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GUEST EDITORIAL

## **Progress in Philosophic Inquiry in Nursing**

Joy L. Johnson

Nursing scholars have a long tradition of philosophizing. In a recent nursing philosophy seminar, I discussed the contribution of what I consider to be the "Top 10" nurse philosophers and how they have influenced nursing thought and action. I selected these 10 leading philosophers on the basis of the breadth of their influence and the significance of their contribution. While the individuals I selected may not have viewed their own work as philosophical in nature, I applied this term because their work considers the nature of nursing using methods of reason and argument (the tools of philosophy). I must admit that I was hard pressed to limit my list to 10. The list included philosophers with whom I do not necessarily agree but whose works have significantly shifted or furthered our understanding of nursing *qua* nursing.

My list is somewhat chronological in order and, not surprisingly, is topped by Florence Nightingale, whose works on the nature of nursing served to shape the profession and discipline well into the 20th century. My second selection is the duo of Lavinia Dock and Isabel Maitland Stewart, for their work on the development of nursing and their writing about the need for nursing to be guided by principles rather than trial and error. I include Hildegard Peplau for her groundbreaking work on the interpersonal aspect of nursing. Peplau was one of the first theorists to articulate the importance of the relationship between the nurse and the patient.

Ernestine Wiedenbach made significant contributions to nursing philosophy with her work on the art of nursing, which analyzes in detail what it means for a nurse to help a patient. Virginia Henderson dedicated her remarkable career to clearly articulating nursing's goals and mission. James Dickoff and Patricia James are the only non-nurses on my list. Their work has made a significant contribution to nursing in that it helps us to focus on the kind of theories required for nursing practice. I include Lorraine Walker for her pioneering dissertation on the discipline of nursing and Barbara Carper, whose inspirational work

has helped us to further understand ways of knowing in nursing. While Patricia Benner's work straddles the border between the scientific and the philosophic, I include her name because she has helped nursing philosophers to refocus their attention on the practice of nursing and has helped to make the knowledge embedded in practice the subject of legitimate inquiry. Interestingly, Benner's discourse in the current issue of *CJNR* addresses the importance of philosophizing to practising nurses. My final inclusion is Rosemarie Rizzo Parse. While her work is controversial, I include Parse because her program of research demonstrates a determination to pursue and refine a vision of nursing. Within Parse's work is a clear call for placing the patient at the centre of nursing care.

I encourage you, as a reader of this issue of the Journal, to consider nursing's philosophic legacy. Your "Top 10" list might be very different from mine. There are numerous nursing scholars, including Moyra Allen, Myra Levine, Dorothea Orem, Martha Rogers, and Rozella Schlotfeldt, who deserve mention. I believe that the legacy of many scholars is presently being formed. The value of preparing such a list is that it prompts us to consider nursing's impressive past in the realm of philosophy.

There are many signs that philosophic inquiry in nursing has a bright future. Academic centres such as the Institute for Philosophical Nursing Research at the University of Alberta and the Centre for Philosophy and Health Care at the University of Wales Swansea are beacons of this promise. These centres support conferences and workshops that bring scholars together to consider philosophic questions relevant to nursing. The first issue of *Nursing Philosophy: An International Journal for Health Care Professionals* was published in July of this year.

It is very encouraging to witness the continuing development of philosophical work in nursing. This issue of the Journal is another significant milestone in this development. When June Kikuchi wrote a guest editorial for the special issue of *CJNR* focused on Philosophy/Theory in the summer of 1995, she expressed concern about the quality of scholarship in the realm of nursing philosophy. In reviewing the manuscripts for this issue, Editor Laurie Gottlieb and I were struck by the high calibre of many of the submissions. This indeed bodes well for nursing philosophy. The response to the call for papers for this issue was very positive. I thank the legion of reviewers who offered critical reviews.

The seven papers published in this issue represent diverse philosophic positions and substantive foci. One of the most important ques-

tions that nursing philosophers have grappled with concerns the nature of nursing knowledge. This issue includes three papers that consider the epistemological foundations of nursing and raise questions about foundational approaches to knowledge development. In the world of philosophy, postmodernism has offered a penetrating criticism of science and foundational epistemology. While many philosophers have focused on the epistemological implications of postmodernism, Holmes and Warelow advance the discourse by considering the promise of postmodernism for nursing scholarship and practice. Browne looks at the role that critical social theory can play in advancing nursing science. She concludes that while critical social theory may have limited implications for nursing science, it provides an important perspective for examining the fundamental ideologies upon which nursing knowledge is developed. Finally, Ceci examines the relationship between knowledge and the knower, arguing that who we are influences what we can know about ourselves and our world. Her claim is that what is considered to be knowledge is a matter of power, privilege, and values. Together these three papers offer some helpful insights into the central questions that are raised about the possibility of developing knowledge in nursing.

Hawley, Young, and Pasco's paper is also epistemological in nature and considers the methods of nursing science. These authors address the criticism that has emerged regarding traditional scientific approaches. In particular, they examine the claim that reductionism in nursing science is antithetical to the values of nursing, and argue that this claim is unfounded. Their paper suggests a realist ontology and maintains that causal explanations are essential for a practice-based profession such as nursing.

Another central domain of concern addressed in these papers is the moral realm of nursing. Bennett Jacobs examines the subject of human dignity and explores how this concept has been used in a variety of discourses. Peter considers the moral knowledge required in the context of home-care nursing and outlines how feminist ethics can form a basis for development of this knowledge.

Romyn considers the realm of nursing education and focuses on emancipatory pedagogy. She delineates the diverse ways in which emancipatory pedagogy has been conceptualized and outlines key areas of agreement and disagreement among philosophers of nursing education.

The dilemma of philosophic inquiry is that it is very difficult to come to closure on any given issue. For every question that is answered

another 10 must be considered. Does this mean that our quest for philosophic understanding should cease? I argue emphatically that philosophy is essential to nursing. As nurses we must consider the nature of our discipline; the work of philosophy is the work of tending to our discipline. The papers included in this issue beckon us to philosophize. I invite you to read these papers with a philosophic eye. Consider whether you agree or disagree with the points raised, and engage in arguments with the authors. In the end it is this process that will aid us in gaining a wider understanding and in coming closer to (dare I say it) the truth.

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## 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 undeligated 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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# Respect for Human Dignity in Nursing: Philosophical and Practical Perspectives

Barbara Bennett Jacobs

*Perdrai-je ma dignité?  
Quelqu'un se souciera-t-il de mon sort?  
Me réveillerais-je demain  
De ce cauchemar?*

(tiré de la comédie musicale *Rent*,  
paroles et musique de Jonathan Larson)

Depuis sa première publication en 1976, le *Code for Nurses with Interpretive Statements* [Code des infirmières, accompagné d'énoncés explicatifs] a servi de cadre permettant d'explicitier les « obligations morales » des infirmières et infirmiers professionnels (American Nurses Association [ANA], 1985). Une refonte de ce code est actuellement en préparation (ANA, Code of Ethics Project Task Force, 1999). Tel qu'exposé dans l'un et l'autre de ces documents, le premier devoir moral de toute infirmière est le respect de la dignité humaine (ANA, 1999) : les infirmières doivent faire preuve de compassion dans toutes leurs interactions professionnelles et respecter la dignité, la valeur intrinsèque et la spécificité de chaque personne, sans égard aux considérations d'ordre social, économique ou personnel, ou liées à la nature des problèmes de santé. (p.4)

Dans les cinq énoncés servant à traduire la portée de ce devoir, on a recours à un certain nombre d'expressions clés, dont, en premier lieu, « le respect de la dignité humaine »; cette notion sous-entend à la fois le respect de la valeur intrinsèque de chaque personne et des droits humains. Issues de la philosophie morale, ces expressions sont couramment utilisées dans d'autres disciplines, notamment en droit, en religion, en médecine et en sciences humaines. La définition même du terme de « dignité » demeure limitée en regard de l'interprétation et de l'utilisation qui en est faite. Cet article propose donc d'étudier cette notion à la lumière de quelques approches choisies en philosophie morale, de définitions tirées des dictionnaires et d'essais contemporains, ainsi que de l'interprétation qu'en font les étudiantes et étudiants inscrits au baccalauréat, à la maîtrise ou au doctorat en sciences infirmières. Ces quatre sources différentes nous servent ici de fondement pour argumenter que l'analyse scientifique seule ne peut que limiter la portée de la notion de dignité. Le respect de la dignité humaine, en conclusion, doit être considéré comme un art qui s'alimente par la praxis et suscite le dialogue entre professionnels des soins infirmiers; sa portée est beaucoup plus large, tant sur le plan ontologique et épistémologique, que celle d'un simple principe énoncé dans un code déontologique.

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*Will I lose my dignity  
Will someone care  
Will I wake tomorrow  
From this nightmare?*

– Music and lyrics by Jonathan Larson  
from the musical comedy *Rent*

## Introduction

Since its first publication in 1976, the *Code for Nurses with Interpretive Statements* has provided guidelines for explicating the “moral obligations” of professional nurses (American Nurses Association [ANA], 1985). The American Nurses Association is currently drafting a new version of the code (ANA, Code of Ethics Project Task Force, 1999). In both documents the first ethical duty of all nurses in the profession is to show respect for human dignity (ANA, 1999):

The nurses, in all professional relationships, practice with compassion and respect for the inherent dignity, worth and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems. (p. 4)

A number of phrases are used in the five interpretive statements of this duty, the first of which is “respect for human dignity.” Inherent in this phrase is respect for *worth* and *human rights*. Such phrases are replete within moral philosophy yet can also be found in other disciplines, including jurisprudence, religion, medicine, and the humanities. The actual definition of a word such as *dignity* is often not as meaningful as how it is perceived and used. The purpose of this paper is to discuss the use of the word *dignity* by examining selected moral philosophical epistemologies, dictionary meanings, current literature, and perceptions of students in nursing programs at the baccalaureate, master’s, and doctoral levels. Based on the discussion of these four sources of ethical knowing, possibilities for future analysis of respect for human dignity are offered that suggest that this concept is underdeveloped if investigated only scientifically. It is concluded that such respect for human dignity can be viewed as a practical art, enhanced through praxis, conducive to dialogue among nursing professionals, and broader both ontologically and epistemologically than a principle in a code of ethics.

## A Moral-Philosophy View

Dignity has no physical properties that natural science can observe or identify, a fact that may contribute to its ineffability. As a concept,



dignity and its attributes may be identified by what human beings experience and the perceptions that the human mind subsequently formulates (Chinn & Kramer, 1999). Because there is no way to directly measure or observe it, dignity is a "relatively abstract" concept that is known through more indirect methods of observation and experience (Chinn & Kramer). Epistemology and knowledge of concepts in the world has been the pursuit of philosophers for centuries. Two epistemologic views, one empirically based and one rationally based, are presented as a philosophical preamble to the concepts of respect and moral agency in explicating an understanding of human worth and dignity within the context of moral principles.

### *Knowledge and John Locke*

In the 17th century, the British empiricist John Locke (1632–1704) believed that a human being is born with a mind that is a blank slate, a *tabula rasa*. The knowledge that eventually fills the slate is derived from experiences. Locke focuses primarily on "objects" in the world using such examples as a rose, ice, and sugar. However, it is, along with other sensations, the smell of the rose, the feel of the ice, and the taste of the sugar that fill the mind with perceptions and ultimately knowledge about these objects (Locke, 1689/1998).

In his *Essay on Human Understanding*, Locke (1689/1998) extends his philosophical thinking about how one knows the world beyond objects to such ideas as pleasure, delight, pain, and power. The posited, empirical belief of how humans come to know these concepts and ideas is still based on the experiences of sensation and reflection. Once the senses provide the brain with information, the mind reflects on the perceptions. Locke states, "we can have knowledge no farther than we have ideas" and "we can have knowledge no farther than we can have perceptions of that agreement or disagreement" (Book IV, Chapter 3, Sections 1 & 2). Perceptions and ideas, Locke believed, are derived from intuition, sensation, and reason.

It would seem reasonable to believe that dignity is a concept guided by intuition. To respect another person's dignity would appear obvious to most moral agents. However, using the senses to garner knowledge regarding dignity may prove perplexing. Locke believed that senses have external causes, an assumption that was later refuted by the Scottish philosopher David Hume. The basis of the refutation is that if the senses are experienced and the external causes are not, then the knowledge derived from the senses could be due to spontaneity and not really experienced at all. Of the three Lockean knowledge

forms, it is reason that was pursued by the next philosopher to be discussed, Immanuel Kant.

### *Rationality (Reason) and Immanuel Kant*

The Lockean belief that knowledge is *a posteriori*, or based on experiences and subsequent perceptions, was counter to the older philosophical belief that innate ideas are known *a priori*. Immanuel Kant, a German philosopher born almost a century after Locke, believed that all knowledge *begins with* experiences but does not necessarily *arise from* experiences (Kant, 1781/1990). The distinction between the two is most relevant to understanding the philosophical and metaphysical bases of morality and respect for human dignity. The most significant insight can be drawn from Kant's (1785/1997) *Foundations of the Metaphysics of Morals*.

Reason or rational knowledge is pivotal to Kantian moral philosophy. Kant describes two forms of rational knowledge, material and formal. Ethics, he believed, is material philosophy in that it is based on a moral philosophy that formulates laws not of nature (as in physics) but of the Will of man as affected by nature. In other words, when philosophy deals with material knowledge regarding objects of understanding (such as dignity and morality) it is termed the Metaphysics of Morals and is known through reason. While Locke was an empiricist, Kant was an idealist. Kant believed that sources of moral knowledge are not individual "feelings or sentiments" based on some nature of the human being, and that moral duty is based on reason (Kant, 1785/1997; Pojman, 1998).

Because moral knowledge is derived from reason, Kant postulates that an unconditional imperative, which he terms categorical, is indeed the imperative that guides moral duty: "...the first proposition of morality is that to have genuine moral worth, an action must be done from duty" (Kant, 1785/1997, pp. 15–16). He also believed that it is "out of love for humanity" that actions are connected to the concept of duty.

### *Respect*

Although dignity is the focus of this paper's discourse, it appears that respect is just as important as dignity since dignity is rather void and moot unless it is respected by another person in a community. The whole idea that practical morality is community-based is credited to Aristotle and reiterated in the following passage from the United States

Catholic Conference of Bishops (1986), as cited in Ashley and O'Rourke (1997, p. 8):

Human dignity can be realized and protected only in community. In our teaching, the human person is not only sacred but also social. How we organize our society directly affects human dignity and the capacity of individuals to grow in community.

Kant postulates that respect is *a priori*. In other words, if respect is *a priori* it is not inductively inferred, may be determined by experience, but does not necessarily require experience to be known and may be known by some other knowledge form (Russell, 1945). Sherman (1997) highlights important Kantian connections between practical reason, emotion, and respect and explains Kant's view this way:

If there are *a priori* practical principles (by which rational agents, such as ourselves, are capable of being moved), and if in addition to being rational agents, we are also affective agents so constituted that we have desires that can always conflict with those principles, then there will always be present the ingredients for respect. Put more simply, respect is just the affective side of our ever available capacity to be moved by practical reason. Respect is not itself a separate sort of motivation. Rather, it is the effect of moral motivation on feeling. In a sense, it is a kind of epiphenomenon. (p. 176)

If intuition, reason, and sensations are knowledge forms of dignity, then Aristotelian and Kantian philosophy become a little clearer. Aristotle believed that emotions "transformed by revisions of our beliefs" subsequently "embrace more adequately our judgments of what is overall good" (Sherman, 1997, p. 178). On the other hand, Kant did not believe in the Aristotelian "connection of emotion with cognition" but did believe that emotions are "sensations." Kant believed that practical reason is the knowledge used for motivational agency but because man is "affective" he is *not motivated* by respect (an emotion) *per se* but respect is an effect of a moral motivation (Sherman). "But though respect is a feeling, it is not one received through any outer influence...thus respect can be regarded as the effect of the law on the subject and not as the cause of the law" (Kant, 1785/1997, p. 17).

Noggle (1999) states that "a person enters the moral realm when she affirms that other persons matter in the same way that she does" and that respect is a way to manifest such "mattering" (p. 449). Some would say we owe respect to other persons (Buss, 1999). A deontological view of respect is based on the belief that persons, because of their moral autonomy (not their individual autonomy) have value, therefore dignity, and thus ought to be respected for that special value

(Beauchamp, 1991). Respect for persons is based on their worthiness to be respected (Buss).

### *Moral Principles*

The connection of the sources of knowledge regarding dignity to actual moral behaviour, according to Chinn and Kramer (1999), "can be reduced to principles and codes, which are shorthand ways of expressing ethical knowing" (p. 163). The most contemporary ethical principles guiding moral behaviour are those of beneficence, nonmaleficence, justice, and respect for autonomy. These four principles are the basis for applied ethics as espoused by such leading ethicists as Tom Beauchamp and James Childress (Beauchamp & Childress, 1994).

Principles may not be sufficient to guide one's moral behaviour, and this applied-ethics method has been questioned. Knowledge about human dignity is one example that Meilander (1995) cites as a concept that may not be addressed solely through the application of principles, since there are disagreements and questions about our self-knowledge regarding human dignity. Meilander believes that a focus on principles does not offer enough "substantive guidance" and is ultimately "deceptive in its clarity — leaving unaddressed the most pressing questions" (p. 19). Pondering the issue of assisted suicide or pondering the issue of abortion are just two examples of how the complexities of respect for human dignity have eluded universality in public opinion, public policy, and the law. If respect for dignity were grounded in moral principles, it would seem that knowledge about dignity would be more universally apparent. However, views concerning the dignity and sanctity of life can be extraordinarily bipolar in certain circumstances, making nurses' moral obligation in the *Code of Ethics* questionable and perplexing.

Principlism (a somewhat negative term used to refer to the four principles cited above) and codes of ethics may have the same goal — that is, "social consensus." Meilander (1995) suggests that this goal is equated with the development of public policy. In 1973 the United States Supreme Court voted to legalize abortion in the famous case of *Roe v. Wade*. This case is an example of how public policy (law) focuses the issues of privacy and the right to reproductive choice in the cloak of respect for autonomy. Such a principle-based, right-based ruling, however, did not take into account "protection for prenatal life" (Devettere, 2000, p. 351) and could be in opposition to persons' self-knowledge regarding the dignity of a potential human life.

The ANA, through its *Code of Ethics*, suggests that dignity has universality, neutrality, and consensus, a suggestion that requires further explication of the meaning of dignity. The focus on dignity in this context perhaps obscures the rich robustness of such a concept in the minds (self-knowledge) of nurses, who view respect for human dignity from other moral perspectives such as relational caring, virtue, feminism, or the Aristotelian perspective of *eudaimōn* and *eupraxia*, meaning, respectively, happiness and living the good life (Aristotle, 1892/1962).

### ***Moral Agency***

The view that ethics (and ultimately respect for human dignity) is more than principles and universal codes is reflective in such ethical theories as care ethics (Groenhout, 1998), virtue ethics (Sherman, 1997), and Christian ethics (Ashley & O'Rourke, 1997). A personal ethic or morality need not be limited to one view or theory. Such philosophers as Aristotle, St. Thomas Aquinas, and Kant (known as the duty-based or deontology-based moral philosopher) stressed the importance of the character and virtue of the moral agents themselves.

Moral agency is a person's property of being able to reason, self-determine, and ultimately act or be moral. MacIntyre (1999) offers three characteristics of moral agency. In this discussion the nurse as agent has: (1) qualities of mind and character that are hers as an individual, not necessarily as a nurse; (2) confidence in her rational moral judgments; and (3) accountability to herself not only as a nurse but also as an individual. These characteristics suggest that if nurses recognize and accept the attributes of their own moral agency they will be directed to free moral agency, even in environments that by their very structure are "compartmentalized" in their social order because they have accountability in that order.

How one chooses, evaluates, decides to execute moral agency (in this discussion how to respect dignity) is a complex process. However, the ANA has chosen to view dignity as a concept that is a "fundamental principle" and therefore uses principles as its moral compass (ANA, 1985; ANA, Code of Ethics Project Task Force, 1999). The difficulty arises, for example, when nurses disagree with what is birth or death with dignity. Some may hold the belief that withholding nutrition and fluids is respecting dignity, while others may hold a belief that it is just the opposite. Reckling (1997), in her study, found that nurses played a passive role in making decisions about withholding or withdrawing life support from patients in intensive-care units. Numerous reasons for such passivity were cited, including "a combination of their profes-



sional expectations and the situational constraints they face" (p. 43). But could it be that nurses in their obligation to respect human dignity are torn between their own moral, religious, and virtuous beliefs and those beliefs that are saturated with principlism, whose very foundation is respect for patient autonomy and family wishes?

Gadow (1999) posits that because nursing is a profession it has moral ends. She articulates three levels of ethics relevant to nursing. The first is non-discursive immediacy, the "subjective certainty" one derives from family, religion, tradition, and community. The second is ethical universalism, an "objective certainty" based on principles, theories, codes, and laws. The third is ethical engagement, an "intersubjective contingency" derived from existential relational narratives. These levels, which correspond to premodern, modern, and postmodern ethics, are philosophically laden but, most importantly, although they appear as historically hierarchical Gadow insists they can coexist.

In conclusion, dignity and respect are two concepts that have philosophical underpinnings, underpinnings that do have some universality of belief. This means not that there cannot be varying beliefs concerning dignity and respect, but that if they are held as *codes* of moral comportment for all nurses perhaps there needs to be considerable concept clarification for them to stand as the basis for a universal moral code of ethics. There is considerable controversy as to the meaning of the two words, their sources of knowledge, and the ultimate utilization of this knowledge in determining moral obligations and judgements.

### Dictionary Definitions

Dictionary definitions provide the lexical meanings of words (Pedhauzer & Schmelkin, 1991). Another form of definition is stipulation — that is, a word means whatever its user stipulates it to mean. For example, the word *toilet* in the phrase *pulmonary toilet* certainly does not have the lexical meaning of a bathroom fixture but refers to the medical regimen of managing a patient's pulmonary problems. Words or phrases may also serve as euphemisms for concepts that appear too harsh or blunt. The ethical, legal, medical, and nursing literature is replete with the phrase *death with dignity*, which may be a euphemism for dying without suffering, dying at home, or dying with some sense of human worth. Although the phrase is used commonly, the moral behaviour that demonstrates respect for human dignity is not limited to the end of life but spans persons' entire lifetimes.

The *Oxford English Dictionary* (1971) accords dignity eight significations (sematology) and two morphologies, one French and one Latin. The French word *digneté* was first used in the 12th century; the Latin word *dignitatem* refers to worth or merit (p. 726). The eight significations are:

1. the quality of being worthy or honourable; worthiness, worth, nobleness, and excellence;
2. honourable high estate, position, or estimation; honour; degree of estimation or rank;
3. an honourable rank, office, or title; a high official or titular position;
- 4 nobility or befitting elevation of aspect, manner or style;
5. [in astrology] the situation of a planet in which its influence is heightened;
6. a company of canons;
7. [in algebra] power;
8. [in German] honour and worth

The index to Beauchamp's (1991) *Philosophical Ethics* gives three locations for dignity in the text, but it also instructs the reader to "see Moral worth" (p. 426). It is interesting that Beauchamp chooses to paraphrase Kant when describing the source of one's dignity. "The person's dignity — indeed, 'sublimity' — comes not from subjection to the law but rather from being the lawmaker — that is, from being autonomous" (p. 181). Beauchamp admits that "dignity can be defined in several ways, but perhaps the best definition treats dignity in terms of free rational agents who are ends in themselves" (p. 198). However, this definition is not particularly relevant for nurses when caring for patients who, because of their physiologic or mental states, are not free rational agents. In an attempt to respect the dignity and worth of free rational agency, the federal government in the United States has legislated self-determination (related to choices involved in medical care) in the form of advanced directives as a proxy for individual autonomy. But in the absence of such pre-articulated values, respect for autonomy can be evoked if the nurse is able to re-embody herself, experience her own subjectivity, then subsequently experience the patient's subjectivity as a form of existential advocacy (Gadow, 1989). How does the nurse who cannot assume the existential advocate role, for whatever reason, respect the patient's worth? It might be that worth is unconditional (Feinberg, 1973). It would appear that this is the belief of the ANA Task Force when it refers to dignity that is "unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems" (ANA, Code of Ethics Project Task Force, 1999, p. 4).

The fact remains that there are those with restricted social status — for example, prisoners in hospital-based prison wards, combative patients tied in four-point restraints, or persons stripped of moral personhood status because of their lack of sentience or cortical function. The relationship of human worth and dignity to the ability of persons to execute moral agency through moral motivation and subsequent judgement is the basis for respecting such worth in others. However, it is clear that nurses are sometimes in a position in which moral personhood is not the focus of their respect for others; in such circumstances nurses respect not moral personhood but moral standing. Moral standing does not require the characteristics of moral personhood (agency, motivation, judgement) but does indicate that persons in such positions have a *capacity* for pain, suffering, or emotional deprivation (Beauchamp, 1999).

### Nursing Views

Three different levels of nursing students were asked to provide an example of code-of-ethics use in respecting a patient's dignity. Four doctoral students responded. Three cited calling patients by name and providing patients with privacy and "covering" their bodies. One student wrote: "I maintained her dignity by providing privacy, recognizing her discomfort and fear, and meeting her educational and emotional needs, and cultural awareness." One student described her beliefs in more detail. She felt that patients fear losing their dignity if they envision being ashamed, naked, vulnerable, or weak or having to beg for something. Running counter, then, to losing dignity is maintaining pride, protection, strength, self-sufficiency through being valued, and feeling valuable. This same student believed that respecting patients' choices concerning medical treatments is another way of respecting dignity.

Five nursing students in a master's program responded. Two equated respect for patients with keeping the body covered. One student stated that she respected a patient's dignity by honouring her decision to die of cancer at home, providing comfort measures, and comforting the family by providing information and support. Two students felt that when physicians asked for their opinions the physicians were respecting nurses' dignity. When describing a combative, rude gunshot victim, one student said, "I treated him with dignity by appreciating who he was at that moment in his life."

Thirty-eight baccalaureate nursing students enrolled in an ethics class responded to the question "what is dignity?". Their responses centred on the following:



- pride, self-confidence, self-esteem, self-respect, and values
- what makes one human — part of the inner being, defines character
- worth and uniqueness
- trustworthy, solemn, earnest, reverent
- being respectful of others — for example, upholding patient confidentiality, protecting privacy
- an absolute moral right, a prima facie right
- stronger than pride, fosters autonomous choices
- respect for and honouring of others
- to act in a dignified manner
- dignity is spiritual — a birthright, not an earned right

Eighteen of these students shared their experiences of respecting patients' privacy. The experiences were related to actual patient encounters. Themes in the descriptions were: referring to patients by name, covering patients with bed linens, providing information to help patients make choices, not talking about patients in front of them, respecting religious beliefs, being there for comfort and support, listening, and promoting personal privacy. The most chilling example was the following:

*A few years ago, EMS brought in a man in his 60s who had been found unresponsive by his wife in the early hours of the morning. A CAT scan determined he had a cerebral hemorrhage that was incompatible with life. His family came in later, and refused to go in and see him. His wife stated he was an alcoholic and had abused her for a very long time. She said discontinue everything and let him go. Some of the nurses remembered him and agreed that he had not been a nice man. So, the triage nurse decided to use his room for the next patient and get this guy down to the morgue. She wanted me to put his body into a morgue bag while his heart was still beating! I felt that no matter what he had done in this life he didn't deserve that type of treatment from me in his dying moments. I refused to put him in a morgue bag until his heart stopped. I hope this was a little more dignified for him.*

This incredible story is antithetical to any concept of dignity or any other professional code of ethics. It was the student who recognized that such action and behaviour were disrespectful and violated all principles and beliefs related to human dignity. Six students interpreted the question about dignity as it specifically related to death. Death with dignity for these students meant that the dying person not be left alone, that the dying person be free of pain, that the death have meaning, that

a patient who decides to forgo treatment be respected for their decision, that patients be viewed as persons whose lives have value, that patients be cared for as more than objects, and that washing patients who have died before the family sees them is a way of according dignity post-death.

### Review of the Literature

Searching the *Bioethicsline* through the National Library of Medicine Internet Grateful Med Search using *dignity* as the search word yielded 717 citations. Searching *dignity* through CINAHL for the years 1989–1999 yielded 81 citations. One concept clarification was found. Mairis (1994), a nurse from England, interviewed nursing students and concludes that there are three attributes of dignity: “maintenance of self-respect, maintenance of self-esteem, and appreciation of individual standards.” She also describes four antecedents or prerequisites for dignity as a concept: “dignity is a human quality, self-advocacy promotes dignity, dignity may be demonstrated by behavior, speech, conduct and dress, and dignity is developed by individual life experiences” (p. 931). Mairis posits that a Kantian view of one of his categorical imperatives (“act only according to that maxim by which you can at the same time will that it should be a universal law”) (Kant, 1785/1997, p. 38) is “insufficient” to promote a patient’s dignity. It is her belief that dignity “is acquired through life experiences” (Mairis, p. 952), a belief that she supports by listing eight ways that dignity can be maintained — for example, feeling valued — and eight ways that it can be lost — for example, feeling disregarded.

In a phenomenological-hermeneutic research study, Söderberg, Lundman, and Norberg (1999) interviewed 14 women with fibromyalgia. They conclude from their three major themes (loss of freedom, threat to integrity, and a struggle to achieve relief and understanding) that the overall experience of having this illness is struggling for dignity. Their interpretation of dignity is derived from the Latin words *dignitus* and *dignus*, meaning, respectively, equivalence and credibility. These two meanings are quite different from those of English versions of dignity and may represent the authors’ Swedish interpretations. The authors do posit, however, that dignity has an internal dimension (credibility and honour) and an outer dimension (reputation, nobility, and status).

“Death with Dignity” is the title of a number of published works (Hayslip, 1998; Madan, 1992; Parry, 1998; Quill, 1992). Madan, in particular, suggests that the spread of Western medical culture with its

technological advances may be “regrettable” in that prolonging life through the use of technology runs counter to the beliefs of some cultures. The author believes that such prolongation of life could result in a failure to respect dignity. Ganzini et al. (2000) report on physicians’ experiences with the Oregon *Death with Dignity Act*. Since 27 October 1997, physician-assisted suicide in the American state of Oregon has been legal. Since this law came into force, 57 persons have been prescribed lethal medications and their cases reported to the Oregon Health Division. Of these, 43 (75%) died from the prescribed medications. In a previous study of the Oregon *Death with Dignity Act*, researchers concluded that the reasons for requesting assisted suicide were not uncontrollable pain or financial concerns but loss of autonomy and loss of control over bodily functions (Chin, Hedberg, Higginson, & Fleming, 1999). Could it be that fear of the loss of autonomy, the loss of being a free rational agent — not whether the patient is physically exposed or is called by name — is really at the core of dignity? As Kant (1785/1997) said, “Autonomy is thus the basis of the dignity of both human nature and every rational nature” (p. 53). Kant’s view of dignity, and its relationship to reason and autonomy, is the thrust of respect for persons in community, not only when death is near but throughout their lives.

Hendin (1995) puts an interesting marketing slant on *death with dignity*, implying that it is a “selling slogan” for supporters of euthanasia and assisted suicide. He suggests that instead of as a slogan the phrase should be used as confirmation of the value and meaning of the life lived.

In a study by Söderberg, Gilje, and Norberg (1997), the core theme of *dignity* was found in 85 different stories of intensive-care nurses who were asked to describe scenarios of ethical difficulty. From these stories, the authors identified the “demands” of respecting patients’ dignity: “attentiveness, awareness, personal responsibility, engagement, fraternity, and active defense of dignity,” and equated such demands with the philosophies of Marcel, Ricoeur, and Weil. The authors also formulated three dignity-related meanings to the nurses’ stories: “transforming disrespect into respect for the inviolable value of the human being, transforming ugly situations into beautiful ones, transforming discord of death into togetherness.”

Although the concept of dignity runs through the literature, two studies illustrate the confusion that surrounds its meaning. Johnson (1998) analyzes the clinical and philosophical use of the term *dignity*, especially as it relates to dying. He notes its ambiguity and concludes

by suggesting that *death with dignity* should be viewed not as an isolated concept but as "an interactive process among the dying and their caretakers. Together this interdependent amalgam engages in humanizing communication toward understanding the final needs and wants of the patient." This suggestion is again reminiscent of the philosophical connection of dignity with the special features of humanity and free rational agency that often define a human as a person. Shotton and Seedhouse (1998) review the meanings that dignity can have in different disciplines, such as bioethics, nursing, and studies concerned with human rights. Their fear is that if dignity is not more clearly defined it will "disappear beneath more tangible priorities."

### Conclusion and Possibilities for Future Analysis

Dignity as a concept is ripe for clarification and analysis. Although Morse (1995) raises questions about the appropriate method for concept analysis, the continued growth of bioethics, the advancement of reproductive technology, and the implications of genetic research are just three reasons why *dignity* needs to be more robustly defined. Morse posits that methods of concept analysis derived from Wilson (1969) have certain flaws, such as the use of single cases; the absence of context, which can contribute to practical application; and the identification of fairly obvious results. Morse suggests the use of six different approaches to explain concepts:

- concept development to describe a concept that is unclear
- concept delineation to demonstrate differences between two "merged" concepts
- concept comparison to describe different, often competing, concepts
- concept clarification to reduce the confusion of certain assumptions about a concept
- concept correction to rectify the lack of fit between a concept and its clinical application
- concept identification to define a new concept.

The word *dignity* is unclear (concept development); dignity has been merged with worth and respect (concept delineation); dignity is often compared with respect for autonomy (concept comparison); assumptions of dignity such as free rational agency may obfuscate the concept (concept clarification); dignity in clinical practice in prisons and mental-health units may be in jeopardy (concept correction); and finally dignity in nursing practice may prove to be an altogether different concept

(concept identification). It appears that dignity requires considerable further research if its meaning is to be understood.

Morse (1995) suggests that qualitative research methods, beginning with a literature review and progressing to data analyses from observation, interviews, and secondary data analyses, are a way of using "rules of relation to identify the attributes of a concept, to delimit the concept, and to document the various forms that the attributes manifest" (p. 36). These methods are a useful means of better defining dignity, yet we must go beyond science (whether using qualitative or quantitative methods) to *knowing* respect for human dignity as an art and as a moral imperative. Ethics is conducive to *phronesis* (an Aristotelian term for the cultivation of praxis or "doing" through an understanding of what ought to be done in certain situations), places respect for human dignity in the realm of what Aristotle refers to as the practical arts, and does not limit the concept development of dignity to science (Carr & Kemmis, 1986).

Locke, as previously mentioned, was an empiricist who believed "morality being [is] capable of demonstration" in a scientific sense: "...measures of right or wrong, I cannot see why they should not also be capable of demonstration, if due methods were thought on to examine or pursue their agreement or disagreement" (*Essay Concerning Human Understanding*, Book IV, Chapter III, Section 18, as cited in Russell, 1945). More contemporary philosophical beliefs would view an understanding of respect for human dignity in realms other than science. As eventually scientism may be a threat to the fullest explanation of dignity, it is clear that dignity/human worth is a moral concept with roots in philosophy and other disciplines such as religion and art. The sources of knowledge to better explicate dignity are numerous. Science, whether achieved through quantitative or qualitative methodology, may not be the most appropriate search engine — and it is certainly not the only one — to validate and clarify the role of respect for human dignity in the nursing profession.

Critical social theory holds promise as a way to "preserve the concerns of classical practical philosophy with the qualities and values inherent in human life" (Carr & Kemmis, 1986, p. 133). The use of scientific research methods alone may not be amenable to such preservation. Is respect for dignity a *classical practical philosophy*? Is it a value *inherent in human life*? The answers to both these questions appear to be *prima facie* positive. The fit of dignity (respect for) in a practical arts paradigm, its clear value in human life, and its rich ontologic and epis-



temologic history are three reasons for suggesting a different existential clarification of its meaning.

Carr and Kemmis (1986) suggest that critical social science lies somewhere between philosophy and science, after reflecting on a question posed by Habermas about how the preservation cited above might be achieved: "...can we obtain clarification of what is practically necessary and at the same time objectively possible?" (p. 133). Critical social science affirms that "science should be justified by epistemology and not vice versa" (Carr & Kemmis). The suggestion that there is not one knowledge form that defines dignity means that epistemology should not justify the science that analyzes dignity as if it were even measurable (a suggestion of Mairis, 1994). If dignity could be measured and if one's knowledge interest could determine some causal explanation for dignity, then perhaps an empirical-analytical approach would be useful. On the other hand, dignity in the ethical sense is practical philosophy with the knowledge interest of understanding, knowledge that could be gained from hermeneutic or other interpretive sciences. If the knowledge guiding interest to understand dignity were an emancipatory one, then critical social science would be ideal. Why critical social science as a means of garnering knowledge about dignity? It would appear that those persons for whom dignity is not respected, for whom worth is not recognized, for whom respect is not afforded, are indeed oppressed. Such oppression is often justified by meeting the interests of others. The following scenario exemplifies oppression and lack of respect for worth and dignity.

*In the emergency department at 6am, Jan, an experienced emergency-department nurse, called the local taxi company to take a 48-year-old patient named Ian home after a 4-hour stay following a seizure. This patient with Down syndrome had been admitted via ambulance from a group home 30 minutes away from the hospital. He was alert, no longer post-ictal, and anxious to go home in time to get to work. Jan had not called Ian's legal guardian/family since she thought that consent for treatment was understood, given that the group-home staff had called for the ambulance and therefore, in essence, consented to treatment, and given that the family had previously written their blanket permission for emergency treatment. The sole staff member at the group home could not leave the other two clients to pick Ian up, so Jan and the physician concluded that a taxi was the most appropriate mode of transport. Ian was a Medicare beneficiary. He did not qualify for ambulance transport home since Medicare rules do not allow non-emergency ambulance or wheelchair transport for patients who can walk. With discharge instructions pinned to his pyjamas, Ian was put into the back of a taxicab, destination instructions were given to the driver, and Jan's encounter with Ian was over.*

This true story illustrates how a critical definition of dignity and its analogous concepts of worth and honour could benefit a nurse's decision-making. The ANA *Code of Ethics* suggests that respect for human dignity is the top priority of professional nursing in a moral sense. Critical social science holds promise as a means of describing knowledge about dignity that extends beyond its subjective meaning and describes an "objective framework within which communication and social action occur" (Carr & Kemmis, 1986, p. 137). This is based on the belief that dignity is moot if it is not considered within the framework of a moral community and that such moral community may distort the understanding of dignity. Habermas (1984), through his ideal speech situation with its four validity claims of truth, comprehension, sincerity, and rightness, suggests that his theory of communicative competence is a collaboration of theory and practice — a collaboration that would serve to emancipate those oppressed by disregard for their dignity, worth, and honour. Harmony of theory and practice is pivotal to nursing as a profession that is both an art and a science.

Dignity appears to be a conceptual something that all persons have and therefore can lose. Dignity is a conceptual something that persons are born with and want to die with. As ubiquitous as it is, dignity deserves to be defined so that it can be understood theoretically and practically within the nursing discipline. Philosophy (theories and principles), science, lived experiences, and the art of moral agency are all contributors to the respect for human dignity that human beings show in community.

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# **The Potential Contributions of Critical Social Theory to Nursing Science**

**Annette J. Browne**

La sociologie critique, de par son orientation théorique et philosophique, informe de plus en plus les champs de la recherche, de la théorie et de la pratique en sciences infirmières, en raison de la nécessité de tenir compte des facteurs socio-économiques accablants qui influent sur la santé et la prestation des soins. Or, bien que la teneur émancipatrice de la théorie critique réponde bien à la mission sociale de la profession infirmière, un examen approfondi des fondements ontologiques et épistémologiques de cette perspective révèle d'importantes incompatibilités en ce qui a trait aux exigences particulières de la discipline des sciences infirmières sur le plan épistémologique, à savoir élaborer des connaissances à la fois spécifiques et généralisables. L'auteure argumente que l'apport le plus significatif pouvant être fait par la sociologie critique aux sciences infirmières pourrait se traduire par une critique des idéologies fondamentales qui ont servi à élaborer le champ des connaissances dans cette discipline. La sociologie critique, en permettant de remettre en question ces présupposés idéologiques et de maintenir l'équilibre entre les diverses exigences de la discipline sur le plan épistémologique, pourrait ainsi contribuer à faire avancer les sciences infirmières vers des buts progressistes et émancipateurs.

As a theoretical and philosophical orientation to science, critical social theory (CST) is increasingly used in nursing inquiry, theory, and practice to address oppressive socio-political conditions influencing health and health care. Although the emancipatory focus of CST is well aligned with nursing's social mandate, the examination of ontological and epistemological assumptions underlying CST reveal important incongruities in relation to the unique epistemological requirements of nursing science for both generalizable and particular knowledge. This article examines the potential contributions of CST to nursing science and areas of philosophical compatibility and incongruity. The author argues that the most significant contribution of CST to nursing science may be achieved by critiquing the fundamental ideologies upon which nursing knowledge is developed. By interrogating these ideological assumptions, and by maintaining the integrity of our diverse epistemological requirements, CST can advance nursing science towards progressive, emancipatory objectives.

## **Introduction**

Debates in nursing on the relative merits of qualitative or quantitative traditions have been supplanted by more complex discussions of the

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ontological and epistemological assumptions<sup>1</sup> underlying the predominant philosophical orientations that guide nursing science. These different ontological and epistemological orientations provide the generalizable, objectively derived knowledge and specific, subjectively derived knowledge required to inform nursing practice. In the early 1980s, however, nursing scholars began to express concern over the lack of attention in nursing science to the social, political, economic, and historical conditions influencing clients, nursing, and health care (Kendall, 1992; Stevens, 1989). Empiricism and interpretivism were seen as lacking the capacity to address issues related to power inequities, structural constraints, and oppressions within society. To address this perceived gap in nursing science, nurse-scholars began to draw upon critical social theory (CST) as a theoretical and philosophical orientation to science that refocuses attention on the socio-political and historical context of health and health care (Ray, 1992).

In many respects, the aims of CST are compatible with nursing's social mandate. Examination of the ontological and epistemological premises underlying CST, however, reveal important incongruities in relation to the unique epistemological requirements of nursing science. In this article, the potential contributions of CST to nursing science are examined with a view to uncovering areas of philosophical compatibility and possible contradiction. The intent is not to discount the very powerful advantages of CST in advancing emancipatory goals for patients; rather, questioning the liberal philosophic underpinnings of nursing science will make apparent the risks in applying CST without adequate attention to the ideological context in which emancipatory ideas arise. Within this context, I argue that the most significant contribution of CST to nursing science may be in critiquing and challenging the ideological assumptions that drive nursing science.

### *Nursing Science: A Working Definition*

For the purposes of this article, nursing science is broadly defined as a practice science, the ultimate purpose of which is to (a) generate knowledge to meet its social and moral mandates, (b) inform nursing practice, and (c) develop possibilities for improving practice (Donaldson, 1995; Gortner, 1990; Johnson, 1991). As nursing is a practice science, the fun-

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1. For the purposes of this paper, epistemologies are defined as justificatory claims about who can be agents of knowledge, what constitutes legitimate knowledge, what kinds of things can be known, and what constitutes legitimate ways of developing knowledge (Harding, 1987). Ontology is concerned with understanding the nature of being and existence, "what is," and the structure of reality (Crotty, 1998).

damental goal of nursing inquiry and knowledge development is to inform and be informed by practice in ways that are socially relevant and scientifically rigorous (Hinshaw, 1989).

Nursing's foundation as a practice-based human science has particular implications for the analysis addressed in this article. The complex nature of nursing's social and moral mandates necessitates the use of multiple modes of inquiry to achieve the goals of nursing science. Nursing must apply general knowledge (e.g., health-promotion principles) for particular care (adapting principles to meet the unique needs of individuals/communities), rather than produce and apply uniform knowledge (applying the same principles in the same way to a wide range of individuals/communities) (Johnson, 1991). To do so, nursing science must generate and apply knowledge derived from different epistemological traditions, including empiricism (objectivist), interpretivism or constructivism (subjectivist), and hermeneutic philosophy (bridging subjectivity and objectivity).

The capacity and necessity to engage with different types of knowledge reflects the pragmatic, practice-based nature of nursing science. For example, generalizable knowledge concerning shared realities, common experiences, and predictable responses to health, illness, and social conditions is required to inform fundamental principles of practice. Inquiries conducted in the empiricist tradition are needed to substantiate claims regarding evidence-based practice, to determine predictable responses to nursing care, and to test deductive theoretical propositions (Monti & Tingen, 1999). At the same time, specific, subjectively derived knowledge conducted in interpretive/constructivist traditions is needed to address multiple realities, diverse experiences, and unique responses, and to tailor nursing practice to individual patient needs. The ability to generate and apply generalizable and specific knowledge in the absence of either empiricism or interpretivism seems untenable. Thus in an applied context, both subjective and objective knowledge must be developed and valued, "[one] neither inherently more true than the other, but each applicable on in its own terms and its own context" (Thorne & Varcoe, 1998, p. 490).

Some nursing scholars (e.g., Allen, 1995; Allen, Benner, & Diekelmann, 1986; Lutz, Jones, & Kendall, 1997; Thompson, 1990) move beyond the Cartesian separation of objective and subjective realms by positioning their work within "hermeneutic philosophy" (sometimes referred to as "Heideggerian phenomenology"). This approach bridges objectivity and subjectivity by highlighting the hermeneutical dimension of science, which focuses on understanding and interpreting mean-

ings that are at once objective and subjective (Bernstein, 1983; Crotty, 1998; Schwandt, 1998). Despite the appeal of transcending objective/subjective divisions, a prominent convention in nursing, as in other health and social sciences, is to treat these two epistemological stances as separate and separable (Bernstein; Guba & Lincoln, 1998; Johnson & Ratner, 1997; Monti & Tingen, 1999; Morrow & Brown, 1994). Realizing that the distinctions between subjective and objective knowledge domains are convenient (and oversimplified) dichotomous constructions, such classifications can be useful when used strategically to navigate among complex epistemological or ontological considerations (Johnson & Ratner). In this paper, I distinguish between objective and subjective forms of knowledge, and their general or particular applications, only as heuristic devices for discussing pertinent issues related to critically oriented knowledge in nursing.

Nursing's designation as a practice science means that our primary scientific mandates are social and moral, not theoretical (Bishop & Scudder, 1995). While theoretical discourse is obviously required to build frameworks for guiding nursing inquiry and practice, our primary responsibilities are actions that will lead to improved health for the collective (society) and individuals. Our science is therefore doubly charged with developing "preferable" forms of knowledge (Allen, 1992) and with enacting knowledge in practice towards a greater social good. Consequently, nursing's scientific responsibilities extend well beyond those of disciplines that are solely theoretically driven: we must produce and apply both theoretical and practice-based knowledge, and evaluate them against the general standards of science and our social and moral mandates. Given the complex mandates and epistemological requirements of nursing science, the central tenets of CST are reviewed and evaluated for areas of philosophical compatibility and incompatibility.

### **Critical Social Theory: Overview of Central Tenets**

Critical theory grew out of the theoretical tradition of the Frankfurt School in the 1920s and 1930s, as left-wing intellectuals endeavoured to reappraise Marxist theory and move the notion of domination and oppression beyond the realm of economic and class struggles (Kim & Holter, 1995; Stirk, 2000). Rather than representing a unified school of thought, CST encompasses different strands of theory heavily influenced by the Frankfurt School theorists. For the analysis, I draw primarily on the version of CST developed by Habermas, one of the most prominent second-generation German critical theorists (Agger, 1991;



Outhwaite, 1994). The decision to focus on Habermas's theory over other forms of critical theory stems from the heavy reliance on Habermas found in the nursing literature and from the need to create parameters for the discussion. In this article, the term *CST* is used to refer to Habermas's theory and the term *critical theory* is used to denote the broader field of critical theories.

CST can be viewed as a metatheoretical framework (theory about theory) for social science generally and nursing science particularly (Morrow & Brown, 1994). Unlike contemporary postmodern and post-structural theories, Habermas's theory is grounded in the Enlightenment tradition emphasizing reason, language, rational argument, a normative foundation for social critique, and a conception of history as moving in a dialectical manner towards emancipatory ideals (Hammersley, 1992; Willette, 1998). Basic assumptions and central tenets of CST particularly relevant for nursing science are synthesized as follows: (a) there is no ahistorical, value-neutral, or foundational knowledge that can be known outside of human consciousness; (b) all knowledge is fundamentally mediated by socially and historically mediated power relations; (c) every form of social order entails some form of domination and power; (d) language is central to the creation of knowledge and formation of meaning; (e) mainstream research generally maintains and reproduces (albeit unwittingly) systems of race, class, and gender oppression; (f) facts (or "truth claims") can never be separated from the domain of values or forms of ideological inscriptions; (g) by explaining and critiquing the social order, critical social science serves as a catalyst for enlightenment, empowerment, emancipation, and social transformation; and (h) critically oriented knowledge should offer social or cultural critiques with a view to transforming normative foundations that maintain the status quo (Boutain, 1999b; Fay, 1987; Habermas, 1968/1971; Kincheloe & McLaren, 1998; Morrow & Brown). Embedded within these tenets are definitive assumptions about the pervasiveness of unequal power relations and oppressive structures within society, and an emancipatory project that seeks liberation from constraints and domination arising from social, political, economic, and ideologic<sup>2</sup> conditions (Stevens, 1989).

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2. Ideology can be defined as "any system of ideas underlying and informing social or political action" and, "more particularly, any system of ideas which justifies or legitimates the subordination of one group by another" (Jary & Jary, 1991, p. 295). Typically, ideologies are not critiqued or challenged because of their taken-for-granted acceptance and domination in society (Boutain, 1999b; Stevens, 1989).

According to Habermas, critically oriented science should produce emancipatory knowledge that promotes social change and a more just society (Morrow & Brown, 1994). Such knowledge is developed through the critique of ideology and relations of dependence, which ideology sets in place as seemingly natural (Crotty, 1998; Habermas, 1968/1971). For a social critique to be liberatory, it must reveal the hidden relations of domination and power inherent in society's fundamental structures and ideologies (Fay, 1987; Thompson, 1987). The ultimate goal is emancipation to the "point where the self-consciousness of the species has attained the level of critique and freed itself from all ideological delusion" (Habermas, 1968/1971, p. 55). Such liberation involves freedom from conscious constraints and false consciousness to achieve uncoerced negotiated agreement as the basis for rational community life (McCarthy, 1978; Ray, 1992). Rationality in this context entails two central values, autonomy and responsibility, enacted (ideally) in the absence of oppressive coercion or manipulation by hegemonic ideology. Truths or knowledge as warranted beliefs are linked to ideas of rational consensus negotiated by a community (Allen et al., 1986). Thus knowledge is created, not discovered or received.

Conceiving of knowledge development as created through a process of self-enlightenment does not imply that knowledge is socially constructed according to a constructivist tradition of inquiry. Rather, Habermas attempts to articulate a distinctive form of epistemology into a "theory of rational communicative action" (Habermas, 1968/1971, 1981/1984). Here Habermas shifts critical social theory from the paradigm of consciousness to the paradigm of communication by connecting language, knowledge, communication, rationality, and action (Agger, 1991).

Using three different categories of knowledge, Habermas (1968/1971) links epistemological paradigms: (1) empirical-analytical (called technical cognitive interests), (2) historical-hermeneutic (practical cognitive interests), and (3) critical social science (emancipatory cognitive interests or emancipatory knowledge). The latter is derived by synthesizing knowledge from the previous two traditions to focus on individual and collective critical self-reflection, enlightenment, and rational mutual understanding (McCarthy, 1978; Ray, 1992). Thus, as Habermas (1968/1971) writes, "Orientation toward technical control, toward mutual understanding in the conduct of life, and toward emancipation from seemingly 'natural' constraint establish the specific viewpoints from which we can apprehend reality" (p. 311).

By drawing on different epistemological traditions, Habermas acknowledges the value in generating predictive, technical knowledge (empirical) and intersubjective knowledge (historical-hermeneutic) (Kim & Holter, 1995; Morrow & Brown, 1994). Because the parameters of empirical science are well understood within nursing, the emphasis here is on explicating the assumptions underlying Habermas's (1968/1971) second epistemological domain: historical-hermeneutics. Historical-hermeneutic knowledge is used to reveal "the intersubjectivity of mutual understanding in ordinary-language communication, and in action according to common norms," making possible "the form of unconstrained consensus and the type of open intersubjectivity on which communication action depends" (p. 176). "Communicative action" in this context refers to a distinctive type of social interaction and action oriented towards mutual understanding (Bernstein, 1985). Clearly, Habermas's conceptualization of historical-hermeneutics does not imply a focus on the individual's personal experiential meanings as in phenomenology or the coexistence of multiple realities or multiple interpretations of reality as in constructivism (Campbell & Bunting, 1991). Rather, historical-hermeneutic knowledge is viewed as a point of contrast in relation to empiricism-objectivism: "It is distinguished from the technical cognitive interest in that it aims not at the comprehension of an objectified reality but at the maintenance of the intersubjectivity of mutual understanding" (Habermas, 1968/1971, p. 176). Although historical-hermeneutic and empirical forms of knowledge are fundamental to and necessary for social existence, they are not sufficient to fully comprehend social phenomena (Kim & Holter). Instead, it is the capacity to move beyond the constraints of each that leads to emancipatory knowledge and social action (Morrow & Brown). Ultimately, it is emancipatory knowledge which has definitive significance for social change, because it involves "the fundamental transformation of individual and collective identities through liberation from previous constraints on communication and self-understanding" (p. 310).

The realist ontological foundation of CST advocates for a better approach to social existence, one that is free(er) of domination, power inequities, and oppression. The idea that there are preferable, better ways of existing as a society indicates a commitment to a non-relativist stance (Allen, 1992; Boutain, 1999b). Relativism, as an ontological and epistemological position, acknowledges the existence of multiple, equally viable realities, truths, and knowledge. Such a stance undermines the ontological foundation of critical theories, including CST (Allen, 1992; Thorne & Varcoe, 1998). To address the paradox of these competing ontologies, Morrow and Brown (1994) describe the ontology

of CST as “critical realism,” a philosophical stance that “rejects the basic polarization between positivism and postmodernist relativism — the standoff between empiricism and subjectivism as the only choices” (p. 77). From this position, legitimacy is granted to the subjectivist view that epistemology cannot be based solely on empiricism; at the same time, ontological scepticism is avoided regarding a historically and socially determined reality that exists independent of our consciousness. Thus CST claims to move beyond the subjectivist-objectivist debate to a dialectical relationship between the two philosophical traditions in an effort to address and alter relations of power that shape social reality.

### *The Appeal of Critical Social Theory for Nursing Science and Nursing Scholars*

Until the early 1980s, CST was virtually absent as a philosophical orientation informing nursing science, theory development, or practice (Boutain, 1999b). Increased interest in critical theory can be found in the literature from the early 1980s onward, as nursing scholars questioned the validity of empiricism as the historical foundation for nursing science and the limitations of interpretivism in developing nursing knowledge (Kim & Holter, 1995; Thompson, 1985). Nursing scientists began to view CST as a framework for broadening the focus of nursing science on domination, oppression, power relations, and political conditions, and developing an emancipatory thrust to nursing science, praxis, and social action. The links between emancipatory theory and action embedded within CST were seen as a means of decreasing the apparent theory-practice gap in nursing (Heslop, 1997). Bringing theory and practice into closer alignment within the framework of CST implied the possibility of a critically oriented praxis: the ability to link knowledge and theory development to practice-relevant social and political actions aimed at improving health, health care, and social conditions (Maxwell, 1997; McCormick & Roussy, 1997). Thus interest in CST was sparked among some nurse-researchers interested in contributing critically oriented knowledge and social action.

Recently, nurse-scholars have drawn upon critical theory (primarily CST) to frame critiques of the socio-political context of nursing practice (e.g., Stevens, 1989), domination within the discipline of nursing (e.g., Thompson, 1985, 1987), liberalism within nursing education (Thompson, 1987), power dynamics within communities and families (e.g., Allen, 1987), and structural constraints within the health-care system (e.g., Thompson, 1987; Wells, 1995). Others have used CST to



develop frameworks for emancipatory nursing actions (e.g., Kendall, 1992; Kim & Holter, 1995; Maxwell, 1997), critical action research (e.g., Holter & Kim, 1995), and critical nursing inquiry (e.g., Boutain, 1999a). Nurse-scholars have also combined the central tenets of CST with socialist-feminist and black-feminist theoretical perspectives, extending the applications of CST to examine gender and race as central forms of oppression and determinants of health (e.g., Boutain, 1999b; Davis, 1995; Thompson, 1987). In some cases, nurse-scholars have collapsed CST and feminist theory<sup>3</sup> as two different schools of thought under the rubric of critical theory. Although it is beyond the scope of this paper to discuss these issues fully, caution is urged against blurring the philosophical, epistemological, and theoretical distinctions between CST and feminist theory (Welch, 1999). This does not imply that the two schools of thought cannot be used together; rather, it suggests that explicit clarification is required to reconcile fundamental philosophical, epistemological, and theoretical differences.

Despite the appearance of CST in the nursing literature in the last 20 years, this body of work represents a relatively small proportion of overall knowledge development in nursing science, particularly in comparison to knowledge produced from non-critical theoretical stances. Nonetheless, the appeal of critical theory as a framework for nursing research, theory, and practice is growing, particularly among nurses interested in social justice and critically oriented praxis.

### **Potential Contributions of Critical Social Theory to Nursing Science**

Drawing on CST as a framework for expanding nursing's emancipatory potential does not imply a prior lack of emancipatory interests for the benefit of patients. Rather, it implies that nursing's goals in relation to clients and our social and moral mandates are inherently emancipatory insofar as they are aimed towards the greater social good. The position I assert, however, is that at this point in our development as a discipline the most significant benefit of CST is in providing a framework for

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3. Because feminist theory evolved from a critical social perspective concerning women's oppression and subjugation, there is a logical coherence between the emancipatory and empowering aims and objectives of CST and those of feminist theory (Allen, 1992; Campbell & Bunting, 1991). However, feminist theorists note that apart from a limited discussion of feminism as a social movement, Habermas's *Theory of Communicative Action* (1981/1984) is silent on the issue of male domination, women's subordination, and gender as a form of oppression (Fraser, 1995). Some nurse-scholars, while not explicitly naming this as a deficiency, use CST in combination with feminist theory to garner the best of both philosophical and theoretical approaches (Allen, 1992; Boutain, 1999b; Thompson, 1987).

explicitly and purposefully examining our science and knowledge in an "openly ideological manner" (Lather, 1991, p. 110). In the analysis that follows, I argue that the ideological critique demanded by CST offers possibilities for new and alternative modes of inquiry that can advance nursing science and our emancipatory potential.

An emancipatory science for nursing implies that there are better, preferable ways of generating knowledge to inform practice. As Thorne (1997b) contends, "It shifts the value of human inquiry away from straightforward knowledge acquisition and into the domain of generating useful or practical knowledge, interrupting patterns of power, participating in socially transformative processes toward such ideals as justice, equity, and freedom" (p. 126). As such, an emancipatory turn to nursing science implies several potentially valuable possibilities.

Operating from the stance of CST commits nursing science to the possibility of a critical, emancipatory praxis (McCormick & Roussy, 1997). In this context, praxis refers to the dialectical relationship among knowledge, theory, and practice that can precipitate emancipatory changes in relation to clients, nursing, and health care. At the very least, praxis from a CST perspective necessitates a critique of the ideological assumptions that drive nursing research, theory, and practice. As I argue, before actions that challenge the status quo can be initiated, nursing science must examine how dominant ideologies influence extant nursing praxis and (perhaps) constrain our future emancipatory potential.

If the transformative potential of CST is to be realized, nurse-scholars will need to engage to a greater degree in the type of ideological critical self-reflection that CST demands. As Habermas (1968/1971) writes, "The emancipatory cognitive interest aims at the pursuit of reflection" (p. 314). Accepting that there is "no social practice outside of ideology" (Hall, 1985, p. 103), critical self-reflection interrogates the philosophical and ideological foundations of nursing science. As Thompson (1987) noted more than a decade ago, critiques of the liberal ideological underpinnings of nursing science are required. Such critiques will reveal and interrupt patterns of complacency with subversive relations of oppression and domination contained within liberal ideological views that support "the inculcation of a positivist frame of reference concerning science, functionalism as the frame of reference concerning the social world, professionalism as an ideology that legitimizes class divisions in the social world, deontological and utilitarian ethical theory as frameworks for social ethics, and if progressive, liberal feminist content as a way of addressing the changing role of women"



(p. 35). Clearly, progress has been made, particularly with regard to interpretivism and (increasingly) hermeneutic philosophy as accepted philosophical orientations for nursing science. However, with several noteworthy exceptions (e.g., see Allen, 1995, 1999; Anderson, 1996; Boutain, 1999b; Culley, 1996; McCormick & Roussy, 1997; Taylor, 1999; Thorne, 1999), Thompson's (1987) call for critiques of our "strong liberal world view" (p. 35) appears to have been largely unheeded within nursing science. Thus critical self-reflection as one of the major contributions of CST to nursing knowledge and science has yet to be fully realized.

Liberal ideology is founded on views of society as essentially equitable, enlightened, and rational, and on notions of free and self-determining individualism (McConaghy, 1998; Weedon, 1997). In consequence, it is positioned in opposition to discourses that privilege structural determinants such as gender, race, and class over individuality. Although egalitarian (or welfare) liberalism "has an eye for social justice" insofar as minimum standards of living are provided through state intervention (Crotty, 1998, p. 163), liberal ideology diminishes the significance of individual and structural inequities that are produced by and sustain the institutional and social practices of our society (Weedon). Ideological critique from a CST perspective would challenge liberal tendencies reflected within nursing science, and lead to a line of questioning that asks, for example, how nursing science is complicit with liberal social and political values; what consequences (and/or benefits) these values have for nursing, patients, and our social mandate; what historical political and social conditions created nursing's affinity for liberalism; to what extent nursing science supports liberal notions of race, class, gender, diversity, individualism, and equity; how liberal social values influence nursing inquiry with disadvantaged groups; how political actions in nursing benefit disadvantaged patients; what aspects of domination and oppression remain unproblematic in nursing inquiry; and to what extent patterns of power and control are reproduced in practice. Though polemical, and potentially disruptive to the status quo, these questions may help nursing science to move beyond the "prereflective" stage towards a more politically critical, counter-hegemonic potential (Thompson, 1987, p. 32).

A second broad area of contribution for nursing science relates to the ontological commitment implied by CST. As noted earlier, CST presupposes a non-relativist orientation. Clearly, to fulfil our social and moral mandates, nursing science needs to adjudicate among competing probable truths, among guiding social and moral principles, and among ideological positions that drive research, theory development,

and practice. Furthermore, from a critical (and feminist) perspective, some social locations and perspectives are considered to be more beneficial than others as starting points for knowledge that seeks to understand and change oppressive social relations (Mann & Kelley, 1997). The priority granted to some perspectives over others, and the commitment to generate knowledge leading to preferred, improved ways of addressing health, preclude extreme postmodern claims that grant legitimacy to all viewpoints and forms of knowledge. Extreme relativist positions (referred to as "judgemental" relativism) have been criticized for undermining the moral grounding of rights-based claims and perpetuating the status quo (Harding, 1991, 1992; McCormick & Roussy, 1997). For example, Fraser and Nicholson (1988) point to the dangers inherent in Lyotard's extreme postmodernist claim that we cannot have (and ought not to have) overarching theories of social justice. These positions are clearly problematic for nursing science. As Morrow and Brown (1994) contend, some form of ontological realism is required to maintain the connection between the sciences and human emancipation. Drawing on "critical realism" as an ontological position within CST, therefore, can prevent the kind of political immobilization within nursing science that can occur when all perspectives and forms of knowledge are considered to be equally legitimate. Thus, claims within nursing science about preferable forms of knowledge can be firmly grounded in a critical realist framework which presupposes the existence of power structures that shape our social world and produce and reinforce individual and institutional inequities. From here, strong assertions about ideals of social justice, improved strategies for achieving health, and emancipatory nursing actions can be realized.

### **Where the Value of Critical Social Theory for Nursing Science Breaks Down**

Although CST offers significant promise for nursing science, critical analysis of its potential for incompatibilities and contradictions is also informative. In the process, attention is drawn to those features of CST that need to be reconciled if nursing science is to meet its social obligations to society and individuals.

There is no disagreement about nursing's fundamental commitment to a greater social good; hence the seemingly logical fit with the emancipatory aims of CST. Philosophical and epistemological inconsistencies arise, however, concerning the emphasis of CST on general forms of knowledge (related to social realities) versus individually

located (particular) forms of knowledge, and epistemological premises concerning false consciousness.

As previously mentioned, the underpinnings of CST are predicated on modernist notions of shared social realities and teleological progress leading to an enlightened and liberated society (Fay, 1987; Hammersley, 1992). An underlying (and characteristically modernist) premise is that people's social identities, aspirations, and actions can be collectively aligned and unified towards emancipatory goals (Boutain, 1999b). The focus of CST on unification, consensus, and the collective tends to erase or homogenize multiple subject-identities and diverse forms of experience and knowledge held by individual members of a community or society. Habermas's (1970, 1981/1984) "ideal speech situation" (a component of Habermas's theory of communicative action), for example, is expressed in terms of mutual expectations, unconstrained agreement, and achievement of universal consensus on emancipatory insights and actions (Crotty, 1998; Outhwaite, 1994). The tacit assumption is that people inhabit a single social, cultural, and political reality about which unifying emancipatory truths can be revealed (Boutain, 1999b). As a result, the focus of CST is on generating generalizable forms of insight and knowledge at the expense of diverse, individually and subjectively located understandings.

Uncritical reliance on CST as a framework for nursing science implies privileging the collective over the individual and general over particular knowledge. The potential consequence for nursing science would be an abundance of knowledge suitable for general application and an underdevelopment of knowledge derived from and applicable to unique, individual situations. Carried to an extreme, the risk would be a proliferation of emancipatory actions aimed at the general population — for example, population-based improvements in health or critiques of structural constraints on health. Although these broad-based efforts are worthwhile, they alone cannot fulfil the aims and objectives of nursing science for general knowledge concerning social realities *and* individually situated knowledge concerning unique realities, diverse contexts, and multiple understandings. Thus, while a general emancipatory orientation for nursing science is not in question, we cannot obviate the need "to always include consciousness of the problem of the individual — the fact that the subjective reality of each unique individual we confront in the clinical encounter must be respected, supported, and dignified" (Thorne & Varcoe, 1998, p. 491).

The notion of false consciousness (both individual and collective) as a central epistemological premise in CST (Fay, 1987; Habermas,

1968/1971) runs counter to the view that individual subjective perspectives are legitimate and necessarily valuable in their own right. False consciousness suggests that people are generally unaware of how commonsense ways of looking at the world are imbued with meanings that sustain their disempowerment and oppressive situations (Lather, 1991). For example, Habermas warns against excessive expectations about individual capacities because of the pervasive, oppressive constraints on identity formation inherent in today's society (Stirk, 2000). Although false consciousness is an important concept to apply in relation to nursing's own political awareness, in a practice context it undermines epistemological assumptions about who can contribute knowledge and what counts as legitimate knowledge. Carried to an extreme, false consciousness has the potential to undermine patients' individual, subjective knowledge as valuable and legitimate. For example, do we support a woman's decision to remain in an abusive relationship, or do we view her as a victim of false consciousness; do we support a terminally ill patient's use of denial as a coping mechanism, or do we attribute it to false consciousness? Pragmatically speaking, nursing science may benefit most from using false consciousness as a self-reflection strategy but refrain from applying the concept to individual patient-care situations. Thus false consciousness applied generally in relation to nursing's own ideological assumptions, biases, and blind spots is potentially valuable; however, the concept breaks down in relation to individual practice-based applications, a consequence of slippage between knowledge that is meant to be general and that which is meant to be particular.

Another challenge arises from the assumptions inherent in false consciousness. This concerns the social and cultural positioning of nurse-scholars and practitioners when patients' perceptions of their situation are considered to be potentially misguided or misinformed (Allen, 1999). As Lather (1991) warns, a central challenge for those committed to the emancipatory aims of CST is "how to maximize self as mediator between people's self-understandings and the need for ideology critique and transformative social action *without becoming impositional*" (p. 64). Spivak's (1987) circumspect comment is worth noting here: that "the desire to 'understand' and 'change' are as much symptomatic as they are revolutionary" (p. 88). In this context, all emancipatory aims are themselves normalizing, disciplining (in the Foucaultian sense), and representative of power. Thus caution is urged to avoid dogmatic applications of CST that presuppose a reality out there waiting for representation by researchers or scholars who play the role of "transforming intellectuals" (Lather, p. 109). To do otherwise would



be to risk past practices of power and control imposed in varying contexts by nurses onto patients (Ray, 1992).

To summarize, assumptions within CST about false consciousness, shared social realities, and mutual agreement about the greater social good are inconsistent with notions of legitimate multiple, coexisting realities (Thorne & Varcoe, 1998). While nursing's scientific, theoretical, and practice-based goals must be guided by shared, socially sanctioned principles that favour the common good, our science must also value a multiplicity of "knowers." A significant limitation of CST for nursing science, therefore, concerns the epistemological and ontological constraints placed on diverse, individually derived forms of knowledge as legitimate and necessary for understanding human phenomena: sources of knowledge that are central to nursing science.

Noting the epistemological and ontological limitations of CST does not imply that nursing science should align more closely with a relativist or constructivist tradition. To the contrary, nursing science could not function without normative direction (McCormick & Roussy, 1997). In this context, CST provides a powerful framework for constructing new forms of emancipatory knowledge. CST, however, under-determines human variability and individual complexities that are of primary concern to nursing science. Drawing on Thorne and Varcoe's (1998) recommendation, what is needed is "a moderate realism that balances absolute claims in the postmodern context and a respect for individual subjective reality that balances ideological primacy within critical theory" (p. 491). There is value, therefore, in drawing upon CST's critical realism; however, it must be balanced with the unique needs of nursing science for subjective, individually based knowledge. Both are needed to fulfil our social and moral mandates to society and individuals.

### **Implications for Nursing Science**

Allen (1992) reminds us that we cannot fully know the parameters of an emancipatory science until we have a fully emancipatory community. This suggests that nursing science would benefit most from developing realistic (though critical and challenging) expectations of CST and emancipatory aims. Other critical scholars concur, warning that aspirations ought to be centred on the *possibility* of emancipatory change rather than on expectations for actual changes (Lather, 1991). Nursing, it seems, would not have difficulty heeding these warnings: our interest in generating efficient, manageable applications of knowledge in practice situations requires pragmatic emancipatory objectives.

As nurse-scholars turn to CST in an effort to expand the depth and scope of nursing's emancipatory knowledge and praxis, it will be essential to maintain the critical focus intended by such a framework. Calls for critiques of domination and emancipatory social actions cannot be met with politically neutral applications in nursing inquiry, theory, or practice. Scholars working in an emancipatory tradition must question the ideological premises that shape knowledge development, and challenge our epistemological foundations to provide a new vision of what knowledge can look like and what social and political influence it might have (Thorne, 1997a). Such a project will require nursing to interrogate its definitions of "critical." In particular, we should remain sceptical of nursing's affinity for liberal ideology — and a slide towards liberal and libertarian applications of CST that paradoxically subvert analyses of exploitation and oppression in favour of maintaining the status quo (Thorne, 1999). If nursing science does not critique and challenge underlying liberal ideological assumptions, liberal approaches to critical inquiry will be promulgated. Attempts to advance so-called emancipatory critiques or actions without understanding the ideological perspectives that inform such critiques are potentially detrimental: unwittingly, we risk reproducing dominant, hegemonic values in nursing science, theory development, and practice. For these reasons, it is imperative that nurse-scholars place their own ideological suppositions, normative values, and philosophical assumptions under scrutiny, in the same "critical plane" as the subject of inquiry (Harding, 1987, p. 9).

From this critical vantage point, I suggest that emancipatory advancement for nursing science needs to occur on two levels. On one level, emancipatory possibilities should continue to be generated in relation to client groups, particularly those who are least advantaged. However, if the ideological context in which these emancipatory ideas arise is not critiqued, we risk reifying ideas as emancipatory when they are not. How, for example, can nursing science address inequities in health care stemming from individual and institutional racism if emancipatory actions are steeped in liberal (and some would argue neocolonial) notions of culturalism, othering, and calls for greater "cultural sensitivity" (Culley, 1996)? Before counter-hegemonic emancipatory critiques and actions can be generated, nursing must critique its own complacency with the ruling relations (Smith, 1987) as they are enacted in research, theory development, practice, and education. Thus the power of CST may be in encouraging nursing to problematize its own political biases, and in requiring nursing to consider the responsibilities



and implications of developing and applying our science in an unjust society (Lather, 1991). To advance nursing as a critically oriented practice-science, we ought to periodically critique the ideological underpinnings of our science and praxis, and challenge prevailing norms and accepted truths (Thorne & Varcoe, 1998). By acknowledging (and acting upon) the call for critique, and by maintaining the integrity of our epistemological requirements, CST can provide a valuable contribution in terms of advancing nursing science towards socially relevant, progressive emancipatory possibilities.

### **Concluding Comments**

By examining in detail the potential applications of CST to nursing science and by being explicit about areas of philosophical divergence, I have highlighted the significant benefits that can be gained by approaching nursing inquiry from the perspective of CST, and the limitations it places on the full range of knowledge that nursing requires. In the analysis, I have argued that we should be explicit about our reliance on the epistemological and ontological assumptions underlying objectivism and subjectivism, and those schools of thought that attempt to mediate between them, particularly critical realism and hermeneutic philosophy. There is value in recognizing (and grappling with) divergent epistemological positions, and in acknowledging how nursing science operates within fundamentally different philosophical approaches: in the process, the complex nature of nursing's knowledge requirements becomes illuminated. If we are to fulfil our scientific and social mandates, therefore, the full range of our epistemological requirements should be expressly identified, affirmed, and positioned accordingly within the framework provided by CST.

As I have asserted here, the most significant contribution of CST to nursing science will be achieved through critical self-reflection that examines and challenges the liberal ideological basis of nursing inquiry, knowledge and theory development, and practice. In the absence of such critiques, we run the risk of maintaining the status quo, inadvertently reinforcing patterns of power and forms of oppression enacted individually and institutionally, and failing to challenge dominant ideologies operating in nursing and health care. Different, openly ideological forms of critique — critiques that interrogate the fundamental ideologies upon which knowledge development is approached — are required. By turning the critical lens inward, we make possible a re-visioning of emancipatory goals for nursing science.

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# Not Innocent: Relationships Between Knowers and Knowledge

Christine Ceci

Jusqu'ici, les débats portant sur la question de la connaissance en sciences infirmières ont surtout cherché à déterminer quels types de connaissances pouvaient s'avérer les plus pertinents ou utiles à la pratique de la discipline. Nos méthodes devraient-elles d'abord et avant tout être de nature empirique? Quelle place faut-il accorder au travail interprétatif? Quelles catégories de connaissances faudrait-il privilégier? Voilà des questions auxquelles il peut sembler impossible de répondre dans l'absolu. Or, en modifiant les prémisses de la discussion, c'est-à-dire en considérant plutôt les liens qui unissent l'objet de la connaissance et le sujet qui connaît, il devient possible de réfléchir au rapport que nous entretenons à ce que nous croyons savoir et connaître. En mettant ainsi en lumière la position du sujet de la connaissance, une telle approche permet alors de voir que les questions portant sur la pertinence des connaissances en sciences infirmières sont également des questions d'ordre éthique et politique, de valeurs et de pouvoir.

Discussions about nursing knowledge have tended to focus on determining what kinds of knowledge are the most appropriate or most useful kinds for nursing. Should our methods be primarily empirical? What is the place of interpretive work? What kind of knowledge should have ascendancy in nursing? Framed in this way, these questions seem unanswerable. However, if we shift the terms of the discussion from appropriate kinds of knowledge and consider instead the relationship between knowledge and knowers, we can reflect on how we, as knowers, are related to what we think we know. Considering the relationship between knowers and knowledge foregrounds the situation of the knower, and questions about appropriate nursing knowledge can be seen to also always be questions of ethics and politics, value and power.

*To know a situation, one needs to sense what lurks in it.*

— James Hillman, *Puer Papers*

It seems fair to say that nursing, as a discipline, has been preoccupied with both the possibilities and the impossibilities of entertaining multiple, frequently conflicting, viewpoints in discussion. On the surface, this sometimes seems a question of simply deciding or choosing ways of thinking that appear most useful or most appropriate for nursing practice, or most congruent with a practice particularly defined. What lurks here, though, is the possibility that such choices may be without certain grounds beyond our own particular perspectives, that these decisions will make sense only within our own interpretive frames. Or worse,

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what lurks here is a fear that our differing views may be incommensurable such that a particular view can gain prominence only through a kind of violent suppression of other ways of thinking. Such a dismal prospect seems quite possible as long as our discussions remain focused on appropriate *kinds* of knowledge for nursing — that is, as long as we champion one or another of the various knowledges available as the most useful kind of knowledge to inform nursing practice.

Yet there are other questions that we could consider and that might perhaps change the tenor of the conversation. Rather than argue or debate appropriate kinds of knowledge for nursing, particularly as different modes of nursing will call on different knowledges, it may be useful to consider how we understand ourselves as knowers to be related to what we think we know. Directing attention to the *relationship* between knowers and knowledge raises different questions, questions that invite us to reflect not on what kind of knowledge is appropriate knowledge for nursing, but rather on *how* it is we position ourselves *as knowers* in relation to the different kinds of knowledge available to us in and for our practice.

It seems reasonable to suggest that, as knowers, we each read and evaluate the viewpoints of others through our own biases, beliefs, and assumptions, and, further, that it is unlikely it could be or should be otherwise. What could be otherwise, however, is the degree of awareness with which we do this. It seems important to understand something here that is also really quite obvious — that is, that we each hold the version of the world that we do, what it is, and how we can know it because we tend to think it is true, or at least truer than other versions of the world. Our beliefs provide for us what we consider to be a better account of what is and what happens, and we feel justified in these beliefs, in part at least because our experience tends to confirm them. When we do not understand another's position, or when we misunderstand it, usually this is not wilful but rather reflects the extent to which we are situated as knowers. Rather than disembodied and detached, our social identity and location necessarily affect our understanding of the world, and we find ourselves always already invested in what we think we know. As Harding (1992/1999) suggests, "what we do enables and limits the kinds of things we can know about ourselves and our world" (p. 458). In these terms, challenges to our beliefs are not experienced as simply challenges to ideas we may or may not hold, but often feel like challenges to ourselves.

It is important to consider this point for two reasons: first, because we should never take our disagreements lightly or engage in discussion

without care, and second, because it points to what this paper is about — how we are related to what we think we know. If we understand ourselves as somehow separate from what we know, with knowledge viewed as “out there” in an external, independently existing reality, then our disagreements still matter but not in quite the same way they do if we understand knowledge as something intimately connected with us, something in which we are implicated. As knowers we figure differently in each discussion. It seems that if knowledge is considered to be something out there, separate from us, then what we have to show is how our way of knowing what is out there more accurately reflects an independently existing world than someone else’s way of knowing. We are concerned with questions of what the world really is and with developing ways of knowing that bring us closer and closer to what really is. In knowledge-seeking activities we believe we simply uncover or discover what is already there, and hence there are ways in which we can think about what we are doing as a kind of neutral activity, without implications beyond the activity itself. However, if we speak of knowledge in light of an understanding of knowers, and hence all knowledge as situated, then we can understand our differences not as disagreements about what the world really is apart from the ways we can know it, but as struggles over *how* to see (Haraway, 1988), *how* to interpret the world, and then we raise questions about what influences and shapes our understanding.

In terms of the relationship between knowers and knowledge, I hold a position of understanding knowers as situated, which for me means that all claims to know something are partial, contingent, temporal, located and locatable. Accepting all knowers, and hence all knowledge, as situated involves recognizing that “all our interactions with reality are mediated by conceptual frameworks or discourses, which themselves are historically and socially situated” (Lennon & Whitford, 1994, p. 4). This is not a kind of radical relativism but rather a view that insists that all knowledge comes from somewhere and the somewhere from whence it comes is epistemologically relevant. Inasmuch as we are in it, there is no way to step outside ourselves or our situations and map knowledge claims against an independently existing reality; there is no possibility of transcendence, no access to reality “as it really is” prior to our theorizing about it. As Kuhn has observed, there is no “theory-independent way to reconstruct phrases like ‘really there’” (cited in Caputo, 1987, p. 221). Rather than mirroring, more or less accurately, an external reality, what is known always returns to “reflect the subject who produced it” (Lennon & Whitford, p. 2).

Understanding knowers as situated interrupts our desire to say what the world *really* is by instead raising questions about how it is that *this* world exists for us, how it is that it is available to us as it is. Here, knowers and their situations become epistemologically significant. As knowers we make decisions, more or less consciously, about which ways of thinking about the world — which of the versions we have available to us — are better. And though it is not always clear how such decisions are made, it does seem clear that we do decide, and so it seems reasonable to suggest that there are ways in which knowledge is always already linked to concerns about ethics and politics. When we make judgements about knowledge claims and about appropriate ways to know something, we are concerned not only with epistemological questions but also with questions of value and power.

### Reading Susan Gortner

That we will not and do not all hold the same views about the relationship between knowers and knowledge, that our understandings will differ, is a given. What is not given, however, is how to understand how these differences matter and, in a sense, what to do with the difference. To explore this problem of difference, I want to look at Susan Gortner's (1993/1999) position in her article "Nursing's syntax revisited: A critique of philosophies said to influence nursing theories." I choose to use this particular article as a point of departure in the discussion because Gortner's articulation of her position is both clear and reasonable. She is concerned with the development of knowledge in nursing and with what kinds of knowledge will be considered legitimate nursing knowledge. She locates herself as a scientific realist and describes the ascendancy in nursing of some phenomenological social philosophies as a threat to this position. She is particularly concerned with the need to retain in nursing the capacity to develop theories that have explanatory power. And so she uses these two requirements, scientific realism and explanatory power, to evaluate the perspectives of empiricism, hermeneutics, feminism, and critical social theory. That she has done this, and done this so clearly, is useful, I think, because it is what we tend to do — that is, we read other positions through our own.

Reading Gortner (1993/1999) as someone who has a somewhat different position — that is, a different understanding of the perspectives she evaluates — is a dislocating experience. It is a matter not of simply agreeing or disagreeing with the substance of her argument, but of seeing my position rendered through her eyes such that it is changed but still recognizable, seeing that, from her position and with her



beliefs, this is what my position looks like. What I would like to do here is talk back to Gortner, to try to get at how we differ and what it is that makes the difference between us. I will suggest that it is how we understand the relationship between knowers and knowledge that is central to our difference. Gortner's position of scientific realism supports a belief in a real world that exists independently of the mind; scientific knowledge refers to and more or less accurately reflects this real world. And even though her positioning acknowledges contemporary critiques of science, such as the value-ladenness of theory, she does not appear to have allowed these critiques to make a difference to what seems to be an underlying belief in the separation between the knower and what is known — that is, knowledge is still held to be referential, about something outside and separate from the knower. It is this underlying belief that makes her account of hermeneutics, for example, seem unfamiliar to me.

I want to look at how this difference plays itself out in the approaches to knowledge that Gortner (1993/1999) describes, but first I want to address a question that often arises in these discussions, and that is the question of the nature of the reality about which we are speaking. Sometimes when one suggests that there is no reality that exists independently of the mind, the suggestion is interpreted to mean that there is no common knowable reality, or even that there is no world outside the mind, that there is nothing — which to all of us is, I think, obviously untrue. Sometimes the suggestion may be made to simply undermine ways of understanding the world that are not grounded in a robust realism, to show how wrong other ways of thinking are, and since I am not grounded in this kind of robust realism I rather wanted to try to put that particular suggestion out of play, or at least lay it to rest for a while.

When I suggest that reality does not exist independently of the mind, I am not saying there is nothing. Rather, I believe quite firmly in a world, a real world, of which we are part. What is a question for me, though, is not so much what this world really is, which I think may be a question that scientific realism tries to answer, but rather how it is that this world exists for us, how it is that it is available to us. Gadon (1990) suggests that we choose, in rather complicated ways, how we will come to terms with the world and ourselves, and these will, even before we say we know anything in particular, contain assumptions about features of the world that will shape in advance what we think we can know and how we think we can know it. We do not apprehend a world that is given or simply there, but rather the world arrives always already interpreted. Approaching the world in order to know it, to

know it as something, requires presuppositions, what Caputo (1987) describes as "a preparatory grasp of what is to be understood" (p. 52). Such forestructures of understanding "belong to the very possibility of knowing" (Caputo, p. 71). This implies a world that is not given but interpreted, construed, from a situated standpoint, a world that can "appear" to us only if we know how to "take it," how to construe it or make it meaningful (Caputo). Our attempts to understand lead us not to the world but rather back to ourselves, albeit "in a deeper, less innocent way" (Caputo, p. 97). In these terms, what the world is, is what it is taken to be, and it is in this way that I would say there is no reality available to us that exists independently of the mind. What the world really is, independent of the ways in which we theorize it, is precisely what it is not possible for us to know.

The reasons why I suggest that Gortner (1993/1999) holds a view quite different to this, one that separates knowers from the knowledge they produce, stem not so much from her account of empiricism but rather from her account of hermeneutics as having to do with purely subjective experience and with her suggestion that knowledge-seeking activities need not always be thought of as inherently ethical and political endeavours. At the same time, I would suggest that within her account of empiricism are the seeds of another way of thinking, understandings that if followed through would perhaps change how she perceives the relationship between knowers and knowledge and hence her understanding of hermeneutics and the relationship between power and knowledge. It seems in some respects a matter of taking up the implications of the critique of traditional modernist science to which she refers and allowing these to make a difference. I would like to try to allow the implications of the critique of science already contained in this article to make a difference in Gortner's account of empiricism, hermeneutics, and political approaches to knowledge, and to consider how focusing on this difference makes a difference.

### **A Different Story About Empiricism**

Gortner (1993/1999) quite clearly differentiates her contemporary empiricist position from the naïve assumptions of logical positivism. There are three, related points that Gortner includes in her description of empiricism that I would like to focus on here: the impossibility of separating fact from theory, the theory-ladenness of observation and experience, and the nondifferentiation of the context of discovery from the context of justification. I want to suggest that if you accept these as characteristics of empirical inquiry, and Gortner apparently does, then



what you are also accepting is the interpretive character of perception and therefore of all knowledge. That is, accepting these involves recognizing that all of our interactions with the world are mediated by conceptual frameworks, theories, and discourses — ways of ordering the world that are themselves connected to specific social and historical contexts. Our capacity to see and know is both shaped and limited by the resources for understanding we have available to us and by our inability to step outside our situation to check these against an independently existing reality. Since our perspectives are partial and situated, access to reality “as it really is,” and prior to our theorizing about it, is not possible.

This is to suggest not that there is no possibility of knowledge that we call scientific or empirical but rather that there is no possibility of what Harding (1991) calls “disinterested knowledge” (p. 109), knowledge that is severed from our pre-existing theoretical commitments, our values, beliefs, and assumptions. My understanding of the critique of empirical science draws primarily on feminist philosophers of science (Campbell, 1994; Gorham, 1995; Harding, 1991; Longino, 1996; Okruhlik, 1994), most of whom seem to be committed to empiricism but to an empiricism that tells a different story about itself. It is probably no accident that feminism has provided many of the strongest critiques of traditional science, since one of the rocks this science has foundered upon is difference, most obviously but not only the difference between men and women as knowers. In this view, men and women are seen to occupy different social locations, to have different experiences and hence to “know” differently (Lennon & Whitford, 1994). In some respects it was the insertion of the female body into discursive spaces that assumed the universality of male embodiment through the presumption of a disembodied subject, that began to complicate and destabilize these discourses. The supposedly universal was interrupted by the particular such that what was thought to be universal could be seen not only as misleading but, more interestingly, as open to interpretation. Mills (1988) suggests that many epistemological critiques originate with a questioning of the privileging of a supposedly universal but actually quite limited viewpoint. And though this viewpoint often turns out to be not only quite particular and very locatable, it is the very essence of a universalizing discourse to ignore or deny its particularity and to conceal actual difference in power and privilege, experience and situation (Strickland, 1994).

I would like to emphasize, as does Longino (1996), that interested or biased science cannot simply be dismissed as “bad” science — that is, science that does not adhere rigorously enough to its own methods

— but rather should be considered science as usual. Longino suggests that we should not be surprised when scientific inquiry displays “the deep metaphysical and normative commitments of the culture in which it flourishes” (p. 256). Background assumptions, values, and beliefs facilitate the creation of a link between theory and data, a link that Longino describes as an “interpretive achievement that involves the collapsing of theoretical and observational moments” (p. 254). The assumptions through which we make or imply substantive claims about that which we theorize are not often subject to rigorous scrutiny, and so these assumptions are also often the vehicle for social or contextual values. Background assumptions may have to do with beliefs about the nature of the reality with which we are concerned, the extent to which and methods by which it is available to us, or about the relative importance of various features of this reality or what will count as plausible evidence of what we are investigating. Since the methods of empirical science, in themselves, are not seen as adequate to screen out these contextual values and assumptions, Longino suggests that it is “not necessarily in the nature of science to be value-free” (p. 256). Rather, since there is no way “to eliminate assumptions from evidential reasoning generally, and hence, no way to rule out value-laden assumptions, there is no formal reason for arguing that an inference mediated by contextual or social values is thereby bad science” (p. 255). Rather, it is simply science as usual. The difficulty she suggests arises because the idea of value-free science is still with us in part because of what the realist tradition suggests that science is supposed to do — that is, “to discover fixed relations of some sort, and that the application of observation, experiment and reason leads ineluctably to unifiable, if not unified, knowledge of an independent reality” (p. 257).

Longino’s (1996) critique has to do, in part, with how the relationship between the context of discovery and the context of justification is conceptualized. Many authors, including Gortner (1993/1999), have conceded that discovery and justificatory procedures cannot be clearly differentiated. This means that if biases and assumptions are acknowledged, as they are, to operate in the context of discovery — that is, in the identification and definition of research problems, the development of hypotheses worthy of testing, and so on — then there is no reason to believe that empirical methods, no matter how rigorously applied, will be sufficient to remove these biases in the context of justification. Campbell (1994) suggests that it is sometimes assumed that norms of empiricism such as the standard of predictive success, the standard of observation independence, and explanatory power are sufficient to remove bias, that they are about the “logic” of justification, and as

norms of logic are therefore inherently apolitical. This view, Campbell suggests, is profoundly mistaken, and he instead argues that the very "logic of confirmation...depends on the context of discovery" (pp. 95–96). That is, whether or not there is evidence that confirms or disconfirms a given hypothesis is not determined independently of the context of discovery where social and political values, beliefs, and assumptions are acknowledged to operate. Predictive success is always assessed or measured in the context of the auxiliary hypotheses and background assumptions that shape the context of discovery. Observation itself also relies on the various assumptions made in the context of discovery, and the norm of explanatory power is always a comparative norm, measured against the presence or absence of other relevant theories that are part of the context of discovery. As Campbell suggests, there is no "sense to the idea of a 'pure' empiricism with respect to hypothesis testing against the evidence — that is, there is no methodology of testing which is apolitical in its application" (p. 97). The norms of empirical testing, the justificatory procedures, require for their satisfactory completion productive supplementation by the assumptions, values, and theoretical commitments that are at play in the context of discovery. And even prior to actual justificatory procedures, it must be kept in mind that the context of discovery "determines what gets put to the empirical test in the first place" (p. 94).

This understanding of the contiguous association between the contexts of discovery and justification highlights the way in which our pre-existing theoretical commitments and assumptions can shape the very content of what we call science. The suggestion is made that there is nothing in the actual processes or practice of empirical science that in itself is capable of rendering knowledge that is, in any sense, value-free. This critique attains more specificity in discussions of the theory-ladenness of observation and in the under-determination thesis.

The theory-ladenness of observation points to the interpretive character of perception. Caputo (1987), following Kuhn, observes that neither facts nor evidence are given but rather what is considered to be a fact or to be evidence "is guided beforehand by a theory, by a certain conception of the way things are" (p. 215). Facts become meaningful observations only in the context of a framework of understanding without which they "can appear to be of no significance whatever" (Caputo, p. 215). And appeals to the evidence, too, depend on one's perspective for "what is important evidence in one view is not important in another" (Caputo, p. 218). This is not only a matter of what we see something as but also, and more interestingly, what we are able to see,

the ways in which our theoretical and background assumptions guide or shape our observations.

Background assumptions are often not something about which we are aware and should not necessarily be thought of as belonging to, or as held by, an individual. Perekeh has suggested that in order to understand how background assumptions work, it may be useful to think of society not as simply a collection of individuals but as a system of positions: "To be a member of a society is to occupy a prestructured social space and to find oneself already related to others in a certain manner.... Since (one's) social experiences are structured, (one's) form of thought, the categories in terms of which (one) perceives and interprets the world, are also structured" (cited in Mills, 1988, p. 245). Our circumstances and situatedness as knowers affects the nature of our experiences, what we take as fact, what we consider to be normal or natural, and this changes over time and across society. This is to suggest not that observation should be thought invalid but rather that what we are able to see, what will count for us as valid observation, may depend on where and how we are positioned. Accepting that all observation is theory-laden, that perception is interpretive, may mean giving up the belief that what we think we know corresponds or refers in any direct sense to a real-world structure (Gorham, 1995).

The under-determination thesis is related to this idea that observation reflects our pre-existing theoretical assumptions and commitments. This thesis, according to Okruhlik (1994), involves the claim that data "cannot pick out a single theory that uniquely accounts for them," the suggestion being that if the data "aren't completely determining our theory choices, then something else must be doing the job" (p. 202). Since any number of theories could potentially be generated and coherently account for the same body of evidence, our commitment to a particular theory must be explainable with reference to something other than the evidence or data itself. This something else is thought to be the pre-existing theoretical commitments, the biases and beliefs, and the background assumptions that shape our interpretation of the relevance and significance of the data, and hence influence our preference for one theory over another.

Some have challenged this thesis, suggesting there is an "unfortunate tendency...to overestimate under-determination" (Okruhlik, 1994, p. 202). Under-determination, critics suggest, would only "be a problem if we were, in reality, faced with an infinitude or even a pair of empirically adequate theories" (Okruhlik, p. 202). This rarely happens, and so there will always be good cognitive reasons for preferring one theory



over another. Those who support the under-determination thesis, such as Okruhlik, suggest that this simply begs the question of why it is we have just this particular set of theories to choose from and not others — that is, the prior question “of how our options came to be determined in the particular ways that they have” remains unanswered (p. 203). Okruhlik goes on to suggest that our options in theory choice will reflect the dominant values and beliefs of the society in which theories are generated, and so our social arrangements, and our situatedness within these, must be considered as epistemically significant.

In situations that are irreducibly comparative, such as when we choose among extant theories to account for our data or evaluate theories in terms of explanatory power, we may need to consider that the theories or explanations available to us are not in any sense neutral, nor is the activity of choosing itself. Though we may be convinced that we are simply choosing theories that are epistemically better than other available theories — in the sense, for example, that we believe they provide better explanations — and though we may believe ourselves to be doing this quite rationally, based on the evidence, if the theories and explanations we have available to us are generated through pre-existing theoretical commitments, values, beliefs, and background assumptions, then we may also need to accept that what empirical science gives us is not the world but rather an interpretation of it (Gadow, 1990). In these terms, Gortner’s (1993/1999) key requirement that world views appropriate to nursing must have explanatory power can be seen as understandable but perhaps inadequate. To have explanatory power means only that there are no better explanations, and though explanation is very important to nursing practice, equally significant may be understanding why it is that we have just these particular explanations available to choose from and not others.

This seems to me a very relevant point given that we live in a society structured by relations of power, stratified by race, gender, and class hierarchies. If scientific theories are generated by scientists operating in a deeply sexist culture, for example, it seems quite likely that the content of science will be, as Okruhlik (1994) suggests, contaminated by sexism. And it may not necessarily be the case that non-sexist theories will never be generated. Rather, it may be that ingrained, often taken-for-granted sexist assumptions will not even be noticed. As Okruhlik emphasizes, sexism in science does not make rational theory choice impossible, but once it is allowed that biases, beliefs, and assumptions influence theory generation and theory choice, there is nothing in scientific methods themselves that can be counted upon to eliminate bias from science (Okruhlik).



Allowing the critique of empiricism to make a difference in our understanding of contemporary empiricism does not deny the value and validity of empirical methods for the development of nursing knowledge. Rather, it tells a different story about empiricism, which may allow us to position ourselves differently in relation to this particular kind of knowledge — that is, to acknowledge that empirical science, as useful as it has proven to be, is still an interpretation of what the world is like, that its grounds are not certain but, rather, shifting. I think this is perhaps part of what Gortner (1993/1999) leaves out — that is, once we recognize the implications of the critiques of empiricism, once we concede that the very content of science is affected by values, assumptions, and beliefs, then our situatedness as knowers must be foregrounded and afforded epistemic significance. In these terms, knowers are implicated in what is known, and politics and values cannot be understood as something other than or outside of knowledge-generating activities. Once again, as Caputo (1987) suggests, we are led back to ourselves “in a deeper, less innocent way” (p. 97).

### **A Difference for Hermeneutics**

My difference with Gortner (1993/1999) is that though she acknowledges the critiques of empirical science, there seems to be little recognition in her writing that empiricism is either an interpretive or a political activity. Rather, interpretation and politics happen in other modes of knowing. This is why I suggest that Gortner has not allowed the implications of these critiques to make a difference in her position. Understanding knowers as situated not only changes our understanding of empiricism but also may make a difference in what identifiably hermeneutic modes of inquiry may be seen to have to offer nursing practice. Hermeneutics begins, I believe, from the position of acknowledging that we live in a world of meaning. Rather than subjectivizing experience, as Gortner suggests, understanding the lived experience is about understanding the structures and relationships that construct our lived realities, the meanings we create from the contexts in which we find ourselves. As Strickland (1994) suggests, “other perspectives inform me not only about them and their situation, but of me and mine” (p. 271). The world of meaning in which we live is a shared world, where self is understood neither as separate from the world nor the absolute origin of experience. Rather, the “subject” of lived experience, the experience with which hermeneutic inquiry is concerned, is a consequence of the world.

It has been suggested that “already” is the word that distinguishes hermeneutics: we are already in a world, already invested in a world, and the work of hermeneutics is about developing a picture of how human experience fits together such that it is comprehensible. Hermeneutics is always worldly, about a world that Leonard (1989/1999) suggests is *a priori* — that is, the world we have is ours by virtue of our historical, cultural, and temporal situatedness: “world is the meaningful set of relationships, practices, and language that we have by virtue of being born into a culture” (p. 317). World, in this sense, is what we require to make sense of our existence; it is that upon which we rely for meaning and intelligibility, or that which is “requisite for anything to be visible to us at all” (Leonard, p. 318). This is a world that has to do with neither the subjectivism of idealism nor the objectivism of realism: “the world is neither held in the mind nor ‘out there’ to be apprehended” (Leonard, p. 318).

This is an understanding of hermeneutic inquiry that Gortner (1993/1999) loses when she renders hermeneutics through the lens of scientific realism, but I think it is an understanding implied in the recognition of the theory-ladenness of observation and experience and of the impossibility of separating fact from theory. The world that we have, the world that both empiricism and hermeneutic inquiry seek to make intelligible, is the same world, a world that depends on our knowing how to take it.

### **A Difference That Matters**

For nurses, the world that we have, the world that is intelligible or meaningful to us, may perhaps be best understood as merely the beginning of knowledge, as signifying what may be thought of as both our limits and our possibilities for understanding. Knowing something of where we begin is a necessary starting point, for, as Vasterling (1999) suggests, “to become aware of something we do not understand, we need a context of what we do understand” (p. 23). Our situatedness, though both the prior and requisite condition for knowledge, is in this way generative — that is, while situatedness speaks to us of what we know, it also points us towards what we do not know. Recognizing our limitedness may inscribe a boundary, but it also suggests that something lies beyond the present limits of our understanding; it gestures outwards. Conceptualizing knowers and knowledges in terms of the partiality and limitedness of situation both reminds and compels us to seek other perspectives and to characterize our understandings in tentative rather than absolute terms.

Knowledge of our own situatedness is also always knowledge that there are and must be other possibilities for understanding, and our openness to the world has to do with how much we are willing to allow what we think we already know to be affected by what happens. Strickland (1994) reminds us that the presence of other perspectives, other views of the world, should be understood, at least in part, as a critique of our own understanding, and so what we may need to consider is not always and only which version is better but also how different versions are related. Recognizing complexity, however, does not mean that we concede that all views of the world are equally valid or valuable for nursing, or that when faced with contradiction we should fling up our hands and do nothing. Rather than absolving ourselves of the responsibility of deciding how to proceed, we may simply need to accept that retaining a certain contingency in our own views of the world may sometimes be a more ethical choice than eliminating or suppressing that which refuses to fit. Knowledge becomes a matter of ongoing critical engagement with the world, knowing an openness to otherness rather than an act of grasping. If we acknowledge that a range of perspectives is possible and linked with the position of the knower, rather than fixing truth claims we can perhaps concern ourselves with discerning the implications of holding particular points of view — for ourselves, for our patients, and for the systems within which we practice.

Nurses and nursing must not only interrogate and try to understand our situatedness as knowers in terms of differences in perspective — that is, how our particular positionings may shape what we claim to know — but also confront the ways in which our situatedness and our claims to knowledge are also always embedded in relations of power. These are not necessarily two distinct activities, for any really meaningful understanding of the relationship between knowers and knowledge will always require a vigilance about power. In a world such as ours, stratified as it is by hierarchical relations of power, some knowers and some situations are already privileged, and, as Collins (1997) suggests, this privileging may have less to do with any internal or inherent criteria of truthfulness or validity and more to do with the power of those positioned in particular ways to enforce or impose their particular perspectives even in the presence of other equally plausible understandings. Often we find that what will count as legitimate knowledge also relies on the techniques and operations of power to make it so, suggesting that knowledge is inextricably tied to webs of domination and

exclusion, privilege and marginalization, some of which we can see but some of which is often invisible to us through its seeming naturalness or inevitability. When claims to know, whether informed by empiricism, hermeneutics, or any other approach to knowledge generation, are uprooted from the systems of power within which they are embedded, those who attempt to take the knowledge and leave the power behind or put it aside are, inadvertently or not, operating in the realm of privilege; that seeming neutrality is itself a mark of privilege (Collins). So when we become involved in conversations about what kind of knowledge is to be understood as legitimate nursing knowledge, we may also need to ask questions about who and what makes it so, and what knowledges we would hope to exclude or marginalize through this process. This is not to suggest that processes of authorization are always unwarranted, but rather to recognize that claiming authority or legitimacy also always involves processes of selection and exclusion, and these are worth paying attention to.

Haraway (1988) suggests that knowledge as vision is always a "question of the power to see" (p. 585). This view of vision is not a disembodied view from nowhere; neither is it the relativistic view from everywhere attributed to some forms of postmodern thought. Rather, Haraway advocates a view from somewhere, an embodied vision that acknowledges that what we think we know is always partial, sometimes distorted, that we see what we are able to see, and, though what we are able to see changes, our situatedness is not transcended. Situatedness offers what I consider to be a profoundly ethical positioning in relation to knowledge. Understanding and accepting our situatedness as knowers allows us to approach knowledge as a "power sensitive conversation" (Haraway, p. 590) instead of something we just do, procedures we just carry out — and who we are in what we know becomes an integral part of the epistemological context. But most important of all, when we understand ourselves as knowers to be situated, "we become answerable for what we learn how to see" (Haraway, p. 583). As nurses, I would suggest, we are challenged to thoughtfully take up the contingencies of our situatedness and called upon to consider how it is that we can experience and believe we have knowledge of the same world, all at once and yet so variably. It seems to me that understanding knowledge and knowers as situated does not create an instability in our grounds for proceeding but rather makes us aware of, and compels us to account for, a certain groundlessness that is already there.

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## **Reductionism in the Pursuit of Nursing Science: (In)congruent with Nursing's Core Values?**

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La philosophie et les perspectives prônées par la science ont fait l'objet d'une critique élaborée par certaines chercheuses en sciences infirmières. Suivant cette critique, les perspectives traditionnellement adoptées en sciences seraient contraires aux principes humanistes préconisés par la profession infirmière, le réductionnisme étant considéré comme une approche incompatible avec les valeurs fondamentales de la discipline. Par conséquent, plusieurs chercheuses en sciences infirmières ont avancé qu'il faut abandonner cette orientation, considérant que les efforts de recherche devraient être guidés par une perspective humaniste. Les auteures de cet article soutiennent qu'une telle position entraînera des conséquences graves pour le développement des connaissances en sciences infirmières, et qu'elle pourrait nuire à l'avancement de la profession et de la discipline dans son entier. Elles réfutent l'argument selon lequel le réductionnisme en sciences infirmières est incompatible avec les valeurs fondamentales de la discipline, vantent les mérites de cette approche et concluent que sans le développement d'une approche épistémologique globale, l'actualisation de ces valeurs risque d'être compromise.

Within nursing scholarship a critique has developed around the philosophy and approaches of traditional science. The central theme of this critique is that the approaches of traditional science are antithetical to nursing's commitment to a humanistic philosophy, as reflected in the premise that reductionism is incongruent with nursing's core values. Several nurse scholars, believing that nursing's humanistic philosophy should guide the research efforts of the discipline, have advocated abandonment of the reductionistic approaches of traditional science. The authors contend that adoption of such a position will have serious consequences for knowledge development in nursing and subsequently will be detrimental to the advancement of nursing practice and the discipline of nursing. They refute the premise that reductionism is incongruent with nursing's core values, argue for reductionism in nursing science, and conclude that without the pursuit of epistemological holism, the actualization of nursing's core values is in jeopardy.

The pursuit of nursing science is an endeavour fraught with commentary and debate, much of which has focused on the nature of nursing science and appropriate modes of inquiry for the development of

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nursing knowledge (Schumacher & Gortner, 1992). While commentary and debate are to be applauded, we are nevertheless concerned about the critique that has developed around the philosophy and approaches of traditional science by critical social theorists and proponents of interpretive views of nursing science (Benner, 1985; Holmes, 1990; Leonard, 1989; Mitchell & Cody, 1992; Moccia, 1988; Munhall, 1982/1997, 1992; Newman, 1992; Sarter, 1987; Thompson, 1987). The central theme of their critique is that the approaches of traditional science are antithetical to nursing's commitment to a humanistic philosophy. This is reflected in their belief that reductionism, in the pursuit of nursing science, is incongruent with nursing's core values. In light of this viewpoint, several nurse scholars have advanced the "purist" position (Gortner, 1993) that the humanistic philosophy of nursing should guide and direct the research efforts of the discipline and have advocated abandonment of the reductionistic approaches of traditional science (Cody, 1995; Holmes; Mitchell & Cody; Moccia; Munhall, 1982/1997, 1992; Sarter).

We are convinced that adoption of this purist position will have dire consequences for the development of nursing knowledge and subsequently will be detrimental to the advancement of nursing practice and the discipline of nursing. Our purpose in this paper is to refute the premise that reductionism is incongruent with nursing's core values and to argue for the continued use of reductionistic approaches and hence the pursuit of "epistemological holism" (Thorne et al., 1998) in nursing science. Our argument is constructed in light of assumptions regarding the social mandate of nursing practice and the discipline of nursing. Before proceeding, we will define reductionism and briefly outline the origins of the critique around the philosophy and approaches of traditional science, as portrayed in the literature.

### **Reductionism**

Reductionism is believed to be the cornerstone of scientific causal explanation of phenomena (e.g., states, behaviours, processes) (Slife & Williams, 1995). From the perspective of Slife and Williams, reductionism is a style of explaining — it explains the basic, fundamental, or principal cause of phenomena. To illustrate simply, they state that "at its most basic level, the notion of reductionism is that some complex phenomenon, X, when properly understood can be shown to really be (an instance of) a simpler phenomenon Y" (p. 128). Accordingly, they consider economy of explanation to be "good explanation" (p. 127). In suggesting that there is a fundamental or principal cause at the base of

many phenomena, they view reductionism as providing the basis for generalization.

Another similar, yet different, use of the term reductionism is evident in the definition offered by Drew (1988). She defines reductionism as a process whereby "complex phenomena can be broken down into causal chains or units from which the whole can be understood by reconstituting the parts" (p. 25). This definition suggests that multi-causal explanations of phenomena are also achievable through reductionism. In the case of the phenomena of concern to nursing, scientific causal explanations are more apt to be complex, multifaceted, and possibly multidirectional (Poole & Jones, 1996; Schumacher & Gortner, 1992). Therefore, we hold that this latter view of reductionism is more applicable to nursing. In either case, reductionism leads to scientific causal explanations of phenomena and is the precursor to prediction and prescription (Gortner, 1990; Poole & Jones; Schumacher & Gortner; Wolfer, 1993).

Yet another perspective of reductionism is alluded to by Munhall (1982/1997). Given that many of the phenomena of interest to nursing are abstract and not directly measurable, the study of such phenomena requires that they be made operational — that is, defined and studied in terms of their observable/measurable attributes. According to Munhall, such phenomena are "reduced to the measurable and empirical" (p. 729), and thus this process constitutes another form of reductionism.

### **The Critique of Reductionism**

Codes of ethics and statements of standards of practice reflect nursing's commitment to a host of core values such as health, patient autonomy, dignity and self-respect of human beings, confidentiality, fairness, accountability, ethical conduct (Canadian Nurses Association [CNA], 1997), holism (Gortner, 1990, 1993; Gortner & Schultz, 1988; Munhall, 1982/1997; Sarter, 1987), and human uniqueness (Munhall, 1982/1997). Yet the substance of the critique that has developed around the use of reductionistic approaches in nursing science focuses on their perceived incongruence with the values of human uniqueness, patient autonomy, and holism. For example, one position is that there is a lack of congruence in the discipline itself, in that while it calls itself holistic it studies parts (Munhall, 1982/1997; Nagle & Mitchell, 1991). If the human being can be understood only as an irreducible or unitary being in mutual process with the environment, as is believed by proponents of this view (Benner, 1985; Cody, 1995, 1996; Mitchell & Cody, 1992; Munhall,



1982/1997; Newman, 1992; Parse, 1992, 1994, 1996, 1998; Smith, 1991), then how can the whole human being possibly be understood through the study of discrete parts in isolation (Packard & Polifroni, 1991)? Furthermore, reductionism is often perceived as being translated directly into practice, which calls into question the ability to provide holistic care — care of the whole person, not just certain dimensions such as the disease (Parse, 1998).

Given that reductionistic approaches are used to generate knowledge that is not only prescriptive but also generalizable, their use has given way to criticism on two fronts, applicable to the two remaining core values under discussion, namely patient autonomy and human uniqueness. The first issue raised by some scholars (Cody, 1993; Gadow, 1980; Moccia, 1988; Munhall 1982/1997; Parse, 1998, 1999) is the appropriateness of the use of prescription to achieve an outcome desired by the nurse, implying control over patients when respect for patient autonomy is espoused. The second issue is whether the uniqueness of the individual can be respected when health-related outcomes are expected to fall within pre-established norms (Cody, 1993, 1995; Holmes, 1990; Munhall, 1982/1997; Parse, 1992, 1994, 1996, 1998) and the prescriptive knowledge, from which interventions are derived, is generalizable.

For example, in Parse's (1992, 1994, 1996, 1998, 1999) view, health is a process of becoming and a reflection of individual choice and value priorities. Rather than a human state, health is considered to be a lived experience, a potentiality co-created in mutual process with the universe and defined as quality of life from the person's perspective at a particular moment in time. From Parse's perspective, therefore, health cannot be objectively assessed nor delimited by norms or such qualifiers as good, bad, more, or less (Cody, 1993, 1995; Parse, 1998). Nor can norms be considered to provide sufficient reason for the performance of nursing acts or the nurse's use of prescriptive power, implying the power to impose the nurse's value system on a patient (Cody, 1993). According to Parse (1992, 1998, 1999), persons co-create health, know the way to health somewhere within the self, and therefore freely choose ways of becoming based on value priorities. Accordingly, nursing practice is "not offering professional advice and opinions stemming from the nurse's own lived value system" (Parse, 1992, p. 40), but, rather, true presence with the other to enhance quality of life.

This critique suggests that opposition to reductionism has surfaced because of perceived discrepancies between the practices and outcomes of traditional science and the values of the profession of nursing. More

specifically, the substance of the critique implies that the use of reductionism in nursing science potentially translates directly into nursing practice, creating conditions in which patients are treated unidimensionally, subjected to control, and depersonalized — conditions incongruent with the profession's core values of holism, patient autonomy, and respect for human uniqueness.

### **Our Argument for Retaining Reductionism**

We begin our argument by claiming that the premise that reductionism, in the pursuit of nursing science, is incongruent with nursing's core values is faulty. We believe that the actual emergence of this premise primarily represents a failure to distinguish between the philosophy of nursing practice and the philosophy of nursing science (Gortner, 1990). Just as nursing practice and nursing science are distinct entities on the basis of their different goals (Batey, 1991), so too are their underlying philosophies. It is nursing's philosophy of practice, not its philosophy of science, that represents the value system of the profession (Gortner, 1990; Salsberry, 1994). Whereas the philosophy of nursing practice identifies the focus and aim of practice and delineates the values that guide both the practice and the practitioner (Salsberry), the philosophy of nursing science focuses on epistemology — that is, what can be known, how knowledge is structured, the basis upon which knowledge claims are made (Schultz & Meleis, 1988), and the appropriate methodologies/research approaches for the development of knowledge to guide nursing practice. Accordingly, it is through artful nursing practice, not through nursing's research approaches, that nursing's core values are actualized.

Furthermore, we contend that the criticisms that reductionism precludes the actualization of these core values in practice are also unfounded. We believe that respect for human uniqueness, through the delivery of individualized care, can be actualized in nursing practice irrespective of the fact that nursing's scientific knowledge of nursing interventions (i.e., prescriptive knowledge) is generalizable in nature. We concur with Johnson (1996) that prescriptive knowledge is meant to "guide" nursing practice and is in no way meant to be rigidly or blindly applied to the particular individual or patient. In artful nursing practice, nurses use this prescriptive knowledge, along with their personal insights regarding the individual and any contingent circumstances, to "choose wisely and well" in applying scientific principles in a particular situation (Johnson). Thus through the use of "artistic nursing prudence"

(Johnson, p. 47) nursing care can be individualized and the uniqueness of the individual recognized.

Regarding autonomy, we agree with Johnson (1996), who argues that nursing has a great deal to sort out about the proper place of patient autonomy in nursing practice. As a reflection of the current discourse, "which emphasizes patient autonomy and derides paternalism" (Woodward, 1998, p. 1046), some nurse scholars, like Parse (1998, 1999) and Moccia (1988), disapprove of prescription and advocate for decision-making based solely on patients' values, desires, or wishes. However, given nursing's social mandate to actively intervene (Thorne et al., 1998) to achieve health-related goals, we contend that prescriptive knowledge is essential to nursing practice and that nurses' involvement in health-related decision-making should occupy a legitimate place. As such, we argue for a more moderate view of patient autonomy, a view in which respect for patient autonomy is balanced with the nurse's beneficent guidance based on sound scientific knowledge and clinical expertise (Woodward). Given this view, we posit that respect for autonomy can be actualized if nurses consider patients' beliefs and values when applying prescriptive principles; respect for autonomy will be achieved in such a way that the moral integrity of both patient and nurse is protected (Woodward). Furthermore, we assert that in artful nursing practice nurses *do* respect patients' autonomous decisions about serious matters that affect their lives, once the nurses are assured that the decisions are informed. Is it not informed decisions that are truly autonomous?

Finally, we believe that the value of holism as it relates to the provision of holistic care can be actualized in artful nursing practice if all relevant knowledge is acquired and used in a balanced and proper way (Clarke, 1995). It is this point that remains relevant as we further develop our argument.

Let us now fuel our argument by stating that we are convinced that abandonment of reductionistic approaches, in the pursuit of nursing science, will preempt the actualization of several core values, specifically the core values of holism, health, and effective and safe nursing care. Our argument rests on the belief that actualization of these core values in nursing practice requires many kinds of knowledge, and that attempts to generate this knowledge require that the discipline embrace many methodologies (Allen & Jensen, 1996; Cull-Wilby & Pepin, 1987; Dzurek, 1989; Dzurek & Abraham, 1993; Ford-Gilboe, Campbell, & Berman, 1995; Letourneau & Allen, 1999; Lutz, Jones, &

Kendall, 1997; Monti & Tingen, 1999; Wolfer, 1993), not the least of which are those that are reductionistic in nature.

We contend that nursing is concerned with both the phenomenal world of lived human experiences of health and the biophysical/psychosocial world of humans as it relates to health, illness, and disease and therefore requires a holistic approach to knowledge development. To develop knowledge about the former world — the world of lived experience — nursing science must be directed towards seeking an understanding through the use of the interpretive approaches advocated by the humanistic sciences. We also acknowledge the link between health and oppression related to gender, race, and class. If nursing is to remain committed to achieving health-related goals, it must also recognize healing that can be achieved through emancipation. To develop knowledge for emancipation, nursing science must also be directed towards seeking an understanding of oppression through the use of emancipatory inquiries such as those advocated by the feminist and critical theorists (Campbell & Bunting, 1991; Gortner, 1993; Henderson, 1995; Thompson, 1987). To develop knowledge about the biophysical/psychosocial world, which has an objective component characterized by regularities and patterns, nursing science must also be directed towards the development of knowledge that is descriptive, explanative, predictive, and prescriptive (Donaldson, 1995; Donaldson & Crowley, 1978/1997; Gortner, 1990, 1993; Schumacher & Gortner, 1992) using the reductionistic approaches advocated by traditional science.

With regard to the biophysical/psychosocial world, there are still many relevant questions surrounding health, illness, and disease whose answers are dependent on inquiry that employs reductionistic approaches (Norbeck, 1987; Schumacher & Gortner, 1992; Weiss, 1995). As for the argument that it is towards causative states or processes that many preventive or therapeutic nursing interventions must be aimed (Schumacher & Gortner), reductionism leading to knowledge of causal explanations is not only relevant but essential for the practice-focused discipline of nursing (Schumacher & Gortner; Weiss). As such, we assert that if the discipline of nursing is dedicated to the achievement of excellence in care through the advancement of nursing knowledge, to reject reductionistic approaches for fear of dehumanization would be "epistemological error" (Shaw, 1993).

Consider the core value of health. Given that health is considered the proper goal or end in nursing (Johnson, 1996; Romyn, 1996; Thorne et al., 1998), it is not surprising to find that it is the first core value listed

in the Canadian Nurses Association *Code of Ethics for Registered Nurses* (CNA, 1997). We believe that health is multidimensional, a phenomenon that extends beyond subjective experience and one that is more than a personal matter (Thorne et al.). Some dimensions of health are universal in nature, capable of being assessed objectively and judged in relation to norms. Without reductionistic approaches to inquiry, the discipline of nursing will not be able to develop advanced knowledge to better assess the biophysical/psychosocial and socio-environmental factors that influence health. Without reductionist approaches, how will the discipline of nursing derive knowledge to better intervene to preserve and maintain the universal aspects of health of individuals, families, and communities?

Consider, too, that nursing's professional mandate will always include the care of the ill (Thorne et al., 1998). Without reductionism, how will the discipline of nursing develop knowledge to more fully understand illness/disease in all its dimensions and forms? How will the discipline of nursing be able to develop scientific knowledge of interventions to reduce or ameliorate the effects of illness? These are a few of the many questions that arise.

Consider next the value of holism, as reflected in the mandate to provide holistic nursing care — that is, nursing care of the whole person (Letourneau & Allen, 1999; Weiss, 1995). The provision of holistic nursing care requires that knowledge development be directed towards the whole of nursing knowledge. While we recognize that lived experience, for example, is an important dimension of the whole person, it is but one dimension. We believe that the body is an equally important one. While it has become increasingly apparent that nursing values the psychosocial and experiential aspects of care more than care of the body (Bjrrk, 1999; Drew, 1988), care of the body is critical to nursing's holistic mandate (Thorne et al., 1998). Although the emphasis on nursing care of the body may vary circumstantially, "care of the physical body remains an important part of nursing practice" (Dunlop, 1994, p. 33). If holistic nursing care is to be achieved, knowledge of care of the body cannot be ignored. Given that reductionistic approaches consider discrete properties as well as complex relationships between these properties, without reductionism the discipline of nursing will lack the knowledge to more fully understand the discrete nature of the body as a physical entity and its complex relationship with the other human dimensions that constitute the whole person. Without reductionism, how will the discipline of nursing be able to develop the knowledge to improve nursing care of the body? Without reductionism,



how will the discipline of nursing achieve the multidimensional understanding required for the provision of holistic care in nursing practice?

In seeking to attain health-related goals, nursing care must be not only holistic in nature, but also safe and effective. Accordingly, interventions must be based on prescriptive theory partially derived from sound scientific principles generated through the use of reductionistic approaches. As stated by Romyn (1996), "if nurses are bereft of the power of generalizability, nursing practitioners could not use the findings of research conducted with patients or clients other than their own and intervention in each practice situation would be the result of trial and error" (p. 144). If this is the case, then safe and effective practice is questionable and the actualization of this core value tenuous.

To support our argument for the continued use of reductionistic approaches, we cite Rising's (1993) study of the relationship of nursing activities to intracranial pressure (ICP) in brain-injured patients. This study explored the effects of selected nursing functions (i.e., bathing, repositioning, and suctioning) on ICP, a physiological and empirically measurable response. Based on the findings, it was recommended that the influence of intervening variables (e.g., age, level of consciousness, degree of agitation, vital signs, medications administered) be examined and that cerebral perfusion pressure (CPP), a measure indicative of brain perfusion and partially determined by ICP, be calculated. It is anticipated that, with further systematic study, nurses will eventually be provided with predictive knowledge about which patients, under what circumstances, are most at risk for fluctuations in CPP as a result of nursing care as well as prescriptive knowledge to ensure that the care of this type of patient will be provided in the least disruptive manner possible. It is also possible that eventually scientific knowledge of prescribed nursing interventions will include those that lower ICP, and therefore increase cerebral perfusion, enabling nurses to provide not only safer but more effective nursing care.

Does a position against reductionistic approaches to nursing science imply that research such as that described above is of no value to nursing practice? We believe it does. And in our opinion this line of thinking is of grave concern. Such research would provide generalizable knowledge invaluable to nurses who strive to provide safe and effective care to all patients at risk for increased ICP and decreased cerebral perfusion. Furthermore, it highlights knowledge development related to nursing care of the body, a dimension critical to the multidimensional understanding we believe is necessary if holistic care is to be achieved in practice (Thorne et al., 1998). Therefore, as the above

example illustrates, if reductionism is abandoned nurses will be without the scientific knowledge to ensure that the care they provide is indeed holistic, effective and safe, and results in the achievement of health-related goals.

### **Conclusion**

We have argued that reductionism in the pursuit of nursing science does not preclude actualization of the core values of human uniqueness, patient autonomy, and holism in nursing practice, and thus have opposed the view of several nurse scholars that the discipline of nursing should adopt a purist position in the pursuit of nursing science. On the other hand, we claim that abandonment of reductionism in nursing science would place actualization of the core values of holism, health, and safe and effective nursing care in jeopardy. Our main concern is that without reductionism the practice-focused discipline of nursing will be without the predictive and prescriptive knowledge considered essential to guide nurses in practice. Without scientific principles to ground decision-making, nursing interventions will be based on trial and error, which will place the safety of patients at risk.

We have concluded that actualization of the core values of holism, health, and safe and effective nursing care requires many kinds of knowledge. Therefore, we have advanced the position that the discipline of nursing ought to pursue "epistemological holism" (Thorne et al., 1998), the development of the whole of nursing knowledge, and that such a pursuit requires that the discipline of nursing embrace multiple methodologies. We believe that if the discipline does not strive to develop the whole of nursing knowledge, it will fall short of fulfilling the social mandate that leads to its creation, the development of knowledge to guide practice (Donaldson, 1995). We also believe that nursing practice will be thwarted in its efforts to meet its social mandate as a result.

Advancement of the discipline of nursing, and ultimately nursing practice, depends on the success of the discipline in its efforts to develop the whole of nursing knowledge. We believe that only by employing a variety of methodologies can this be achieved. As stated by Omery, Kasper, and Page (1995), it takes more than one rope to climb a mountain. Equipped with a strong, relevant scientific knowledge base and a humanistic philosophy of nursing practice, nursing will be well supported on its journeys towards excellence.

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# Some Implications of Postmodernism for Nursing Theory, Research, and Practice

Colin A. Holmes and Philip J. Warelow

Le présent article analyse l'influence de la pensée postmoderne sur la théorie et la recherche en sciences infirmières. L'accent est mis ici sur la réflexion amorcée à l'intérieur de ce courant sur l'épistémologie et le langage, en particulier en ce qui concerne la notion de vérités multiples, la nature incertaine et provisoire de la connaissance et la finalité de son développement. Les thèmes courants du postmodernisme sont exposés, y compris la critique des fondements, la divergence des discours et le rejet des grands systèmes théoriques. Une brève liste de suggestions concernant l'application de l'approche postmoderne à la pratique de la profession infirmière est présentée en guise de conclusion.

This paper explores ways in which some aspects of postmodernist thought impact upon nursing theory and research. The focus is on postmodernist accounts of epistemology and language, in particular notions such as multiple truths, uncertain and provisional knowledge, and claims as to the purposes of knowledge development. Common themes of postmodernism are articulated, including antifoundationalism, the dissonance between competing discourses, and the rejection of "grand theories." The paper concludes with a short set of suggestions for a postmodern approach to nursing practice.

## Introduction

We take the liberty of anticipating that most readers will have as their dominant way of viewing the relationship between theory, practice, and research the modernist ideal of total integration. Success in pursuing this ideal requires faith in the potential of the cosmic jigsaw to yield a coherent picture, and sufficient patience to sort, assemble, and interpret the pieces. Put like this, our examination here is thus about ways of viewing the universe and our role within it. The dominant view assumes that the universe is a system that yields its truths through careful observation and analysis, that the knowledge thus acquired is universal, singular, and constructive, and that our practices are shaped

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by, and aspire to, the ideals these imply. In this paper we will outline some postmodernist challenges (Best & Kellner, 1991; Cheek, 1998; Rosenau, 1992; Seidman & Wagner, 1992) to these assumptions, and briefly indicate what they mean for the relationship between nursing research, theory, and practice. Our position loosely corresponds to what Rosenau terms "affirmative postmodernism" (pp. 14–15). It is a postmodernism leavened by neo-Marxist sympathies that admit the pungency of postmodernism as a continuation of, or adjunct to, traditional critical social theory but that are wary of its potential for epistemological chaos and sociopolitical nihilism.

### **Nursing Theory — Some Postmodern Approaches to Theorizing**

Once we admit that theoretical statements of any kind are part of some discourse formation that primarily serves political ends — that is, power-related ends; for example, scientific, religious, professional, or domestic — then reality, or at least our understanding of it, becomes a matter of linguistic convention and our access to that reality is through discourse alone. Making sense of reality becomes synonymous with talking about and dealing with reality in ways that conform to the rules of the appropriate discourse. To do otherwise is perhaps characteristic of children, poets, fools, mad folk, and perhaps postmodernists.

Postmodernists attempt to operate outside the boundaries of the grand discourses that underpin the dominant ways of seeing the world and the regulative principles on which they are founded. They reject, to varying degrees, the traditional monolithic notions of truth and rationality, in favour of pluralistic ways of knowing. This anti-foundationalism (Cheek, 1998) entails the view that postmodernists themselves strive to be both post-disciplinary and atheoretical. In substance, their statements therefore reflect a concern for context rather than universality, specificity rather than generalization, uniqueness rather than sameness, and relativism rather than absolutism, whilst in form they are often metaphorical, fragmented, blurred, and problematic. Postmodernists challenge and dissolve the distinctions between, for example, the intelligible and the nonsensical, fact and fiction, literal and poetic, sacred and profane, ludicrous and profound, speculative and historiographical, objective and subjective, personal and impersonal, and scientific and aesthetic, and playfully cross the conventional boundaries between the research report, art work, and metaphysical treatise. For many nihilistic postmodernists, inquiry is conducted more for its potential to generate interesting, curious, playful, ironic, subversive, and awesome texts than for its performativity.

A consequence of accepting postmodernist antifoundationalism is that whilst reality becomes a matter for competing discourses, no discourse is intrinsically superior since we are free to choose whichever one(s) suit our purpose(s). We are not bound to a particular discourse and/or way of doing, but rather are free to exercise a creative pluralism in which multiple voices, views, and methods vie alongside each other (Cheek, 1998) and in which contradictory positions are valued for their capacity to generate alternative meanings. For Lyotardian postmodernists, on the other hand, knowledge claims are to be judged according to their usefulness, or performativity (Lyotard, 1992, p. 75), according to which what is said is more true if it is more productive. Many postmodernists reject performativity, however, as an appeal to the modernist enlightenment project (Rosenau, 1992, pp. 134–136).

Is there any evidence of postmodernist theorizing in nursing? Holmes (1991a) argues that although Martha Rogers, Margaret Newman, and Barbara Sarter are modernist grand theorists, drawing on familiar long-established discourse formations and their underlying metanarratives, and their work would be subject to devastating postmodernist deconstruction on that account, their theories do have some postmodernist features. Benner's work, likewise, in as much as she is content to develop purely local understandings, has a postmodernist flavour. They are nursing theory's equivalent to a modernist avant-garde, and offer some interesting pickings for the scavenging postmodernist nurse.

Even those nurses who are critical of traditional polarities in nursing theory nevertheless continue to be bewitched by universalism and the obstinately cherished illusion of a grand theory. Packard and Polifroni (1991, p. 10), for example, argue in a much cited paper for the legitimacy of "pure science" approaches to nursing knowledge. In this argument they complain about the lack of a clear, central direction for all of nursing science as evidenced by the absence of an all-encompassing question and bemoan the resulting confusion, lack of consensual aims, and inconsistencies in the definition of nursing. Suggesting that other disciplines have a history of a single, clearly defined purpose, they hanker after "the true essence of nursing science" and refer to "...the question all scholars in a particular discipline are searching to answer" (p. 11). Significantly, they conclude that if this question cannot be identified, nurses "should emphasize the creativity of the craft, call themselves artists and lay science to rest" (p. 12). Postmodernists, in contrast, would relish the creative potential this lack of a totalizing paradigmatic research objective allows and the fluidity with which nursing is able to conceptualize its disciplinary purposes. They would vigor-

ously oppose all attempts to tie nursing down to absolute definitions of its nature and objects, and to the implied universal grand theory; they would also, of course, reject the implied dichotomy between nursing as science and nursing as art or craft (Holmes, 1991b, 1992; Lister, 1997; Watson, 1995).

A postmodernist analysis enjoins us to reject, overthrow, or transform all forms of theory that constitute or rely on grand theories (Lister, 1991), including those founded on totalizing metaphysical, political, or ideological metanarratives. In the case of nursing theories the offending grand theories are not difficult to identify. In some cases one or more grand theories form the explicit framework within which the theory is constructed, including systems theory, positivism, holism, evolutionism, panpsychism, humanism, existentialism, and phenomenology. It is not difficult to correlate these with specific nursing theories. The implicit metanarratives include, among others, liberal-democratic political theory, Aristotelianism, deontological ethics, Platonic idealism, reductionism, behaviourism, Cartesian dualism, Christian theology, fatalism, determinism, verificationism, falsificationism, utilitarianism, racism, ageism, androcentrism, mysticism, rationalism, economism, scientism, technologism, aestheticism, and classicism. These are less easy to discern in nursing theories and are rarely discussed in published commentaries, but one would not be surprised by their presence since there are common threads in the intellectual contexts out of which Anglo-American nursing theory has arisen.

It might reasonably be asked what we are left with if we abandon these kinds of theoretical positions and commitments. One postmodernist approach to constructing nursing knowledge would be to filter out metanarratives by dealing directly with the world "as we find it." It would acknowledge multiple realities and pursue micro-explanations — that is, small-scale accounts aimed at localized understandings, perhaps similar to those developed by Benner, although resisting her attempts to ground these in the grand narratives of phenomenology. Postmodernism would recommend a flexible pluralism that takes no offence at contradictions and discontinuities. It would expect knowledge construction to benefit from "passionate discourse," a notion that has been briefly introduced in the nursing literature (Parsons, 1995). Whilst valuing expertise, it would expect theorists to make no special claims and would value clinicians and patients alike as sources of valuable insights and sensitivities. It would recommend that theoretical statements be judged according to their ability to generate new insights, rather than to the extent that they correspond to some notion of ration-



ality, truth, or falsity, since it accepts these as having only temporary, localized authority, and once again Benner (1984) comes to mind.

Postmodernist knowledge construction would reject language's overproduction of cognitive certainty and would avoid traditional dichotomies generated by the reification that language induces — that is, the conviction that because there are antonyms, such as "good" and "bad," these must refer to dichotomies that exist "out there" in the world. Other such linguistically authorized dichotomies include those between health and illness, science and art, objective and subjective, right and wrong, and beautiful and ugly. Some progress has been made towards deconstructing these in favour of more fluid concepts in which traditional understandings are problematized and overlap. The dichotomization of health and illness, for example, is giving way to alternatives that see them not as categories but as "aspects of being," so that, as Margaret Newman suggests, one person's illness may be another's wellness. Illness and health, according to this view, are outmoded categories that do not adequately represent people's experiences and that unnecessarily constrain the relationships between the people involved. The negative valuation of illness is also being reconsidered: according to those of Newmanian persuasion, a person's condition is "right" for them at that time rather than inherently "good," "bad," "ugly," or "beautiful." From a postmodern perspective these are, indeed, simply ascriptions that we may or may not make depending on the extent of our immersion in the dominant discourses around illness. Nursing literature speaks increasingly of the beauty in illness rather than the ugliness, of the positive as well as negative aspects of all life's experiences. It is not that postmodernists wish to drain the world of descriptive discourse; rather, they want discursive rules to be recognized as dispensable in order to develop an even richer descriptive understanding. The dispensability of existing constructions, such as health and illness, needs to be assessed against the productivity of the alternatives that breaking the discursive rules allows us to generate — in other words, a more reflexive relationship between theory and practice, in which the analysis of practice can highlight and begin to deconstruct the multiple layers, truths, and perspectives they afford.

Increasing disillusion with conventional epistemologies, and the science founded upon them, is leading nurse theorists ever nearer to a postmodernist antiphilosophical position. The value of nursing theories is increasingly called into question, for example, and, like postmodernists, clinicians regard them as outmoded and unproductive because of their divorce from the vagaries of the real situation. Clinical practice, like all aspects of our daily existence, does not conform to pre-packaged

theories; rather, it is liable to be disjunctive, fragmented, full of contradictions, complexities, and irrationalities, and, perhaps more problematically, awash with competing discourses. Many nurses will sympathize with this view and will share the postmodernist belief that grand nursing theories are of primarily historical interest. This opinion is reflected in the oft-quoted comments of Afaf Meleis.

Meleis (1987, p. 17) tells nurses to "get off their (theoretical) band-wagons and get on with the development of the business of nursing," and suggests that that we should "revise" some of the current positions in nursing academia, beginning with our "passion for methodology, for science, and for philosophy." In calling for a "passion for substance, for the business of nursing...for the knowledge itself, and *not how we get the knowledge*" (p. 8, italics added), she essentially recommends a postmodernist epistemology, namely the renunciation of technique as the basis for establishing knowledge. We are invited to value knowledge for its ability to further "the business of nursing" — that is, its performativity rather than its approximation to truth or its conformity with a predetermined theoretical standpoint. Similarly, Meleis also recommends that we abandon the old polarized debates concerning particularism and holism, and pursue a "need for the future development of other modes more congruent with the emerging shape of ontological beliefs" (p. 9). What Meleis seems to unwittingly recommend, in short, is nothing less than a postmodernist antirationalism, in which each individual is free to construct her/his own truths and retain those that they find useful, using the wisdom of those who have gone before. Of course, this has the potential to be both liberating and dangerous. Such radical reconstruction can lead us to view homosexuality, for example, in terms of "gay pride" and the positive affirmations this entails, or equally in terms of genetic inferiority, threats to the communal gene pool, and the horrendous policies of Nazism regarding the other! With the spectre of genetic manipulation looming ever closer, there is a clear need to be vigilant over the constraints placed on a postmodern rewriting of health and illness.

### Research: Playing Games and Solving Problems

As indicated above, postmodernists reject the assumptions that have underscored the Enlightenment scientific research paradigm, most notably the assumption that research gives privileged access to a singular reality through the application of certain well-defined procedures. They reject the focus on causality, the subsequent elevation of prediction to a methodological and epistemological touchstone, and the gen-

eration of probabilistic knowledge with specified degrees of certainty. They champion uncertainty, provisionality, and "intertextuality" (Rosenau, 1992, pp. 112–113) — that is, the interaction of different accounts and readings.

Whereas traditionalists regard objectivity as a virtue, postmodernists dismiss it as dehumanizing and dehumanized; whereas traditionalists regard replicability as a virtue, postmodernists dismiss it as entailing decontextualization; whereas traditionalists believe that science should be value-free, postmodernists believe that science and values are inseparable. Postmodernists suggest that although all understandings can be legitimately pursued, no amount of "knowledge" will ever complete the illusory "cosmic jigsaw." They regard the Enlightenment project as a failure and argue that science and technology no longer serve its supposed ends. From a postmodernist perspective, science is not only value-laden, but the values are complex and contradictory; science is viewed not merely as often having negative consequences for humankind, but as producing effects that can no longer be evaluated; and much of present-day research is viewed as being dedicated to the exploitation and reproduction of cultural icons in order to further the interests of a powerful, wealthy minority.

The research domain within any particular discourse formation often assumes its own very distinctive form, and new researchers often feel like they are going up to bat without knowing the rules of the game. In some discourses, however, these rules have failed to become highly regulated. Sociology, for example, has been at the forefront in challenging the rules that its practitioners have adopted from adjacent discourses. Researchers in nursing, by contrast, have readily assumed the discursive rules of a variety of fields of inquiry and generally failed to submit them to critical challenges and creative development. What they have taken to be adjacent discursive fields are primarily the natural sciences, and that is why so much nursing research continues to resemble college biology experiments.

Postmodernist nursing research would not be concerned with generalization or the creation of probabilistic knowledge. It would prefer local accounts, everyday talk, context-specific understandings, and local utility. It would encourage creative expressive forms using a variety of styles and media, and it would prefer accounts that fragment the smooth flow of traditional thought processes by exposing contradictions, discontinuities, and lacunae in our understanding. In short, it would represent a radical alternative to the existing discourse of nursing research.

In terms of traditional research concepts, it offers a licence to disregard the conventional wisdom. If Lyotard suggests any rule, it is to "break the rules." Thus postmodernist nursing research would pursue a creative post-paradigmatic pluralism, rejecting the sacrifice of creativity on the altars of ideology, theory, or methodology. Linguistically legitimated research dichotomies such as qualitative-quantitative, subjective-objective, and science-art would cease to command respect in the research process or in matters of interpretation. Researchers would be encouraged to utilize concepts that presently lie beyond traditional science, and, as consideration of the contents pages of Rosemary Parse's *Nursing Science Quarterly* reveals, this is indeed beginning to happen in nursing (Barnum, 1989; Newman, 1990; Sanchez, 1989). Serendipitous, haphazard, and theoretically uncommitted inquiry may be profoundly fruitful, and indeed Feyerabend (1975), in his anarchistic *Against Method*, long ago suggested that these are research virtues to be nurtured rather than eliminated. For postmodernist researchers, consistency, validity, and reliability would be deemed irrelevant since there is no single reality they would be attempting to expose. They would reject the principle that research must be logical in the traditional sense; rather, the touchstones of success would be creativity, flexibility, uniqueness, and local value. They would not be required to establish the probable truth or falsity of their findings; instead, the research would be judged according to its relevance and usefulness for practitioners and its potential to generate further inquiry.

Avant asserted that, "In the final analysis, nursing science will be judged by whether or not it can solve 'significant disciplinary problems' (DeGroot, 1988) or offer defensible interpretations of the multiple realities of interest to nurses" (Avant, 1991, p. 2). This may be achieved through the process of research as much as through the insights it generates, and Avant concludes that "[a] postmodernist approach to science is a most appropriate way to achieve these goals" (p. 2). This approach would be kickstarted, we believe, if nurses exposed and challenged the metanarratives that underlie the discourse of nursing research, as it occurs not only in research reports but in research texts, in research teaching, and in the use of research by nurses. Whilst social theorists have begun to expose the metanarratives that underlie medical and psychiatric discourse and practice, postmodernist inquiry into the nature of nursing is still rare (Watson, 1995, pp. 22-23). There is a desperate need for deconstructive analyses which reflect Lyotard's advice that we provisionally accept, and work within, a variety of language games but that we create novel, disturbing variations, disrupting, fragmenting, and destabilizing existing games (Lyotard, 1984, p. 60). Such



analyses could, for example, inform the longstanding antagonism between nursing and medicine, which has often been based on a failure to understand or respond effectively to each other's discourses.

### **Practice: Six Postmodern Suggestions**

Postmodernism suggests a number of re-visions of nursing practice. First, the revaluing of the experience and insights of practitioners and their patients, over and above those of armchair theorists, would rehabilitate respect for practice and practitioners, and clinical practice would share centre stage. Second, as we have already noted, nurses would be enjoined to consciously expose underlying metanarratives and commence a program of demystification by disrupting and undermining the existing discourse. Third, there would be a rejection of underlying universals, absolutes, and dichotomies, and the stereotyped games that nurses play would give way to more creative and fruitful discourse. Fourth, the nurse's role would also be dramatically changed through abandonment of traditional notions of illness and wellness, since this would entail revising our notions of treatment, care, and cure. Fifth, nurses would be encouraged to look beyond not only the traditional boundaries between disciplines, but also those between nurses and non-nurses and between patients and non-patients. Finally, nurses would be encouraged to recognize and accept tensions, discontinuities, and differences within their own practices and understandings — clinical, ethical, relational, and political.

The postmodernist rejection of positivistic science, and its openness to marginalized discourses, also offers nurses an opportunity to practise according to alternative ways of knowing and according to theories that draw on prepositivist, postpositivist, and postmodernist insights. This might include, for example, the use of non-Western therapies such as shiatsu and acupuncture, or even unconventional non-scientific interpretive frameworks such as astrology and the paranormal.

Before leaving the issue of practice, it is worth noting that nursing has generally assumed a humanistic psychology in its conceptualization of the person, their needs, their problems, and the psychological techniques to which they are susceptible. The postmodernist position against humanistic psychology, most notably that derived from the work of Heidegger and Foucault, holds that as knowledge of the nature of persons increases, so the notion of the transcendental self or ego, freely choosing and creating, evaporates (Schwartz, 1990; Soper, 1986). Another strand to this position is the view that the humanist subject is a masculinist concept (Soper, 1990; Weedon, 1987), a view that is perhaps



immanent in the work of feminist nurse scholars (Parker, 1991) but rarely articulated. In these circumstances, not only the concept of the person as "patient" becomes problematic, but so too does that of the "reflective practitioner," and the postmodernist rejection of the humanistic self would undoubtedly entail a major turn-about in nursing theorization and practice.

### (In)conclusions

As we have tried to indicate, postmodernism is not a single set of clearly articulated doctrines. Our brief review has focused on specific aspects that are common themes in some accounts of postmodern theory, especially as they concern language and epistemology. Forms of postmodernism that oppose universal theories and systematic philosophy, and thereby set thinking free from the anchor of absolute principles, have been criticized for undermining rationality and language as bases for the systematic construction of knowledge. Critics such as Crook (1990, 1991) insist that social order would thereby be destroyed and that postmodernism's political radicalism (Best & Kellner, 1991; Cheek, 1999; Rosenau, 1992) amounts to a destructive nihilism. Indeed, Crook argues that postmodernism is inherently nihilistic in coupling a program for change with a refusal to provide a rationale or to specify possible mechanisms for bringing it about (Crook, 1990, p. 59). At worst, then, postmodernism offers only "regressive amalgams of metaphysics and nihilism" (Crook, 1991, p. 167).

However, others have suggested that for some postmodernists "each language game is sustained by values that must be respected" (Murphy, 1988, pp. 106–107) and that they do not entirely jettison truth and order (Lyotard, 1984). We might say that their analyses do not allow for the indiscriminate acceptance of just any interpretation of reality: rather, interpretation must be based on a careful consideration of the strengths and weaknesses of each language game. What counts is what actually happens in the game, not theoretical principles, and, as suggested above, at least some postmodernists seek to establish new, temporary rules, governed by utility, rather than to abolish rules altogether. This revision of grand narratives is also suggested by the observation that, in its own discourse, postmodernism comes very close to establishing implicit metanarratives of its own. Whilst opinions clearly differ and postmodernism is not a homogeneous position (Rosenau, 1992, distinguishes between "sceptical" and "affirmative" postmodernists, for example), we may say that Lyotard's postmodernism recommends the fragmentation of language games, the rejection of meta-

narratives, and the dissolution of traditional disciplinary boundaries. At best, then, postmodernism heralds a post-disciplinary intellectual process, not in pursuit of any unitary epistemology or holistic explanation, but in order to maximize creativity and to generate knowledge that is useful in the real, unbounded world of the discontinuous and the unexpected.

What of the nexus between theory, research, and practice? Postmodernists reject the ideal of a smooth dialectical flow between them and the underlying notion of the "cosmic jigsaw," as well as the assumption that complex phenomena should be understood according to discursively legitimated categories such as "theory," "research," and "practice." For many, more nihilistic, postmodernists any evaluative criteria are to be avoided, but for the Lyotardian and "affirmative" postmodernists performativity is a criterion that may be applied across the board and will be served by the breakdown of the discursive barriers between those categories. In any case, nursing is simply what it is and to call it "science" or "art" or both, or to force the activities of nurses into neat categories such as "theory," "research," or "practice," is to constrain or enlarge it for political — that is, power-related — purposes. To refer to these categories is, for postmodernists, to locate nursing within particular discourse formations sustained and legitimated through a variety of metanarratives, the assumptions of which are at least questionable and the purposes of which are always political.

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# **The Politicization of Ethical Knowledge: Feminist Ethics as a Basis for Home Care Nursing Research**

**Elizabeth Peter**

Les soins de santé sont de plus en plus souvent prodigués à domicile, une évolution qui soulève, pour les infirmières, des problèmes d'ordre déontologique nouveaux auxquels on a prêté peu d'attention jusqu'à maintenant. Les connaissances actuelles en déontologie au sein de la discipline ne permettent pas cependant de cerner adéquatement ces questions. Le présent article fait état d'une nouvelle méthode de recherche visant à mettre au point ces connaissances. L'auteure passe d'abord en revue les approches phénoménologiques en matière de déontologie des sciences infirmières, vues comme importantes puisqu'elles informent à la fois les fondements théoriques et empiriques de ce domaine de recherche. Or, argumente-t-elle, la phénoménologie ne tient pas suffisamment compte des contraintes de nature politique et de leur influence sur l'infirmière ou infirmier en tant qu'agent moral. L'auteure fait ensuite valoir les mérites de l'éthique féministe comme fondement conceptuel de la réflexion en matière de déontologie des sciences infirmières. Enfin, elle présente une méthode alternative pouvant être mise en pratique dans le contexte de la recherche en déontologie des soins à domicile.

Increasingly, health-care services are provided within the home. This change has resulted in the emergence of new, largely unexplored ethical concerns for nurses. The current state of ethical knowledge in nursing, however, is not adequate to address these issues. The author describes the development of a new research method to develop this knowledge. First, she examines phenomenological approaches in nursing ethics, which are important because they have rigorously used a philosophical perspective to inform both theoretical and empirical enquiry in nursing ethics. Nevertheless, the author argues that phenomenology is not adequately sensitive to the impact of political constraints upon the moral agency of nurses. Second, she describes the benefits of using feminist ethics as a conceptual basis for nursing ethics inquiry. Third, she describes the development of an alternative method and demonstrates how it can be applied to home care ethics research.

As a result of health-system restructuring, both acute and long-term services increasingly are provided in the homes of Canadians (Health Canada, 1999). The consequences of these rapid changes are of ethical importance because they can affect the relationships among care recip-

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ients, family members and friends, and home care providers. Ethical concerns and dilemmas that prevail in home care, however, have only begun to be identified (Arras, 1995; Liaschenko, 1994; Twigg, 1999). The following are specific issues that require further exploration and analysis: (1) the "medicalization" of personal life and relationships (Burrows & Nettleton, 1995; Gastaldo, 1997; Liaschenko, 1994; Morgan, 1998), which may affect the balance of power in nurse-patient relationships; (2) the complexity of relationships between and among home care workers, family caregivers, and care recipients (Abbott, 1998; Aronson & Neysmith, 1997; Bagihole, 1996); (3) the use of in-home technology, which may have an impact on privacy, personal boundaries, body image, and self-esteem (Arras); (4) the extraordinary physical and emotional demands placed on home care workers (Abbott; Aronson & Neysmith; Twigg) and family members and friends (Baillie, Norbeck, & Barnes, 1988; Low, Payne, & Roderick, 1999). Women, who perform most caregiving functions, may be very vulnerable (McKeever, 1992, 1994; Rutman, 1996; Wuest, 1998). In addition, informal caregivers often must develop elaborate skills related to using medical technology (Arras).

Nursing, however, may not have the ethical knowledge to address these new issues. New research methods to develop ethical knowledge may be required. In this paper, I describe the development of a new research method informed by feminist ethics. The paper is divided into three sections. First, I critically explore previous approaches developed by Benner (1991, 1994) and Bishop and Scudder (1990, 1997, 1999), who have used phenomenology as a basis for the development of ethical knowledge in nursing. I have chosen to look at their work because it has rigorously used a philosophical tradition to derive both theoretical and empirical knowledge in a manner consistent with my own approach. Second, I discuss the benefits of using feminist ethics, as opposed to phenomenology, to inform further advancements in the creation of ethical knowledge. Third, I outline the development of a new qualitative research method, describing how it could be applied to home care ethics research.

### **Phenomenology as a Basis for Nursing Ethics**

Bishop and Scudder (1990, 1997, 1999) view nursing phenomenologically as a practice that has a dominant moral sense — that is, it fosters human good. Instead of deducing the philosophy of nursing, including the "good" of nursing practice, from philosophical bioethics, they articulate the meaning of nursing from practising nurses themselves.

Initially, Bishop and Scudder (1990) drew the meaning of nursing from empirical studies that have explored how nurses experience the moral sense of nursing practice. They then used phenomenology to interpret these data, generating an interpretation of the meaning of nursing. Bishop and Scudder (1999) summarize their interpretation of nursing as:

Nursing, as we have interpreted it, fosters patient/client well-being through a direct personal-professional relationship between nurse and patient/client and through coordinating this relationship into wholistic relationships with physician, family, community, and institution. Nursing is the practice of caring in which the practice of care and the sentiment of caring are integrally related. Nursing is a practice in that it is a historically developed way of fostering human good in which the way and the human good sought are integrally related to each other. The practice of nursing presupposes a sentiment of caring that focuses the nurse on the situation of the one cared-for and identifies the client/patient's well-being with that of the nurse. (p. 26)

Within this interpretation of nursing the related themes of patient/client well-being, nurse-client/patient relationships, caring, and fostering human good predominate.

Similarly, Benner (1994) speaks of "articulating major areas of socially embedded knowledge and notions of the good in nursing practice" (p. 138). Benner (1991) suggests that expert practitioners have the capacity to recognize the good/the ought in their practice. Consequently, knowledge of the good can be revealed through empirical research using narratives describing the everyday ethical comportment of expert nurses. Some of the goods Benner (1991) identifies from her study of expert nurses include themes of healing, fostering care and connection, being present, learning the skill of involvement, and facing death and suffering.

In summary, Benner (1991, 1994) and Bishop and Scudder (1990, 1997, 1999) develop ethical knowledge through empirical research grounded in phenomenology. They clearly illustrate the importance of ethical theory and moral comportment existing dialogically so that each shapes the other. Their work is exceptional and important in this regard, because it has used a philosophical tradition consistently and coherently and has avoided compartmentalizing theoretical and empirical enquiry in ethics.

### **Problems with a Phenomenological Approach**

Phenomenological approaches, however, may not be appropriate for current research in home care. These approaches may not have the dimensions necessary to critically evaluate notions of the good and to situate them within a broader political context. Nursing must be very sensitive to the possibility that its practices reflect disempowering structural relations that could render aspects of the good inherent in these practices ethically problematic. The structural and situational constraints to the moral agency of nurses within the health-care system have been widely commented upon (Bowden, 1997; Chambliss, 1996; Curtin, 1982; Hamric, 1999; Liaschenko, 1993, 1995; Peter, 2000; Yarling & McElmurry, 1986). Phenomenological perspectives fail to examine critically the origins of nurses' ethical comportment and the impact of this comportment on patient care and on nurses themselves. If these constraints are not made visible, it is possible that nursing ethics could function as a vehicle of further oppression by idealizing the often-exploited ethical commitment of nurses. Thus, like Allen (1992), I suggest that phenomenological research should be limited to describing belief systems, not prescribing them.

Bishop and Scudder (1999) acknowledge that the excellence or inherent good of nursing can be restricted by powerful agencies outside of nursing. They state, "We have given insufficient attention to how these restrictive forces can be combated" (p. 23). I agree with this statement, and I believe that feminist ethics provides a means of bringing attention directly to these restrictive forces within both a theoretical and an empirical approach. In this way, feminist ethics has the potential to bring ethical knowledge in nursing to a more advanced level.

### **Feminist Ethics**

For a number of reasons, I believe feminist ethics has the potential to provide a better perspective from which to structure the development of ethical knowledge in nursing. First, feminist ethics regards oppression as a fundamental moral and political wrong and seeks to transform existing structural relations that foster oppression (Baier, 1994; Brennan, 1999; Sherwin, 1992; Tong, 1996). It is sensitive to the dominant culture's devaluation of caring and nurturing practices, like caring for the sick and dying, mothering, and the education of children (Baer & Gordon, 1996; Tronto, 1993; Whitbeck, 1984). Nurses' caring work has also been described as unacknowledged, invisible, and devalued (Colliere, 1986; Falk Rafael, 1996). Consequently, feminist ethics can be effective in

addressing forms of devaluation and oppression that have an impact on the well-being and moral agency of both nurses and informal caregivers, all of whom tend to be women.

Second, feminist ethics makes visible the moral significance of values held primarily by women (Brennan, 1999; Morgan, 1987). It includes care perspectives such as those of Gilligan (1982, 1987) and Noddings (1984). Gilligan (1982, 1987) characterizes an ethic of care as consisting of the following moral considerations: the care and nurturing of self and others, the alleviation of hurt and suffering, the maintenance of relationships, and the emphasis upon contextual details of concrete situations. She contrasts the ethic of care with what she calls an ethic of justice, which is characterized by the following moral considerations: abstract rules and principles, fairness and reciprocity, and duties and obligations for self and society. The ethic of care on its own is problematic because it may grow out of and perpetuate women's unrecognized and exploited caregiving, leading to further powerlessness and oppression (Tong, 1996). Thus some feminist ethicists, such as Baier (1985, 1986) and Sherwin (1992), have suggested combining the care and justice perspectives so that problems inherent in either perspective on its own can be overcome. This combination is also appropriate for nursing research, because the moral reasoning of nurses (Cooper, 1991; Lipp, 1998; Millette, 1993, 1994) and nursing students (Peter & Gallop, 1994) has been found to be characterized by the ethics of both care and justice. Furthermore, combining the two can provide a means to address a greater breadth and complexity of ethical issues in health care (Carse, 1991, 1996; Sarvimaki, 1995).

Third, feminist ethics, like the ethic of care, tends to view persons as connected to others and interdependent — that is, vulnerable, unequal in power, and not wholly autonomous. Persons are also described as unique, gendered, racialized, and embodied, and as existing within specific historical, political, economic, and cultural contexts (Baier, 1985, 1986; Held, 1987, 1995; Morgan, 1987, 1991; Sherwin, 1992, 1998). This definition of persons is appropriate for nursing because nurses tend to work with people who are vulnerable and dependent. The importance placed upon interdependence also is in keeping with the relational emphasis in nursing ethics. Nurse-patient relationships have been viewed as the moral foundation of nursing practice (Benner, 1991, 1994; Bishop & Scudder, 1990, 1997, 1999; Yarling & McElmurry, 1986).



Fourth, feminist ethics tends to concern itself primarily not with crisis issues like the withdrawal of life-support but with issues of everyday life involving our relationships with others (Mullett, 1992; Warren, 1989). This emphasis on the everyday is relevant to nursing research because little is known about nurses' everyday moral struggles. The research of Benner (1991, 1994, 1999) and Bishop and Scudder (1990, 1997, 1999) has begun to describe important aspects of nurses' moral life, but more research is needed, especially research that offers a political critique.

Fifth, feminist ethics de-centres moral and epistemic privilege. Baier (1985), Held (1984), and Walker (1992) suggest that the social impact and usefulness of moral theorizing should be explored. Feminist ethics emphasizes the need to challenge ethics and bioethics. Without this challenge, bioethics has the potential to simply reproduce existing power structures. Implied in the neglect of certain issues is that they are of such little importance that they do not require serious reflection and examination. For instance, bioethics tends to assume that the site of health care is the hospital, leaving the ethical issues of home care largely invisible.

Sixth, feminist ethics can inform the development of a research method that integrates theory and moral experience. Feminist ethicists argue that ethical theory is best developed and redeveloped or tested in actual experience, not just in hypothetical experience, in order for ethical theory to be relevant to real life (Baier, 1985, 1994; Brennan, 1999; Held, 1984, 1993; Sherwin, 1996). Baier (1994) describes the need for moral perspectives to be informed by psychological, political, and historical knowledge. Held (1993) and Sherwin (1996) advocate revising Rawls's (1971) method of reflective equilibrium, which recommends a dialectical process in which theoretical considerations are developed and tested against considered moral judgements, into a method of experimental morality.

Thus feminist ethicists recommend an approach to the development of ethical knowledge that in some ways resembles aspects of phenomenological approaches in nursing. Caring is retained as a central moral concern; an emphasis is placed on everyday moral experience, not just situations of moral quandary; the significance of human connectedness is highlighted; and the need for theory to be accountable to moral experience is emphasized. Nevertheless, the additional attention paid to power and privilege makes feminist ethics a more suitable basis for nursing ethics research.

### **Development of an Empirical Research Method**

There is no accepted empirical method that uses feminist ethics as its conceptual basis. This deficiency is not surprising, because theoretical and practical activities in bioethics tend to be distinct. Sherwin (1996) speaks of a "bifurcated ethics landscape" (p. 188) whereby conceptual and practical concerns are worked out separately. Philosophers address the former issues, practitioners the latter. She suggests bringing these activities together. Presumably, this project would be an example of such an undertaking.

Despite the lack of a method, related work using critical theory has provided me with an understanding of how I can translate feminist ethics into an empirical method. Critical empirical research presents a means of going beyond the data to draw out broader ethical and political implications. The term *critical theory* usually refers to a theoretical tradition developed by a group of German scholars, the Frankfurt School, in the 1920s. Today there are a number of schools of thought within this tradition. These tend, however, to have a number of commonalities, such as: all thought is believed to be mediated by power relations; certain groups in all societies are privileged over others; facts cannot be separated from values; and oppression is forcefully reproduced when subordinates accept their status as natural or inevitable (Kincheloe & McLaren, 1994).

Critical empirical research does not simply represent the world. It interrogates any objective description to uncover inherent contradictions and hidden assumptions (Kincheloe & McLaren, 1994). Consequently, a critical researcher assumes a "reflexive" posture towards knowledge and the empirical research process. Reflexivity refers to the capacity to reveal the political nature of knowledge through the questioning of every step of the research process. This reflexive posture enables the researcher to recognize alternative ways of viewing reality and thereby avoid perpetuating the status quo (Eakin, Robertson, Poland, Coburn, & Edwards, 1996). As such, critical research is value-driven and does not simply describe data. Instead, it reinterprets data in light of critical theory. Similarly, one cannot simply describe data when using feminist ethics as a conceptual basis. Data need to be reinterpreted in light of feminist ethics. As in critical theory, a high degree of researcher interpretation is accepted, and indeed required, in the development of knowledge.

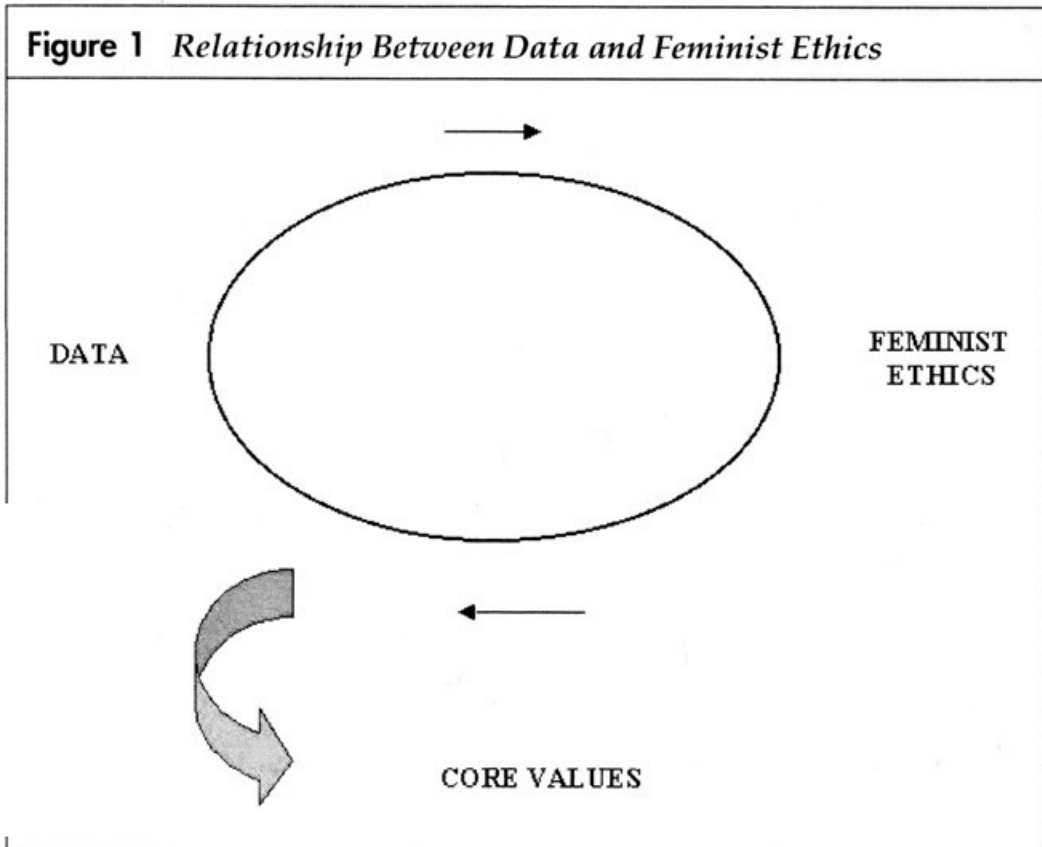


Figure 1 illustrates the relationship between data/moral experience and feminist ethics. Data and feminist ethics exist in a dialectical relationship whereby data are interpreted through feminist ethics — that is, theory and data ultimately inform feminist ethics. In time, a domain-specific feminist ethic for nursing can evolve as the data come to refine the theory. In this regard, the approach I am describing is similar to that used by Benner (1991, 1994) and Bishop and Scudder (1990, 1997, 1999), with feminist ethics as a substitute for phenomenology.

A third element, however, is required if the central values of feminist ethics are not to be lost in the process of developing coherence between theory and moral experience. I call this third element the core values. Specifically, I derive the following four values from common characteristics of feminist ethics: the development and maintenance of relationships; care; justice; and freedom from exploitation and oppression. The development and maintenance of relationships reflects the conception in feminist ethics of persons as interdependent. The values of care and justice are the core values of the ethics of care and justice. Lastly, freedom from exploitation and oppression is central to feminist ethics and therefore needs to be made explicit. These values ensure that

changes to theory or practice do not result in a coherent, yet unethical, system of theory and moral experience.

### **An Application to Home Care Ethics Research**

In this section, I discuss how a qualitative empirical method informed by feminist ethics could be used in home care ethics research in nursing. Specifically, I comment on the potential characteristics of the research participants; the methods of data collection, coding, and analysis; and the processes that ensure rigour. For the sake of clarity, I present examples of data analysis processes that use the aforementioned approach of developing coherence between the data and theory.

#### ***Research Participants***

To remain consistent with the principles of feminist research, this research should value women's experiences, ideas, and needs (Hall & Stevens, 1991). Therefore, it should draw upon the experiences of both male and female home care nurses and home care recipients. Input through partnerships formed with these participants could shape the focus of the specific research questions so that they reflect the participants' most urgent needs and ethical concerns.

#### ***Methods of Data Collection, Coding, and Analysis***

Semi-structured interviews could elicit accounts of everyday home care practices and concerns. Focusing on everyday concerns is consistent with feminist ethics (Mullett, 1992; Warren, 1989). Furthermore, this approach avoids constructing the topic and drawing responses from participants that are in the traditional language of bioethics. Devault (1990) describes the importance of opening the boundaries of standard topics so that participants can provide accounts that are grounded in the realities of their lives and that are not framed by dominant language and meaning. The mundane details of life and practice can provide a means of discovering embedded everyday ethical knowledge. Conventional methods, which in this case would likely ask participants to describe ethical dilemmas in home care, could lead to conventional answers. Conventional understandings, however, can distort women's experiences (Smith, 1987).

The data coding and analysis would require an inductive and a deductive phase. The inductive phase of data categorization would ensure comprehensiveness. The deductive phase would ensure that the

data are reinterpreted in light of feminist ethics. Using an example from Benner's (1991) research, the inductive phase could reveal that some home care nurses learn to find the right kind and amount of involvement with patients and their significant others. If researchers do not go beyond this description, it could easily be concluded that "good" nurses can learn to become skilled with respect to this facet of ethical comportment. Yet if the lens is broadened and this category is examined through feminist ethics — that is, the deductive phase — it is possible to identify the potential structural impediments to the nurse participant's moral agency. Perhaps nurses who cannot find the right kind of involvement are facing issues that go beyond their immediate relationships. Nurses and informal caregivers often lack the resources to provide adequate care (Ward-Griffin & McKeever, 2000). Many nurses do not have the time to develop relationships that reflect an ideal level of involvement. In addition, the relative isolation of home care nurses from their peers may present challenges related to maintaining professional boundaries with patients. These issues need to be understood through a perspective that addresses concerns regarding power and justice.

Using another example, this time from the research of Benner (1991, 1994) and Benner, Hooper-Kyriakidis, and Stannard (1999), home care nurses when interviewed may talk about the importance of respectfully listening to all involved, including the patient, family, and multidisciplinary team. They may state that the best clinical understanding can thus be achieved, preserving what is ultimately good for the patient and family. Again, the deductive phase is required in order to critically examine what is meant by "the best clinical understanding." What is the basis of clinical understanding, beyond the perspectives of the multidisciplinary team? Nurses need to be cognizant of the power of medicalization and its increasing influence in home care. Feminist ethics and bioethics, such as the work of Morgan (1998) and Sherwin (1992), offer useful ways of reflecting on these issues.

These reinterpreted data can then be used to develop a feminist ethic for nursing. In this way, the data and the theory exist in a dialogical relationship. Recommendations for practice could be eventually drawn out and evaluated. Again, all modifications made to establish coherence between theory and the data/moral experience cannot violate the following core values: the development and maintenance of relationships; care; justice; and freedom from exploitation and oppression.



### ***Ensuring Rigour or Trustworthiness***

With the development of any new research method come concerns about trustworthiness. The trustworthiness of this method can be ensured through the incorporation of both highly formalized processes, such as participant validation and auditability, and less formalized processes. Participant validation involves taking data, interpretations, and conclusions back to the participants so they can assess the credibility of the account (Creswell, 1998). This process should occur after completion of the inductive coding, not after completion of the deductive coding. The level of deductive coding involves reinterpretation of the data in light of theory. Consequently, it may not directly reflect the experience of specific participants. This flexibility in the use of participant validation will ensure that this procedure remains true to the interpretive character of qualitative research (Sandelowski, 1993).

Auditability is also possible. Auditability is achieved when researchers describe and justify their research process, leaving a clear decision trail for the study from inception to conclusion (Rogers & Cowles, 1993; Sandelowski, 1986). Field notes should be taken to describe the setting and the non-verbal behaviours of participants; the methodological decisions made; the analytic or theoretical insights of researchers during data analysis; and the assumptions, interests, and philosophic perspectives of the researchers.

More important, however, trustworthiness or rigour must also be established through less formalized processes. *The Canadian Oxford Dictionary* (Barber, 1998) defines rigour not only as "the strict enforcement of rules," but also as "logical exactitude" (p. 1242). A logical exactitude or consistency must flow from its theoretical basis through to every aspect of the research process, as illustrated in the home care application. Other theorists have made reference to similar ideas concerning rigour. Creswell (1998) describes the need for the research questions to drive the research methods, rather than the reverse, and Jacob (1987) asserts that qualitative researchers should "seek to employ the totality of a tradition, not just generic assumptions or methods" (p. 1). Ultimately, less formalized methods may be more consonant with the spirit of qualitative research than traditional procedures.

### **Conclusion**

Nursing could benefit from innovative research methods to address crucial ethical issues in home care. Phenomenological approaches in

nursing have revealed the richness of moral life in nursing, but these approaches are not sensitive enough to the political dimensions inherent in current ethical issues. A method that uses feminist ethics as its conceptual basis can better encompass the complexity of moral life in home care nursing. It provides a rigorous means both philosophically and empirically of furthering the development of ethical knowledge in nursing.

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# **Emancipatory Pedagogy in Nursing Education: A Dialectical Analysis**

**Donna M. Romy**

Au cours des deux dernières décennies, le besoin d'élaborer un nouveau paradigme en enseignement des sciences infirmières a souvent été exprimé, traduisant une volonté d'affranchir professeurs et étudiants des contraintes imposées par les modèles behavioristes en usage. Plusieurs conceptions inspirées de la pédagogie émancipatrice ont été mises de l'avant, si bien que l'on n'a encore de ce courant qu'une compréhension fragmentée. Le but de la présente étude est donc de présenter un aperçu global et systématique des différentes approches concernées, en mettant en lumière les divergences soulevées à propos de l'existence d'une telle pédagogie, de sa nature et de sa valeur. Pour ce faire, la méthode dialectique mise au point par Adler a été employée. Quatre conceptions de la pédagogie émancipatrice ont été dégagées, à savoir qu'elles constituent des philosophies de l'enseignement qui visent à : (1) inculquer un sens critique; (2) établir des rapports de pouvoir égalitaires; (3) sensibiliser aux injustices systémiques fondées sur les différences entre les sexes; (4) transformer, au sein du champ élargi des sciences infirmières, les structures sociales oppressantes. Le terrain commun entre toutes ces approches, c'est que la pédagogie émancipatrice est nourrie par un projet politique, celui de libérer les infirmières de l'oppression. Les principaux points de convergence et de divergence entre les auteurs ont été repérés pour chacune d'entre elles, dans le but d'alimenter les débats futurs sur cette question.

Over the past 2 decades there has been a call for a new paradigm in nursing education that will liberate teachers and students from the authoritarian constraints of behaviourist models of nursing education. Different conceptions of emancipatory pedagogy in nursing education have been set forth, resulting in a diverse and fragmented understanding of it. The purpose of this study was to render this diversity of opinion more intelligible by constructing, from the literature, controversies concerning its existence, nature, and worth. The philosophic dialectic method developed by Adler was utilized. Four conceptualizations of emancipatory pedagogy were identified — teaching that functions to: (1) foster critical thinking, (2) construct egalitarian relations of power, (3) increase awareness of systematic gender-based injustices, and (4) transform oppressive social structures within the larger social context of nursing. Common to all is the notion that emancipatory pedagogy functions as a political endeavour to free nurses from oppression. Key points of agreement and disagreement (issue) among authors were identified for each conceptualization, laying the groundwork for future dialogue and debate.

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Over the past 2 decades there has been a call, by some nurse educators, for a revolution in nursing education. This call stems, at least in part, from a growing awareness that nurses have a social responsibility to work towards transforming the current patriarchal health-care system and a concern that the behaviourist paradigm, which currently underpins much of nursing education, is inadequate in preparing nurses to effectively work towards this goal (Moccia, 1990; Tanner, 1990). Many have argued that what is required instead is a paradigm that liberates teachers and students from the authoritarian constraints of behaviourist models of nursing education and empowers them to become agents of social change. Despite a seemingly shared view that nursing education should have an emancipatory function, considerable diversity of opinion exists as to what, specifically, this entails. Only rarely have the proponents of emancipatory forms of pedagogy engaged in explicit discussion or critique of the conceptions that have been set forth; as a result, the existing discourse related to it is diverse and fragmented.

### **The Dialectic Method**

The purpose of this study was to render this diversity of opinion regarding emancipatory pedagogy more intelligible by constructing, from the nursing literature, points of agreement and disagreement among its advocates (Romyn, 1998). To do so, the philosophic dialectic method developed by Adler (1958, 1961) was utilized. It entailed a systematic analysis of works published in English from 1975 to 1998 concerning the nature, existence, and worth of emancipatory pedagogy in nursing education. To aid in identifying the relevant literature, emancipatory pedagogy was broadly defined as teaching that has a freeing or liberatory function.

The initial step in the analysis was to determine whether emancipatory pedagogy was conceptualized in an identical manner by all of the authors whose works were examined. Four distinct conceptualizations (or subjects of special controversy) were identified — namely, teaching that functions to: (1) foster critical thinking, (2) construct egalitarian relations of power, (3) increase awareness of gender-based injustices, and (4) transform oppressive social structures. In some instances, authors were found to subscribe to more than one of these conceptions. Common to all four is the notion that emancipatory pedagogy functions as a political endeavour to free nurses from oppression, and it is this notion that unifies the discourse.

For each conceptualization, key points of agreement and disagreement among authors were formulated. Authors were said to be in

agreement if they were of one mind with regard to questions concerning the nature, existence, or worth of emancipatory pedagogy in nursing education and were said to be in disagreement (to join issue) if they could be construed, either explicitly or implicitly, as taking opposing positions on such questions. Together, these points of accord and disaccord (issue) constitute the special controversies concerning emancipatory pedagogy in nursing education and are highlighted in what follows. Included also is a brief analysis of some of the assumptions underlying the issues identified and their potential implications for ongoing discourse concerning the pursuit of emancipatory forms of pedagogy in nursing education.

### **Fostering Critical Thinking**

Consider first the conception that emancipatory pedagogy functions to foster critical thinking. As used by authors party to this special controversy, the term *critical thinking* broadly refers to thinking that calls into question commonly held beliefs and assumptions in nursing education and practice. Nurse educators are implored by these authors to redefine teaching and learning and to incorporate strategies to foster critical thinking in their practice. Among the authors who share this conception of emancipatory pedagogy are<sup>1</sup>: Allen; Bevis; Bevis and Murray; Bevis and Watson; Boughn and Wang; Clare; Diekelmann; French and Cross; Harden; Hawks; Hedin and Donovan; Jewell; Krieger; Owen-Mills; Perry and Moss; Rather; Spence; and Wilson-Thomas. Points of agreement among them include the fact that teaching which functions to foster critical thinking (1) involves the development of critical consciousness, (2) entails approaches to teaching and learning that exist outside the behaviourist paradigm, and (3) is characterized by dialogue.

Like many of her colleagues, Wilson-Thomas (1995) echoes the views of Habermas (1968/1971) and Freire (1970) and posits that central to emancipatory education is "'conscientization' or an awakening of critical consciousness" (p. 574). This "awakening" ensues from critical reflection on reality and permits examination of power relations embedded in the structures and functions of society that constrain one's actions. According to French and Cross (1992), through critical reflec-

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1. In this and subsequent sections of the paper, all of the authors who are party to a particular conceptualization of emancipatory pedagogy in nursing education will be listed even though their particular contributions to the discussion may not be noted in what follows because of space limitations.

tion nurses can gain knowledge about and "power over the forces which control and shape [their] lives" (p. 84).

Bevis (1993) asserts that critical thinking entails openness to alternative ways of viewing the world. Without such openness, "students and teachers accept oppressive ways unquestioningly and do not look for the assumptions that underlie them or the practices that uphold them" (p. 102). She eschews behaviourism because it fails to allow "for emancipatory education, for critical thinking" (p. 103). Allen (1990a) characterizes behaviourist forms of curricula as "mind-numbing and authoritarian" (p. 313) and posits that the fostering of critical thinking demands a shift from a "banking model" of education wherein "faculty deposit information in student receptacles" to approaches that empower students to "acquire and analyze information on their own" (p. 314). Harden (1996) is in accord with this view, noting that nursing's "obsession with the know-that form of learning" prevents students "from learning how to challenge and critique" (p. 35), while Bevis and Murray (1990) argue for approaches to teaching that are "congruent with a philosophy of emancipation" (p. 326).

One such approach said to foster critical thinking is dialogue. Echoing Diekelmann (1990), Jewell (1994) characterizes dialogue as more than mere conversation; it is "engaged listening, seeking to understand, and being open to all possibilities" (p. 301). Diekelmann (1990) posits that dialogue empowers students because it increases their powers of inquiry, self-knowledge, and critical thinking. Others argue that through dialogue "the structures and constraints which shape nursing education and practice [can be] critically examined" (Perry & Moss, 1988/89, p. 40) and nurses can "develop the critically reflective skills that are required to transform practice" (Spence, 1994, p. 188). Harden suggests that dialogue can be fostered by problem-posing, which allows students to "perceive critically the way they exist in the world [and] come to see the world not as a static reality, but as a reality in transformation" (p. 34). According to Hawks (1992), problem-posing "allows the teacher to situate learning in the students' own experiences, to challenge the present state of affairs, and to examine problems in social, historical, political and cultural contexts" (p. 615). It is for reasons such as these that Bevis (1993) sees problem-posing as an "antidote" to the banking model of nurse education.

Despite these points of agreement, some authors differ in their opinions regarding the appropriateness of other select teaching strategies in fostering critical thinking. Whereas some hold that lecture is appropriate because it provides the information needed for critical



thinking (Boughn & Wang; 1994; Diekelmann, 1993), others, while acknowledging a need for information, nevertheless argue that "lecture is, by its very nature, oppressive and counter-emancipatory [because it] does not teach [students] how to learn, how to critique, nor how to come to [their] own meanings" (Bevis & Murray, 1990, p. 327). Bevis (1993) concurs, making a distinction between information, which is factual, and knowledge, which she maintains results from "reason, deliberation, interpretation, insights, reflection, dialogue, and meaning-making" (p. 104). In her view, lecture is oppressive because it teaches students *what* to think rather than *how* to think.

The second issue in this special controversy considers the congruence of critical thinking with use of the nursing process. On one hand, Bevis (1993) suggests that the two are congruent *if* the latter is informed by critical reflection. On the other hand, French and Cross (1992) and Wilson-Thomas (1995) argue that the two are incongruent because they differ with respect to their ends: whereas critical thinking pursues emancipatory knowledge, the nursing process seeks instrumental knowledge in order to bring about particular outcomes. Like Nagle and Mitchell (1991), Wilson-Thomas argues that use of the nursing process serves to perpetuate paternalistic beliefs and assumptions related to power and control in nursing practice and, hence, fails to foster critical thinking.

Underlying these issues are assumptions related to how one comes to know, what constitutes knowledge, and the nature and place of emancipatory knowledge in nursing. The view that lecture is oppressive has been adopted by other nurse educators in formulating their conceptions of emancipatory pedagogy. However, the distinction between information and knowledge, upon which this view is based, has not been challenged to determine whether it is sound. How is it that information derived from lecture can, at one and the same time, be oppressive *and* be "used to raise consciousness, to alter perceptions, to shape criticisms, and to feed meanings," as suggested by Bevis and Murray (1990, p. 327)? Are there factors, beyond mode of delivery and perhaps intent, that influence whether information is oppressive or emancipatory?

Similarly, there is work yet to be done to determine the proper place of instrumental and emancipatory knowledge in nursing practice. Whereas French and Cross (1992) take the position that both are essential, implicit in the works of Wilson-Thomas (1995) and Nagle and Mitchell (1991) is the view that knowledge related to prediction and control has no proper place in nursing practice. Yet when one contem-

plates the nature of nursing practice it becomes evident that nurses rely upon such knowledge in decision-making regarding, for example, which one of several interventions is most likely to result in a desired outcome. If there is indeed no place for instrumental knowledge, on what basis would such decisions be made? Are there some instances, but not others, in which such knowledge is appropriate? Failure to answer questions such as these will result in continued confusion regarding how (or if) each of these forms of knowledge ought to be pursued.

For the most part, authors party to this conceptualization of emancipatory pedagogy have been silent concerning the evaluation of critical thinking. Although most concur that current methods of evaluation reflect behaviourist traditions and, as such, are inappropriate with respect to emancipatory ends, there is a paucity of debate regarding potential alternatives. Nor have these authors addressed the larger question of whether it is possible (or desirable) to evaluate critical thinking and, if it is, the criteria by which it should be evaluated.

### **Constructing Egalitarian Relations of Power**

A second conception of emancipatory pedagogy concerns teaching that functions to construct egalitarian relations of power between teachers and students. As used by the authors who hold to this conception, this notion implies a sharing of power within the classroom. These authors agree that such teaching (1) is inconsistent with patriarchal views of power, (2) connotes giving "power to" students, (3) entails developing partnerships between teachers and students, and (4) involves mutual decision-making within the classroom. Among the authors who share this conception are: Allen; Bevis; Bevis and Murray; Bevis and Watson; Boughn; Boughn and Wang; Chally; Chinn; Clare; Diekelmann; Gray; Hedin and Donovan; Heinrich and Witt; Hezekiah; Jewell; Keddy; Nelms; Perry and Moss; Rather; Schuster; Symonds; Tanner; and Wheeler and Chinn.

Without exception, these authors argue that patriarchal views of power prevail in nursing education and are incongruent with emancipatory aims. Chinn (1989) characterizes most nursing education settings as "patriarchal institutions, arranged in power-over hierarchies" (p. 10). Teacher-student relationships reflect the view that the teacher "knows and gives," whereas the student "does not know and absorbs that which is given, preferably without questioning" (p. 10). Imbalances in power exist because "the teacher has the power to grade, to offer opinions and judgements, and to speak.... [The] student is institutionally

defined as a receiver of grades, a receiver of the teacher's opinions and judgements, and the listener" (Wheeler & Chinn, 1991, p. 90). Teachers are endowed with power and students must submit to that power in order to succeed (Chally, 1992). The authority of teachers gives rise to "reward, punishment, compulsion, and conformity" (Bevis, 1989b, p. 69) and reinforces passivity among students (Allen, 1990a).

The notion that teachers should give "power to" rather than assume "power over" students constitutes a second point of agreement among these authors. Giving "power to" is held to promote equality and sharing of one's influence; assuming "power over" is said to increase personal power by taking power away from others (Wheeler & Chinn, 1991). Boughn (1991) posits that educators "can transfer [their] power to the students" (p. 80), as a result of which students are empowered. This notion gives rise to a third point of accord, which calls for the formation of partnerships between teachers and students. Bevis (1989c) argues that students must become "partners in education, not objects of education" (p. 129) with "shared control of the learning process" (1993, p. 104). Within such partnerships "there is no strict dividing line between teacher and student" (Jewell, 1994, p. 362); faculty become "facilitators, sometimes guides, but most often partners in learning" (p. 364). Allen (1990a) opines that partnerships allow nurse educators to relinquish the "'burdens' of our current models of control and expertise" (p. 315) and to view students "not as 'raw material' to be hammered into a 'product' but as participants who share some of our goals (but not others) and with whom we can negotiate" (p. 314).

Yet a fourth point of agreement centres around the notion of mutual decision-making within the classroom. Bevis and Murray (1990) assert that emancipatory curriculum arises from "a philosophical context that provides that general directions be conjointly determined" (p. 328). Consistent with this notion, several authors advocate mutual decision-making in determining course objectives, methods of evaluation, and the assigning of grades as means of empowering students (Boughn, 1991; Boughn & Wang, 1994; Hedin & Donovan, 1989; Hezekiah, 1993).

Despite these points of agreement, disagreement exists among some authors concerning how the notion of shared power is enacted. One such issue centres around the question of whether it is possible for teachers and students to share power equally. Authors taking an affirmative position on this issue maintain that within egalitarian relations of power, teachers and students are equal (Boughn, 1991; Chinn, 1989; Hedin & Donovan, 1989; Schuster, 1993; Symonds, 1990; Wheeler &

Chinn, 1991) and hence, as Symonds succinctly states, "no one opinion or person is [held to be] more valid or powerful than another" (p. 48). Other authors argue that circumstances within educational settings in fact preclude the equal sharing of power. Included among these are potential sanctions that faculty control because of their power to assign grades (Boughn & Wang, 1994; Gray, 1995; Nelms, 1991; Tanner, 1990), student discomfort with notions of shared power (Gray; Hedin & Donovan), and patient safety concerns (Allen, 1990b). These authors hold that while action may be taken to reduce power gradients, equal power-sharing is not possible. These views give rise to a second, related issue, which concerns the underlying intent in constructing egalitarian relations of power. Whereas some authors argue that the intent is to *displace* hierarchical and authoritarian relations of power between teachers and students (Allen, 1990a; Bevis & Murray, 1990; Chinn; Moccia, 1988; Symonds; Wheeler & Chinn), others suggest that the intent is to render them *less* hierarchical and authoritarian (Beck, 1995; Hedin & Donovan).

There is a dearth of discussion among authors who share this conception of emancipatory pedagogy regarding the assumptions upon which the notion of shared power is based. This is problematic because, in the absence of such discussion, it is not possible to determine whether their recommendations are sound. Gore (1992, 1993) notes that underlying the notion that teachers can give "power to" students is the assumption that teachers are powerful and aim to empower and that students are powerless and need to be empowered. Rather than displacing hierarchical and authoritarian views of power, these assumptions serve to reinscribe them. Clearly this is contrary to the stated intent of authors who advocate shared power. A second assumption is that altering the balance of power is sufficient to eliminate conditions of dominance and control within the classroom. Gore (1992) questions this on the basis that seeking to change the distribution of power maintains a focus on *who* is in power rather than on *how* relations of power function to perpetuate dominance and control. Yet a third assumption underlying the notion of shared power is that the *effects* of the exercise of that power by the teacher and the student are necessarily complementary (Gore, 1992). Although Allen (1990a) notes that teachers and students may not always have the same end in view, there is little indication in the works examined that authors who advocated shared power recognize that this may result in *net outcomes* that are less than, or contrary to, the intended outcome. Nor is there discussion about how potential conflicts between teachers and students concerning the ends to be attained, and the means to be used in attaining those ends, are to be resolved (or if indeed they need to be resolved).



In order to resolve the aforementioned issues, substantive debate is required regarding the proper place of authority in emancipatory forms of pedagogy and the circumstances (if any) under which it is appropriate for teachers to retain authority in their relations with students. Furthermore, there is a need for debate related to the notion of equality. What is meant by the notion of equality? Are teachers and students equal in all respects, or are they equal in some respects (e.g., their humanity) but not others (e.g., their level of expertise and their consequent authority in the educational process)? Questions such as these have important implications for delineating the principles governing the distribution of power in the classroom.

### **Increasing Awareness of Systematic Gender-Based Injustices**

Hedin and Donovan (1989) assert that a "freeing" or emancipatory education in nursing is concerned with the "identification and transformation of those structures and relations in society that lead to the oppression of women" (p. 9). This belief underpins a third conception of emancipatory pedagogy in which teaching functions to increase awareness of systematic gender-based injustices against nurses. Authors who share this conception agree that such teaching (1) reflects the fundamental belief that nurses, as women, are oppressed, (2) entails understanding how systematic gender-based injustices perpetuate their oppression, and (3) necessitates making teachers and students cognizant of their own oppression and ways in which they are oppressive of others. Authors who share this conceptualization include: Andrist; Beck; Bevis; Boughn; Boughn and Wang; Cameron, Willis, and Crack; Chinn; Gray; Harden; Hedin and Donovan; Heinrich and Witt; Hezekiah; Jewell; Keddy; Lenskyj; Mason, Backer, and Georges; Mason, Costello-Nickitas, Scanlan, and Magnuson; Millar and Biley; Nelms; Rather; Roberts; Ruffing-Rahal; Schuster; Symonds; Tanner; Valentine; Watson; and Wheeler and Chinn.

Common to all these authors is the fundamental belief that because of systematic gender-based injustices, nurses, as women, are oppressed. Substantiating this, Harden (1996) claims that the "history of the domination of nursing is inextricably linked to the domination and oppression of women" (p. 33). Perpetuating the oppression of women are "prevailing societal patriarchal hierarchies [which] have relegated women to the least rewarding and least powerful positions within society" (Jewell, 1994, p. 362). As a result of their oppression, nurses "lack autonomy, accountability and control over their own profession" (Harden, p. 33).



That emancipatory pedagogy entails helping women come to understand how systematic gender-based injustices perpetuate their oppression represents a second point of agreement among these authors. Ruffing-Rahal (1992) notes that confronting the socially constructed and gendered aspects of nursing helps explain many of nursing's collective experiences as "a consequence of patriarchy and the subordinate status of women" (p. 247). More specifically, Boughn and Wang (1994) call for a scrutiny of factors that perpetuate inequality within the profession, including "lack of professional autonomy, inequity in financial compensation, and lower social status of nurses, [none of which are] commensurate with the educational qualifications, the professional demands, [or] the working conditions required of nurses" (pp. 112–113). Boughn (1991) similarly advocates the "relentless questioning of policies that ignore or diminish the contributions of nurses in the health care system" (p. 77). Andrist (1988), who is in accord with this view, posits that coming to "recognize sexual politics in the medical care system as 'institutionalized relations of power'" will enable nurses "to reclaim the culture of the profession, ultimately politicizing them towards activism and change" (pp. 67–68). Hezekiah (1993) shares this view, noting that "educating women (nurses) to the reality of the structures that oppress them [helps them] take constructive action to change their lives" (p. 57).

Yet a third point of agreement related to this conception of emancipatory pedagogy is that it necessitates making teachers and students cognizant of their own oppression and the ways in which they are oppressive of others. Reflecting the work of Freire (1970), several authors note that nurses exhibit many of the characteristics of oppressed groups, including adhesion with the oppressor, horizontal violence, fear of freedom and emotional dependence, belief in the omnipotence of the oppressor, adherence to prescribed behaviour, self-deprecation, apathy and fatalism (Hedin, 1986; Hedin & Donovan, 1989; Jewell, 1994). Other characteristics include a lack of self-esteem, self-hatred, and disdain for other nurses and other women (Roberts, 1983). While Hedin and Donovan see such behaviours as "counterproductive and unintelligible," they suggest that conceptualizing nurses as an oppressed group helps explain many of their behaviours, including their oppressiveness towards each other.

Jewell (1994) declares that "some nurses, including [students and faculty,] are so submerged in their oppression that they are unaware of it" (p. 364). Because of this, Nelms (1991) declares, as nursing educators "we must come to know how we are oppressed as nurses, as women,

as blacks, and as other ethnic minorities and...how we have participated in our own oppression and the oppression of others...[in order to create] educational environments for liberation and emancipation" (p. 7). Jewell cautions that coming to recognize the "oppressor within [oneself] is a painful experience" (p. 363) but asserts that doing so is crucial, "lest we perpetuate the oppression that for too long has been part of the profession's reality" (p. 363). Tanner (1993) likewise implores nurse educators to think about "ways in which [they] reproduce the dominant paternalism in the classroom... and ways in which [they] might shape [their] teaching to change traditional power relationships" (p. 51). Like the foregoing authors, Bevis (1989a) believes that while "few teachers deliberately oppress students, oppression is a subtle, culturally accepted, and condoned way of conducting the educational enterprise" (p. 122).

Boughn (1991) notes that "in [our] paternalistic society, most students arrive at academic institutions without a feminist perspective. Of those attracted to nursing, most feel comfortable with nursing's image as a traditional female profession" (p. 76) and many may resist courses that "challenge their expectations, ideals, and beliefs about nurses and nursing" (Cameron, Willis, & Crack, 1995, p. 337). Mason, Backer, and Georges (1991), however, argue that traditional roles must be challenged, because they "act as a means of social control...[restraining] nurses' expectations for power, privilege and access to self-determination...[and] keep the dominant groups in positions of advantage and power" (p. 75).

For the most part, authors who share this conception of emancipatory pedagogy are of like mind. Some disagreement is evident, however, and centres around questions concerning who can come to understand systematic gender-based injustices against women and whether teaching awareness of such injustices is valued. With respect to the former, several authors suggest that being a woman is neither necessary nor sufficient to understanding such injustices (Beck, 1995; Boughn, 1991; Hedin & Donovan, 1989; Mason, Backer, & Georges, 1991; Mason, Costello-Nickitas, Scanlan, & Magnuson, 1991; Miller & Biley, 1992; Tanner, 1993). In contrast, Ruffing-Rahal (1992) and Symonds (1990) suggest that only women, by virtue of having experienced such injustices, can do so. With respect to the second issue, Boughn (1991), Boughn and Wang (1994), and Schuster (1993) maintain that such teaching, because of its political agenda, is (or should be) valued by all nursing teachers and students. Contrary to this view, Heinrich and Witt (1993), Keddy (1995), Lenskyj (1993), and Miller and

Biley argue that despite its political agenda, such teaching is not valued by all and, as a result, resistance to it is evident.

These issues, and the positions taken on them, reflect differences in opinion as to whether women possess an essential nature. While both adhering to and letting go of notions of essentialism have important implications for political action aimed at eliminating gender-based injustices, essentialism has not been a subject of debate in the examined literature. Mohanty (1991) argues that in addition to reinforcing binary dichotomies based on gender, notions of essentialism also serve to define power relations in binary terms, locking them into the structure of powerful:powerless. Disrupting current social structures would consequently take the form of a simple inversion of the power relations that currently exist. She believes that this is problematic in that it does not deal with the social structures that allow inequities in power relations to occur. While none of the authors who are party to this subject of special controversy explicitly advocate such an inversion in power relations, the notion that female (feminist) views of power are to be preferred over male (patriarchal) views is evident in many of their works.

Essentialist views of gender also undergird the issue concerning the valuing of increasing awareness of systematic gender-based injustices perpetrated against women. Although some authors acknowledge that not all women value such teaching and some may in fact resist it, little evidence of in-depth analysis of the reasons for their resistance was found in the examined literature. This has important implications. If the reasons for students' (nurses') resistance are not known or questioned, how can effective teaching strategies be designed to increase awareness of and formulate political action to eliminate the oppression of women and of nurses?

### **Transforming Oppressive Social Structures**

A fourth conception of emancipatory pedagogy centres around the view that many of the social structures within which nursing education and practice are situated are oppressive and must be transformed, if nurses are to abolish the forces that "so powerfully perpetuate the conditions of their own domination" (Owen-Mills, 1995, p. 1192). Authors who concur hold that emancipatory pedagogy aimed at transforming oppressive social structures (1) requires critical awareness of the ideologies that uphold them, and (2) entails political action to transform them. These authors include: Allen; Bent; Bevis; Bevis and Watson; Chavasse; Clare; Diekelmann, Allen, and Tanner; Gray; Hagell; Harden; Krieger; Lenskyj; MacLeod and Farrell; Mason, Backer, and Georges;

Mason, Costello-Nikitas, Scanlan, and Magnuson; Moccia; Owen-Mills; Perry and Moss; Rather; Spence; Tanner; Watson; and Wilson-Thomas.

According to these authors, transforming oppressive social structures first requires that teachers and students become cognizant of the ideologies that uphold them. Rather (1994) defines ideology as a "system of ideas, values, or beliefs about social reality that serves to legitimate the vested interests of powerful groups" (p. 265). Clare (1993b) posits that in nursing "the dominant values and beliefs of policy and decision makers...permeate and shape the consciousness of teachers and students...and, in effect, [make them] unconscious participants in their own domination" (p. 285). Furthermore, nursing education "helps create and legitimize forms of consciousness which reinforce existing hegemonic structures" (Clare, 1993a, p. 1034). In this way, ideologies reduce "resistance to acts of power" (Diekelmann, Allen, & Tanner, 1989, p. 25).

Bent (1993) claims that nurses, in becoming aware of oppressive ideologies, can work towards "reclaiming the environment in which [paternalistic] mechanisms for oppression have worked against nursing" (p. 300). One such mechanism is the instrumental rationality of institutions that "has resulted in nurses having a preoccupation with means rather than ends; with method and efficiency rather than purpose; with the desire to control and exercise power over others" (Perry & Moss, 1988/89, p. 38). Moreover, this "ensures that actions nurses take are constrained by organizational factors such as time limits, tasks and procedures, individual workloads, staffing levels, relations of power and in many cases still, the demands of doctors" (p. 38). Bent suggests that to recognize "sexual politics in the medical care system as institutionalized relationships of power is to open those relationships to further analysis" (p. 299). Although Clare (1993a) does not disagree, she cautions that "it is easier to be radical at the level of ideology...than at the level of socio-political action where [nurses] are more effectively constrained by the daily exercise of power" (p. 285).

A second point of agreement among these authors is the fact that nurses must not only critically examine but also engage in political action to transform oppressive social structures. Like MacLeod and Farrell (1994), Clare (1993b) charges that this action component is missing in the "current curriculum revolution rhetoric" (p. 285) in the nursing education literature. Spence (1994) concurs and maintains that nursing education must facilitate the development of nurses capable of shaping "the broader social and political context in which their practice occurs" (p. 188). Mason, Costello-Nickitas, Scanlan, and Magnuson



(1991), however, caution that "it cannot be assumed that nurses have the confidence or skills to make changes in the workplace in politically astute, effective ways" (p. 5). In keeping with this view, Krieger (1991) suggests that nurses need to learn how to be politically active early in their educational experiences if they are to determine, for themselves, the conditions of their practice.

Despite these points of agreement, disagreement exists among some authors as to what is entailed in taking action to transform oppressive social structures. Some authors question whether the power to do so resides within nursing. Taking an affirmative position, several posit that not only the power but also the responsibility to do so lies within nursing (Moccia, 1988; Tanner, 1990; Watson, 1989). In contrast, others hold that this is not necessarily the case because inherent within these social structures is the power to constrain the actions of those who seek to do so, thus rendering them resistant to change (Clare, 1993a, 1993b; Diekelmann, Allen, & Tanner, 1989; Gray, 1995; Spence, 1994). A second and related issue centres around the question of whether the individual's perception of the costs of taking action (the risk of potential sanction) constitutes sufficient reason *not* to do so. Although none of the authors party to this issue condone inaction, some acknowledge that the fear of sanction may in fact result in a conscious decision not to act (Clare, 1993a, 1993b; Perry & Moss, 1988/89; Spence). Clare, however, cautions that failure to act resigns nurses to being governed by them.

Underlying these issues are differing views of how power is exercised and its consequent effects on social structures. On the one hand, the exercise of power by nurses is seen as having a direct and positive effect. In this view, nurses are charged with sole responsibility for transforming these social structures and, by extension, blame if they fail to do so. Clearly, this view warrants further examination. On the other hand, the exercise of power is seen as taking the form of a struggle between opposing forces, both capable of wielding and resisting power and resulting in outcomes that are neither direct nor certain. This latter view represents a shift in thinking from a focus on *where* power resides to *how* power, in the form of real or anticipated sanctions, renders oppressive social structures resistant to change. The potential for sanction, from within as well as outside nursing, however, has only rarely been addressed in the works examined and gives rise to the question of whether the individual nurse has an obligation to put him/herself in jeopardy in the pursuit of the collective good of the profession. While issues such as these, which involve disputation with respect to moral oughts, are not easily resolved, they must be disputed if nurses are to



come to a fuller understanding of what is entailed in taking (or not taking) action against oppressive social structures in nursing education and practice.

### **The Controversy as a Whole**

Adler (1958, 1961) defines a controversy as consisting in the dispute of issues by way of arguments both for and against particular positions taken on them. In light of this definition, it can only be concluded, based on the findings of this study, that relatively few controversies exist concerning the nature, existence, and worth of emancipatory pedagogy in nursing education. It is important to note, however, that the issues set forth in this analysis include only those that have been explicitly or implicitly addressed in the examined literature, and, consequently, it would be erroneous to conclude that there are no other issues. Although a number of potentially contentious notions exist in the literature examined, in keeping with the dialectic method these notions cannot properly be termed issues because authors have not, as yet, engaged in either implicit or explicit dialogue on them or taken opposing positions on questions related to them. Yet other potential issues are embedded in the assumptions underlying each of the conceptions of emancipatory pedagogy, as is noted in the preceding discussion.

Although numerous conceptions of emancipatory pedagogy have been proffered, only rarely have nurse authors engaged in debate on them. Several explanations may account for this. First, it may be that because the notion of emancipatory pedagogy in nursing education is relatively new, insufficient time has been available for such dialogue. Second, it is possible that nurse educators are of like minds with respect to their conceptualizations of emancipatory pedagogy. Third, it may be that the conceptions that have been set forth have simply been accepted without critical examination. There may be yet other explanations. Whatever the case, in light of the issues and questions formulated in the preceding discussion, it does not seem unreasonable to suggest that there is no lack of substance for further examination and debate.

### **Limitations**

Despite the utility of the dialectic method in setting forth the controversies concerning emancipatory pedagogy in nursing education, this study is not without its limitations. Although the researcher endeavoured to ensure that the identification and selection of relevant

literature was comprehensive, some relevant works may have been inadvertently omitted. Furthermore, because works were selected *only* if they directly pertained to nursing education, the literature selected does not necessarily reflect the full range of thinking on emancipatory pedagogy among educators in general, nor does it necessarily reflect the breadth and depth of emancipatory thought in nursing as a whole. This thinking is reflected only inasmuch as the authors whose works were examined cited it in developing their conceptions of emancipatory pedagogy.

A second limitation stems from the fact that the analysis is confined to published descriptions of emancipatory pedagogy. These descriptions often contained ideas that were only implicitly stated by authors, and, as a result, a fair degree of interpretation was required on the part of the researcher in constructing the controversies. The degree to which the resulting interpretations can be considered valid is dependent on the degree to which they are supportable by reference to what the authors explicitly do say about emancipatory pedagogy.

A third limitation relates to the dialectic method, which, as described by Adler (1958, 1961), seeks to identify issues that authors discuss with a view to resolving them. It demands that authors be positioned on one or another side of an issue. However, in constructing the issues that make up the controversies concerning emancipatory pedagogy, the researcher saw clearly that some authors viewed some of these issues not as requiring resolution but rather as dynamic tensions within which contradictory points of view can indeed coexist. Remaining faithful to the dialectic method limited, to a certain extent, reflection of these dialogical tensions.

### Conclusion

Over the past 15 years there has been a proliferation of works published by nurse educators concerning emancipatory forms of pedagogy, and these authors are to be commended for their efforts. Such thinking is different from, and oft times contrary to, traditional ways of thinking about nursing education. As is evident in the preceding discussion, authors often differ with respect to their understandings, which may in fact result in confusion and misunderstanding as others try to comprehend this new way of thinking about teaching (and learning) in nursing education. This study has contributed, albeit in a small way, to a clearer understanding of it by setting forth the points of accord and disaccord that underlie this diversity of thought. Ongoing dialogue concerning

the issues and assumptions inherent in these conceptualizations will assist nurse educators in forming critical judgements regarding the pursuit and development of emancipatory forms of pedagogy in nursing education.

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## Book Review

### *Philosophy of Nursing: A New Vision for Health Care*

J.M. Brencick and G.A. Webster

Albany: State University of New York Press, 2000, 247 pp.

ISBN 0-7914-4380-9

Reviewed by Sally Thorne

Some books are designed to provoke controversy, and this new volume by Brencick and Webster seems no exception. Tantalizingly entitled *Philosophy of Nursing*, it will attract readers who are interested in understanding something of the nature and status of philosophizing within the discipline or who hope to find a particular philosophical perspective clearly articulated. In my opinion, this book accomplishes neither.

The basic premise of the book is that nursing relies upon knowledge of universality in direct application to the singularity of individuals. Because of this, it affords a special context in which the insights of the philosophers can be uniquely applied. The foundation for this volume is that nursing theories are inherently grounded in the knowledge of disciplines other than nursing, and therefore are inadequate to the task of conceptualizing the challenge of this particular discipline. Instead, the authors advocate for a philosophy of nursing, which they attempt to work out in this volume. They intend for their philosophy to deepen our understanding of what is already known in such a manner that it will "illuminate nursing using the lens of universality and singularity" (p. 3). As such, they argue that it will represent a new vision for health care.

The book's structure is creative and intriguing. Following an introductory discussion to set the stage for the subsequent chapters, a rather poetic and reflective "nursing event" is dissected and articulated in rich and colourful detail. This illustrative diversion is intended to reframe the reader's perceptions about what nursing events entail, and immerse the reader in a complex, emotionally charged, and philosophically interesting encounter between a patient and a nurse. It is intended to locate the philosophy to be developed in a genus of nursing encounter that is intensely subjective and captures the essence of human experiences within illness. It places the nurse, as a sensing and thinking person, at the centre of the experience, raising questions, concerns,

thoughts, and feelings that might be inherent in such an encounter. Two subsequent chapters involve a "thought experiment," set up as an imaginary dialogue between one of the co-authors and a series of early and modern philosophers. Following upon this examination of the traditions of philosophical thinking that might be relevant to a philosophy of nursing, the next chapter summarizes the foundations of Jean Watson's "theory of caring." Finally, the concluding chapter presents specific and particular opinions about some of the ideas that might be embedded in a treatment that extends Watson's work into a full-fledged philosophy.

While the structure and form of *Philosophy of Nursing* are unique and highly creative, and while the book advances a great number of ideas that will undoubtedly stimulate debate and dialogue, this philosophy of nursing flounders in its attempt to sort through the available ideas and present a coherent and convincing argument that will guide philosophical reasoning for the discipline. A number of problems contribute to this difficulty. By drawing on examples from the text, I will try to illustrate what they are and why they matter.

An immediate concern that arises for the reader is the surprisingly scant consideration of any literature representing either nursing theory or the philosophy of nursing. Since the foundational claim of the book is that nursing theories are inadequate because they derive so strongly from the ideas of other disciplines, this omission is rather glaring. Beyond very brief references to the work of Martha Rogers and Betty Neuman, there is no mention at all of a rather substantial body of theoretical writing in nursing over the past several decades. In contrast, there is an extensive reliance on the writings of Jean Watson, without any critical examination of the degree to which her work might have been influenced by the very factors that are presumed to render the remainder of the literature irrelevant. Indeed the selection of Jean Watson as a foundational theorist is justified several times throughout the book on the basis of her personal relationship with one of the co-authors and the claim that her conceptualization of the caring occasion might be understood as a basic concept in nursing. Further complicating this gap is the absence of any mention that others in nursing have written about, examined, or theorized about a philosophy of nursing and what that might look like. Thus the rationale for *Philosophy of Nursing* appears to be grounded in a somewhat misrepresentative portrait of how philosophy has informed and intrigued numerous nurse scholars for over a century.

Although I admire risk-taking and creativity in scholarly writing, I must confess that I was troubled by many aspects of the dialogue set up between one of the co-authors and the philosophers of historical time. Where this technique is successful, it engages the reader in an imaginary discussion in which questions that might trouble nurses are posed to the philosophers whose ideas have been most influential in our current ontological and epistemological understandings. However, in a great many instances the creative writing of this section shifts rather heavily into a somewhat disturbing debate in which the philosophers are set up as defending the extreme interpretations of their positions while the nurse tries to help them appreciate the error of their ways. In articulating her own personal responses to the claims as she imagines them, the nurse co-author makes explicit her own questions and confusions as if they represent nursing's inevitable interpretations. While it is somewhat appealing to have these thinkers humanized in this kind of dialogue, the degree to which they crack jokes or doodle on their napkins leans towards absurdity, which may not always serve the intended purpose. When Kierkegaard uses the word "yuck" to express his displeasure at the idea of referring to persons as patients, we get the sense that the author has perhaps taken the imaginative exercise one step too far. Her analysis of the potential relevance of his opinions fulfils little of the promise that such a creative exercise might offer: "I am taken aback by Kierkegaard, and even worry a little bit about his sanity. But I have to admit that he does make some valid and important points" (p. 123). Towards the conclusion of this exercise, when she is able to get Husserl to change his mind about the nature of the body and its ability to influence experience, the reader can be excused for losing patience.

A curiosity of this book, something I found irritating until I developed a theory about it, is the peculiar variation that occurs with the use of the first person and the "voice of the author." Throughout the first five chapters, reference to the authors in the first-person plural is interspersed with specific mentions of the ideas of the "nurse co-author." Over the course of the work, the reader comes to understand that individual as the primary author of all but the final chapter, where the style and tone change dramatically and the masculine first person is sometimes used. Thus the reader who detects this pattern comes away with an impression of some creative experimentation on the part of a nurse author, with a philosopher completing the exercise by weaving some of its threads into a philosophical tapestry that is intended to extend the creative thinking into a coherent set of claims.

Finally, because *Philosophy of Nursing* purports to represent a philosophy of nursing, the essence of the final chapter is one that should be of great interest to many nurse scholars. Clearly, the philosophy articulated here builds upon Jean Watson's work, but in the concluding chapter is somewhat more critical of that work than has been apparent in the earlier chapters. Surprisingly, the focus of this philosophy departs from the embodied and transactional experiences that have been depicted as central to nursing in the early chapters. In this philosophy of nursing, the emphasis is on intuition, contemplation, and spirituality. Persons are understood as "communities of experiencing entities" and much of the discussion revolves around issues associated with defining how caring is different when the body of the patient is dying or dead. It is argued that practising nurses, through caring, make a significant contribution to the "creation of the consequent nature of God" (p. 184), suggesting a theological thrust that has not been explicit in the work to this point. By relying on illustrations of "diseased spirituality" and orienting a vision of nursing practice that depicts acts of caring as "of special interest to God," the concluding chapter is both thought-provoking and disturbing.

Despite the promise of its title, this book will not be the definitive text on philosophy of nursing that so many of us have been seeking. In fact, it may not even make the reading list. But I am confident that it will stimulate passionate responses and heated debate. And in that, it will have made a contribution.

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***Economics of Nursing Care***

**June 2001 (vol. 33, no. 1)**

Research on the economics of nursing care focuses on the cost implications of nursing services. These may take the form of cost-minimization, cost-benefit, cost-utility, or cost-effectiveness analyses. Economic evaluation in nursing is still relatively new. Papers are sought that examine the economic aspects of nursing care, which may include the use of system resources such as length of stay or emergency visits. Priority will be given to papers that examine the effects and expense of nursing care from multiple points of view.

**Guest Editor: Dr. Gina Browne**

**Submission Deadline: October 15, 2000**

***Home Care***

**September 2001 (vol. 33, no. 2)**

The home has become the predominate site for the delivery of health care and supportive services in Canada. Many health-care institutions have closed and those that remain have been reduced in both size and range of functions. This shift in the site of care delivery is a result of the combined effects of medical, pharmaceutical, and technological advances, together with a political climate of fiscal restraint. This issue of the *CJNR* will focus on the implications of this major change for nursing practice, research, education, ethics, and politics. Theoretical, philosophical, and research-based manuscripts on the provision or receipt of nursing and other supportive services in the home are solicited.

**Guest Editor: Dr. Patricia McKeever**

**Submission Deadline: January 15, 2001**

Please send manuscripts to:

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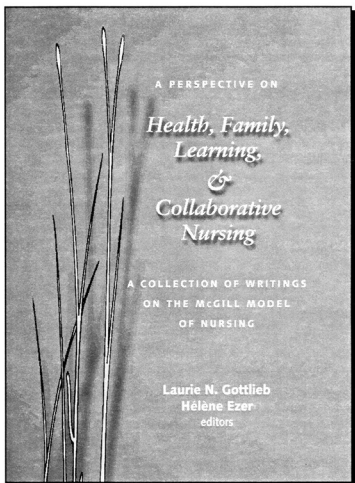
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All manuscripts must follow the fourth edition of the *Publication Manual of the American Psychological Association*. Research articles must follow the APA format for presentation of the literature review, research questions and hypotheses, method, and discussion. All articles must adhere to APA guidelines for references, tables, and figures. Footnotes should not be used.

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