Defining nursing knowledge

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The question of what constitutes nursing knowledge is a vital one for nurses to consider for a number of reasons. Nurses use a wide range of knowledge in practice, some theoretical and some practical, so identifying what nursing knowledge is should be central to practice. This paper attempts to define nursing knowledge by discussing the evidence. It suggests that such knowledge is important to raise awareness of personal and professional accountability, inform the dilemmas of practice and improve patient care.

‘What is nursing knowledge?’ is a complex question, the answer to which helps define nurses as a profession. It is also difficult to answer because nursing is dynamic, evolving and a relatively new profession. However, as knowledge is central to the issue of professional accountability it is vital to attempt to answer the question.

Nurses use a wide range of theoretical and practical knowledge in their work. In recent years they have needed a considerable amount of new knowledge to provide the appropriate level of care for patients.

Their knowledge may be acquired by different means – some is ‘hidden’ in practice, but from whatever source it originates it should be evaluated, and hopefully that which is without merit will be discarded. The key to success in such activity is to question beliefs from all sources.

Identifying nursing knowledge

Nursing knowledge is the means by which the whole purpose of caring for patients is achieved because it underpins what we actually do. It is what defines us as nurses as opposed to similar professions such as doctors or physiotherapists, and helps to differentiate us from lay carers or care support workers.

Knowledge is basically what classifies us as a profession because having a ‘unique body of knowledge’ is one of the things that defines a profession in society.

It is important that the question ‘what is nursing knowledge?’ is debated because professional nursing should be characterised by clinical effectiveness and by professional enquiry (Department of Health, 1998). A number of authors have written on the subject over the past few decades, attempting to define what constitutes nursing knowledge (Chinn and Kramer, 1999; Marriner-Tomey, 1994; Benner and Wrubel, 1989; Parse, 1987; Benner, 1984; Watson, 1979; Carper, 1978).

For individual nurses today there are practical reasons for identifying nursing knowledge. With increasing accountability there is a growing expectation that nurses explore their profession’s beliefs, discarding those without merit and consequently developing adequate knowledge to care for their patients in a competent manner. Nursing knowledge will, for example, enable them to justify actions or indeed stop unsafe or poor practices. Nursing knowledge can literally mean the difference between life and death for some patients.

In some situations nurses with inadequate knowledge will be called to answer to the NMC for their decisions. Some of those who have been judged to have inadequate knowledge have been removed from the professional register and are no longer able to practise as registered nurses.

The situation is complex, partly because nurses are expected to have a wide range of knowledge. For example, it has been suggested that some nurses have been found to have inadequate knowledge of a medical condition (Castledine, 2002), although this type of knowledge has traditionally been the domain of doctors rather than nurses.

In terms of practice, all suitable knowledge should be incorporated appropriately into care. A vital part of this is that nurses evaluate what they are told or what they read or observe in practice. It is crucial that they question practices and do not undertake care for which they do not understand the rationale.

Most nurses should now understand the implications of professional accountability. This is a responsibility, yet part of the richness and the reward of nursing originates in the need for the wide variety of knowledge required in order to provide excellent care. There is the added challenge of the need for continuous professional development as nursing knowledge is constantly evolving.

Defining nursing

Historically nursing was regarded as a vocation and to some extent was seen as a duty. Past definitions of nursing knowledge have included those of Conrad (1947), who described nursing knowledge as ‘knowing what the patient wants before she (the nurse) is asked’, and Katz (1969) who described it as ‘knowledge of the heart’.

These definitions of nursing knowledge reflected the status of nursing at the time, when nurses were largely still doctors’ handmaidens and their work...
nursing in practice play a profound role in shaping the culture and accepted practices and beliefs of often ‘embedded in practice’.

However, justifying the existence of a nursing knowledge base to other professionals and the public is not without difficulty. For example, nursing still remains a predominantly female profession. This is especially relevant to the issue because the caring role – talking to patients, caring, listening and supporting patients – is still seen to some extent in society as women’s work and nursing is still seen by some as a duty or calling rather than a profession. In addition, nursing is a largely practical profession and many people still believe it is not necessary to have academic qualifications such as a diploma or degree to be a good nurse.

Partly as a result of such attitudes, nursing is struggling for recognition, status and remuneration compared with other professions. A wide range of issues affect what is regarded as nursing knowledge and these issues consequently affect the status of nursing as a profession. Agenda for Change, multidisciplinary working and an acknowledgement of the value of both theoretical and practical knowledge may all help to ensure that nurses are supported and nursing as a profession may be led into multidisciplinary roles.

As already highlighted, nursing practice draws on knowledge from a range of sources and some is embedded in practice. Importantly, knowledge needs to be that which can be communicated to others and judged by the profession to be the knowledge we need to practise.

For example, we need to be able to teach this knowledge to future nurses and indeed to demonstrate our worth in terms of remuneration and professional standing with other professionals in health care. Certainly Chinn and Kramer (1999) define nursing knowledge in terms of that which can be ‘communicated’.

We have to decide what knowledge or theory to teach our nursing students, and indeed postregistration nurses, as well as help to identify what these learners can learn from practice. It is possible that if nursing does not define its knowledge base, then other professions will do it for us and nursing as a profession may be led into directions we do not wish it to go.

This loss of control is already happening to some extent because, to reduce junior doctors’ hours, we see many nurses gaining knowledge in medical procedures and taking on doctors’ tasks. This has resulted in some nurses moving away from their traditional roles.

These new types of knowledge will provide varying goals for the profession. Nurses must decide what aspects of the profession they value and then, as the foundations and roles of nursing change, the knowledge imparted can change to reflect this.

### Knowledge in practice

Describing nursing knowledge is a complex exercise partly because, as Benner (1984) identified, it is often ‘embedded in practice’.

Certainly from experience of practice it is clear that the culture and accepted practices and beliefs of nursing in practice play a profound role in shaping what nurses describe as knowledge and in the way knowledge is disseminated. In order to educate nurses and to establish and maintain ourselves as a profession we must try to identify what nursing knowledge is and express this. In doing this it is important not to confuse opinion and beliefs with nursing knowledge.

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### Table 1: Definitions of Nursing Knowledge

<table>
<thead>
<tr>
<th>AUTHOR</th>
<th>WORK ON NURSING KNOWLEDGE</th>
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<tr>
<td>Carper (1978)</td>
<td>Fundamental patterns of knowing in nursing</td>
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<td>Watson (1979)</td>
<td>Nursing science and human care: a theory of nursing</td>
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<tr>
<td>Benner (1984)</td>
<td>From novice to expert</td>
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<td>Parse (1987)</td>
<td>Nursing science, major paradigms theories and critiques</td>
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<tr>
<td>Benner and Wrubel (1989)</td>
<td>The primacy of caring, stress and coping in health and illness</td>
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<td>Marriner-Tomey (1994)</td>
<td>Nursing theorists and their work</td>
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### Key Words

Education, Nursing, Professional

### REFERENCES


It is clear that the nursing knowledge required to care for patients has already changed considerably. Nursing knowledge is dynamic and multidimensional and this does not help with answering the question as to what nursing knowledge is.

**Range of knowledge**

Nursing knowledge may be acquired by different means and knowledge is frequently identified by its source. Nurses often use knowledge from biological sciences, such as physiology, as well as knowledge from the social sciences, such as psychology. Nursing uses knowledge from a wide range of sources and is a mixture of types of knowledge, which makes it even more difficult to define what nursing knowledge actually is.

It is our communication skills that enable us to use our knowledge for the benefit of patients. Nursing is perhaps the profession in the health service most dependent on communication skills and, because nurses interact with patients when they are at their most vulnerable and often have to perform intimate procedures on them, it is the communication and interpersonal skills that link our theory and practical knowledge.

**Practical versus theoretical**

There is a conflict for nurses between this practical experiential knowledge (practice knowledge) and propositional knowledge (theoretical knowledge).

This clear distinction between the two main types of knowledge is often referred to as the ‘know-how’ and the ‘know that’ (Ryle, 1947).

‘Know-how’ knowledge is often gained through personal experience. It is usually not articulated but is learnt during practice, which equates with the art of nursing. ‘Know that’ is knowledge that usually comes from theory and research. It is generally more easily communicated verbally and could be described as the science of nursing.

The competition between the statuses of the two fundamental types of knowledge is well documented and is often referred to as the art-science debate. The gap between these two knowledge sources is sometimes known as the theory-practice gap.

It should not be forgotten that it is experience that is needed for the generation of nursing knowledge and that both types of knowledge are needed to care for patients effectively (Schultz and Meleis, 1988). The UKCC (1986) recognised that it is not enough to only have knowledge – nurses also need the ability to apply it in their practice and need to be ‘knowledgeable doers’.

Nursing knowledge informs care from both theoretical and practical perspectives. Nurses should value knowledge gained from practice perhaps even if it was arrived at by intuition just as much as if it was arrived at by theoretical or scientific means – but only when they are confident that it is of benefit to their patients.

Nursing knowledge is sometimes referred to in terms of its origins, for example whether it comes from concepts such as health, or from ideas or a mode of enquiry or research methodology. The will for professional status and the need to justify financial rewards have contributed to the debate on the sort of knowledge nurses should have. Initially, nursing tried to align with medicine and began to value ‘research’ (Marriner-Tomey, 1994).

As the profession tries to discover what knowledge is specific to nursing, there is an increasing recognition that knowledge both from the humanities and the sciences should be part of nursing knowledge and that there should not be a hierarchy but all knowledge types should be valued and combined in the interests of patients.

Because nursing knowledge is multifaceted, nurses need to take an eclectic approach, choosing the best from different sources. Knowledge of communication skills and interpersonal skills, as already identified, is paramount (Naish, 1996).

Fortunately, nursing is gradually becoming regarded as both an academic and a practical discipline, as the need to integrate appropriate theory and practice into the care of patients is being recognised. Interestingly, in Wales the decision has been made that nursing should become an all-graduate profession.

From a philosophical perspective, care should be based on what is ‘probably true’. Many important aspects of care have changed over the years as new information becomes available. Of course, nursing knowledge can only be based on the best evidence at the time, with nurses regularly reviewing their practice (DoH, 1998).

**Rituals and nursing knowledge**

It is often said that in the past nurses took a task-oriented approach to care provision and that care was ritualistic – based on tradition and myth (Hicks, 1996; Behi and Nolan, 1986). Many nurses reading this will remember task allocation, observation rounds, back rounds and the cleaning of the sluice rota.

It should, however, not be forgotten that some rituals developed by trial and error and logical deduction. Although these tasks and indeed this type of knowledge lack status, they should not all be discarded just because of their unscientific origins. From my own practice I remember the back rounds in particular as a rather ritualistic, pressured area of care. They were discarded because they lacked scientific basis, but they had some merit.

Some rituals have been replaced by more scientific or theoretical ones. Whether the nursing process and...
nursing models have actually improved care for patients is debatable. It also remains to be seen whether clinical supervision, reflection, deciding interventions and perhaps nursing diagnosis will improve patient care in the future or if these are just further contributions to the theory-practice gap.

Tradition is evident in much of practice. There are some other aspects of care that perhaps originate in religion or superstition, for example leaving a window open to let the spirit out when a patient dies. Traditional beliefs are learnt in practice but there is a lack evidence to support their use and there is a conflict with logic or common sense.

However, bodies deteriorate more slowly at cooler temperatures and opening a window may provide some comfort to relatives who believe in an afterlife, so perhaps there is some evidence to support this practice after all.

Rather than continuing rituals without question or discarding them without investigation, it is more appropriate to research all these traditional aspects of care and discard those that are ineffective or harmful. Practices from all knowledge sources should be subject to questioning, including information practice and evidence from research, as knowledge from any source may be false or need revision.

Numerous authors write about nursing knowledge from a range of viewpoints. Carper (1978) tried to capture all types of knowing in nursing, referring to aesthetic, emotional, personal and ethical elements to knowing. This has been used as a model for reflection (Johns, 1995) and the existence of intuition, for example, is debated (Turnbull, 1999; Marks-Moran, 1997).

There is little written about the use of senses such as sight, hearing, touch and smell to generate nursing knowledge and about the practical need for dexterity, for example. All these types of knowledge are needed to do a dressing well, for instance, and are important aspects of knowledge. These are all elements we subconsciously use in practice and that are hidden to some extent.

Types of knowledge that are difficult to identify

Nurses in practice often have their own humour and own terms for things. This knowledge can be linked to the particular department and is rather like the knowledge of a cult, hidden from the uninitiated, and difficult to identify and teach. This may be a way of coping with stress but can be part of socialisation or means to identify who belongs to that team or department.

Nursing knowledge in academia is often not understood. This nursing knowledge created away from practice may need interpretation if it is to be used in practice and if it is not to contribute to the theory-practice gap (Haines and Donald, 1998). It is important that the ideas expressed are not lost in the interpretation. Knowledge needs to be translated into good practice (Joyce, 2000).

Nurses need to be taught how to evaluate all sources of knowledge and must learn how to become critical thinkers, as this will increase the amount and quality of nursing knowledge. Nurses also need, perhaps, to think about practice elements and to learn from experience. Reflective practice seems to be in vogue (Rashotte and Charnevale, 2004). It is the application of knowledge that is unique to nursing (Mckenna, 1993).

The need for nursing knowledge is of course influenced by patients. Patients are becoming more informed and ask nurses increasingly about aspects of health and care that affect them.

As pointed out, nursing knowledge originates around the form of enquiry but is often rooted in other professions. As professions tend to be formed around a clear classification of knowledge, establishing professional status is more difficult for nursing. Some nursing knowledge is acquired via socialisation into an organisation – boundaries of behaviour become part of our nursing knowledge, for example.

Expert nurses and those who are motivated, innovative and perhaps take the profession forward help to push the barriers in terms of knowledge. Those who question practice, understand the rationale for what they do, explain it to patients as well as apply it appropriately prove to be the best nurses.

Conclusion

Knowledge breeds knowledge and the clinical skills and knowledge needed to care for patients continue to change dramatically.

Nursing knowledge has become more complex and specialised and is constantly evolving. New types of knowledge will continue to be evident – the complexities of practice create more debate than the old, ritualistic care-giving.

What could be called nursing knowledge comes from a variety of sources including both theoretical and practice perspectives – clinical decisions should be based on what is evidence rather than just opinion or belief. The aim for the profession should be to improve practice by questioning findings from all sources.

Gaining knowledge raises an awareness of personal and professional accountability and the dilemmas of practice. Knowledge is what improves care if the nurse is aware of the best knowledge or evidence to use in practice.

The question of what nursing knowledge is should remain central to research, practice and teaching because it is essential in ensuring the provision of high-quality care for patients.

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