Discourse

Links Between Philosophy, Theory, Practice, and Research

Patricia Benner

Nurses are a practical lot. Like other practitioners, we may brush aside the philosophical as "hypothetical" or irrelevant. To say that something is a philosophical question often means that it is too abstract to be of consequence. I want to rehabilitate the term *philosophical* by describing the goals of three different philosophical styles of inquiry. (1) Critical thinking evaluates theories, research, and practice. (2) Creative and edifying philosophies generate new possibilities. In nursing, for example, new understandings and possibilities for care and ways of facilitating recovery, healing, and health-care delivery require creative or edifying philosophies. (3) Articulation thinking and research gives language to and illustrates experiential learning and practical knowledge of patients' families or of community nurses or other health-care practitioners. The goal is to articulate meanings and knowledge embedded in everyday lived worlds that may be poorly described or lack an adequate public language. Unlike categorizing and naming things for classification or diagnostic systems, articulation seeks to illustrate how commonly held meanings, qualitative distinctions, and practices function in everyday life.

Critical Thinking

Analytic philosophy has traditionally been concerned with critically evaluating thinking and therefore primarily with epistemology — that is, how and what we can know. As members of a practice discipline we need to critically evaluate nursing assessments, interventions, and outcomes, and to critically evaluate theories of disease, illness, recovery, health promotion, development, and so on. Analytic philosophy offers

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tools for critically testing and evaluating logical systems and theories. The analytic tradition is well suited for critically evaluating theories and research from an objective stance, from an outside-in perspective. For example, rational-technical thought lies within the analytic tradition and can also be critically evaluated within this tradition. It is less well suited for critiquing the limits of objectivity and rationality.

A rational-technical model of thinking is relevant and even necessary for many areas of nursing practice. However, rational-technical thought falls short of critically thinking about the sources of questions or issues behind a rational-technical system of verification. Taylor (1993) calls rational-technical thought a system of criterial reasoning designed to yield absolute *yes* and *no* decisions. Taylor calls this a snapshot form of reasoning because it examines situations at particular points in time. Taylor points out that this system assumes that all the relevant features of the practical situation can be filled out completely and that all the relevant criteria *can* be spelled out (i.e., made operational, explicit, or formal). As a logical system, rational-technical thought cannot formally evaluate transitions in thinking — that is, gains or losses in the thinker's understanding across time. Evaluating gains or losses in the thinker's understanding across time is a form of practical reasoning that requires narrative. Taylor compares this form of narrative or historical reasoning with a moving picture rather than a snapshot. While rational-technical thought can be used in clinical reasoning, it is not sufficient in this function. Clinical reasoning requires reasoning across time, taking into account gains and losses in understanding the situation and the directionality of the changes, both in the situation and in the thinker's understanding of the situation (Benner, 1994b; Benner, Hooper-Kyriakidis, & Stannard, 1999).

This discussion of the powers and limits of rational-technical thought offers the opportunity to provide a brief illustration of critical thinking. Thinking critically allows one to evaluate what a theory or method makes apparent and what it leaves out, or cannot notice (theoretical or methodological blind spots). For example, rational-technical thought cannot address the broader task of creative discovery or thinking about health and illness in new ways, though its critical powers may clear the way for new ideas and creative thinking.

Plato saw that all questions foretell or frame the range of possible answers. Even the most open-ended questions circumscribe what can possibly be thought in terms of answering a particular question. Any theoretical system can be critically deconstructed to analyze what questions it might generate and what kinds of answers will meet discipli-

nary expectations. Questions may also be critically examined for what they obscure or cannot address. A fruitful approach to thinking critically within a discipline is to analyze the kinds of questions that are being asked in research, theory, and practice. For example, the managerial strategy of developing and using critical pathways (one form that rational-technical thought may take) may generate questions about timing, or sentinel events or benchmarks. Most of the questions might be framed in terms of when or how a patient reaches certain predictable milestones, or to what extent the patient's recovery varies from the predicted recovery trajectory. This allows for critical comparison of the patient's progress with a particular population. By their logical structure, critical pathways typically do not generate questions about the quality of the patient's experience or concerns. Also, caregiving issues for the patient's informal caregivers may fall outside the critical pathway questions, except in terms of how they relate to the timing of the patient's recovery, or hospital admission or discharge.

Logstrup (1995) points out that generative thinking entails more than subsuming things under categories, though classifying and cataloguing information are indeed useful and necessary ways of getting around in our complex, information-rich worlds. Classifying and categorizing information for retrieval, called *informatics* or *knowledge management*, have become essential in the current global information explosion. However, information management is not the same as generative thinking. Managing information and knowledge brokering have become so central for practitioners of all kinds that those skills of original inquiry or other forms of thinking may seem less legitimate or relevant.

Information management can become a proxy for knowledge generation and may be considered a thinned-out version of rational-technical thought. In both practice and educational settings, nurses and physicians become accustomed to rational-technical strategies of thinking — for good reason, as they simplify and clarify actions. Rational-technical thinking is especially powerful for organizing complex systems and standardizing procedures and actions. It takes the form of establishing criteria for evaluating actions and outcomes. As a system for thinking, rational-technical thought fits more closely with the model of classifying and ordering things. Outcomes are sometimes inadequately questioned in this mode of thought, because one might assume that they already know what outcomes are preferred. A rational-technical model of thought assumes that many different means might be linked to good outcomes. Relative to outcomes, therefore, means are rendered less visible. Separation of means and ends is assumed to be

unproblematic. Consequently the logic of rational-technical thought can lead one to be relatively indifferent to the means as long as the outcomes are good. Often the uncoupling of means and ends increases useful options for achieving outcomes. However, in areas where means are inextricably linked (e.g., birthing, dying, suffering) this form of rational technicality can lead to errors, or even unethical disassociation of means and ends (Borgmann, 1984; Taylor, 1994).

Creative or Edifying Philosophies

The possibilities of care and the theories of health are examples of thought projects in nursing that require generative thinking and edifying philosophies (Benner, 1994a, 1994b; Benner & Gordon, 1996). These and other topics require that the thinker go beyond critical analysis or deconstruction to generate notions of good or alternatives to what has been critically rejected or deconstructed. While necessary, deconstruction and critical analytical philosophy are not sufficient to generate positive projects or to create new visions of what constitutes health, illness, recovery, growth and development, rehabilitation, or peaceful dying. Analytic strategies or deconstruction may liberate our thinking from oppressive or untenable systems of thought; however, within their logical structure they cannot generate, for example, new visions or constructions of worthy ends of nursing practice or what constitutes health and illness. For these areas of moral vision we need to turn to philosophical anthropology or to religious, aesthetic, philosophical, or ethical examination of what constitutes a good life. For example, having deconstructed a Cartesian view of mind/body dualism, the next step is to re-think embodiment (Benner, 2000; Benner & Wrubel, 1989; Leder, 1998). How do we think about the social, sentient, embodied person? Currently we have elaborate theoretical grids for the mind that include psychological constructions, attitudes, beliefs, values, and so on. And we have elaborate theoretical systems for describing the body in physiological substrates (Benner & Wrubel). Philosophers like Merleau-Ponty (1962) have developed theories of embodiment that fall between the two theoretical constructions of mind and body. A number of nurse thinkers and researchers have drawn on the work of Merleau-Ponty to give a fuller account of embodiment than is contained in a Cartesian view of the body (Benner, 2000; Benner & Wrubel; Doolittle, 1990; Kesselring, 1990; Leonard, 1994, 1996; Schilder, 1986; Wynn, 1997). Nurses learn much about the person as embodied and situated within a particular lifeworld, and this practical knowledge enriches their thinking on embodiment.

Articulation Thinking

Charles Taylor (1989, 1991) demonstrates philosophical thinking by giving public language to taken-for-granted self-understandings lodged in cultural traditions. Taylor's philosophical strategy is one of dialogue that constructs a conversation between two or more schools of thought or practices, articulating meanings, practices, and notions of good in each. My colleagues and I have drawn extensively on the methods of articulation research in studies of nursing practice (Benner, 1994b; Benner, Hooper-Kyriakidis, & Stannard, 1999; Benner, Tanner, & Chesla, 1996; Day, 1999) and in the practical, lived experience of illness and symptoms of patients and their families (Benner, Janson-Bjerklie, Ferketich, & Becker, 1994).

Nurses have developed much practical, experiential knowledge that has not been adequately described or articulated. For example, Patricia Hooper-Kyriakidis (Hooper, 1995) studied nurses' practice of titrating multiple vasoactive drugs to clarify the practical knowledge and judgement strategies nurses use in maintaining patients within certain hemodynamic parameters. While descriptions of physiological mechanisms were fairly complete, the practical variations due to the patient's unique hemodynamics; interaction with other medications; or interaction with emotions, physical positioning, or activity were left virtually unexplored. Also omitted were descriptions of clinical signs that experienced nurses use when titrating vasopressors.

Lisa Day (1999) describes the moral and practical experience of caring for a potential transplant donor. She found that undescribed social practices created the social and moral space for both caring for potential donors and obtaining informed consents that were neither coercive nor so ill-timed as to render organ donation impossible.

During the past 30 years the nature of physicians' directives has changed dramatically, as has medical technology. Much experiential clinical learning in nursing is undescribed because of the social misunderstanding that nurses just "apply" well-established medical knowledge under the direct supervision of doctors. Yet many areas of nursing practice have developed new and uncharted knowledge, of both the delegated and undelegated kind. Articulation research is not a substitute for empirical quantitative and qualitative research. However, it does offer a viable way of further developing clinical knowledge and creating a dialogue between knowledge development through practice and knowledge development through science.

Conclusion

Nurses bring a rich experiential wisdom to their thinking. Much of that wisdom is poorly articulated and misunderstood. All three modes of philosophical thinking are needed to do justice to the concerns and goals central to nursing. We need critical powers to evaluate practice, theory, and research. We need creative and edifying philosophies to create an adequate vision for the goals of nursing practice. Finally, we need articulation research and thinking to describe what we know and do not know in our practice.

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