

THEORY AND PRACTICE

Practice and knowledge: an action research approach

How can health visitors begin to understand and explain their knowledge and skills to inform improvements in practice? In the second of two papers, the authors explain how they developed a model to explore the knowledge and skills they use in practice and some contradictions built in

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A group of six health visitors used an action research approach to explore the question: 'How can we understand, evaluate and explain our health visiting skills and knowledge in the endeavour of improving our practice?' The process is described in the first paper in February's *Community Practitioner*.¹

A literature review² helped clarify what is already written on the subject of nurses' knowledge and developing expertise.³⁻⁷

It seems professional knowledge evolves for each practitioner through an integration of personal characteristics, experiences and information to form attitudes and perceptions which colour how future experiences are understood.

Professional knowledge described in this way implies 'total' available knowledge, which includes aesthetic, empirical, ethical and spiritual patterns of knowing, as well as the unique influence of the 'self' on how to do things and what is known.^{3,5-7}

The socio-political context provides the setting for what we know.⁷ All knowledge, it appears, is subject to revision and change over time, and is thus 'living' knowledge.^{3,8}

Professional knowledge and attitudes are, therefore, made unique for each nurse by personal influences. Figure 1 shows an adaptation of patterns of nurses' knowledge.^{3,5-7} We used this framework as the basis for our discussions and developed it through story telling about health visiting.

Aesthetics

Aesthetics describes an 'art of health visiting', a creative, expressive style visible in the way our actions are experienced by others. It is professional knowledge presented with tim-

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ing, pace and form and 'tuned' by experience to suit the circumstances of the moment.³

At its best, it is an effective and satisfying experience which makes a difference for our clients. Our 'art' involves putting multiple theories and ways of knowing into practice and by doing so, creating new theories about our world and how to act in it.

Reflection on past experiences internalises our knowledge providing a complex body of clues to be used when approaching future circumstances. It is the wider perception skilled health visitors have, beyond the mere recognition and classification of clues, which gives our actions or conversations an aesthetic quality.^{3,9}

As Benner⁴ describes it: 'Often the perceptual grasp of a situation is context dependent; that is the subtle changes take on significance only in the light of a patient's past history and current situation.'

Skilled health visiting involves an appreciation and creation of singular, particular and subjective expressions of imagined possibilities.³ Each expression is transformed into a health visiting action with a purpose in mind. In other words, each health visiting action arises from our individual perceptions of unique situations with responsive solutions.

Benner⁴ describes how skills and knowledge progress from that of a novice, who utilises specific techniques in order to know how to do things, through various stages of skill acquisition, to the knowledge of an 'expert' who 'just knows' intuitively. In the group we recognise this 'sixth sense' when we

cannot fully explain how we are able to come to conclusions quickly. It seems right to say our knowing is in our doing.⁹ However, even the knowledge of experts is constantly subject to review and change.⁸

Empirical knowledge

Empirical knowledge emerges from the tradition of scientific research and is primarily focused on generating explanations which can be used widely in anticipating what might occur in similar situations.

It is limited to phenomena which can be identified, tested repeatedly and verified publicly, for example, in the development of the Edinburgh Postnatal Depression Questionnaire.¹⁰

But scientific theories provide information to guide only a fraction of what we use and come to know in our caring and health promoting roles. The empirical pattern of knowing clearly needs to be expanded to accommodate knowledge created through descriptive, interpretive or critical enquiry,⁷ and the explanations of individual practitioners.^{8,11}

This is the knowledge we use in practice. Professional practice such as ours is characterised by a series of unique events which cannot be found in books.

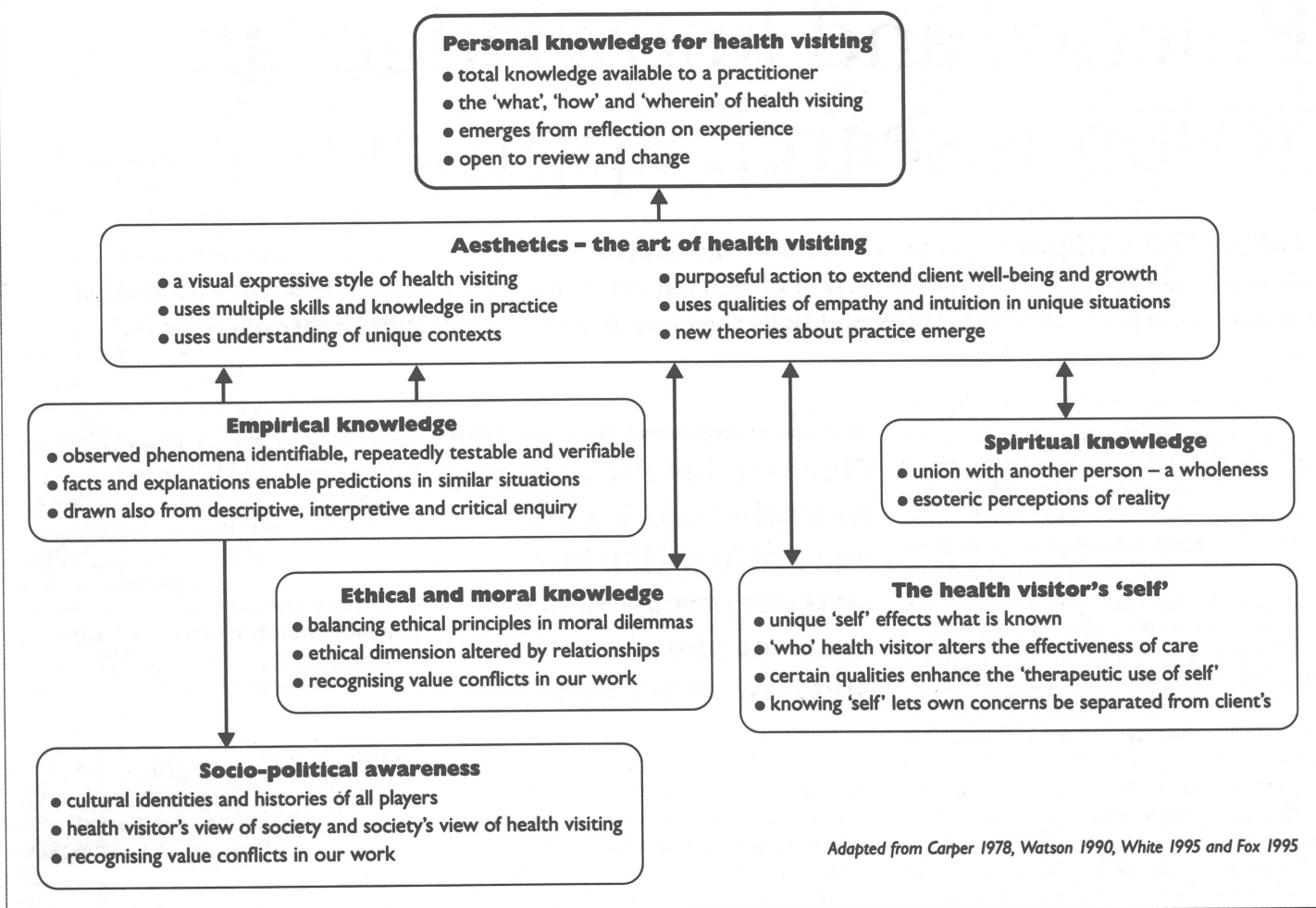
Each unique case calls for an 'art' of practice which might be taught', Schon says, 'if it were constant and known, but it is not constant'.⁹ In an art of practice there are no common properties only recognisable similarities.³

Ethical and moral knowledge

Ethical and moral knowledge describes our perceptions of right and wrong and our commitment to take action on it in our work. Client rights, client autonomy, the concept of service to people (the restoration and promotion of health), and our obligation to duty (what ought to be done) are some of the concepts of 'principle-oriented ethics'.¹² Using reason we weigh and balance ethical principles as particular situations arise. ►

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Figure 1: How we can understand the knowledge we use in health visiting



In health visiting we sometimes have to balance clients' needs with those of their children, especially in child protection decisions. The child's needs might override those of our adult client, causing strains on relationships. Cooper describes how principle-oriented ethics may not help in these dilemmas.¹²

We may also be using a more 'complex, uncertain and emotionally laden process of moral struggle' to include patient's concerns and wishes in an 'ethic of care'.¹² Thinking about the conflicts within ourselves, between our personal values and those of our clients, colleagues and the policies defining our practice, we increase our knowledge of the ethical dimensions of our role.⁵

Personal way

A personal way of knowing describes the part played by our own 'selves' in what we know. Carper³ singles out this aspect of the personal as being 'concerned with the knowing, encountering and actualising of the concrete, individual self'. This personal perspective melds together and colours what we know and how we respond to situations.

Outcomes from our health visiting responses are clearly dependent on the sort of

people we are.^{3,5,13-14} Our actions involve becoming certain sort of people and not merely doing certain sorts of things.^{3,11} Effective practice is, therefore, not simply the acquisition of skills. It involves a process of personal deconstruction and reconstruction in dealing with these issues.⁵

As Hall¹⁴ points out: 'A nurse needs to learn who she is so that her own concerns will not interfere with the patient's exploration of his concern.' In the group we spoke about our own agendas arising from our personal experiences and how our life experiences might alter the way we present ourselves and what we notice.

A key consideration in our relationship with clients is not only the degree of empathy, but also the personal involvement we allow. Caring requires involvement with our clients if the care is to be effective. If we count ourselves as a necessary component in the health promoting and caring processes of health visiting, we cannot be dispassionate, detached, objective, rational or 'clinical' towards the client.^{5,14}

Rather, we strive for an authentic personal relationship in which the client is not 'a fixed entity but constantly engaged in a process of becoming', much as we are ourselves.^{3,11}

Spiritual knowledge

Spiritual knowledge felt very personal and we had difficulty coming to a common explanation. We agreed it was different from the formalised practices and doctrines of religious knowledge and more to do with a general awareness and connection with esoteric concepts of how we relate to people.

Caroline's words provide the closest idea that we could agree to: 'It's individual. Spirituality is a part of oneself that you are prepared to share with the client. It is "heart listening" – you open yourself to whoever you are with. It requires openness without judgement or expectation. It's about sharing, an empathy. It's like a link between the two of you.'

'A spiritual contact with another, is when you open up. A bond is formed and there's a flowing, a wholeness within that union. In other sessions your heart is closed, the client's heart is closed and there is no union.'

Socio-political awareness

Socio-political awareness in health visiting informs the context in which the other five patterns emerge. Considering this pattern lifts the gaze from individual client relationships to the wider environment in which

health visiting takes place.⁷ Socio-political knowing includes the cultural identities and histories which inform the attitudes and beliefs of each 'player' – client, health visitor, policy maker.

Collaborative reflections

To examine these patterns of knowing we told stories about our work. By asking questions about incidents which felt important, we tried to identify the meld of knowledge and skills we were using. We looked first at times when the work had gone well and we asked what it was that worked for clients.

In turn, we generated understanding from the themes that emerged. In our stories contradictions in the focus of health visiting became apparent. It is these conflicting aims of our work we offer for readers' comment.

Health visiting underpinned by health as a valuable attribute uses four main principles:¹⁵

- The search for health needs.
- The stimulation of the awareness of health needs.
- The facilitation of health enhancing activities.
- Influencing policies that affect health.

We accept that people do not like being told how to behave or having their competence undermined¹⁶ and self-determination for clients is at the root of empowerment.¹⁷ It was easy to find examples where client-led activity increased the effectiveness of our work, but how could we justify the opposite – when we took the lead and made decisions about what was necessary?

When we deliver information on health we establish ourselves as experts. When we shift into child protection mode and reduce the parent's decision-making skills we assume power, and when we undertake surveillance of children, the parent's knowledge, skills and decision-making may not be given priority. We have an aim to empower clients but we asked, are some of our actions disempowering?

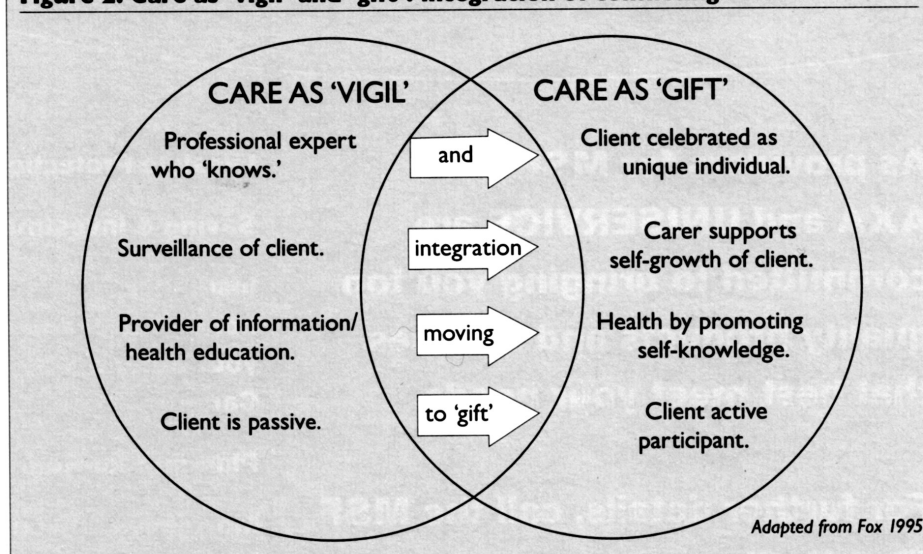
Fox's model¹³ of the 'vigil' and the 'gift' helped clarify the contradiction and spawned reflection. Professional-led activities Fox calls 'the vigil' because of the implied dependence of the patient on the professional. In health visiting these activities are surveillance, problem identification, solution planning and advice.

In other words, the knowledgeable role of the professional expert who may 'tell' the more compliant client what to 'know' and 'do'. In direct contrast, Fox identified an opposing relationship, 'the gift', which we identify as fundamentally important in health visiting.

This 'gift' he describes as the nurturing, enabling, accepting aspect of nursing intention.¹³ A client-led, partnership approach to promoting health, is intended to celebrate the individual 'specialness' of clients and foster self-growth and independence.

From accepting clients' perceptions of

Figure 2: Care as 'vigil' and 'gift': integration of conflicting roles



their world we gain valuable insights to increase our own experiential and intuitive knowledge.

Fox¹³ describes, however, how our attempts at nurturing client self-confidence and growth may be affected adversely by our being the ones who 'know' in our professional role. We see this tension in our stories. As Kate said: 'They are in conflict, but we are trying to do both and that's what makes health visiting so difficult to do and to explain.'

Interim support, advice and limit setting can relieve the situation and make it manageable until the client is able to take control, cope, move on and grow again. We identified 'holding' of clients in various forms to be a necessary part of helping clients to cope.

In child protection our aim might be to help children find space to grow. Parents can also be freed up and begin to 'repair' themselves in these circumstances. Our aim is to support clients as they move towards self-determination, personal growth and independence from us (Figure 2).

Carper's four patterns of knowing³ – aesthetic, empirical, ethical and the personal 'self' – extended to add spiritual knowing⁶ and socio-political knowledge,⁷ gives a foundation for understanding the complexity of our evolving knowledge as health visitors. The onus is on us to remain open to improving what we are doing through critical reflection.

Fox's model¹³ of the 'vigil' and 'gift' provides a useful vehicle for understanding two aspects of health visiting which are continually in conflict. Melding together the professional knowing of experts, the 'vigil', and being client-centred and accepting of the individual's own perception of their world, the 'gift', appears to begin to describe health visiting.

References

- 1 Pound R, Dams M, Gammon K *et al.* Practice and knowledge: an approach to action research. *Community Practitioner* 2001; 74, 2: 54-56.
- 2 Pound R. How can we understand the knowledge we use? Unpublished paper. Bristol: Faculty of Education, University of the West of England, 1997.
- 3 Carper B. Fundamental patterns of knowing in nursing. *Advances in Nursing Science* 1978; 1, 1: 13-23.
- 4 Benner P. From novice to expert. Excellence and power in clinical nursing practice. Menlo Park, California: Addison Wesley, 1984.
- 5 John C. Framing learning through reflection within Carper's fundamental ways of knowing nursing. *Journal of Advanced Nursing* 1995; 22: 226-234.
- 6 Watson J. Caring knowledge and informed moral passion. *Advances in Nursing Science* 1990; 13, 1: 15-24.
- 7 White J. Patterns of knowing: review, critique, and update. *Advances in Nursing Science* 1995; 17, 4: 73-86.
- 8 Whitehead J. The growth of educational knowledge. Bournemouth: Hyde Publications, 1993.
- 9 Schon D. The reflective practitioner. New York: Basic Books, 1983.
- 10 Cox JL, Holden JM, Sagovsky R. Detection of postnatal depression: development of the ten item postnatal depression scale. *British Journal of Psychiatry* 1987; 150: 782-786.
- 11 Rogers C. On becoming a person. Boston MA: Houghton Mifflin, 1961.
- 12 Cooper M. Principle-oriented ethics and the ethic of care: a creative tension. *Advances in Nursing Science* 1991; 14, 2: 22-31.
- 13 Fox N. Postmodern perspectives on care: the 'vigil' and the 'gift'. *Critical Social Policy* 1995; 44/45, 15: 2/3, 107-125.
- 14 Hall L. Nursing: what is it? *The Canadian Nurse* 1964; 60, 2: 150-154.
- 15 Twinn S, Cowley S (eds). The principles of health visiting: a re-examination. United Kingdom Standing Conference on health visitor education. London: HVA/UKSC, 1992.
- 16 Pearson P. Clients' perceptions: the use of case studies in developing theory. *Journal of Advanced Nursing* 1991; 16: 521-528.
- 17 Department of Health. Strategy for nursing. London: HMSO, 1989.

