produce the evidence for my suggestion. The irony of the situation seemed to be lost on my colleagues: that in order to argue against evidence it is still necessary to produce evidence in support of your argument.*

As discussed in Chapter 2, in the context of evidence-based practice, the most acknowledged and accepted form of evidence is that derived from scientific research, in particular large scale randomised controlled trials and meta-analyses of the results of smaller scale studies. The model of technical rationality is concerned with the application of such evidence to professional practice problems. Rhetorically, in the above extract, the author seems to personify reflective practice – attempting to get a look in, as it were, but rebuffed by the dominant model of technical rationality, personified by his colleagues. The language used by the author to present his argument to colleagues contains a number of hedges and qualifications, for example, '*rather timidly*', '*suggested*', and '*perhaps*', which connote hesitancy and a lack of certainty. This contrasts with terms such as

'*challenge*' and '*produce*', attributed to colleagues, which convey authority and strength. The author's predicament as illustrated in this account of his experience with colleagues could serve as a metaphor for reflective practice in a nursing world dominated by the model of technical rationality.

What began as something radical, a step outside the dominant paradigm, appears, however, to be quickly subdued and neutralized. Just as reflective practice has had to submit to the model of technical rationality, so also, the author's writing style soon reverts to a more conventional academic format. The 'introduction' is followed by an account of the main ideas of eminent theorists of reflection and reflective practice, such as Dewey, Mezirow and Schön (Rolfe, 2002). Arguments for and against the model of technical rationality in nursing are presented, supported by evidence from research studies and other publications (Rolfe, 2002). The '*I*' of the introduction disappears and the author refers to himself and his previous publications using the recognised format for citations. When Rolfe (2002, 24) argues that '*even advocates of reflective practice feel the need to apologise for its lack of compliance to the paradigm of technical rationality*', he does not refer back to his own experience with colleagues which he recounted in the introduction to the paper. Instead, he supports his assertion by citing the publications of other authors from the academic literature.

In terms of the logic of Rolfe's (2002) argument for paradigm change in nursing, and the re-institution of reflective practice as an alternative model of professional knowledge, the argument appears to hinge on what constitutes an appropriate knowledge base for the discipline. Although technical rationality is dominant, as a model of professional knowledge for nursing, its limitations are identified as follows:

> *...the negative aspect of technical rationality is that propositional knowledge derived from research findings tends to overshadow what has traditionally been seen as the practitioners' own knowledge, derived from experience and from their therapeutic relationships with their patients* (Rolfe, 2002, 23).

Not only has the model of technical rationality not recognised the experiential and personal knowledge generated by practitioners, neither has it enabled the creation of a body of disciplinary nursing knowledge nor addressed the gap between nursing theory and nursing practice.

> *...nursing appeared to make little headway as a research-based discipline and concerns were beginning to be expressed about the so-called theory-practice gap between what researchers believed ought to be happening in practice and what nurses were actually doing (see, for example, Hunt, 1981 and numerous papers since). Despite a concerted effort to close the gap through technical rationality, it proved to be intransigent, leading some theorists (e.g. Rolfe, 1993, Clarke et al. 1996) to question whether scientific research really does provide the most appropriate knowledge-base for nursing, or whether reflection might offer a better source of knowledge for practice* (Rolfe, 2002, 23).

Reflection offers '*...an alternative paradigm for nursing*' (Rolfe, 2002, 24). A paradigm determines, among other things, '*how the knowledge-base of a discipline is built and maintained, what is to count as knowledge, and importantly, what are to count as valid ways of generating knowledge*' (Rolfe, 2002, 24). Citing Kuhn's theory of how paradigms function, Rolfe (2002, 24) remarks:

> *...they* (paradigms) *are founded on incompatible principles and cannot exist side-by-side without coming into conflict. One paradigm has to dominate, and furthermore, 'because it is a transition between incommensurables, the transition between competing paradigms cannot be made a step at a time...it must occur all at one* ***or not at all****' (Kuhn, 1996, my* (Rolfe's) *italics). And most often the status quo prevails and it occurs not at all. Rather than overthrowing the dominant nursing paradigm of technical rationality in what Kuhn referred to as a scientific revolution, reflective practice has gradually become immersed into mainstream practice.*

If reflection is established as a new paradigm for nursing, then reflection in and on nurses' clinical experiences and interactions with patients becomes a valid way of generating knowledge. However, when Rolfe (2002, 25) comes to outline the knowledge base needed for expert nursing practice, it seems that both paradigms – reflective practice and the model of technical rationality - are relevant.

> *...expert practitioners employ at least three distinct kinds of knowledge in their practice. Firstly, propositional or scientific knowledge, which is acquired mainly from research, informs us about what generally happens in the majority of cases. Secondly, experiential knowledge, gained from reflecting on past cases from our own practice, informs us about how this particular case might differ from the general. And thirdly, personal knowledge, gained from therapeutic relationships with individual patients, informs us about the specific needs of this specific person, and just as important, about ourselves and our needs.*

Scientific knowledge is ranked first among the knowledge bases, which suggests that it comes first and forms the base upon which the other two kinds of knowledge depend. Since each base is described as distinct, it is unclear how one relates to the other but it is reasonable to assume that the influence of technical rationality would be detectable on detailed exposition and analysis of both experiential and personal knowledge. This calls into question the possibility of experiential and personal knowledge forming distinct knowledge bases. Rolfe (2002) isolates one particular context where propositional knowledge must predominate since it is the only source of knowledge available for practice. In the case of a nurse who is beginning practice experience in an unfamiliar setting, Rolfe (2002, 25) states:

> *Basing practice solely on research findings might be the only option for the* ***novice*** *practitioner with little previous experience who is nursing a patient with whom she has no prior relationship (Benner, 1984), but research-based knowledge only tells her what generally happens in most cases* (Rolfe's emphasis).

When there is no other source of knowledge, the nurse draws upon propositional knowledge to inform her practice. Given that the novice practitioner gains experience in the course of basing her practice on research findings, it seems inevitable that propositional knowledge will be implicated in the acquisition of both experiential and personal knowledge, and influence both the form and content of these latter two knowledge bases. Reflective practice, therefore, cannot function 'strictly' as an alternative paradigm. It must, to a certain extent, co-exist with the dominant scientific paradigm. It is, perhaps, not possible to go fully '*Beyond technical rationality*' (Rolfe, 2002, 25) in nursing practice. As Johnson (1980, xi) remarks: '*The very impulse to "go beyond" is an impulse structured by a binary opposition between oneself and what one attempts to leave behind*'.

In the context of nursing education, Rolfe (2002) contrasts a reflective curriculum with a curriculum which follows a technical rational model. In the latter approach, which is acknowledged as dominant in current nursing education and likely to be more so as nursing education is university-based, the student is exposed initially to propositional knowledge, presented largely by didactic methods of instruction (Rolfe, 2002). This is followed by learning how to apply such knowledge to practice by way of models and frameworks of practice (Rolfe, 2002). The student is then exposed to a period of supervised clinical experience during which time previously learned knowledge is applied (Rolfe, 2002). A reflective nursing curriculum, by contrast, would take the following form:

> *...the first phase of a reflective course must be to immerse the student in practice so that she might acquire concrete experience of the messy complexities of nursing. In the second phase she should be facilitated to reflect on her practice and begin the difficult task of turning experience into concrete knowledge and theory; that is, knowledge and theory specific to* ***that*** *student in* ***that*** *situation. And thirdly, she should be helped to see her specific experiential knowledge in relation to general propositional knowledge and theory* (Rolfe, 2002, 27-28) (Rolfe's emphases).

The reflective curriculum, whose outline is proposed in the above extract, does not constitute a replacement for the dominant technical rational model in nursing education. Even if the student were to be immersed in practice without any prior exposure to propositional or applied scientific knowledge, she would still have to acquire that knowledge in order to see how her experiences in practice related to it. This she is required to do in the third phase of the reflective curriculum. And if the student's experiential knowledge is specific to her and the particular clinical situation in which the student finds herself, as emphasised above, then there is little possibility of a shared body of experiential knowledge that could form the basis for teaching and learning nursing practice.

In the first phase of the education programme, as the student is immersed in practice, she must be considered a novice as she has no experience of the practice situation. Since a novice depends upon propositional knowledge, and since the student does not have any by virtue of the structure of the reflective curriculum, it is unclear what knowledge will guide the student initially. Were there no propositional knowledge to draw upon in the practice setting, and if nurses' reflections, even those of experienced nurses, were specific to each individual practitioner, it follows that the practice the student is being immersed in is practice guided by the experiential and personal knowledge of the individual nurse providing supervision at that particular time in that particular clinical situation. It would also follow that this knowledge 'base' would change, potentially, with each subsequent supervising nurse. The implications of a reflective curriculum for teaching, learning, and assessment would, therefore, be considerable.

Knowledge generation under a new reflective paradigm would involve changes to the current roles of practitioner, researcher, and educator (Rolfe, 2002). In the context of the existing dominant paradigm which determines what counts as knowledge for practice and authorises how such knowledge is to be generated, Rolfe (2002, 27) asserts:

> *...the ownership and control of the knowledge-base of nursing rests with researchers and academics, who have the power to define, generate and disseminate nursing knowledge, whereas the practising nurse is supposed merely to read and apply it. In the new paradigm, this power and authority would be invested in practitioners, who become researchers into their own practice.*

In the new paradigm, the practitioner becomes *'...the originator of her own context-specific practice-based knowledge'*, and the role of the researcher is to facilitate *'...the practitioner to research her own practice through small-scale case study and action research'* (Rolfe, 2002, 27). This suggests that practitioners, while they may become researchers into their own practice, are not vested with full or sole authority to do so. Rolfe (2002, 27) remarks: *'...the practitioner and the academic become* ***equal partners*** *in enabling the nurse to explore and discover her own knowledge predominantly from her own practice'* (My emphasis). The extent to which the practising nurse is truly *'the* ***originator*** *of her own context-specific practice-based knowledge'* may, therefore, be debated (My emphasis). The idea of equal partners implies equal influence in terms of the process of knowledge generation, and, potentially, joint ownership of the knowledge so created. Nor does the researcher abandon completely their traditional role in *'producing generalizable scientific knowledge'*; they are now merely *'less concerned'* with it (Rolfe, 2002, 27).

While the roles of practitioner and researcher in the generation of discipline-specific knowledge within a new reflective paradigm are fairly well defined, the role of the nurse educator in this process appears ambiguous. Rolfe (2002, 27) identifies the existing nurse educator role as concerned mainly with *'disseminating knowledge'*. Neither a producer nor a user of professional knowledge, the educator occupies a vague space in the arena of nursing knowledge as defined by the dominant paradigm. The role of the educator in a reflective paradigm is envisaged as follows:

> *...facilitating the practitioner to explore her own practice through reflection-on-action. This applies not just to post-registration nurse education, where the nurse brings with her a vast store of practitioner knowledge and usually a number of issues and problems she wishes to explore, but also to pre-registration courses where the student might have little or no prior experience to draw on* (Rolfe, 2002, 27).

From the above description, it might be assumed that the educator's role is pivotal to generating nursing knowledge. The educator facilitates the process of reflection-on-action, and reflecting-on-action is one of the ways of accessing the practitioner's '*vast store*' of experiential and personal knowledge. Furthermore, it is not unreasonable to assume that the issues and problems the practitioner wishes to explore emanate from the practice situation and, as such, are recognised as stimulating reflective inquiry (Schön, 1983). The practitioner's vast store of knowledge is quite likely to have a role in formulating solutions to the issues and problems being reflected upon, although such a connection is not made in the text above. The educator, therefore, seems to be ideally positioned to facilitate knowledge generation. Why is it, then, that the description of the educator role does not make specific reference to knowledge generation? Why does the facilitation provided by the academic and the researcher result in knowledge whilst the facilitation provided by the nurse educator does not? Is it because knowledge generated by reflecting on practice is not recognised as 'knowledge'? Is it only when approved research methodologies such as case studies and action research are used that something is produced that may warrant the designation 'knowledge'? That no connection is made between the educator's role and knowledge generation could be read as an example of a 'theory-practice' gap. Practitioner and educator together address what might be described as the 'messy' issues and problems of practice, without apparent reference to any kind of knowledge base, either practitioner or research knowledge, whilst academic and practitioner, together, engage in the generation of knowledge.

As indicated at the beginning of this deconstructive reading, Rolfe (2002) has acknowledged the dominance of the model of technical rationality as a model of professional knowledge in nursing and the difficulty of displacing it. Nothing less than a paradigm change is required to do so (Rolfe, 2002). Rolfe (2002) has attempted, both in the form and content of his writing, to step consciously outside the dominant paradigm and reveal an alternative. The implications of paradigm change in the form of reflective practice for nursing practice, nursing education, and nursing research have been outlined (Rolfe, 2002). However, the dominant model remains detectable in the text that describes its demise. A deconstructive reading reveals a suppressed message which renders problematic the identity of reflective practice. Its identity is constituted by its difference from technical rationality but that difference may be seen '*as an uncertainty over separability and as a drifting apart within identity*' (Johnson, 1980, x).

Some of the paradoxes readable in Schön's (1983) account of reflective practice as a new epistemology of practice and as outlined in earlier analysis chapters, are replicated in the nursing texts that have been analysed in this chapter. Tensions between technical and reflective forms of knowledge are apparent. Although proposed as an epistemology of practice that makes up for the limitations of the model of technical rationality, it is difficult to disentangle reflective practice from the dominant model of professional knowledge in the textual constructions that seek to elaborate the identity of the former. The attempt to distinguish reflective practice from technical rationality can sometimes lead to reflection becoming divided from itself.

Chapter 9 Deconstructing reflective practice in nursing texts 2

The purpose of this chapter is to analyse a number of texts that address the issue of the knowledge base appropriate for nursing. Justification for the inclusion of these texts is provided in Chapter 4 (Section 4.10.1, p149). Of particular interest in the deconstructive reading is how reflective practice is positioned within the knowledge base. Details of the texts in question are provided in Table 9.1 below.

Title of Paper	Publication	Author(s)	Year of Publication
Critical reflective inquiry for knowledge development in nursing practice	Journal of Advanced Nursing	Hesook S. Kim	1999
What counts as evidence in evidence-based practice?	Journal of Advanced Nursing	Jo Rycroft-Malone Kate Seers Angie Titchen Gill Harvey Alison Kitson Brendan McCormack	2004
Towards a nursing science of the unique. Evidence, reflexivity and the study of persons	Journal of Research in Nursing	Gary Rolfe Lyn Gardner	2005

Table 9.1 Details of journal articles B

The following introductory paragraph from one of the texts included in the analysis provides a sense of the evolution of a knowledge base for nursing:

> *During the last three decades, nursing knowledge has been developed mostly applying the accepted empirical methods of inquiry with the primary aim of establishing a systematic, generalized knowledge-base for practice. In the recent years, however, this orientation has been modified by an increased interest in and acceptance of various interpretive methods such as phenomenological, hermeneutic and critical approaches to advance nursing knowledge. The discipline of nursing certainly needs to apply both of these methods (i.e. the empirical and interpretive) in order to address the complex nature of its subject matter and for the development of its science. Additionally, nursing needs to develop and apply methods that draw from the situated, individual instances of nursing practice in order to develop and augment the knowledge necessary to improve its practice. This is based on the recognition that nursing knowledge production must also be viewed in conjunction with practice itself as practice involves not only the use of knowledge but gaining of new knowledge as well* (Kim, 1999, 1205).

The creation of a systematic knowledge base for nursing by the use of accepted empirical research methods comes first chronologically and in the above extract. Interpretive methods of inquiry and the knowledge produced by them come next in the chronologic and textual order. They also seem to come second to accepted empirical methods and systematic generalised knowledge in terms of legitimacy; they have yet to be accepted in the same way. While interpretive methods have reoriented the discipline away from an exclusive focus on systematic generalised knowledge, the latter is still required to advance nursing knowledge and science. And while interpretive methods may not have the same legitimacy as empirical inquiry, there is no question of their relevance to the development of nursing's knowledge base. The status of a proposed third method of inquiry and its role in generating knowledge is less certain. Textually, it follows the definitive statement regarding the role of empirical and interpretive methods in the advancement of nursing knowledge and science which places a third method outside that reference. The word '*Additionally*' prefaces the introduction of a third approach in the text which suggests something added on rather than something integral. The contribution made by the, as yet unnamed, method is to '*draw from the situated,*

individual instances of nursing practice in order to develop and augment the knowledge necessary to improve its practice' (Kim, 1999, 1205). The lack of any syntactic or grammatical connection between the words '*nursing practice*' and '*knowledge*', together with the ambiguity of the word '*develop*' as used in this context – creating something new versus adding to something already existing – enables a reading that separates knowledge and practice. Further textual evidence for such an interpretation is provided in the final sentence of the extract: *'...the recognition that nursing knowledge production must also be viewed in conjunction with practice itself as practice involves not only the use of knowledge but gaining of new knowledge as well*' (Kim, 1999, 1205). The connection between knowledge and practice appears to be contingent or accidental rather than necessary. Knowledge production and nursing practice are presented as parallel tracks that may or may not intersect. Practice involves using knowledge and gaining new knowledge. Gaining cannot be taken to be synonymous with producing.

Although knowledge and practice appear somewhat distanced in the introduction section of the paper, Kim's (1999, 1206) later elaboration of the third inquiry method provides some clarity on the relationship of knowledge to practice:

> *The complexity of practice in terms of knowledge use and knowledge production suggests the need for nursing as a human science and a practice discipline to develop a method of inquiry that involves practitioners in the inquiry. This proposed method of inquiry therefore involves critical examination of what is actually going on in situations of practice through a systematic self-reflection, reflective discourse, and critically oriented change.*
>
> *...Hence, we can say that some form of nursing knowledge is produced in everyday settings of practice and that there are theories of application being used to co-ordinate and package new and old knowledge and experiences in practice.*

A distinction is drawn between knowledge produced in practice and knowledge derived from empirical methods of science.

> *...the knowledge produced in situations of practice differs from that produced in the scientific arena in three senses: (a) knowledge produced in practice is the knowledge of application that is tailored to specific situations, so the question of generalizability does not enter into its production; (b) it is the practitioners who are intimately and directly involved in production as well as in judging the validity claims about that knowledge insofar as such knowledge is not exposed to specific processes of validation beyond practice itself; and (c) knowledge produced in practice is likely to remain as personal knowledge.*

Although scientific knowledge forms the point of reference, it appears that practice knowledge does not have to submit to its norms. Practitioners are not only the producers of knowledge in practice; only they can make a judgement as to its validity. Critical reflective inquiry provides the method of accessing knowledge that would otherwise remain personal to the individual practitioner. However, what are presented as strengths and positive attributes of practice-produced knowledge may also be undesirable.

> *This means that knowledge production through nursing practice may be done poorly or expertly and result in knowledge that is good or bad, or that is innovative or redundant. Hence, an inquiry into the nature of knowledge production and processes of application needs to involve practitioners in a reflective and critical mode* (Kim, 1999, 1206).

The knowledge that Kim (1999, 1206) refers to in the above context is practitioners' "*theories-in-use which tend to be oriented to routinization and self-interest and are often quite different from their espoused theories. This suggests that what nurses do in practice may not be as good as what the nurses believe they are doing. Hence, it is necessary to assume actual practice as being 'good' or 'effective' as well as being 'inadequate' or 'poor'*". What the method of critical reflective inquiry offers, therefore, is not access to practitioner knowledge *per se* but a means of determining whether the practitioners' theories-in-use tend towards effective or inadequate practice, and to what extent their theories-in-use match their espoused

theories. It will be for the practitioners themselves to judge the outcome of the critical reflective inquiry method (Kim, 1999).

At the same time, a sense persists in the text that there is a great deal of good knowledge produced in practice that cannot be explained in terms of espoused theory and needs to be made publicly known through reflective practice, for example:

> *...knowledge regarding how practitioners produce positive outcomes in clients. Nurses are confronted with multiple sets of theories regarding human conditions and nursing therapeutics which sometimes provide competing, conflicting or mutually supportive knowledge as well as a deficiency in providing comprehensive explanations and/or definitive approaches to solving nursing problems. Still, nurses are able to provide good care and often have effective outcomes most of the time* (Kim, 1999, 1206).

The critical inquiry method "*...begins with Schön's notion of reflection-on-action but extends it further to be used not only as a way to add to professional's personal knowledge but also as a method to be used to develop knowledge in the public domain, that is, 'shared knowledge'*" (Kim, 1999, 1206). It must be assumed that personal knowledge derived from the practitioner's reflection-on-action, even if it is not shared, is good knowledge that enables effective practice, and not poorly done resulting in bad knowledge. Critical reflective inquiry consists of three phases - a descriptive phase in which instances of practice are related in the form of narrative accounts which are analysed for completeness (Kim, 1999). This is followed by a reflective phase during which narratives are analysed in light of, among other things, '*The scientific aspect of practice* (which) *refers to the use and application of empirical knowledge that is drawn either from a general scientific knowledge-base or from personal knowledge*' (Kim, 1999, 1208). The distinction drawn earlier between scientific and personal knowledge appears to be dissolved and practice knowledge is judged in terms of the scientific knowledge base. The final phase is the '*Critical/emancipatory phase*' which involves changing ineffective

or inadequate practice or '*moving forward to future assimilation of new innovations emerging from practice*' (Kim, 1999, 1209).

The practitioner is not the sole producer of practice knowledge. Kim (1999, 1209) identifies a role for the researcher during each of the three phases of critical reflective inquiry which is delineated as follows:

> *The researcher's role is essential in that the researcher needs to help practitioners not only in the reflecting act but also in constructing the frames with which the reflection must be carried out.*
>
> *...Through the researcher's questioning and probing, practitioners can engage in self-dialogue and argumentation with themselves in order to clarify validity claims embedded in their actions, bringing forth the hidden meanings and disguises that systematically result in self-oriented and unilateral actions or ineffective habitual forms of practice.*
>
> *...Practitioners and the researcher can develop a process of practice that incorporates self-emancipation from routinized practice. In addition to self-emancipation, this phase* (the critical/emancipatory phase of critical reflective inquiry) *can also be used to bring about an emancipatory culture in clinical settings, through some form of change process involving staff of a unit (or a hospital) as a group* (Kim, 1999, 1209).

This description of the critical reflective inquiry method suggests that the researcher has a quite significant part to play in the production of knowledge from practice and the validation of that knowledge, despite earlier claims about the practitioner's role in this endeavour. 'Helping' includes not just helping in terms of the activity of reflecting but also in terms of constructing the 'frames' with which reflection must be carried out. If frames, in this context, designate a viewpoint or perspective through which an aspect of practice is viewed, it is possible that the researcher's frame is likely to differ, perhaps quite considerably, from the practitioner's. Differences in perspective and the relative influence of different frames are not mentioned in the text, but it is not inconceivable that, since critical

reflective inquiry is a research method, the researcher's frame is likely to predominate.

Kim (1999) seeks to mitigate or suppress the influence of the researcher in the critical reflective process, although there is an irony in describing practitioners as engaged in '*self-dialogue and argumentation with themselves*', while the other party to the interaction, namely, the researcher, questions and probes. The extent to which the researcher's questions and probes shape self-dialogue and influence clarification of validity claims and the bringing forth of hidden meanings may not be inconsiderable. A certain paradox is detectable in the reference to '*self-emancipation*' in the final paragraph of the above extract. It presupposes that practitioners need and wish to free themselves from routinized practice. It also presupposes that someone other than the individual who needs and wishes to free themselves will play a role in determining how that process is to occur. A potential coercive effect may be read in the above account of the critical/emancipatory phase of critical reflective inquiry. It seems to go unrecognised by the author, who, as a researcher, may espouse a value system more akin to scientific method than reflective inquiry. The text does not appear to be fully under the control of its author. Authorial intention seems undermined by the autonomy and disseminative capacity of language.

An example of the method of critical reflective inquiry is included in the paper. Kim (1999, 1209) explains the background to the example presented in the following way:

> *Because the major goal* (of the project) *was to introduce the critical reflective model of practice to nursing at the hospital, the researcher and the nurse administrative leaders decided on a project that would first introduce and prepare nurse leaders to become familiar with this method of inquiry and also to internalize the philosophy of critical reflective culture of nursing practice. A 2-day retreat was instituted in which 75 nurse leaders of the hospital, composed of nurse managers, supervisors and head nurses, participated.*

For an approach that is oriented to self-emancipation and an emancipatory culture, it is ironic that it is a researcher and a group of nurse leaders who are deciding how change is to be effected. Neither party is likely to be engaged primarily in clinical practice; therefore, neither is in a position to generate knowledge in practice. Furthermore, it is not unreasonable to suppose that the nurse administrative leaders involved in the project have considerable positional power which calls into question the possibility of a genuinely emancipatory culture. The researcher has already displayed considerable force and influence in the process of critical reflective inquiry and it seems unlikely that that will diminish in the context of the project described above. A further irony is evident in the way the method is introduced – by way of a '*retreat*' (presumably away from the clinical setting of the hospital) and beginning with the 'theory' of the approach. The medium is potentially at risk of undermining the message of critical reflective inquiry.

Articulating the knowledge derived from nursing practice by processes similar to Kim's (1999) critical reflective inquiry method is proposed by Rycroft-Malone et al. (2004). The proposal arises in the context of a discussion regarding potential sources of evidence that may be used to inform nursing practice (Rycroft-Malone et al., 2004). Knowledge originating in practice becomes a source of evidence for practice through a process of public scrutiny (Rycroft-Malone et al., 2004). However, the authors argue that, in the context of health care, the only source of knowledge that is accepted as evidence is that derived from empirical inquiry, in particular, research that demonstrates the effectiveness of interventions, such as the randomised controlled clinical trial (Rycroft-Malone et al., 2004). To attain the status of evidence, other sources of knowledge must be subjected to robust and rigorous processes of verification (Rycroft-Malone et al., 2004). This is necessary because if non-research sources of knowledge do not attain the status of evidence, they are likely to be marginalised or disregarded in the context of '*evidence-based*' healthcare as described below (Rycroft-Malone et al., 2004, 83):

> *The prominence ascribed to research evidence has meant the relative neglect of other forms of evidence in the delivery of health care, in terms of making them available for critical scrutiny and public review.*

The authors identify a number of different sources of knowledge that are used to inform practice and argue that evidence from each source is necessary if patient-centred, evidence- based care is to be provided (Rycroft-Malone et al., 2004). Nursing, in particular, is oriented towards patient-centred care (Rycroft-Malone et al., 2004). The nurse-patient relationship is recognised as a central component of caring (Rycroft-Malone et al., 2004). Two broad categories of knowledge for practice are identified: propositional and non-propositional knowledge (Rycroft-Malone et al., 2004). These categories are explained as follows:

> *Propositional knowledge is formal, explicit, derived from research and scholarship and concerned with generalisability. Non-propositional knowledge is informal, implicit and derived primarily through practice. It forms part of professional craft knowledge (the tacit knowledge of professionals) and personal knowledge linked to the life experience and cognitive resources that a person brings to the situation to enable them to think and perform (Higgs & Titchen 1995, 2000, Eraut 2000). Unlike research-based knowledge, professional craft knowledge is not usually concerned with transferability beyond the case or particular setting. However, this non-propositional knowledge has the potential to become propositional knowledge once it has been articulated by individual practitioners, then debated, contested and verified through wider communities of practice in the critical social science tradition of theory generation (see Titchen & Ersser 2001)* (Rycroft-Malone et al., 2004, 83).

It seems clear from the above description that propositional knowledge forms the benchmark or standard to which non-propositional knowledge aspires. The differences between propositional and non-propositional knowledge are described in terms of binary oppositions as illustrated below:

Propositional knowledge.....Non-propositional knowledge

Formal..... Informal

Explicit..... Implicit

Derived from research and scholarship.....Derived primarily through practice

Concerned with generalisability.....Not usually concerned with transferability

Propositional knowledge represents the norm or standard, while its binary opposite represents a deviation. Propositional knowledge is temporally and qualitatively prior to non-propositional knowledge. It is not necessary to overturn or subvert the binary oppositions that have been presented. By textual 'sleight of hand', as it were, non-propositional becomes propositional knowledge. If the former is to function as an evidence base for nursing practice, it appears it must assume the identity of propositional knowledge. The dominance of the latter seems, once again, to be asserted.

A more overt challenge to the dominance of research knowledge as the evidence base for nursing practice is discernible in Rycroft-Malone et al.'s (2004) identification of four distinct sources of knowledge from which evidence for practice may be produced. These sources are presented in the text in the following way:

- *research*
- *clinical experience*
- *patients, clients and carers*
- *local context and environment* (Rycroft-Malone et al., 2004, 83)

Research is identified first, and in the section of the paper that describes this evidence source, its priority in health care is acknowledged (Rycroft-Malone et al.,

2004). However, the description that follows seems oriented to undermining or calling into question the dominance of research as an evidence base. For example, certain limitations of research knowledge are cited:

> *...research evidence tends to be perceived as providing watertight answers to the questions posed. However, such evidence rarely attains absolute certainty and may be changed as new research emerges. Upshur (2001) suggests that to conflate research evidence with the concept of truth will lead to serious misunderstandings because definitive studies are comparatively rare* (Rycroft-Malone et al., 2004, 83-84).

The question of '*objectivity*' of research findings is also alluded to in the description of research evidence, as well as the impact of social processes on the production of research. It is the authors' contention that these factors testify to the tentative status of research knowledge (Rycroft-Malone et al., 2004). Arguing that '*there is no such thing as* ***the*** *evidence*', the authors cite a research study consisting of '*a cross-case comparison and synthesis of seven evidence-into-practice studies, including 49 cases (involving 1400 interviews)*' in support of their assertion (Rycroft-Malone et al., 2004, 84). (Rycroft-Malone et al.'s emphasis). In highlighting the paradox of attempting *"to attain a level of 'objectivity'"* in a process that is '*social as well as scientific*' (Rycroft-Malone et al., 2004, 84), the paradox of using research evidence to undermine research knowledge as the dominant evidence base for practice appears to go unrecognised. The authors conclude that evidence from research:

> *...is not certain, acontextual and static, but dynamic and eclectic.*
>
> *This indicates that, whilst research evidence is important to delivering evidence-based care, it is less certain and less value free than is sometimes acknowledged* (Rycroft-Malone et al., 2004, 84).

The problems that have been identified with research knowledge are used to justify the need for other sources of knowledge in evidence-based nursing practice (Rycroft-Malone et al., 2004). However, the limitations that the authors have

chosen to highlight and the conclusions they reach have the effect of making research knowledge appear more like non-propositional knowledge. The description given for propositional knowledge in the above extract could apply equally as a description of non-propositional knowledge. If propositional knowledge may be recognised as non-propositional knowledge, then any difference between these two evidence bases is dissolved which undermines the argument for two distinct types of knowledge. Such an alternative reading, which the text affords, could be viewed as extending rather than reducing the dominance of research knowledge.

Knowledge from clinical experience is another source of knowledge that may form an evidence base for evidence-based health care (Rycroft-Malone et al., 2004). This kind of knowledge is described as '*expressed and embedded in practice and is often tacit and intuitive*' (Rycroft-Malone et al., 2004, 84). Research knowledge is also cited, in the context of the discussion of knowledge from clinical experience, as evidence that nurses produce and use practical knowledge.

> *Not only do practitioners act on their own practical knowledge, but recent research has verified that nurses also draw on the expertise of others to inform their practice (Thompson et al. 2001a, 2001b, McCaughan et al. 2001), which of course could itself be research-based* (Rycroft-Malone et al., 2004, 84).

Using the terms '*Not only...but...also...*' in the above extract tends to create an effect of sameness, as if practitioners' own practical knowledge and the expertise of others belong in the same category. Acknowledging that the expertise of others could '*of course*' be research-based allows for the possibility that practitioners' own knowledge could, likewise, be research-based. This has the effect of breaking down any distinction between research knowledge and practical knowledge with research knowledge once again dominating. However, the problem that such an interpretation would create for the argument being advanced appears to be overlooked. Attention turns instead to describing how knowledge from clinical experience can become an evidence base for nursing practice.

> *...in order for an individual practitioner's experience and knowledge to be considered credible as a source of evidence, it needs to be explicated, analysed and critiqued. Stetler et al. (1998) call this '**affirmed experience**', which means that experiential observations or information have been reflected upon, externalized, or exposed to explorations of truth and verification from various sources of data* (Rycroft-Malone et al., 2004, 84). (Rycroft-Malone et al.'s emphasis).

The sources of data that might be used to explore the truth and verification of practitioners' practical knowledge are not identified. The word '*data*' tends to be associated with scientific research, which could imply that one of the ways of verifying practical knowledge is by reference to research evidence. While the word '*explorations*' connotes uncertainty as to a final destination, the word '*truth*' connotes certain knowledge comparable to propositional knowledge. Indeed, the word '*truth*' was referenced in the context of Rycroft-Malone et al.'s (2004) discussion of research evidence, with a tendency to conflate research evidence with the concept of truth recognised as problematic (Rycroft-Malone et al., 2004).

A variety of signifiers are used in the context of describing '*Knowledge accrued through professional practice and life experiences*' (Rycroft-Malone et al., 2004, 84), for example, "'*practical knowledge*'", "'*professional craft knowledge*'", "'*practical know-how*'", '*Knowledge from clinical experience*', '*clinical common sense*', '*tacit knowledge*' (Rycroft-Malone et al., 2004, 84), and '*Professional Knowledge/clinical experience*'(Rycroft-Malone et al., 2004, 87). Such variety, perhaps, points to an absence of stable meaning. Rycroft-Malone et al. (2004, 84) explain the reason for the inclusion of this source of knowledge in the evidence base for nursing practice as follows:

> *A number of scholars have explored the nature of different ways of knowing and producing knowledge and have substantiated the contribution of different sources of knowledge to practice beyond the technical or propositional (e.g. Carper 1978, Benner 1984, Reason & Heron 1986, Edwards 2002, Hunt et al. 2003, Titchen & McGinley 2003).*

The nature of knowledge from clinical experience is such that, unlike research evidence, substantiation by scholars is not sufficient to warrant it as evidence in an evidence base.

> *Despite this, we argue here that there is still an underlying assumption in the field and practice of evidence-based health care that such sources of knowledge are idiosyncratic, subject to bias and, as a result, lack credibility. However, we propose that the delivery of individualized evidence-based health care not only* ***requires*** *professional craft knowledge and reasoning, but requires such knowledge and reasoning to integrate the four different types of knowledge discussed here within the contextual boundaries of the clinical environment. In order to do this, however, it is essential that clinical experience or tacit knowledge is made explicit in order for it to be disseminated, critiqued and developed* (Rycroft-Malone et al., 2004, 84). (Rycroft-Malone et al.'s emphasis).

Not only does professional craft knowledge form a distinct evidence base for nursing practice but it is also the evidence base that integrates evidence from all four knowledge sources. This gives it an added significance relative to the three other evidence bases. The authors also note that when knowledge from practice accords with scientific knowledge, practitioners are more inclined to use research findings and vice versa (Rycroft-Malone et al., 2004), which attests to the power of knowledge from practice over research knowledge. While the discussion of research knowledge is oriented to 'talking down' its significance as evidence for practice, the discussion of knowledge from practice appears oriented to 'talking up' its importance in practice. Support for the assertion that clinical experience knowledge impacts on the utilisation of research knowledge in practice, and that if the former is at variance with the latter then research evidence may not always be utilised, is provided by citing a case study which investigated the use of a particular drug by orthopaedic surgeons (Rycroft-Malone et al., 2004). Referring to the drug, the authors state:

> *Its use in orthopaedic surgery is controversial because the research base about its effectiveness is variable.* (In the case study)*...use of the drug was influenced by the beliefs of a core group of orthopaedic surgeons, whose views were based on experiential knowledge. There was dissonance between the research evidence and clinical experience and as a result the uptake of the new drug was described as 'patchy'* (Rycroft-Malone et al., 2004, 85).

The example of the case study supports a reading 'otherwise', that is, as research evidence being consonant with clinical experience and, perhaps, even determining clinical practice. If the research evidence of the effectiveness of the drug in question is variable, and if research evidence is being used to inform practice, one might be unsurprised to find that the uptake of the drug in practice is also variable, or '*patchy*' as described above.

The need to ensure that care is individualised is offered as justification for the non-use of evidence from research in clinical practice situations as indicated below:

> *In addition, practitioners, taking the particularity of patient and context into account, may be making the right decision for a particular patient* (Rycroft-Malone et al., 2004, 85).

Knowledge of the particular patient and the particular care situation provides the evidence upon which practitioners base their practice, and that evidence takes priority over research evidence. However, when the authors add: '*Conversely, where particularity accords with the research evidence, practitioners may still not use the research evidence*' (Rycroft-Malone et al., 2004, 85), it appears to contradict their earlier assertion, that is, where clinical experience knowledge is consistent with research knowledge, the latter is more likely to be utilised in practice. While privileging evidence from clinical experience over evidence from research, and using the former to justify the non-use of research evidence in practice, seems acceptable when the evidence from each source is at variance, it is unclear on what basis the non-use of research evidence can be justified in situations where it is in accord with practice knowledge. In the above scenario, if evidence from research

is not used even though it is consistent with evidence from clinical experience, then it must be assumed that practice is based on neither knowledge source which begs the question of what evidence base, if any, is being used to inform practice.

Knowledge from clinical experience or professional craft knowledge, as indicated earlier, appears to have at least two meanings: it constitutes a distinct evidence base and it is required to integrate the evidence from all four evidence bases in practice (Rycroft-Malone et al., 2004). In terms of the first meaning – constituting a distinct evidence base – the process of ensuring robustness of knowledge from practice is described as follows:

> *...for clinical experience, a systematic and documented process of gathering evidence of the different types of knowledge used in everyday practice, and their impact on patients, colleagues and the organisation, in combination with reflection and cross-checking, may be appropriate. Cross-checking could occur in ever-widening ripples from individual practitioners' clinical supervision, 360° feedback or action learning, progressing to, for example, colloquia, seminars, debates, consensus workshops within their immediate, then regional, national and international communities of practice. This critical social science approach to generating potentially transferable knowledge would provide systematically collected bodies of knowledge whose credibility have been tested, which other practitioners can draw on* (Rycroft-Malone et al., 2004, 87).

The second meaning of professional knowledge as an evidence base – the integration of evidence from the four distinct knowledge sources – appears to follow immediately on the first as indicated in the extract below:

> *However, this suggestion does not exclude the need to exercise clinical judgement when caring for individuals during clinical encounters. There will always be a need to particularize and tailor these evidence sources to individual circumstances* (Rycroft-Malone et al., 2004, 87).

The two meanings seem to be not only different but quite opposing. The first meaning is oriented to making the particular general and the second to making the general particular. It is difficult to envisage how the enormous volume of diverse information that must be collated, and the ever-widening ripples which take that knowledge further and further from its source, can subsequently be particularised and tailored to individual circumstances. And in becoming particularised again, could it not be assumed that professional craft knowledge in the first meaning of the term is a redundant evidence base. However, it is not professional craft knowledge in the first meaning of the term that is vulnerable to becoming redundant.

Rycroft-Malone et al. (2004, 85), in another reference to the verification of professional craft knowledge, describe the process as helping practitioners:

> *...to surface, articulate and then reflect on their practical knowledge and its melding with other forms of evidence. The aim is to make this knowledge and its blending available for dissemination to a range of other practitioners for comparison, debate and critique; consensual validation and verification could then be sought.*

Blending knowledge from various sources is part of practical or professional craft knowledge in the sense of the second meaning of the term, that is, in the sense of exercising clinical judgement, particularising and tailoring evidence sources to individual circumstances, and so on. If this element of professional craft knowledge is also generalised, as suggested above, that has the effect of eliminating professional craft knowledge in the second meaning of the term, and, with it, the goal of individualised care. Professional craft knowledge could be considered an example of an 'undecidable' in the context of this deconstructive reading. Its meaning is never anywhere punctually present. It is sustained by what it is not; its identity constituted by its difference from itself.

Rycroft-Malone et al. (2004) present a framework which represents the four evidence bases and how they interact with each other in terms of practice knowledge. The framework is reproduced in Figure 9.1 below.

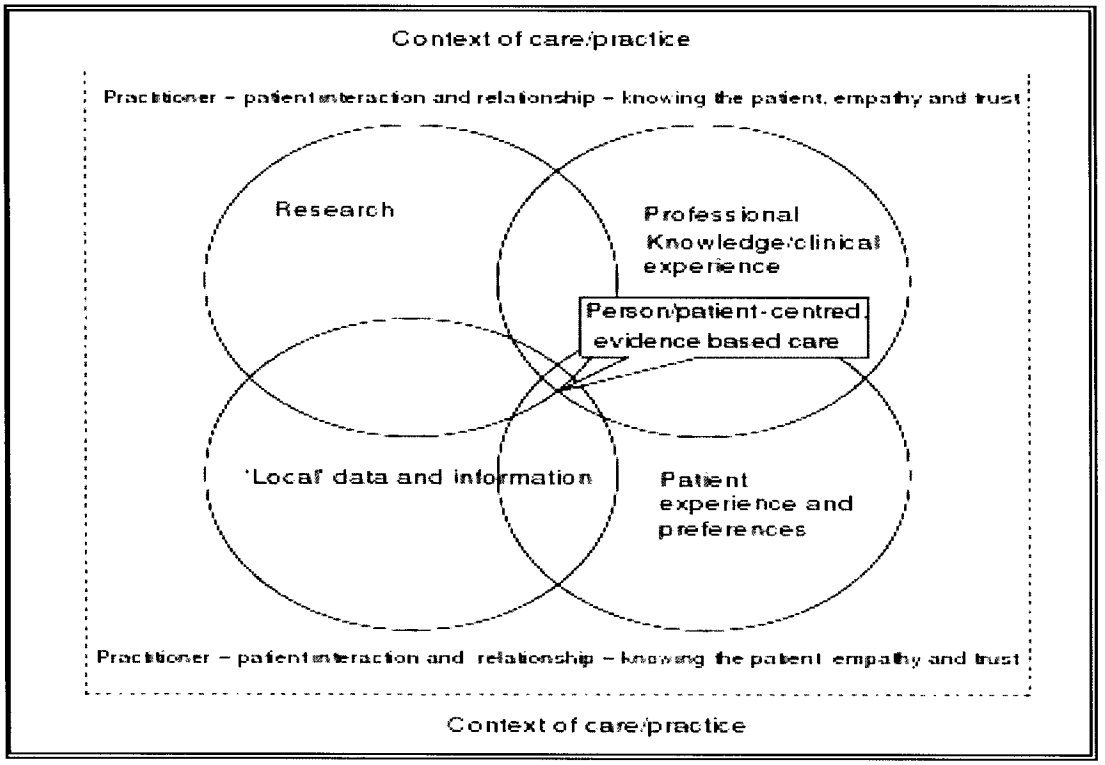

Figure 9.1: A framework for evidence-based practice (Source: Rycroft-Malone et al., 2004, 87)

The four sources of evidence for patient-centred, evidence-based practice are depicted as four equally large intersecting circles. The circles are contained within two large squares, the outer square representing '*Context of care/practice*', and the inner one '*Practitioner-patient interaction and relationship – knowing the patient, empathy and trust*' (Rycroft-Malone et al., 2004, 87). At the centre of the framework is a small area where all four circles overlap; this area represents '*Person/patient-centred, evidence based care*' (Rycroft-Malone et al., 2004, 87). It is reasonable to assume that this small area represents the melding of evidence from all four bases, where knowledge is particularized and tailored to meet individual needs and circumstances, and clinical judgement is exercised. The portion of evidence included from each base to provide person centred, evidence-based care is extremely small relative to the amount of evidence contained in each base or

circle. This suggests that the practitioner is required to be conversant with quite substantial quantities of diverse knowledge and to possess quite sophisticated powers of selection. Not only is the practitioner required to meld evidence from all four bases in a practice encounter but they are also required to meld evidence from different bases in the following way:

- Research and professional knowledge/clinical experience;
- Research and local data and information;
- Local data and information and patient experience and preferences;
- Patient experience and preferences and professional knowledge/clinical experience;

In terms of size, each of these overlapping areas represents quite significant amounts of evidence.

Evidence is also required to be melded from the following bases, represented by the areas where three of the four circles overlap:

- Research, local data and information, and patient experience and preferences
- Research, professional knowledge/clinical experience, and patient experience and preferences
- Professional knowledge/clinical experience, patient experience and preferences, and local data and information
- Research, professional knowledge/clinical experience, and local data and information,

As outlined above, the framework could be interpreted as consisting of twelve distinct bases of evidence rather than four. Melding evidence from twelve distinct bases would present considerable challenges to an individual practitioner.

The central argument of the paper is that the concept of evidence in the context of evidence-based practice must be broadened to include more than just

propositional or research knowledge. Having identified the various sources of knowledge that are used in practice, the authors suggest certain processes by which such sources, in particular, non-propositional knowledge sources may become evidence (Rycroft-Malone et al., 2004). Professional craft knowledge is an evidence base and also a source of knowledge for integrating evidence from all sources. If the processes suggested are followed, this will enable patient-centred, evidence-based practice. Since it is being argued that all knowledge used in practice can be based on evidence with the addition of clinical judgement to determine which evidence from what bases is appropriate in a particular care situation, it begs the question of the purpose of the two outer square areas in the framework figure above. It might be imagined that both '*Context of care/practice*' and '*Practitioner – patient interaction and relationship – knowing the patient, empathy and trust*' would be accommodated within an evidence base, or indeed be positioned at the centre of the framework where all four evidence bases intersect. Is the purpose of the framework not to enable the practitioner to draw on appropriate evidence bases and tailor them to the individual patient and the particular context of care? Positioning '*context of care*' and '*practitioner-patient interaction*' so far from the centre of the framework may be an unconscious acknowledgement that, contrary to the overt argument advanced in the paper, some elements of caring cannot be contained within the categories of evidence. The elements that have escaped the categories might be considered those that are most resistant to evidence as it has been presented in the text. Their position seems also to belie the inclusion of clinical judgement within an evidence base. Ironically, the authors' final statement is a call for testing the '*framework for patient-centred, evidence-based care...through rigorous empirical research*' (Rycroft-Malone et al., 2004, 88). Evidence from research is once again dominant in determining the validity and utility of the proposed framework, although the complexity of the latter might indicate that more than empirical methods are required.

While Rycroft-Malone et al. (2004) claim that knowledge from practice may become a source of evidence for practice by processes which include critical reflection, Rolfe & Gardner (2005) argue that reflection provides the only source

of what may properly be called evidence, if this word is used in its correct and original sense. Practice may be truly evidence-based if reflective practice is at the centre of the process, rather than, as it is currently positioned, on the margins of evidence-based practice (Rolfe & Gardner, 2005). Changing how evidence-based practice is understood is all the more important for nursing since, in its current construction, it is at odds with nursing's fundamental values and philosophy (Rolfe & Gardner, 2005). With reflection at the centre of evidence-based practice, a new science of nursing may be developed, which reflects nursing values and distinguishes nursing from medical science (Rolfe & Gardner, 2005). The authors explain why evidence-based practice, as it is currently conceived, is not appropriate for nursing practice and research. The evidence upon which practice is based is arranged in a hierarchy, with findings from large scale quantitative research studies, in particular randomised controlled trials, at the apex and other forms of evidence arranged in descending order of importance (Rolfe & Gardner, 2005). Evidence from qualitative research studies, reflective practice, expert opinion, and so on, tends to be positioned at the base of the hierarchy and thus rank as least important in terms of evidence-based practice (Rolfe & Gardner, 2005). This has led to such sources of knowledge being devalued or disregarded (Rolfe & Gardner, 2005). The most highly regarded forms of evidence are research studies that produce findings that are generalisable to a population which shares the same characteristics as the sample used in the research study (Rolfe & Gardner, 2005). Nursing is concerned with unique individuals in unique circumstances and, as such, is a person- or patient-centred activity (Rolfe & Gardner, 2005). Evidence-based practice, as it is commonly understood, is biased towards the evidence produced by quantitative research approaches (Rolfe & Gardner, 2005). As an 'evidence-based' practice, nursing is compelled to adopt this same view of evidence, and accord quantitative research findings the highest status. Such an approach is in conflict with nursing as a patient-centred practice providing individualised care to persons (Rolfe & Gardner, 2005). Nursing, as a science, is concerned not with populations or large numbers of people but with individuals (Rolfe & Gardner, 2005). Therefore, quantitative research approaches should not set the standard for knowledge generation in nursing (Rolfe & Gardner, 2005).

The authors explain how generalisable research findings, which are applicable to many people, are not appropriate in a practice that is concerned with the individual person:

> *The RCT* (randomised controlled trial) *is often justified in nursing research by comparing the testing of new drugs with the testing of new nursing interventions. It might be argued, for example, that since we would be reluctant to accept a drug that has not been fully tested by a clinical trial, we should also be reluctant to accept a nursing intervention that has not been tested in the same way. However, our discussion of people and persons would suggest that this is a mistaken comparison, since whilst drugs generally produce very similar effects on all* ***people****, nursing interventions operate on the level of the individual* ***person****.*
>
> *Of course, it is* ***sometime****s useful for nurses to see the bigger, more general picture, for example when planning for future bed occupancy or when making decisions about overall ward policy. And as we have seen, the bigger picture is also required when prescribing and administering medication or when carrying out other technical procedures. However, we are arguing that there is a serious discrepancy when a discipline which is defined by its focus on unique interpersonal interactions has as its gold standard a research methodology which can offer little or no insight into those interactions* (Rolfe & Gardner, 2005, 303). (Rolfe & Gardner's emphases).

In the course of arguing for the inappropriateness of generalisable research findings in nursing practice, the authors concede that such findings are sometimes useful. The emphasis on the word '*sometimes*' seems designed to convey a sense of the infrequency of such occasions. And the words '*It goes without saying*' could be substituted paradigmatically for the intensifier '*Of course*', with which the sentence begins, indicating that the point is so obvious it does not need to be stated. The authors probably wished they could avoid saying what follows the '*Of course*', as it seems to undermine their argument for the inappropriateness of generalisable research findings in nursing. Generalisable research findings are identified with

technical aspects of nursing practice. Linking quantitative research findings with technical aspects of nursing could be regarded as an attempt to diminish or marginalise those aspects of nursing practice, as if to say, 'Of course nursing practice sometimes consists of technical aspects but we can disregard that as far as creating a new science of nursing is concerned'. Why might the authors seek to diminish or marginalise the technical aspects of nursing practice? Is it because, in acknowledging that nursing has a technical dimension that requires technical knowledge, it must be conceded that the randomised controlled trial may be the best way of producing such knowledge? And in conceding that, it goes without saying that any new science of nursing must include knowledge generated by randomised controlled trials. Diminishing the technical aspects of nursing may be interpreted as a way of maintaining a binary opposition between the technical and the interpersonal, so that the latter is not contaminated by the former. At the same time, and using the example given above once again, it could be argued that all technical procedures, including prescribing and administering medication, are nursing interventions that occur at the level of an individual person and take the form of an interaction between a nurse and a patient. Such an interpretation has the effect of connecting the technical and the interpersonal. That such a connection is not identified or acknowledged by the authors may again reflect their efforts to maintain these two approaches in opposition to one another. If the technical and the interpersonal are imbricated in nursing practice, then a science of nursing must, it would seem, include both.

The difficulty of maintaining generalisable research as something separate from and incompatible with the doctrine of individualised care becomes evident again in the following extracts:

If research has demonstrated that a particular intervention is most effective for a general condition then, depending on the validity of the research study, the practitioner is obliged to apply that intervention to any patient suffering from the condition in the population described by the study. ***There may be exceptions, such as cases when the patient refuses to accept the treatment, or when the nurse decides that the patient is too frail or otherwise unsuited to the treatment*** *(DiCenso et al., 1998), but as a general rule, generalisable findings from research are applied to individual cases which fall within the scope of the generalisation* (Rolfe & Gardner, 2005, 304). (My emphasis).

This model is based on a science of ***people*** *which regards patients as members of a collective group, each of whom is likely to respond in a similar way to the same intervention* (Rolfe & Gardner's emphasis). *Although clearly there are ethical implications to this position of nursing people as though they were all the same, it is not simply a moral issue. Our intention is not to condemn nurses working under the traditional EBP model as not caring for or about their individual patients; rather, we are pointing out* ***the logical impossibility of truly individualised care****. The logic of generalising from a population to individuals within that population depends upon the assumption that each and every one of those individuals is fundamentally alike* (Rolfe & Gardner, 2005, 304). (My emphasis).

The authors appear to describe what they do not wish to convey. '*Exceptions*' to the general application of research findings listed above would suggest that generalisable research findings may be 'individualised' to the particular patient. Contrary to the argument that practice based on quantitative research evidence regards all patients as the same and all nurses as simply applying research findings to eligible people, and consistent with the description given in the first paragraph of the above quotation, it is clear that the 'evidence' in evidence-based practice may be mediated by nursing judgement and individual patient preferences. Evidence-based practice, as so described, is not antithetical to individualised care. Once again the authors eschew an opportunity to mark a connection between the

general and the particular. If truly individualised care is logically impossible under the traditional EBP model, then how are the '*exceptions*' to the model to be explained? What I wish to suggest is that the concluding statement of the second paragraph above could be rewritten, without contradicting what preceded it in the first paragraph, in the following way: *'we are pointing out the **logical possibility** of truly individualised care using the EBP model. The logic of **particularising** from a population to individuals within that population depends on the assumption that each and every individual is fundamentally **different**'*. (My emphasis).

As well as arguing, inadvertently perhaps, for the possibility of generalisable research findings being particularised in light of nursing judgement and patient preference, the authors also acknowledge the possibility of 'generalising the particular' as evident in the following quotation:

> *Of course, whilst all therapeutic encounters are unique, they also share similarities, and so it is always possible to generalise to some extent. However, the inexorable logic of our position that each and every clinical encounter is unique is that the traditional and usually accepted model of evidence-based practice is only of limited use to the nurse* (Rolfe & Gardner, 2005, 305).

The words '*Of course*' again precede a statement (*it is always possible to generalise...*) that could be seen to be at variance with the argument against generalisation in a nursing science of the unique person. The '*always*' possibility of generalising from the particular is tempered by the addition of the qualifier '*to some extent*'. The limited use that evidence from randomised controlled trials (RCTs) and the traditional model of evidence-based practice has in a new nursing science is outlined as follows:

> *If we are serious about promoting nursing as a science of unique persons rather than a science of people in general, then we need to reconsider the methods and methodologies the discipline authorises and promotes for the generation of nursing knowledge.*

> *We wish to argue that this reconceptualisation extends well beyond simply replacing the RCT with some other research methodology as the gold standard for generating evidence. It even extends beyond the view expressed by some writers that there is no gold standard. Rather, it questions the fundamental concept of evidence-based practice as simply the application of evidence of any kind to practice. We wish to argue that, if nursing is truly a science of the unique, then this is merely the first stage of the process of evidence-based practice, which must then generate further evidence from the nursing encounter itself in an ongoing reflective/reflexive cycle of action and evaluation* (Rolfe & Gardner, 2005, 303-304).

Although the authors assert that they are not substituting one gold standard for another in their concept of a new science of nursing, they acknowledge that qualitative research and reflective practice '*...**do** address questions of individual nursing encounters...*' (Rolfe & Gardner, 2005, 303). (Rolfe & Gardner's emphasis). They describe the new nursing science as a '*wet*' science, arguing that knowledge relevant to practice must be discovered in the messy world of practice, using Schön's (1983) metaphor of a '*swampy lowland*' to describe the practice setting (Rolfe & Gardner, 2005, 300). Of this science and its method of knowledge generation, they add:

> *We must refrain from regarding qualitative and reflective research as an inferior 'soft' cousin to the 'hard' sciences. Rather, we must rise to the challenge of developing a complementary 'wet' science, in no way inferior to 'dry' biomedical science, but rather a science attuned to the practice of nursing which can stand side-by-side with medical science without apology or concession* (Rolfe & Gardner, 2005, 300-301).

Even though the above extracts could be read as privileging knowledge generated by qualitative research and reflective practice in a nursing science of unique persons, this proves not to be the case. In terms of evidence upon which to base practice, it seems that knowledge generated in the practice context is limited in the same way as research findings generated by randomised controlled trials. This is

so, the authors argue, because the word 'evidence', as used in 'evidence-based practice', is used incorrectly. Rolfe & Gardner (2005, 305) assert that the original meaning of the word 'evidence' is '*the outwardly visible sign of an event, an indication that the event has taken place*'. Therefore, evidence cannot precede an event; it can only follow it. Correctly used, then, the word evidence means '*evidence **from** or evidence **of***' (Rolfe & Gardner, 2005, 305). (Rolfe & Gardner's emphases), and not evidence **for**, as it is used to signify in the context of evidence-based practice. That being the case, no source of knowledge, however compatible and consistent it may be with a nursing science of the unique person, qualifies as evidence for practice. Among the potential sources of knowledge listed are: '*findings from qualitative or quantitative research, findings from reflection on our practice, knowledge that we have about this particular patient, our 'gut feelings' (intuition), or the accumulated experience of colleagues and other professionals*' (Rolfe & Gardner, 2005, 306), the latter sources constituting what the authors refer to as a '*rich accumulation of experiential knowledge*' (Rolfe & Gardner, 2005, 306). All are to be regarded equally, not as evidence for practice but, rather, as motivating certain actions and behaviours in unique practice situations. The practitioner is not compelled to act on research findings, or knowledge from any other source, because there is no '*logical*' connection between such sources and unique practice situations (Rolfe & Gardner, 2005, 306). This lack of any logical connection between sources of knowledge and the unique situations of practice is elaborated as follows:

> *...if each and every therapeutic encounter is unique, then we simply have no way of predicting its outcome in advance and hence no way of deciding what might be the most effective intervention. Statistical generalisations such as those produced by RCTs are of little use because the laws of probability do not apply in individual cases.*

> *But, by the same logic, the naturalistic generalisations of 'fittingness' (Sandelowski, 1986) or 'transferability' (Guba and Lincoln, 1989) from one case to another as advocated by qualitative researchers and reflective practitioners also do not apply if every case really is unique. An ethnographic study of a particular ward culture will only have limited application to a different ward; a phenomenological study of the lived experiences of 10 nurses will not necessarily apply to an eleventh nurse; a reflection on my experiences with a particular patient will not necessarily tell me very much about even my next encounter with the same patient* (Rolfe & Gardner, 2005, 304-305).

All sources of knowledge, or what may otherwise be regarded as evidence, serve as '*clues*' to the interventions appropriate in each '*unique clinical situation*' (Rolfe & Gardner, 2005, 307). This is merely a first step in evidence-based practice in nursing as a science of the unique person (Rolfe & Gardner, 2005). 'Evidence' in the true meaning of the term comes from reflecting in and on the unique clinical situation.

> *Our initial nursing intervention is therefore motivated by some or all of these sources of knowledge, but as we have seen, they can only give clues to the unique clinical situation we find ourselves in. Importantly, then, we must seek feedback on the effects of our action and modify it accordingly. This initial feedback is, according to our definition, the first firm evidence that we have specifically about this unique situation, and is then used to affirm or disconfirm our initial motivation, which in turn directs our subsequent actions* (Rolfe & Gardner, 2005, 307).

The authors represent their conceptualisation of evidence-based practice in a model which is reproduced in Figure 9.2 below.

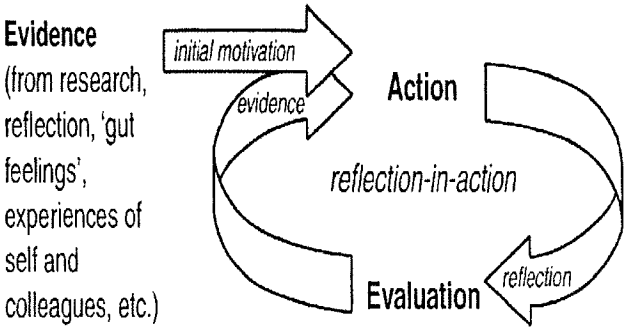

Figure 9.2: A reflective/reflexive model of evidence-based practice (Source: Rolfe & Gardner, 2005, 307).

In the list of evidences on the left hand side of the model, research features first. The arrow which directs '*Evidence*' towards '*Action*' and is labelled '*initial motivation*' overlaps slightly with the curved arrow labelled '*evidence*' (Rolfe & Gardner, 2005, 307). This 'evidence', if the logic of Rolfe & Gardner's (2005) argument is followed closely, becomes part of the initial motivation for a subsequent action or nursing intervention, so an overlap is appropriate although it could perhaps be of a greater magnitude than represented in the model. 'Evidence' functions as evidence only in the context of a unique clinical encounter or situation. Even in a subsequent encounter between the same nurse and the same patient, the evidence from the first episode of care can provide no stronger motivation for action than any of the other sources of knowledge because the next episode of care is also to be regarded as unique. Since no knowledge source is privileged in the reflexive model of evidence-based care, and since evidence is generated in, and limited to, each unique clinical situation, it appears that multiple research methodologies that generate multiple sources of knowledge are required for nursing practice.

Rolfe & Gardner's (2005) insistence on using the word 'evidence' in its correct and original meaning is accompanied by relatively loose use of other terminology. For example, the terms 'nursing intervention' and 'interpersonal interaction' are used synonymously in the context of the argument for the inappropriateness of

generalisable knowledge in person-centred nursing practice. The word 'intervention' connotes a deliberate action which is planned in advance and could apply to many patients in similar circumstances, whereas the term 'interpersonal interaction' suggests a more immediate reciprocal activity which cannot be planned fully in advance but must evolve over the duration of the encounter. If a distinction is drawn between a nursing intervention and an interpersonal interaction, then it could be argued that generalisable knowledge is appropriate as a basis for a nursing intervention whereas it may be of more limited use in informing an interpersonal interaction. The other instance where terminology is conflated is in relation to qualitative research and reflection. These terms are frequently co-located in the text, for example, '*reflective practice and even qualitative research are barely tolerated*' (Rolfe & Gardner, 2005, 299); '*refrain from regarding qualitative and reflective research as inferior*' (Rolfe & Gardner, 2005, 300); '*qualitative and reflective methodologies which **do** address questions*' (Rolfe & Gardner, 2005, 303) (Rolfe & Gardner's emphasis); and, '*advocated by qualitative researchers and reflective practitioners*' (Rolfe & Gardner, 2005, 304), which creates an effect of sameness or similarity between the two terms. When it comes to explaining how 'evidence' is generated from practice, the terms 'reflection' and 'qualitative research' are used synonymously as indicated in the extracts below:

> *Evidence-based practice is therefore a reflective/reflexive cycle in which we are gradually modifying our responses in the light of immediate feedback (Figure 1). This process has been variously referred to as reflection-in-action (Schön, 1983), nursing praxis (Rolfe, 1996) and action research (McNiff, 1993; Rolfe, 1998).*

Although some writers have described such a process as the artistry of nursing (Picard, 1995; Johns, 2001), our view is that it is part of a long scientific tradition of single-case experimentation which involves forming and testing hypotheses and theory-generation. Indeed, Schön (1983) refers to this process as 'experimenting-in-action', adding that 'when someone reflects-in-action, he becomes a researcher in the practice context'. Such research 'in the practice context' that is also a component of practice itself is, for us, the most valid and important form of research for the generation of evidence from practice.

...'small scale' research projects can be the personal reflective evaluations of practitioners of the consequences of their own interventions as part of an ongoing sequence of actions and evaluation of those actions. Evidence-based practice is therefore elevated from a dry, dispassionate judgement about research validity prior to and remote from the practice setting, to a series of on-the-spot reflective clinical judgements made in the midst of an evolving practice situation (Rolfe & Gardner, 2005, 307-308).

A preference for viewing reflection-in-action as '*part of a long scientific tradition*' rather than as '*the artistry of nursing*' would indicate that a choice is possible between two different meanings of the term, as art and science are generally opposed to each other. Artistry might be more readily identified with what happens in evolving situations of practice. That the authors opt to align reflection-in-action with the scientific tradition and make it indistinguishable from case study method may be indicative of a concern that, as artistry, the claim that reflection-in-action is the most valid and important form of research for the generation of evidence from practice might be more easily dismissed. Earlier in the article, the authors expressed criticism of the Editor of '***Qualitative Health Research***' journal for dismissing *'invention, imagination and 'alternative' forms of representation such as narrative*' in qualitative inquiry (Rolfe & Gardner, 2005, 299). In an opinion attributed to the Editor, such approaches tended to make qualitative research less acceptable to the scientific community. Although critical of this narrow view of qualitative inquiry, Rolfe & Gardner's (2005) own argument is presented in a

language of which the Editor of '***Qualitative Health Research***' journal would undoubtedly approve.

In the conclusion to the article, the authors describe reflection as '*at the heart*' of evidence-based practice (Rolfe & Gardner, 2005, 308); they add: '*In particular, we have asserted that it makes as little sense to demand RCT evidence for the effectiveness of reflection as it does to demand reflective evidence for the effectiveness of RCT*'. However, if the reflective/reflexive model of evidence-based practice is consulted, it seems clear that reflective evidence is demanded for the effectiveness of RCT. In the unique patient encounter, evidence from RCT may be used as initial motivation for action. The process of reflection-in-action then determines whether that initial motivation was appropriate. Therefore it seems reasonable to suggest that it is via the reflective process that evidence of RCT effectiveness is established.

As in the previous chapter, it seems difficult to maintain the distinction between propositional and reflective knowledge in nursing texts. While separation is being asserted, the texts appear to describe something other.

Chapter 10 Conclusion

This study set out to examine the textual construction of reflective practice as a model of professional knowledge in nursing education. Reflective practice originated as a new epistemology of practice, one that sought to legitimise practical knowledge and to challenge the hegemony of the dominant model of professional knowledge in practice disciplines. Deconstruction was chosen as the research methodology for the study. This approach involves a close, patient, fine-grained reading of selected texts; a reading that is attentive to all possible meaning-creating textual and linguistic resources. As indicated in Chapter 4, the aim of a deconstructive reading is not to arrive at some new theory or set of themes. However, certain threads appear to run through and connect the readings undertaken in previous chapters. An attempt is now made to describe this reading 'otherwise' and to identify the potential implications for nursing knowledge and nursing education.

All of the texts analysed suggest that reflective practice as a model of professional knowledge in nursing education does not escape the shadow of the dominant epistemology of practice. In the writings of Schön (1983), which so influenced nursing education's subsequent espousal of reflective practice, the model of technical rationality appears implicated in the new epistemology of practice. Although insisting on differences between these two epistemologies, the texts appear to rebel against their author's stated intention. Just as the writer endorses reflective practice as distinct from the model of technical rationality, the signifier betrays another meaning. Johnson (1994, 86) remarks: *'...there is not really an outside to the discourse...we are all in it...some of the discourses that would like to oppose dominant discourse from the outside don't recognize the ways in which their formulations of the issues are drawing massively on concepts that themselves are central to the tradition'.*

Likewise, in the texts drawn from the nursing literature, the binary oppositions, upon which the unique identity of reflective practice as a model of professional knowledge in nursing education depends, are shown to be characterised by instability. Referring to Derrida's reading of Rousseau's text, Johnson remarks: '*...Rousseau's text functions* ***against*** *its own explicit (metaphysical) assertions, not just by creating ambiguity, but by inscribing a* ***systematic*** *"other message" behind or through what is being said*' (Derrida, 2004a, xiii-xiv, Translator's Introduction) (Johnson's emphases). All of the authors whose work has been analysed in the final two chapters of the thesis declare that reflective practice, unlike the model of technical rationality, is an epistemology congruent with nursing philosophy and capable of creating knowledge from, and for, nursing practice. However, it becomes clear in a deconstructive reading that their descriptions do not always match their declarations. The model of technical rationality remains detectable, and implicated, in textual constructions of reflective practice, creating effects of which the authors seem, at least consciously, unaware.

In terms of nursing knowledge, reflective practice, so this reading 'otherwise' would suggest, does not appear anywhere punctually present, as a self-identical entity, in the texts that strive to construct its identity. Its identity is complicated by that which it seeks to exclude, that which is posited as its 'other'. The distinction between the two epistemologies – reflective practice and the model of technical rationality - does not hold. What is thereby created could be said to be more than the opposition allows.

The implications of this reading for nursing education would appear to dictate a cautious stance in the face of any theory that is presented as self-enclosed and definitive. This does not however mandate inaction. Johnson (1994, 82) refers to undecidability and deconstruction as not '*the unmistakable sign of the privilege of those who can afford not to know*'. She adds that undecidability *'won't tell us what to do...But just saying* ***that*** *won't either. Theoretical statements, whether about decision or about undecidability, are all equally detached from any* ***particular*** *intervention*' (Johnson, 1994, 84) (Johnson's emphases). Classes must still be given and nurses must still function in the service of their patients, clients, families and

wider society. What a deconstructive reading does offer nursing knowledge and nursing education, I should contend, is another way of examining concepts and theories, permitting searching questions to be asked, and presuppositions and assumptions to be revealed. As indicated already in earlier chapters, a deconstructive reading "sounds" a lot like reflective practice.

From my own personal perspective as a nurse, a midwife, and a teacher, I have learned from doing this research to what extent, in my interaction with textual material, I read for meaning. I am also very aware now of the extent to which I pass over, ignore or otherwise edit out textual features that I take to be insignificant, and how I reconcile what appear to be quite obvious discordant elements with what I take to be the main theme of the writing. I am also very aware now of how I may have too hastily dismissed constructions of reflective practice that differed from my own, and the extent to which those constructions and conceptualisations have validity had I the openness and curiosity to pursue them further. Commenting on how social change may be accomplished, Johnson (1994, 86) states: *'if intellectual patterns have any determining effect on the way people live...then working on how the reflexes of thinking are inculcated might have an impact'*. Derrida's ideas and writings, and the writings of those who have rendered his original texts accessible to the average reader, among whom I include myself, have opened up new, exciting, and productive avenues of inquiry for me. The sense of possibilities created - other ways of seeing and doing – is, in my opinion, most liberating, democratic, and consistent with what is best in any educational endeavour.

I cannot conclude finally without drawing attention to the contradiction at the heart of the study itself. The text is a blending of two styles: an earlier part which consists of propositions, assertions and other performative statements, and a later part which attempts to unsettle assertions and declarations. It might perhaps have been more consistent to include only deconstructive readings of texts. However, I invite readers to read this writing deconstructively, both the earlier chapters and, indeed, the later ones. As Sturrock (2003, 140) points out: *'the necessary work of*

confusion and misapprehension will be done by language, in all its glorious autonomy.'

References

Abel-Smith, A. (1960). *A History of the Nursing Profession*. London: Heinemann.

Aggleton, P., & Chalmers, H. (1986). *Nursing Models and the Nursing Process*. Basingstoke: Macmillan.

Aggleton, P., & Chalmers, H. (2000). *Nursing Models and Nursing Practice* (2nd ed.). Basingstoke: Macmillan Press Ltd.

Alligood, M. R., & Marriner Tomey, A. (2006). *Nursing Theory: Application & Utilization* (3rd ed.). St. Louis: Elsevier Mosby.

An Bord Altranais. (1994). *The Future of Nurse Education and Training in Ireland*. Dublin: ABA.

An Bord Altranais. (1999). Requirements and standards for nurse registration programmes. Dublin: ABA.

An Bord Altranais. (2000). Scope of nursing and midwifery practice framework. Dublin: ABA.

An Bord Altranais. (2003). Guidelines on the key points that may be considered when developing a quality clinical learning environment. Dublin: ABA.

Atkins, S., & Murphy, K. (1993). Reflection: a review of the literature. *Journal of Advanced Nursing, 18*, 1188-1192.

Avis, M., & Freshwater, D. (2006). Evidence for practice, epistemology, and critical reflection. *Nursing Philosophy, 7*(4), 216-224.

Bally, C., Sechehaye, A., & Riedlinger, A. (Eds.). (1986). *Ferdinand de Saussure Course in General Linguistics* (3rd ed.). Chicago and La Salle: Open Court.

Baly, M. (1973). *Nursing and Social Change*. London: Heinemann.

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

Benner, P. (2001). *From Novice to Expert. Excellence and power in clinical nursing practice. Commemorative Edition*. New Jersey: Prentice Hall.

Bennington, G. (2000). *Interrupting Derrida*. London: Routledge.

Bennington, G., & Derrida, J. (1993). *Jacques Derrida* (G. Bennington, Trans.). Chicago: The University of Chicago Press.

Bonis, S. A. (2009). Knowing in nursing: a concept analysis. *Journal of Advanced Nursing, 65*(6), 1328-1341.

Boud, D., Keogh, R., & Walker, D. (Eds.). (1985). *Reflection: turning experience into learning*. London: Kogan Page Ltd.

Boud, D., & Walker, D. (1998). Promoting reflection in professional courses: the challenge of context. *Studies in Higher Education, 23*(2), 191-206.

Boyd, E. M., & Fales, A. W. (1983). Reflective learning: key to learning from experience. *Journal of Humanistic Psychology, 23*(2), 99-117.

Briggs, A. (1972). *Report of the Committee on Nursing*. London: HMSO.

Brookfield, S. D. (1995). *Becoming a Critically Reflective Teacher*. San Francisco: Jossey-Bass Publishers.

Caputo, J. D. (Ed.). (1997). *Deconstruction in a Nutshell. A conversation with Jacques Derrida*. New York: Fordham University Press.

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

Carroll, D. P. (Ed.). (1992). *Notes on Nursing by Florence Nightingale* (Commemorative ed.). Philadelphia: J.B. Lippincott Company.

Carroll, M., Curtis, L., Higgins, A., Nicholl, H., Redmond, R., & Timmins, F. (2002). Is there a place for reflective practice in the nursing curriculum? *Nurse Education in Practice, 2*(1), 13-20.

Chinn, P. L., & Kramer, M. K. (2004). *Integrated Knowledge Development in Nursing* (6th ed.). St. Louis: Mosby.

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.

Commission on Nursing. (1998). Report of the Commission on Nursing. A blueprint for the future. Dublin: The Stationery Office.

Cooney, A. (1999). Reflection demystified: answering some common questions. *British Journal of Nursing, 8*(22), 1530-1534.

Cotton, A. H. (2001). Private thoughts in public spheres: issues in reflection and reflective practices in nursing. *Journal of Advanced Nursing, 36*(4), 512-519.

Culler, J. (2008). *On Deconstruction. Theory and Criticism after Structuralism* (25th Anniversary ed.). London: Routledge.

Cullum, N., Ciliska, D., Haynes, R. B., & Marks, S. (Eds.). (2008). *Evidence-Based Nursing. An Introduction.* Oxford: Blackwell Publishing Ltd.

Derrida, J. (1973). *Speech and Phenomena and other Essays on Husserl's Theory of Signs* (D. B. Allison, Trans.). Evanston: Northwestern University Press.

Derrida, J. (1977). *Limited Inc* (S. Weber, Trans.). Evanston: Northwestern University Press.

Derrida, J. (1982). *Margins of Philosophy* (A. Bass, Trans.). Chicago: The University of Chicago Press.

Derrida, J. (1997). *Of Grammatology* (G. C. Spivak, Trans. Corrected ed.). Baltimore: The Johns Hopkins University Press.

Derrida, J. (2001). *Writing and Difference* (A. Bass, Trans.). London: Routledge Classics.

Derrida, J. (2004a). *Dissemination* (B. Johnson, Trans.). London: Continuum.

Derrida, J. (2004b). *Positions* (A. Bass, Trans. 3rd ed.). London: Continuum.

Deutscher, P. (2005). *How to Read Derrida.* London: Granata Books.

Dewey, J. (1933). *How we Think. A restatement of the relation of reflective thinking to the educative process.* Lexington, Massachusetts: D.C. Heath and Company.

Duffy, A. (2007). A concept analysis of reflective practice: determining its value to nurses. *British Journal of Nursing, 16*(22), 1400-1407.

Duke, S., & Appleton, J. (2000). The use of reflection in a palliative care programme: a quantitative study of the development of reflective skills over an academic year. *Journal of Advanced Nursing, 32*(6), 1557-1568.

Durgahee, T. (1996). Promoting reflection in post-graduate nursing: a theoretical model. *Nurse Education Today, 16*, 419-426.

Eraut, M. (1994). *Developing Professional Knowledge and Competence.* London: The Falmer Press.

EU Directive 77/453/eec. Retrieved 16 January, 2012, from **http://eur-lex.europa.eu/smartapi/cgi/sga_doc?smartapi!celexapi!prod!CELEXnumdoc&numdoc=31977L0452&model=guichett&lg=en**

EU Directive 89/595/eec. Retrieved 19 January, 2012, from **http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:31989L0048:EN:HTML**

Fawcett, J. (2005). *Contemporary Nursing Knowledge. Analysis and Evaluation of Nursing Models and Theories* (2nd ed.). Philadelphia: F.A. Davis Company.

Fealy, G. M. (2006). *A History of Apprenticeship Nurse Training in Ireland.* London: Routledge.
Fealy, G. M. (Ed.). (2005). *Care to Remember. Nursing and Midwifery in Ireland.* Cork: Mercier Press.
Fowler, J. (2006). The importance of reflective practice for nurse prescribers. *Nurse Prescribing, 4*(3), 103-106.
Gasché R. (1986). *The Tain of the Mirror. Derrida and the Philosophy of Reflection.* Cambridge, Massachusetts: Harvard University Press.
Ghaye, T., & Lillyman, S. (2000). *Reflection: Principles and Practice for Healthcare Professionals.* Wiltshire: Quay Books.
Gilbert, T. (2001). Reflective practice and clinical supervision: meticulous rituals of the confessional. *Journal of Advanced Nursing, 36*(2), 199-205.
Glaze, J. E. (2001). Reflection as a transforming process: student advanced nurse practitioners' experiences of developing reflective skills as part of an MSc programme. *Journal of Advanced Nursing, 34*(5), 639-647.
Glendinning, S. (Ed.). (2001). *Arguing with Derrida.* Oxford: Blackwell Publishers.
Greenwood, J. (1993). Some considerations concerning practice and feedback in nursing education. *Journal of Advanced Nursing, 18*, 1999-2002.
Gustafsson, C., & Fagerberg, I. (2004). Reflection, the way to professional development? *Journal of Clinical Nursing, 13*, 271-280.
Hannigan, B. (2001). A discussion of the strengths and weaknesses of 'reflection' in nursing practice and education. *Journal of Clinical Nursing, 10*, 278-283.
Hargreaves, J. (2004). So how do you feel about that? Assessing reflective practice. *Nurse Education Today, 24*(3), 196-201.
Heath, H. (1998). Reflections and patterns of knowing in nursing. *Journal of Advanced Nursing, 27*(5), 1054-1060.
Heilbronn, R. (2008). *Teacher Education and the Development of Practical Judgement.* London: Continuum International Publishing Group.
Howells, C. (1998). *Derrida. Deconstruction from Phenomenology to Ethics.* Malden: Polity Press.
Hunter, L. A. (2008). Stories as integrated patterns of knowing in nursing education. *International Journal of Nursing Education Scholarship, 5*(1), 1-13.
Hyde, A. (2009). Thought piece: reflective endeavours and evidence-based practice: directions in health sciences theory and practice. *Reflective Practice, 10*(1), 117-120.
James, C. R., & Clarke, B. A. (1994). Reflective practice in nursing: issues and implications for nurse education. *Nurse Education Today, 14*, 82-90.
Jarvis, P. (1992). Reflective practice and nursing. *Nurse Education Today, 12*(3), 174-181.
Johns, C. (1995a). Framing learning through reflection within Carper's fundamental ways of knowing in nursing. *Journal of Advanced Nursing, 22*, 226-234.
Johns, C. (1995b). The value of reflective practice for nursing. *Journal of Clinical Nursing, 4*, 23-30.
Johns, C. (1999). Reflection as empowerment? *Nursing Inquiry, 6*, 241-249.
Johns, C. (2001). Reflective practice: revealing the (he)art of caring. *International Journal of Nursing Practice, 7*, 237-245.
Johns, C. (2009). *Becoming a Reflective Practitioner* (3rd ed.). Chichester Wiley-Blackwell.
Johnson, B. (1980). *The Critical Difference. Essays in the contemporary rhetoric of reading.* Baltimore: The Johns Hopkins University Press.

Johnson, B. (1987). *A World of Difference*. Baltimore: The Johns Hopkins University Press.
Johnson, B. (1994). *The Wake of Deconstruction*. Oxford: Blackwell Publishers.
Kershaw, B., & Salvage, J. (Eds.). (1986). *Models for Nursing*. Chichester: John Wiley & Sons.
King, P. M., & Kitchener, K. S. (1994). *Developing Reflective Judgement*. San Francisco: Jossey-Bass Publishers.
Kinsella, E. A. (2007). Technical rationality in Schon's reflective practice: dichotomous or non-dualistic epistemological position. *Nursing Philosophy, 8*, 102-113.
Kinsella, E. A. (2009). Professional knowledge and the epistemology of reflective practice. *Nursing Philosophy, 11*, 3-14.
Kolb, D. A. (1984). *Experiential Learning. Experience as the source of learning and development*. New Jersey: Prentice Hall.
Lentricchia, F., & McLaughlin, T. (Eds.). (1995). *Critical Terms for Literary Studies* (2nd ed.). Chicago: The University of Chicago Press.
Liimatainen, L., Poskiparta, M., Karhila, P., & Sjogren, A. (2001). The development of reflective learning in the context of health counselling and health promotion during nurse education. *Journal of Advanced Nursing, 34*(5), 648-658.
Luntley, M. (2010). What do nurses know? *Nursing Philosophy, 12*, 22-33.
Maggs, C. J. (1983). *The Origins of General Nursing*. London: Croom Helm.
Mantzoukas, S. (2007). Reflection and problem/enquiry-based learning: confluences and contradictions. *Reflective Practice, 8*(2), 241-253.
Mantzoukas, S., & Jasper, M. (2004). Reflective practice and daily ward reality: a covert power game. *Journal of Clinical Nursing, 13*, 925-933.
Marriner Tomey, A., & Alligood, M. R. (2006). *Nursing Theorists and their Work* (6th ed.). St. Louis: Mosby Elsevier
McKenna, H. (1997). *Nursing Theories and Models*. London: Routledge.
Meerabeau, L. (1992). Tacit nursing knowledge: an untapped resource or a methodological headache? *Journal of Advanced Nursing, 17*, 108-112.
Meleis, A. I. (2012). *Theoretical Nursing. Developments & Progress* (5th ed.). Philadelphia: Wolters Kluwer Health / Lippincott Williams & Wilkins.
Melnyk, B. M., & Fineout-Overholt, E. (2011). *Evidence-based Practice in Nursing and Healthcare. A Guide to Best Practice* (2nd ed.). Philadelphia: Wolters Kluwer Health / Lippincott Williams and Walkins.
Mezirow, J. (1981). A critical theory of adult learning and education. *Adult Education, 32*(1), 3-24.
Mezirow, J. (1990). *Fostering Critical Reflection in Adulthood. A guide to transformative and emancipatory learning*. San Francisco: Jossey-Bass Publishers.
Moon, J. A. (1999). *Reflection in Learning and Professional Development. Theory & Practice*. Abingdon: RoutledgeFalmer.
Munhall, P. L. (1993). 'Unknowing': toward another pattern of knowing in nursing. *Nursing Outlook, 41*(3), 125-128.
Nelson, S. (2012). The lost path to emancipatory practice: towards a history of reflective practice in nursing. *Nursing Philosophy, 13*, 202-213.
Newell, R. (1992). Anxiety, accuracy and reflection: the limits of professional development. *Journal of Advanced Nursing, 17*, 1326-1333.
Nicholl, H., & Higgins, A. (2004). Reflection in preregistration nursing curricula. *Journal of Advanced Nursing, 46*(6), 578-585.

Nielsen, A., Stragnell, S., & Jester, P. (2007). Guide for reflection using the clinical judgement model. *Journal of Nursing Education, 46*(11), 513-516.
Norris, C. (2002). *Deconstruction. Theory and Practice* (3rd ed.). London: Routledge.
Nursing and Midwifery Council. (2002). *Supporting nurses and midwives through lifelong learning*. London: NMC.
Nursing and Midwifery Council. (2004). Standards of proficiency for pre-registration nursing education. London: NMC.
Nursing and Midwifery Council. (2006). The PREP Handbook. London: NMC.
O'Connor, A., & Hyde, A. (2005). Teaching reflection to nursing students: a qualitative study in an Irish context. *Reflective Practice, 42*(4), 291-303.
Paget, T. (2001). Reflective practice and clinical outcomes: practitioners' views on how reflective practice has influenced their clinical practice. *Journal of Clinical Nursing, 10*(2), 204-214.
Parahoo, K. (2006). *Nursing Research. Principles, Process and Issues* (2nd ed.). London: Palgrave Macmillan.
Pearson, A., Vaughan, B., & FitzGerald, M. (2005). *Nursing Models for Nursing Practice* (3rd ed.). Edinburgh: Butterworth Heinemann.
Peters, M. A., & Biesta, G. (2009). *Derrida, Deconstruction, and the Politics of Pedagogy*. New York: Peter Lang Publishing.
Picard, C., & Henneman, E. A. (2007). Theory-guided evidence-based reflective practice: an orientation to education for quality care. *Nursing Science Quarterly, 20*(1), 39-42.
Pierson, W. (1998). Reflection and nursing education. *Journal of Advanced Nursing, 27*, 165-170.
Platzer, H., Blake, A., & Ashford, D. (2000). An evaluation of process and outcomes from learning through reflective practice groups on a post-registration nursing course. *Journal of Advanced Nursing, 31*(3), 689-695.
Platzer, H., Blake, D., & Snelling, J. (1997). A review of research into the use of groups and discusion to promote reflective practice in nursing. *Research in Post-Compulsory Education, 2*(2), 193-204.
Porter, S. (2010). Fundamental patterns of knowing in nursing. The challenge of evidence-based practice. *Advances in Nursing Science, 33*(1), 3-14.
Porter, S., & O'Halloran, P. (2009). The postmodernist war on evidence-based practice. *International Journal of Nursing Studies, 46*, 740-748.
Powell, J. H. (1989). The reflective practitioner in nursing. *Journal of Advanced Nursing, 14*, 824-832.
Royal College of Nursing. (1985). *The Education of Nurses: A New Dispensation. Report of RCN Commission on Nursing Education*. London: RCN.
Reece Jones, P. (1995). Hindsight bias in reflective practice: an empirical investigation. *Journal of Advanced Nursing, 21*, 783-788.
Reid, B. (1993). 'But we're doing it already!' Exploring a response to the concept of Reflective Practice in order to improve its facilitation. *Nurse Education Today, 13*, 305-309.
Richardson, G., & Maltby, H. (1995). Reflection-on-practice: enhancing student learning. *Journal of Advanced Nursing, 22*, 235-242.
Richardson, R. (1995). Humpty Dumpty: reflection and reflective practice in nursing. *Journal of Advanced Nursing, 21*, 1044-1050.
Risjord, M. (2010). *Nursing Knowledge. Science, Practice, and Philosophy*. Chichester, West Sussex: Wiley-Blackwell.

Rolfe, G. (1997). Beyond expertise: theory, practice and the reflexive practitioner. *Journal of Clinical Nursing, 6*, 93-97.
Rolfe, G. (2002). Reflective Practice: where now? *Nurse Education in Practice, 2*(1), 21-29.
Rolfe, G., Freshwater, D., & Jasper, M. (2001). *Critical Reflection for Nursing and the Helping Professions*. Basingstoke Palgrave.
Rolfe, G., & Gardner, L. (2005). Towards a nursing science of the unique. *Journal of Research in Nursing, 10*(3), 297-310.
Roper, N., Logan, W., & Tierney, A. J. (2003). *The Roper Logan Tierney Model of Nursing*. Edinburgh: Churchill Livingstone Elsevier.
Royle, N. (Ed.). (2000). *Deconstructions. A User's Guide*. Basingstoke: Palgrave.
Ryan, D. (2008). Third-level nurse education: learning from the Irish Experience. *British Journal of Nursing, 17*(22), 1402-1407.
Rycroft-Malone, J., Seers, K., Titchen, A., Harvey, G., Kitson, A., & McCormack, B. (2004). What counts as evidence in evidence-based practice? *Journal of Advanced Nursing, 47*(1), 81-90.
Ryle, G. (1949). *The Concept of Mind*. London: Penguin.
Sackett, D. L., Rosenberg, W. M. C., Muir Gray, J. A., Haynes, R. B., & Richardson, W. S. (1996). Evidence based medicine: what it is and what it isn't. *British Medical Journal, 312*(7023), 71-72.
Saylor, C. R. (1990). Reflection and professional education: art, science, and competency. *Nurse Educator, 15*(2), 8-11.
Scanlan, J. M., Care, W. D., & Udod, S. (2002). Unravelling the unknowns of reflection in classroom teaching. *Journal of Advanced Nursing, 38*(2), 136-143.
Scanlan, P. (1991). *The Irish Nurse. A Study of Nursing in Ireland: History and Education 1718-1981*. Manorhamilton, Co. Leitrim: Drumlin Publications Limited.
Schön, D. A. (1983). *The Reflective Practitioner. How Professionals Think in Action*. USA: Basic Books.
Selden, R. (Ed.). (1995). *The Cambridge History of Literary Criticism. Volume VIII. From Formalism to Poststructuralism*. Cambridge: Cambridge University Press.
Silverman, H. J. (Ed.). (1989). *Derrida and Deconstruction*. New York Routledge.
Simons, H., Clarke, J. B., Gobbi, M., Long, G., Mountford, M., & Wheelhouse, C. (1998). *Nurse Education and Training Evaluation in Ireland. Independent External Evaluation. Final Report*. Southampton: University of Southampton.
Smith, P., James, T., Lorentzon, M., & Pope, R. (Eds.). (2004). *Shaping the Facts: Evidence-based Nursing and Health Care*. Edinburgh: Churchill Livingstone.
Stocker, B. (2006). *Routledge Philosophy Guidebook to Derrida on Deconstruction*. Abingdon, Oxon: Routledge
Sturrock, J. (2003). *Structuralism*. Malden: Blackwell Publishing.
Sturrock, J. (Ed.). (1979). *Structuralism and Since. From Levi Strauss to Derrida*. Oxford: Oxford University Press.
Taylor, C. (2003). Narrating practice: reflective accounts and the textual construction of reality. *Journal of Advanced Nursing, 42*(3), 244-251.
Teekman, B. (2000). Exploring reflective thinking in nursing practice. *Journal of Advanced Nursing, 31*(5), 1125-1135.
United Kingdom Central Council for Nursing, Midwifery and Health Visiting. (1986). *Project 2000: a new preparation for practice*. London: UKCC.
van der Peet, R. (1995). *The Nightingale Model of Nursing*. Edinburgh: Campion Press.

Weber, E. (Ed.). (1995). *Points...Interviews, 1974-1994 Jacques Derrida*. Stanford: Stanford University Press.

Wellard, S. J., & Bethune, E. (1996). Reflective journal writing in nurse education: whose interests does it serve? *Journal of Advanced Nursing, 24*, 1077-1082.

White, J. (1995). Patterns of knowing: Review, critique, and update. *Advances in Nursing Science, 17*(4), 73-86.

Wong, F. K. Y., Kember, D., Chung, L. Y. F., & Yan, L. (1995). Assessing the level of student reflection from reflective journals. *Journal of Advanced Nursing, 22*, 48-57.