PRACTICAL VISION AND RESEARCH

by

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Contemporary nursing research articles are replete with suggestions relative to the need for, and ways of facilitating, the collaboration of nursing "practitioners" and "researchers" in the conduct of nursing research.[1] This movement can be conceptualized as an attempt to promote some change in the present relationship among nurses which would result in improved nursing practice. Now, the specific types of change sought in dealing with the perceived problem, and the methods employed to achieve these are inexorably linked to the initial interpretation of the problem. This is simply to say that should the rationale behind the need for change be tenuous or based on faulty assumptions, one could question, the validity of the change sought or the efficacy of the methods employed to achieve it or both. In this paper the writer does not take issue with the validity of the change sought: That is, that all nurses be involved in the continuous study of nursing practice. It is rather the way in which the problem to be solved by this change has been interpreted and the methods suggested to achieve this goal which are to be challenged.

Looking first at the nature of the problem. In stating that "practitioners" and "researchers" should be helped to pursue cooperative ventures, one is accepting as fact the idea that nurses are dichotomously distributed between these two roles, or that these are two of a number of mutually exclusive roles assumed by nurses. Practice and research in this model are conceived as "two types of skill" and "two points of view" which must be integrated.

An alliance of practitioners and researchers would, first, reduce something labelled "resistance to change" or "resistance to research" on the part of practitioners and second, permit those who function in the delivery of care to identify the "real" problems for the researcher. It is usually believed that achievement of these goals would enhance the "climate" for research in agencies where nursing is

6

carried out and would decrease the "theory-practice" gap in the practice of nursing. This gap is said to have been created because the researcher is "theoretical" but "flexible", while the practitioner is "practical" but "rigid".

It is not difficult to hypothesize the origins of this practice-research dichotomy. Nursing as an identifiable occupation began more than a century ago. It has always been conceived as "practical" in the sense that the skills and abilities of the nurse have been directed toward solving the actual and immediate health problems of real people. From practice and tradition one learned nursing and provided nursing services in a "service" setting as opposed to an academic one. Concomitantly, scientists in the university were developing something labelled "scientific method", assumed to be the one valid way of acquiring new knowledge in all fields. Problems were selected for their intellectual or heuristic value and the scientific method was "applied to" these problems to render a solution primarily in an area divorced from the real world.

In spite of the evidence suggesting that all contemporary nursing practice and nursing research cannot be aptly described by these two positions, the dichotomous conception continues. Research in nursing is seen as external to the practice of nursing, as applied to it. Researchers in nursing are perceived as applying the method of research to the solution of nursing problems. Validation of this "common-sense" conception of nursing and nursing research has been achieved not only by the parallel but separate development of each, but also by the medical model of care characterized by its orientation to the application of *a priori* knowledge of disease and cure to patients on a one-to-one basis. These factors have had enormous and far-reaching effects upon the development of both practice and research in nursing and the relationship of one to the other.

One of the ways society uses to distinguish and understand differences in type and nature of expertise is through something labelled role differentiation within some system. In concert with the basic thesis that nursing research and nursing practice are inherently different, if not diametrically opposed, it is not surprising that two mutually exclusive roles for practitioner and researcher have been hypothesized. The hand of the social scientist, whose tentative formulations with respect to role theory have since been turned into dogmas, is much in evidence. Like the creation of "community power structures" and "social class", role theory has become fact in the sense that what were to have been general and tentative theoretical constructs became instrumental in creating different nursing roles as a social fact. Moreover, in the application of some theoretical posi-

tions, role is actually perceived as a determinant of behavior. These notions, assuming at least two conflicting and competing positions with respect to the practice of nursing and the study of nursing situations, do in fact help to create the conflict between practitioners and researchers.

So far we have attempted to identify and to challenge the interpretation of the problem as presently perceived. We have done this by noting the tenuous nature of the assumptions on which the interpretation rests. That is, that these two positions may be simply embodiments of theoretical constructs which may no longer be useful for understanding the behaviors of nurses. It is now possible to understand better the techniques and methods utilized to date to solve the problem, for they are all based upon ones commonly employed to bring about a marriage between or among "recognized" diversities.

Everyone reading this paper will be familiar with most or all of the strategies described below to bring practitioners and researchers together for they have been suggested over the years as being effective supervisory tools. Beginning with the famous "Hawthorne Experiments" in the thirties, industrial relations experts have sought to develop ways of bringing about a new relationship between worker and management. Popularized as the "human relations" approach, each "side" seeks to have the other "side", "understand" his role, "participate" in some finite way in his work, "accept" his goals as different but try to achieve a "common purpose" and "support" him in the quest for solutions to his problems. The operative norms are "group dynamics", and "democratic leadership". This is essentially a social explanation of behavior; the notions that the individual is subjugated to the primary informal group, that success is measured by morale or getting along as opposed to accomplishment, and that the non-planned, non-rational elements of organizational behaviors are the important entities to understand. While some of these methods undoubtedly have merit in helping people work together, the assumption that their purpose is to bring about consensus amidst difference, militates against their potential contribution to organizational and personal achievement. At best they can only be perceived as manipulative devices permitting the innate superiority of one side over the other. They have been largely unsuccessful and will surely continue to be unsuccessful in solving the problem of how to promote the development of nursing practice.

We have come full circle. We are left only with the statement at the beginning: that all nurses be involved in the continuous study of nursing practice to promote its development. Is there an alternative, **a more fruitful or meaningful way** to interpret the nature of the

problem and the subsequent methods which might be utilized to achieve its solution?

First we must reject unconditionally all former assumptions with respect to the need for collaboration between dichotomous practitioner-researcher roles and the accompanying polarity of practice and research as variables in understanding nursing behaviors. Instead, we will describe our goal in the following fashion: that All nurses need to be involved in nursing practice, which includes the gathering of information about the nature of the care provided and the assessment of outcomes of care for the persons nursed. In this way, new data are supplied which feed into consequent practice. The nurse whose main function is to care for people uses the new knowledge engendered in this dynamic process in the immediate situation to change and improve the care of the individual. There are others who may take these data as instances of particular cases, which when grouped together over time, lead to more general concepts of care. Development of conceptual models is then possible and, with higher level abstraction, these models may be brought together in the formation of a theory or theories of nursing which may then be tested, elaborated and refined. The notion that the practice of all nurses is part of the same process is basic to the thesis to be explored in this paper. Conceived in this way participation in the process of nursing brings all nurses together in the development of the practice of nursing. To use some very old but still novel ideas of Follett, in working together nurses evoke responses from one another relating to how each sees the situation and its important variables.[2] Through interacting on stage they share experiences directly and indirectly and together they search for emergent ideas with respect to future action. This description of the goal is intrinsically different from that of the goal of collaboration. The latter assumes two rather static positions being brought together. The former assumes a dynamic process of involvement.

This process also differs in important ways from the following example of a common exhortation to nurse researchers. "Much of the distance between nurse researchers and practitioners can be lessened when the researcher is interested in studying problems of practice. Then, the knowledge and abilities of both the researcher and the practitioner become relevant to one another. . . At least an occasional contact with patients in the role of a nurse is both stimulating and clarifying."[3] Here the author, still supporting a two role system, is suggesting collaboration through one group moving closer to the other in behaviours: That is, one takes over the other's role upon occasion. As a solution, this comes closer to our suggestion than

other methods, but the two areas of involvement are not perceived as facets of a single process.

But this re-interpretation of the goal has not yet solved the problem. Perhaps the discriminating reader will be saying to herself "Are we really to believe that there are no behavioral differences among nurses with respect to the study of nursing?" If we disparage the idea of such differences emanating from roles and positions, then to what are differences linked?

At the outset it seems that skills, abilities, careers, work orientations, and motivation of nurses are variable. At least they seem to be. But upon what primary dimension do these vary, becomes the question. As an alternative hypothesis to "role" determinism, we would propose that the basic dimension on which behavioral variation occurs crucial to this discussion is the degree to which the individual nurse assumes a critical approach to her own "practical vision". It matters not what position the individual holds but rather to what extent she has the skill, ability, work orientation, and motivation to criticize her own "practical vision". The concept of "practical vision" is one used by Greer to refer to the behavior of man in everyday life situations.[4] We can apply it to everyday nursing situations using Greer's suggestions with respect to its general applicability.

Much of the training and experience of nurses is directed towards a primary interest in the ends of action, with the acceptance of the means as given. This tends to promote behaviors not overly concerned with observing and identifying important facets of nursing situations but rather to carrying out habitual and routine actions. This precludes the development of the inductive reasoning required to generalize from the specific case. When, and only when, the recipe for action fails in some important way, or she faces a completely new situation, is this nurse moved to worry about contingent laws and the larger framework. It is then and only then she asks herself "under what conditions does this work?" This practical vision is usually called "common sense". "It is what every (nurse) knows and nobody bothers to question since it works. It is a universal and conservative mode of behavior in (nursing)."[5] Even when the individual recognizes that some explanation is necessary for an apparent failure of action or to allow for some novel circumstance, knowledge or material to be drawn into her perception of the situation, the scope of the experiments or studies or assessments exployed to provide the explanation are variable. In point of fact most deal with the conceptualization that is relevant to a given narrow set of circumstances only. Because practical vision is universal we tend to use it most of the time. Continuing our adaptation from Greer, instead of a radical

critique of thought, most nurses nurse primarily through the practical vision they have inherited from the nursing culture. This is to say, their "interpretations of (nursing) are judged not by formal logic or rigorous and skeptical inquiry, but by their congruence with the common vocabulary of the (nursing) culture and specifically, the important listeners".[6]

In addition to the above elaboration of practical vision our tentative hypothesis depends for clarity upon some notion of our meaning of "degree". Since all nurses make use of "known" methods and techniques of carrying out nursing action, which according to our definition, preclude skeptical inquiry relative to their use, how do we vary vis-a-vis behaviors pertinent to the study of nursing? It seems unlikely that one could conceive of the ability and motivation of the individual to criticize her practical vision as either present or absent, as a constant at a polar extreme. Rather it is a variable among people on what might be hypothesized as a continuum indicating the extent to which it is done, and indeed along a similar continuum for the same person at different points in time and in different circumstances.

The extent to which the nurse perceives her practical vision as a rigid constraint in a situation bears a direct relationship to the extent to which she will criticize her perception of a situation. The more the common sense approach appears constraining to the nurse the more she will attempt to acquire improved sense data which would allow her to assess and perhaps identify other, and more useful, or appropriate behaviors. In short, she is less accepting of the infallibility of the "known" ways.

But there is another respect in which nursing behaviors vary and which is an essential part of this conceptual model. It was suggested earlier that once criticism is directed by an individual against a practical vision approach to a situation, it may take various forms which can be differentiated on at least one essential dimension, that is, its scope or level of generality. In its simplest sense, the criticism may take the form of the nurse adding a few observations to her repertoire and reassessing her performance in the light of these new observations. She plans and/or adjusts her care of this patient at this point in time. But the criticism in other instances and with other nurses may not stop with this particular assessment and response. It may include an attempt to link the particular data to other data; in other words, to make increased theoretical demands upon the data and compare these to other schemes of abstraction based on valid experience. Through this process of induction new and more general forms are created. Thus, in gathering information about particular

11

instances of common nursing problems and in subjecting these to some systematic study, the basic underlying variables can be identified and understood to become subsequently the elements of significant bodies of empirically grounded theories of nursing.

But so far we have left ourselves vulnerable to the attack of methodologists who cannot accept this view of research. A defence of the method is the proper subject of another paper, but to anticipate cristicism a short response is in order. Research has usually been conceived in a much more formal guise than that presented here. Formal, at least, in the sense that it requires a preconceived and highly structured plan. In this vein, Dickoff et al. suggest that "both practice and research are modes of openess to empirical realities. . . (but) . . . research tends to be vitiated when not done according to a perconceived plan."[7] It is possible, however, to reject even this sacredly held principle if one is prepared to accept the validity and reliability of research methodology which has as its purpose the generation of theory as opposed to the verification of hypotheses based on pre-existing theory. In generating theory the research plan evolves as the data analysis proceeds. The categories of analysis are discovered by the examination of the data. It involves a "process" of research. "Generating a theory from data means that most hypotheses and concepts not only come from the data, but are systematically worked out in relation to the data during the course of the research."[8] Moreover, "what is required is a different perspective on the canons derived from vigorous quantitative verification on such issues as sampling, coding, reliability, validity, indicators, frequency distributions, conceptual formulations, construction of hypotheses and the presentation of evidence."[9] Because our major task in nursing at this time is the development of a theory or theories of nursing the methodology presented here appears eminently suited to the task.

The second type of criticism levelled at this mode of research design centers on the suspected subjectivity of the field observation techniques employed. Becker suggests quite the opposite.

> Field observation is less likely than the more controlled method of laboratory experiment and survey interview to allow the researcher to bias the results he gets in directions suggested by his own expectations, beliefs or desires . . . We should take field work data seriously as evidence. . . (because) . . . the people the field worker observes are ordinarily constrained to act as they would behave in his absence by the very social constraints whose effects interest him: he therefore has little chance compared to practitioners of other methods, to influence what they do, for more potent forces are operating. Second, the field worker inevitably, by his continuous presence, gathers much more data and, . . .

makes and can make many more tests of his (tentative) hypotheses than researchers who use more formal methods.[10]

If we conceive of nursing and the study of nursing in this fashion, we are interpreting the problem in a very different light. The problem, instead of being oriented to bringing together two opposites, researchers and practitioners, is directed toward stimulating a particular method of nursing in which practice and the study of that practice are both part of the method itself. They are inseparable.

Reconceptualized, the specific objectives of change necessary to promote concurrent practice and study consists in helping all nurses to subject their practical vision of nursing situations to critical analysis more frequently — on a day-to-day basis — so that they become the nucleus of the data- collecting team. The outcome of this type of "Nursing-as-Process"[11] approach has gains in immediate situations relative to the care of a patient or patients and in the long run as part of an accumulation of the data necessary for the development of nursing theory. Concomitantly, the nurse who has additional skills and abilities in the strictly methodological aspect of the conduct of research may not only acquire data in an identical fashion through participation but may observe others in the practice of nursing and utilize all data collected in these ways as contributions to the analytic process.

Because the objectives now differ from those of our initial formulation of the problem we must also reconsider the methods and techniques to be used to achieve solutions. There is some evidence that students in educational programs within the general system of education are learning "Nursing-as-Process". This approach can effectively eliminate a good deal of the reliance upon practical vision as a determinant of nursing behaviors among persons now being socialized into the profession. But this is insufficient to induce change in and by itself in the immediate future. We must evolve other mechanisms whereby the process can be expedited. In its most idealistic form an organization for the provision of nursing care which includes nurses with a high degree of skill in the assessment and planning of care as key members to work with other nurses directly could have far-reaching effects. In a recent editorial, Notter suggests:

> "The clinical specialist brings a new focus to clinical practice, a substantial knowledge of the specialty, and a commitment to the improvement of patient care through developing and testing theories relevant to that care . . . The development of clinicians prepared to develop not only relevant theories, but also to test these theories empirically, may prove to be one of the best ways to initiate, stimulate, and

13

carry out clinical research in nursing."[12]

We would agree with this thesis, and in addition, our conception suggests that she work hand in hand with other "non-research" nurses. This person provides complementary skills in supplying analytical and interpretational acumen. The particular organizational position held by this "specialist" is unimportant as long as she has a recognized and accepted place which allows her maximum opportunity to nurse with others, to guide and assist others to be committed to the constant improvement of practice. The relationship among these two types of persons is one of complete sharing of experience through constant interaction and integration of functions. As we suggested earlier this is the crux of the development of emergent ideas among them.

In summary, the development of this kind of program now in as many areas as possible where nursing is provided, increasing the number as skilled people are available, would provide a situation whereby research was automatically built into the action program. Both the nursing behaviors of the personnel and the conceptual schemes evolving therefrom would be in a continual state of adjustment. The continuous monitoring and assessment of nursing behaviors "would allow an increasing specification of theories, increasing understanding of processes and at the same time a closer fit between means and ends, action and goal."[13]

Footnotes
1. See for example: Voda, Anna M.; Butts, Stanley and Gress, Lucille. "On the Process of Involving Nurses in Research," *Nursing Research*. Vol. 20, No. 4, July-August, 1971, p. 302. Dickoff, James; James, Patricia and Wiedenbach, Ernestine. "Theory in a Practice Discipline," *Nursing Research*. Vol. 17, No. 6 Nov.-Dec. 1968.
2. Follett, Mary Parker. "The Psychology of Consent and Participation," in Metcalf, Henry and Urwick, Luther. *Dynamic Administration*. N.Y. Harper and Row, 1940, pp. 210-229.
3. Conant, LucyH. "On Becoming a Nurse Researcher," *Nursing Research*. Vol. 17, No. 1, Jan-Feb. 1968, pp. 70-71.
4. Greer, Scott. *The Logic of Social Inquiry*. Chicago: Aldine Publishing Co. 1969, p. 48.
5. Ibid., p. 51
6. Ibid., p. 49
7. Dickoff, James and James, Patricia. "Researching Researchers Role in Theory Development," *Approaches to Nursing Research and Theory Development: Readings from Nursing Research*. I. p. 38.
8. Glaser, Barney and Strauss, Anselm. *The Discovery of Grounded Theory*. Chicago: Aldine Publishing Co. 1967, p. 6.
9. Ibid., p. 8.
10. Becker, Howard S. *Sociological Work*. Chicago: Aldine Publishing Co., 1970, pp. 42-44.
11. Allen, Moyra and Reidy, Mary. *Learning to Nurse: The First Five Years of the Ryerson Nursing Program*. Registered Nurses Association of Ontario 1971, p. 166.
12. Notter, Lucille E. "Empirical Research in Nursing," Editorial *Nursing Research*. Vol. 20, No. 2, March-April 1971, p. 99.
13. Greer, Scott. op. cit, p 195