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Clinical Epistemology: A Dialectic of Nursing Assessment

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L'évaluation clinique des soins infirmiers allie une connaissance générale basée sur la théorie à la recherche basée sur la connaissance particulière que l'on a d'un malade. On doit faire un compte rendu philosophique de cette synthèse pour élucider le paradoxe d'une connaissance à la fois générale et particulière. La méthode exposée dans le présent document est un modèle dialectique de connaissance clinique qui mène à une sécurité existentielle plutôt qu'à une certitude épistémique. Dans ce modèle, l'évaluation des soins infirmiers consiste à montrer comment l'on passe d'une vulnérabilité subjective à travers différents niveaux d'objectivité (désengagement, réduction, holisme) à une intersubjectivité par laquelle l'infirmière et le malade expriment ce qu'ils comprennent de la situation par un récit en relation mutuelle. L'article se termine par une réflexion sur le rôle de la théorie dans un récit clinique complet sur le plan de la dialectique.

Clinical assessment in nursing combines general knowledge from theory and research with particular knowledge about a client. A philosophical account of this synthesis is required to elucidate the paradox of knowledge that is both general and particular. The approach developed here is a dialectical model of clinical knowledge that culminates in existential safety rather than epistemic certainty. In the model, nursing assessment is the progression from subjective vulnerability through levels of objectivity (disengagement, reduction, holism) to an intersubjectivity in which nurse and client express their combined understanding in a relational narrative. The discussion concludes with reflection on the role of theory in a dialectically complete clinical narrative.

Advanced nursing practice is based on expert clinical assessment, combining knowledge from nursing theory and research with knowledge about a specific client. Clinical assessment, in short, creates a synthesis of general and particular knowledge. Underlying advanced practice is the epistemological question that nursing must address: *How* does clinical assessment unite general and particular knowledge?

The answer to that question will have important implications for nursing practice and theory. If nursing assessments are theoretical judgements, they cannot express the particularity of a client's situation, and they fall short of expert practice: "... there is no higher court than the expert's reading of a particular situation" (Benner, 1984, p. 177).

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On the other hand, if clinical knowledge expresses particularity it cannot be theoretical, even though it is theory–based: ". . . there is theory and the use of theory, but no theory of the use of theory" (Jonas 1982, p. 199).

If clinical assessment is indeed a synthesis, it somehow combines general and particular knowledge. Since these are mutually exclusive in most epistemological traditions, nursing assessment evidently represents an advance beyond the traditional dichotomy. What is the philosophical description of that advance? In the following discussion I employ dialectic as the framework for a philosophical account of nursing assessment. In the model I develop, clinical knowledge involves a process in which the very meanings of *general* and *particular* undergo a series of changes, culminating at a level at which knowledge is co-authored by client and nurse together in their relational narrative.

The dialectic framework is especially useful for illuminating a process such as clinical assessment in which the opposition between general and particular is overcome. The concept of dialectic used here is adapted from Hegel's philosophy (1967). For Hegel, the most advanced understanding of a situation is one that achieves completeness through a process wherein each level of understanding evolves as an overcoming of the specific limitation at the former level. The essential point in Hegel's model is that the overall process, not the outcome, of dialectical development is epistemologically complete. The conclusion, apart from the process, has neither truth nor value. Knowledge is complete when it represents a dialectic that incorporates — not omits — opposing elements in the overall progression.

To elaborate the model of clinical knowledge as dialectic, I will describe five levels of nursing assessment and illustrate the client's experience at each level with examples from Arthur Frank's (1992) autobiographical account of illness. Conceptualizing clinical knowledge as a series of levels is a heuristic device; it displays the logic of self-correction whereby knowledge moves from one type of understanding to another. Epistemologically, the dialectic reaches completion only when all of the levels have been opened — *and remain open* — to exploration, not when a series of stages has been followed to its end and earlier levels abandoned.

Vulnerability

Logically, the first level of a dialectic is the level of greatest immediacy. In a clinical situation, immediacy can be translated as urgency. Immediacy characterizes a client's distress when it is not mediated by explanation or intervention. Breathing difficulty, for example, can be an experience of terror when there is no interpretation within which it becomes intelligible. A corresponding immediacy is felt by a nurse who recognizes the person's terror and acts to alleviate the dyspnea without pausing to reflect on etiology.

The importance of this level is clear. Many conditions might be ignored unless urgent symptoms demand attention. Moreover, some symptoms may be so threatening that immediate measures are required before etiology can be addressed.

The limitation at this level is equally clear. Distress cannot always be relieved by mere symptomatic treatment and, even when it is relieved, can mysteriously return. Lacking explanation, illness becomes for the sick person a situation of limitless vulnerability. Frank (1992, p. 27) describes vulnerability as an overwhelming sense of unreality and danger when he was told he had cancer: "The future disappeared . . . I was walking through a nightmare . . . My body had become a kind of quicksand, and I was sinking into myself." A nurse's response to him at this level could take many forms, as immediate as his own experience, as simple as impulsively reaching for his hand.

Disengagement

The dialectic advances when assessment moves beyond immediacy to an interpretive level, by means of disengagement from subjectivity and vulnerability.

With the move to reflective disengagement, experience becomes meaningful for a new reason: not only because it is distressing, but because it refers or signifies. Breathing difficulty is not a problem in itself that demands attention only because of the discomfort it brings. It is a clue that must be investigated to identify an underlying pathology.

Pathologies are general categories. They are the opposite of subjective, particular experience. Disease entities, as abstract categories, transcend the persons who manifest them. Normal conditions, too, are

abstractions, defined objectively: the healthy family, the low-risk pregnancy. The extreme objectivism at this level is the same whether a situation is a case of disease or of health. Either can be translated into "a case of . . . " as a means of understanding it. In that objectification, the subjectivity of the first level is overturned and the client's experience is redescribed in general terms. Knowledge takes the form of the clinical gaze (Foucault, 1975) straining to glimpse the category that will explain, the category for which the case is merely an indicator.

Subjective experience — the basis for knowledge at the first level — is now an impediment to assessment. Understanding requires abstraction from contingencies that obscure the category. Both individuals, the client and the nurse, can be a source of distortion. Personal characteristics have to be ignored, because the focus of knowledge at this level is general, not particular. Disengagement from vulnerability produces knowledge that is entirely impersonal: ". . . *my* body becomes *the* body" (Frank, 1992, p. 12).

The categories seen by the clinical gaze of the nurse will be inaccessible to clients who cannot look beyond the urgency of their experience. For this reason the level of disengagement can involve not only opposition between client subjectivity and nursing objectivity, but conflict between client and nurse. The only reconciliation available at this level is achieved by a client adopting the same disengagement that the nurse uses to maintain a reflective distance from subjectivity. Client and nurse can collaborate in the translation of experience into categories. Frank (1992, p. 10) describes the negotiation: ". . . we talked about my heart as if we were consulting about some computer that was producing errors in the output . . . . Hearing this talk, I knew full well that I was being offered a deal. If my response was equally cool and professional, I would have at least a junior place on the management team. I knew that as a patient's choices go, it wasn't a bad deal."

Translating concrete experience into abstract categories provides a way for both client and nurse to escape the force of subjective immediacy. But in the move from experience to explanation, the person is erased: ". . . the individual must be *subtracted* to understand the disease" (Foucault, 1975, p.14). In disengagement the force of immediacy is countered by a new force, the power of objectification — a force so strong that experience itself can be objectified, reduced to its simplest parts.

Reduction

In conventional medical diagnosis, reductive knowledge is exemplified by the examination of tissue to explain symptoms (Baron, 1985; Foucault, 1975; Leder, 1984). Abstract categories are replaced by concrete phenomena as the basis for diagnostic certainty. Cells, not concepts, are the reality behind a client's condition. The previous level's esoteric essentialism gives way to its opposite, a straightforward positivism. The purest example of medical empiricism is postmortem dissection, the definitive reduction after subjectivity has disappeared altogether.

The fact that nurses typically do not practise reduction in the form of tissue analysis does not prevent them from relying on that reduction as a source of certainty to validate nursing assessments. Nurses as well as physicians may appeal to the pathology report as the authoritative verdict on a client's situation. More importantly, reductionist nursing diagnoses are not limited to physical findings. Other reductions include historical, economic, social, psychological, developmental, and environmental analyses. Clients' conditions can be explained in terms of childhood trauma, nutritional depletion, occupational exposure, etc. In all of its forms, reduction is the reliance upon a single, objectively identifiable element in a client's situation as the basis for diagnostic certainty.

Clients themselves can find reassurance in that certainty, as did Frank (1992, p. 18) during his angiogram: "After months of staring at the abstract cardiograms of my heartbeat, here at last was a chance to see the real thing in action." Reductionism can be defined in no clearer terms than the search for "the real thing" underlying the symptoms and the categories.

When more than one explanatory element is identified, however, certainty is eroded by ambiguity. And if an element is not objectively identifiable, certainty is further compromised. The problem with reduction as a basis for clinical knowledge is that more than one element is always available for interpreting a situation, and many elements may not be verifiable in positivist terms. Reduction, then, far from producing a convincing univocal basis for certainty, produces its opposite: a wealth of possible factors, some objective and others not.

Outside a dialectical model of knowledge, the outcome of reduction would be an impasse, an endless and futile search for the diagnostic touchstone. But viewed dialectically, reduction is not a dead-end.

It carries within it the means for its own correction. Instead of dissecting a situation into a single basic cause — genes, emotions, allergies — reduction reconstitutes the situation as myriad incommensurate causes, all vying for primacy. Originally a device for simplification, for locating the one "real thing," reduction contradicts itself in generating the ingredients for greater complexity. That self-contradiction is the self-correction inherent in reduction, the basis for movement to the next level.

Holism

The level of assessment that emerges from the self-correcting tendency in reduction can be termed holism, the view that definitive knowledge about a situation incorporates knowledge of *all* of the concrete particularities in the situation.

How does the dialectical turn from reduction to holism occur? And why does the turn logically occur after reduction rather than after disengagement? Reduction, like disengagement, abstracts away from the concrete situation. Biopsies examine physical specimens that are as remote from a client's experience as abstract disease categories are. But unlike disengagement, reduction focuses on the individual, looking for explanatory factors within the concrete situation. The biopsied tissue, the childhood trauma, belong to a particular person. The tendency of reduction to refocus inquiry on the individual, combined with its identification of many factors rather than one, is the tendency that leads assessment beyond reduction to holism.

At the level of holistic assessment, there are still persons with empirical lesions, but they are persons who also have families, anxieties, histories, and values (Kramer, 1990). All of the elements in an individual case — elements that reduction has identified — have equal significance initially. None is discounted; each may signal a recurring configuration that will be thematic for interpreting the situation. Holistic assessment can be as comprehensive as the diversity of data permits, encompassing particulars from as many realms of interpretation as can be analyzed in a given case.

Viewing the client's situation as a field in which no single type of data is privileged provides a more comprehensive view than cell pathology, social history, or personality alone. Frank's (1992, p. 112) repudiation of cancer personality theories is a call for a more holistic view: ". . . the genius of the cancer personality argument is that . . . the fault and the fear are safely contained, locked up inside the cancer

patient. Cigarette companies stay in business, polluters can pollute, advertisers can glorify sunbathing, and those who enjoy good health can believe they have earned it. Only the ill are left to feel guilty."

Holistic assessment allows a situation to emerge with more complexity than either reduction or disengagement allows. But like those levels, holism provides only objective knowledge of the person. The client emerges as an object assembled by data analysis, not as a subject encountered by another subject. The person is viewed not as a self-unifying whole but a set of frequencies, a field of elements without intrinsic unity (Callicott, 1986). Enlarging the field of data to include not only cells but emotions, pollutants, and politics corrects reductionism but does not correct objectivism.

In viewing the person as a field of data, the observer decides what constitutes "the whole," with no assurance that the image constructed corresponds to the client's own view. The whole that is described is not yet the client as *self*-interpreting. Holism assumes for the nurse the responsibility for deciding how to reconstruct the whole that reduction dissected. For that reason, holistic knowledge remains objective, and nurse and client remain disengaged. At its objectively most encompassing level, that of holism, clinical assessment must return to its origin — subjective experience — and engage the client as subject through relationship with the nurse as subject.

Engagement

Through engaging the client as author rather than object of the assessment, clinical knowledge moves beyond an objectively constructed image of the whole. Only the client can bring the image to life. Through engagement, the client becomes the person by whom the whole is constituted as meaningful. Meaning is not a final datum the client adds to the nurse's collection. Meaning is the internal coherence of all of the data when interpreted by the client.

Centrality of the client does not mean the dialectic is finished, the nurse dismissed, while a client completes the assessment in isolation. That is the difference between the subjectivity at the two levels of vulnerability and engagement. At the first level a client experiences an immersion in subjectivity. Clinical assessment by the nurse at the three levels of objectivity is the attempt to offer safe passage out of that isolation, into a new and now shared subjectivity at the level of engagement.

Engagement is the intersubjectivity whereby client and nurse become co-authors of a relational narrative (Gadow, 1994), reconstructing the situation as one in which meaning resides. A situation that is meaningful is the only one in which a person can reside. Through the narrative, a situation becomes unified, not objectively but existentially, as a *lived* situation. The assessment narrative that client and nurse together construct can interpret their situation in such a way that it becomes liveable. In Frank's (1992, p. 81) words, "we have to choose carefully which stories to live with, which to use to answer the question of what is happening to us." His own assessment, the "personal mythology of illness" in which he lived, included adventure, exile, medical colonization, admiring wonder toward his body, intimate ceremony around care of his central line, and a belief in "prevailing until the sun rose" (p. 82).

Nursing assessment culminates in participation with clients in revising a situation of vulnerability into one of safety, where it is possible to be at home. Regrettably, in Frank's situation, no nurse seems to have become engaged with him in crafting his personal mythology. No doubt, nurses were involved at other levels of assessment, but none continued through the dialectic to its culmination. It is not difficult to imagine the reason. Modern nursing emphasizes objectification as the means of alleviating vulnerability, and nursing ethics emphasizes autonomous self-determination of the client as individual. The dialectic proposed here includes yet transcends modern objectivism and its ethical corollary, individualism. The dialectic brings nursing beyond modern epistemology to a postmodern level at which subjectivity and relationality are central, and epistemic certainty is neither possible nor desirable.

Implications for Nursing Theory

Clinical assessment can be characterized as the struggle to understand what is happening, "the dialectical or layering process through which knowledge is created" (Lam, 1994, p. 884). Knowledge created in layers requires a continuing synthesis. The relational narrative illustrates the synthesis of layers that are general with those that are particular. A dialectically complete narrative will comprise all of the epistemic layers described above. Moreover, the narrative itself as the embodiment of clinical knowledge is both general and particular. The meaning expressed in the narrative is general in that it transcends the singularity of each author — nurse and client — at the same time that it remains particular to their situation. The narrative embodies their relationship

and thus extends beyond the particularity of either person alone, but it does not extend beyond their relationship. It is, so to speak, general without being generalizable. A relational narrative creates a new objectivity in the form of intersubjectivity, an advance beyond the subjectivity of vulnerability and the antisubjectivity of objectivism.

A new question arises with a dialectical model of clinical knowledge. If the general-particular dichotomy loses its force, what is the role of theory in nursing assessment?

Theory explains phenomena by reference to their general aspects; it abstracts from the particular existence of individuals. It relies, in short, on the force of the dichotomy between general and particular knowledge; it employs only the impersonal voice. Even the particular voice of the theorist as an individual is muted. "Theory speaks of the world as if the world itself were speaking" (Gouldner, 1978, p. 45).

As a form of certainty about the world, theory is a remedy for ambiguity, but it is limited to the layers of general knowledge in dialectical assessment. Thus only the levels of objectification — disengagement, reduction, and holism — lend themselves to theory. No theory of vulnerability can adequately render subjective urgency such as terror or hopelessness. Nor is a theory of engagement possible; the objective voice fades as the personal voices of client and nurse emerge. The clinical knowledge they create — their narrative — will incorporate elements of objectivity, just as a novelist uses words that have general meanings. But the narrative is not a logical derivation from those elements. It is a freely authored interpretation of them.

Freedom of interpretation is possible because more than one meaning for a situation will always be available. Some meanings may seem more compelling than others, but none is intrinsically privileged or correct. Hermeneutically, every situation is open rather than closed. Its meaning is ambiguous, but the ambiguity is not a defect: it is the possibility for freedom, the space in which choice among meanings can occur.

The paradox of dialectical assessment is not only that it culminates in ambiguity rather than certainty, but that in so doing it offers nurse and client a safer narrative in which to locate themselves, existentially, than could be found in objective certainty. That certainty would be bought at the cost of their particularity. Their reality as individuals would be jeopardized as much by the strict objectivity of theory as by

the quicksand of vulnerability. The aim of nursing assessment is to provide safe passage beyond both, through creation of an existential home, a place where client and nurse can belong, a narrative that encompasses the particular as well as the general nature of their situation together.

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