

# Knowledge in Nursing: Contemplating Life Experience

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Le vécu des infirmières génère une perception subjective face à un événement, laquelle est ancrée dans les croyances, les valeurs, les traditions, l'appartenance religieuse et culturelle et les autres aspects contextuels de la vie. Dans le but de mieux comprendre les connaissances relatives à la pratique infirmière, nous devons donc mettre en lumière la connaissance provenant du vécu et examiner comment le contexte entourant la vie des infirmières ainsi que la pratique établissent les limites de son expression. Peu d'auteurs ont fait explicitement référence à la vie des infirmières à l'extérieur du milieu clinique ou tenté de comprendre leur vécu façonnant leurs connaissances de la pratique. Cet article décrit la connaissance basée sur le vécu et sa nature et explique pourquoi il est nécessaire d'en tenir compte pour mieux comprendre les connaissances qui se rattachent à la profession.

Nurses' life experiences result in a subjective way of knowing an event, a way of knowing that is embedded in beliefs, values, traditions, religious and cultural observances, and other contextual layers of life. Thus, in order to more fully understand nursing knowledge, we must illuminate knowledge that comes from life experience and examine how the context of nurses' lives, and practice, delimits its expression. Few authors have made explicit reference to nurses' lives outside clinical practice, or have sought to understand how life experiences contribute to the way in which they know nursing. This article describes life-informed knowledge, what it is and why it needs to be considered to further our understanding of nursing knowledge.

*In 1975, right after graduation, I went to work on what was then called a terminal care unit. I remember very clearly my first experience of a patient's death. However, the part of the experience I want to share is the aftermath of that death. A new orderly and I were assigned to post-mortem care. In the man's bedside table I found a bus pass with his picture on it, a picture of him before cancer and surgery had made him almost unrecognizable. I showed it to the orderly and started to cry, overwhelmed by what this man had endured. He was alone at the end of his life, with two strangers putting his things in bags. I was a very new nurse at the time, with only a few months of clinical experience. This was, in fact, my first experience of death since the death of my grandfather when I was 13. He too died alone.*

Nurses engage with other human beings at profoundly intimate times, providing care and support in circumstances they may have experienced themselves. Such experiences produce a unique and subjective

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way of knowing a particular event, a way of knowing that is embedded in beliefs, values, traditions, religious and cultural observances, and other contextual layers of life. Chinn (1992) challenges us to reveal knowledge arising in our "non-clinical" lives, to integrate "into our legitimate realm of inquiry that which we know from our own experience" (p. 7). I take Chinn's words very seriously. I seek to understand how my own and others' non-clinical life experiences inform our nursing knowledge. The story I share with you is part of that effort. What I realize, in writing about that first "professional" experience of death, is that my nursing program included no courses on death or palliation. I do not remember a discussion, in 4 years of nursing education, about the end of life. My knowledge of dying did not, therefore, come from my nursing education or clinical experience. My only experience of death was my grandfather's, 6 years before I entered nursing.

### **Knowledge Development in Nursing**

My position in this discussion of nursing knowledge is grounded in three assumptions. First, nurses are reluctant to explicitly claim knowledge acquired in life. Dunlop (1986) suggests our lack of attention to nurses' lives can be attributed in part to contradictory messages in nursing education: "Nursing sought to teach me to maintain both separation and linkage in my practice — separation, 'you must remember that the other is a stranger' and linkage, 'you must think and act as if he were not'" (p. 663). The pursuit of separateness is sadly revealed in the words of a nurse caring for a patient with the same diagnosis as her mother: "Because my own mother had [breast cancer]...personal feelings can get into it. You have to really ignore that, leave your feelings at home" (Will & Fast Braun, 1997, p. 12). According to Pinar (1981), "our life histories are not liabilities to be exorcised, but are the very precondition for knowing" (p. 184), but this nurse appears to view her personal experience as the former, a liability better left at home.

The second assumption in which my position is grounded is that the reluctance to embrace life-informed knowledge originates in a positivist bias that recognizes only knowledge that results from empirically tested theories. This view is shared by Newman (1992). She states that, despite a 30-year shift away from the scientific medical model towards a more holistic model, "we seem to be hedging. Are we afraid to give up the certainty in knowing that the positivist view offers?" (p. 13).

The third assumption is that this positivist bias is in part a consequence of nursing's quest for professional status. There is substantial evidence in the nursing literature of a history of such status-seeking.

Turkoski's (1992) 80-year review of the *American Journal of Nursing*, published by the American Nurses' Association, is particularly revealing. "Professionalism is referred to as 'rank', 'an elevated position', a symbol of 'social status' that is normally and naturally higher than that accorded to 'mere trades', 'commerce', or 'manual labour'" (p. 155). Further, Turkoski's review identifies two primary assumptions that still hold today: professions are superior in status to non-professions, and recognition as a profession is desirable for nursing (p. 154). On the basis of these assumptions, nursing has spent the better part of half a century attempting to achieve professional status.

In this quest for professional status, nursing has accepted the premises of a trait-based model of professionalism (Carter, 1994; Larson, 1977; O'Neill, 1992; Rafferty, 1996; Witz, 1992). One of these premises is that occupations to which society ascribes professional status feature essential traits, and when other occupations adopt these traits they will necessarily achieve professional status (Witz). As medicine has achieved virtually unparalleled success as a profession (Larson; Witz), it is medicine's unique traits that nursing has actively sought to adopt. Consistent with the medical model, the development of nursing knowledge has been grounded in the empirico-deductive or positivist paradigm, emphasizing reductionism and empirical validation (Kidd & Morrison, 1988; O'Brien & Pearson, 1993). Many nurses, however, reject these assumptions of positivism, perhaps believing that when human experiences are reduced to theory "the subject has become the object, the person has become the statistic, the creative has become constrained, the human being has become the abstraction" (Plummer, 1983, p. 77).

In the late 1970s, nurses examining knowledge embedded in clinical practice (Benner, 1984; Benner & Tanner, 1987), intuitive knowing (Agan, 1987), aesthetic, personal, and ethical knowing (Carper, 1978), and nursing epistemology in general (Kidd & Morrison, 1988; Schultz & Meleis, 1988) began to challenge the positivist status quo and to call for the inclusion of multiple sources of knowledge in nursing. "There are different ways of knowing, different unknowns to be known, different propensities of knowers for knowing and different aspects to be known about the same phenomenon" (Schultz & Meleis, p. 220).

Interest in multiple ways of knowing in nursing has surged. Clinical knowledge, particularly, has been extensively examined, but inquiry into other ways of knowing has primarily been theoretical, and life-informed knowledge is apparently being taken for granted. It is acknowledged not in the form of direct reference to nurses' non-clinical

life histories, but in references to experiences that cannot possibly be limited to clinical practice. Reed (1996), for example, states that "building knowledge entails observation of human processes...and observation of human patterns" (p. 30), and Benner and Tanner (1987) suggest that nurses come to recognize subtle trends in patients' experiences by incorporating into their expert practice in-depth knowledge of the human world. Silva, Sorrell, and Sorrell (1995) state that lived experiences are "profoundly felt...but often inexplicable, and to those who have never experienced it, unknowable" (p. 10). These authors are clearly referring to knowledge acquired outside the domain of clinical practice and understand knowledge to be life-informed, as does Drew (1997), in seeking to illuminate the meaning of experiences that nurses identify as significant in their clinical practice. While Drew's focus is meaningful caregiving experiences, she acknowledges that "the experiences which [nurses] found meaningful reflected what they considered important in their non-professional lives" (p. 417). What is important, however, has only been alluded to, particularly by Benner (1984), Benner and Tanner, and Carper (1978), in her seminal discussion of personal knowing. Life-informed knowledge has yet to be fully developed in relation to nursing knowledge.

### Contemplating Life Experience

Each and every encounter with another human being provides nurses an opportunity to reflect on our own experience of an event or to imagine it happening to ourselves or a family member. In this process we draw not only on our clinical experiences, but also on our myriad life experiences. As Moch (1990) says, "nursing contexts are replete with encounters in which...knowledge can be gained through imagining or *experiencing* events such as surgery, the death of a loved one, or even being a hospital patient" (p. 157; italics added). Nurses have even used their homes as experimental ground, "where emotional management can be tried out, sometimes unconsciously, before confronting a similar situation at work" (Staden, 1998, p. 151).

Meleis (1987) champions the consideration of life experiences. She argues that an examination of nursing knowledge must consider nurses' experiences, perceptions, and personal meanings, *and* the contexts in which they are understood. "Personal meanings are understood in the nursing situation within the context of societal and cultural meanings. Meanings attributed to multiple realities create the context for understanding of responses" (p. 13). Despite Meleis's contention,

few authors explicitly contemplate the ways in which nurses' non-clinical life experiences inform nursing knowledge.

### **Life-Informed Knowledge**

I am aware that many nurses may intellectually reject the notion that life-informed knowledge is integral to nursing knowledge. Kikuchi's (1992) argument for the adoption of philosophical inquiry in nursing is a case in point. Having differentiated scientific and philosophical questions, Kikuchi turns to the matter of what kinds of questions constitute philosophical questions. Of particular importance to a discussion of life-informed knowledge are epistemological questions. Kikuchi argues that exploration of questions of this nature has failed to make an important distinction — that between "the knowledge nurses use in order to nurse" and "the knowledge that comprises the body of nursing knowledge" (p. 33). She suggests that the latter is part of the former. Her words concede that the knowledge nurses use to nurse is broader than an evident, recognizable "body" of knowledge. This belief is echoed in Chinn and Kramer's (1999) claim that "as nurses practice, they know more than they can communicate symbolically or justify as knowledge" (p. 2).

Kikuchi (1992) goes on to suggest that it is only the body of nursing knowledge that members of the profession are responsible for developing. She dismisses what she calls preclinical knowledge as taken on assumption and outside the discipline. And she dismisses personal knowledge as subjective, incommunicable, and *publicly unverifiable*. Here she parts company with Chinn and Kramer (1999), who do believe that much of what nurses are unable to communicate has the potential to be formally expressed. Kikuchi's articulate argument against knowledge gained outside the discipline is a powerful barrier to explicit articulation of life-informed knowledge. It is also a paradox.

Kikuchi (1992) argues that because a nurse's ontological and epistemological perspectives are private, subjective, and exclusively her possession, they cannot be shared, and therefore educators are not responsible for them. This is the paradox. Members of the nursing profession are responsible for its body of knowledge, but not for the knowledge used by its practitioners to nurse. Philosophical inquiry, exploring ontological and epistemological questions, is fundamental to creating and understanding the nature of that body of knowledge. Yet inquiry that explores the very nature, scope, and object of any nurse's nursing knowledge, her own ontological and epistemological perspectives, is not perceived as nursing's responsibility.



Life-informed knowledge is precisely what Kikuchi (1992) argues against. It is knowledge that is intensely personal, private, and subjective, an implicit form of knowledge by Mayeroff's (1971) definition, because it cannot be easily articulated. It is each nurse's way of being in the world, and the manner in which that way of being finds expression in her practice. Life-informed knowledge does not suggest pride or arrogance. It is not one nurse's resolute insistence that her way of knowing is the "right" way. It is knowledge acquired during a lifetime of non-clinical as well as clinical experience, a well-established personal ontology. We cannot disregard it, and it is naive to suggest that we can. As Mayeroff states, "restricting the meaning of knowledge in this way [to that which can be verbalized] is as arbitrary as assuming that only words can be communicated and restricting the meaning of communication to what can be put into words" (p. 10).

It is, admittedly, difficult to reveal life-informed knowledge. But it is not impossible. Every nurse's clinical practice illustrates her way of being with people. "Human reality is understood as conversation and action, where knowledge becomes the ability to perform effective actions" (Kvale, 1999, p. 101). Reflection on relationships, and examination of actions, can, therefore, illuminate our understanding of nursing knowledge. Reflection can be undertaken individually and introspectively, in diaries or journals, or collaboratively, as in the context of a research relationship. I describe elsewhere (Will, 2001) how the life-history research method can be used to reveal life-informed knowledge, through one nurse's interpretation of another nurse's personal, introspective, and contextual story.

### **Life-Informed Knowledge and Nursing Knowledge**

Current conceptualizations of nursing knowledge, while providing a wealth of information on its character and scope, do not explicitly recognize and affirm life-informed knowledge. This failure perpetuates a spurious distinction between nurses' personal and professional lives. It widens the chasm between knowledge that is verifiable and communicable and the knowledge that nurses use to nurse. It sustains a division between an academic elite and thousands of bedside nurses who are not encouraged or supported to "behold themselves as experts" (Maeve, 1994, p. 14). Its implicit acceptance, and its explicit absence from our discourse, serves to prevent fuller understanding of what it means to know and of how knowledge is expressed.

I suggest that nursing knowledge has multiple sources, including life experiences outside the clinical realm, artfully blended together to

create a mindful whole. The key word is mindful. A focus on empirical knowing alone could, for example, result in a preoccupation with cure and technological intervention. By the same token, a focus on life-informed knowledge alone could result in a nurse believing that her experience, in and of itself, provides nursing knowledge and competence. Each, without consideration of the other, could be perceived as an incontestable form of knowledge.

Rubin's (1996) study of impediments to the development of clinical knowledge reveals the notion of "patterns gone wild" (Chinn & Kramer, 1999), the dilemma created when ways of knowing exist in isolation from one another. In Rubin's study, a nurse who is a recovering alcoholic leaves her assigned responsibilities to care for a patient admitted for treatment of alcoholism. The nurse sees nothing wrong in this, perhaps believing that her life experiences enable her to contribute something unique and important to the patient's care. Rubin interprets her actions as indicating a lack of clinical knowledge. My perspective is somewhat different. I see the nurse's life experience as informing her nursing knowledge in a manner that she views as acceptable and others view as lacking. I also see, in this instance, evidence of "patterns gone wild," wherein the nurse acts on life-informed knowledge in a manner that is not responsible or particularly mindful. It is interesting to speculate on how different the example might be had the nurse been enabled to reflect on her experience of alcoholism. Had she understood the particular way in which her life experiences informed her nursing knowledge, she might have used that knowledge differently in her nursing practice.

### **Conclusion**

The women and men who seek to become nurses, and those who are nursing and/or pursuing post-basic education, have vast reservoirs of unarticulated knowledge acquired in life experience that informs how they know nursing, and therefore how they practise their art. It is no longer acceptable to assume that who they are can be held at arm's length, where it will have no impact on their nursing care. Life-informed knowledge, by its very nature, demands that we attend to it, not once, but on an ongoing basis over the course of our nursing careers. I propose that every nurse commit to lifelong reflection and analysis in response to the overarching question "Who am I as a nurse?"

Nursing knowledge is extraordinarily complex. In our effort to explicate just how complex, members of the profession have invested

time and energy into articulating the "core" of nursing. In doing so, we have focused on process, on the act of caring. We have failed to consider that it is what we know that is the core of nursing, and we have failed to reveal all aspects of our knowledge, in all of its richness and depth.

The "core" of nursing is nurses, who we are and what we bring to each and every encounter with other human beings. I recently encountered Walker (1994), who suggests that the concept of caring resists representation because it "resides in the flesh and sinews of nurses" (p. 53). The idea that the essence of nursing resides in our flesh and sinews is a captivating one. It suggests that we must attend in a more mindful way to understanding nurses and their lives, and to exploring, in nursing education, practice, and research, how knowledge acquired in life experience contributes to nursing knowledge.

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