Acknowledgments

This study would not have been possible without the support of my own institution, Thames Valley University, and the co-operation, commitment and enthusiasm of the participants representing education, practice and management who so willingly gave up their time in the interest of furthering knowledge.
Exploring the relationship between nurses’ perceptions of knowledge and research-based practice.

by

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Thesis submitted for the degree of Doctor of Philosophy

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2001
Abstract

This study explores the relationship between nurses’ perceptions of knowledge and research-based practice. It also examines the extent to which nurses view themselves as professional practitioners and the relationship between professional values and research-based practice.

It is a descriptive study which uses a combined quantitative and qualitative research methodology. A group discussion, questionnaires, and open-ended interviews were used to obtain data from a sample of nurse practitioners comprising qualified clinical practitioners, student nurses, clinical and educational managers, and nurse lecturers. A content analysis approach was taken to analyse data from the group discussion, pilot and main questionnaires. Following an exploration of discursive psychology, a discourse analysis method was used to analyse data from the 12 open-ended interviews.

The conclusions of this study focus on the three important areas, namely, knowledge, research-based practice and professionalism, which directly concern practitioners in education, clinical practice and management. Education of practitioners for the future will need to raise more awareness of the significance of knowledge as a basis for making decisions about research-based practice.
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Chapter 1

Introduction to the study

1.1: Introduction:

In this introductory chapter, the aims of the research study, the rationale for choice of research topic and the research questions upon which the whole study is based and developed will be presented firstly. Secondly, the main argument being advanced throughout the work will be presented, together with a discussion of its underpinning epistemological framework. The latter has been provided by the work of Benner (1984), based on the Dreyfus and Dreyfus (1980) model of skill acquisition. Thirdly, several critiques of Benner’s work will be presented to illuminate the ongoing debate surrounding her work before returning to the main argument. Fourthly, some preparatory discussion of the key terms and concepts contained within the research questions will be offered as a means of providing a fundamental basis for understanding some of the responses given to the questions being posed to the participants taking part in this study. Finally, an outline of the subsequent structure and content of the thesis will be presented.

1.2: Aims of the study:

The first aim of the study was to examine the relationship between nurses' perceptions of knowledge and research-based practice. The second aim was to examine the extent to which nurses view themselves as professional practitioners. The third aim was to examine the relationship between professional values and research-based practice.
1.3: Rationale for choice of research topic:

The rationale for choice of this research topic stemmed from a long-standing keen interest in, and a serious concern about, the areas of knowledge, professionalism and research-based practice within nursing. **Firstly,** I had already begun to explore these areas in a small-scale research study undertaken as part of a Master's Degree in Educational Studies. In this latter study, I was examining the role of professional and continuing education in maintaining professional competence in nurse education and practice in relation to nurse teachers. However, in the course of conducting this study, my interest in the above mentioned areas increased to the extent that I wanted to find out what views were held by other groups of practitioners within the profession about knowledge, research, professionalism and research-based practice. **Secondly,** with the advent of the United Kingdom Central Council’s (UKCC) Standards for Post-Registration Education and Practice Policy (PREPP), the purpose of which was to improve standards of patient and client care, it was becoming increasingly important that nurses should become more aware of the different kinds of knowledge, including research knowledge, used in professional practice. Furthermore, by critically examining those different kinds of knowledge through a process of reflection, nurse practitioners would then be better able to make more informed decisions about, and justify the need for, research-based practice. Overall, therefore, this increased awareness of the different kinds of knowledge used in practice would be seen to be addressing the need to develop clinical practice and improve standards of client care. Furthermore, nurses would be seen to be professional practitioners exercising professional accountability. Thus, it seemed important to me that nurse practitioners should be able to articulate what they meant by the terms 'knowledge', 'research knowledge', 'research-based practice', and 'professionalism'. The UKCC Register has been described as an instrument of public protection and the only means by which an employer or a member of the public can check the expertise of individuals for the delivery of safe and effective care. Thus, the regular updating of knowledge and the raising and maintenance of standards of practice might be seen to be a prerequisite for the development of nursing as a profession. It seemed to me that this was a significant issue for nursing since it is said to be in the stages of 'professionalising'. Indeed, it is stated within the PREPP document:
For any professional there is a need to maintain skills, to reinforce a critical attitude to one's work and to keep up-to-date with developments and research.

(PREPP 1990:5.1.21)

One of the important recommendations identified in the PREPP document was that in the future nurse practitioners would be required to maintain a personal professional profile, documenting their professional development, and which would be reviewed on an ongoing basis every three years. However, this requirement begged the important question as to whether or not nurse practitioners would view this as an achievable objective. Thus far, it seemed to me that nurse practitioners had not given sufficient consideration to the area of knowledge, the relationship between knowledge and practice, particularly research-based practice, and the concept of professionalism. I also doubted whether nurse practitioners recognised the importance of being aware of the different kinds of knowledge available to them and of being able to justify their own use of these different kinds of knowledge in the everyday decision-making processes of professional practice. Indeed, the aim of drawing up the National Health Service Research and Development Strategy was to create a knowledge-based service in which clinical, managerial, and policy decisions were to be based on sound information about research findings and scientific developments (Department of Health, 1997). Clearly, the aim of this strategy is also reflected in the main argument being raised within my own study which posits that nurse practitioners need to be aware of the importance of the relationship between knowledge and research-based practice. The argument is that nurse practitioners need to be able to examine critically through a process of reflection the different kinds of knowledge they use in practice so that when and where possible appropriate decisions can be made about the need for research-based practice. A review of the literature, however, has indicated that this area, namely, nurses' perceptions of knowledge related to their practice, particularly research-based practice, has not previously been explored. Similarly, the extent to which nurses view themselves as professional practitioners has been little explored. In contrast, there are numerous examples of studies in the literature highlighting the lack of utilisation of research in practice by nurses. The literature and research
studies related to these areas will be critically examined and more fully discussed in the literature review in Chapter 2.

Thirdly, nurses are professionally accountable for their practice and have a responsibility to make appropriate use of research. Thus, the relationship between ethics and research is an important one. The central focus of accountability is on having a suitable knowledge base so that decisions can be made and justification for actions given. However, without an awareness of the different kinds of knowledge informing their practice, nurse practitioners cannot be said to be fully accountable. If nursing is to move beyond the ritual stage and improve the quality of care, then research knowledge is needed to test and refine nursing's scientific knowledge and ethical and aesthetic bases for practice (Maloney, 1992). Nurse practitioners have a responsibility to clients to use research as a tool for developing the quality of nursing decisions, prescriptions and actions and thus to provide a better service overall. Neglect of that responsibility could be classed as professional negligence. Thus, as nursing moves towards full professional status, research and the exercise of professional accountability must be seen to be part of that development. However, the extent to which the value of research as a basis for practice has become accepted within the nursing profession's belief system requires further examination. This study will attempt such an examination by exploring nurse practitioners' views about professional values and research-based practice. To facilitate this process, Benner’s (1984) model will be used as an epistemological framework and provide a basis for interpreting and understanding those views.

From a review of nursing's statutory body discourse, it appears that research is assuming a much higher profile. The UKCC's PREPP document (1990) has already been discussed in this chapter. There is no direct mention of research and practice in the Code of Professional Conduct (1992), although it would appear that in referring to the exercise of professional accountability the statement encouraging the practitioner to 'maintain and improve professional knowledge and competence' (1992:3) also implies research knowledge within the overall remit of professional knowledge. In the UKCC's Guidelines for Professional Practice (1996) research has been given emphasis and it is pointed out that increasing numbers of registered practitioners are carrying out, or are involved in, research or audit (1996:82:34). It is also noticeable that it highlights the need for practitioners to adhere to the criteria for safe and ethical conduct in the pursuit of all types of research, some of which it outlines.
The Code of Professional Conduct (UKCC, 1992) sets out the professional accountability of the nurse practitioner and provides principles to aid decision-making. However, the Guidelines for Professional Practice (UKCC, 1996) emphasise the decision-making process more as being fundamental to accountability. It points out that accountability is an integral part of professional practice, since practitioners in the course of their practice have to make judgements in a wide variety of circumstances (UKCC, 1996). It states 'Professional accountability is fundamentally concerned with weighing up the interests of patients and clients in complex situations, using professional knowledge, judgement and skills to make a decision and enabling you to account for the decision made.' (UKCC, 1996:7:8). Thus, from a review of these statutory statements, it is clear that the issues of knowledge, research and accountability have a high priority on the agenda for the future development of professional practice. What is important, however, is to examine the extent to which nurse practitioners share the same beliefs as the statutory bodies about knowledge and practice which is based on research evidence.

1.4: The research questions:

Having discussed at some length the rationale for choosing this particular research topic and having outlined some of the main concerns associated with these issues, it is now pertinent to present the series of questions which arose for me in relation to those concerns. The questions which I formulated were as follows:-

1. What are nurses' perceptions of knowledge?
2. What types of knowledge do nurses use in practice?
3. What are nurses' views about research-based knowledge?
4. Do nurses view themselves as professional practitioners?
5. Do professional values and beliefs constrain research-based practice?
Before proceeding to present some preparatory discussion of the key concepts within the research questions, it is essential to make explicit the main argument upon which this research study is based and to examine the epistemological framework which undergirds it.

1.5: The main argument:

Thus, the main argument being advanced is that it is important for nurse practitioners to be aware of and critically examine the different kinds of knowledge used in practice so that whenever possible decision making can be informed as to whether or not practice should be research-based. This means that nurse practitioners need to be aware of their own traditional beliefs alongside that of research knowledge, and that, if research knowledge emergs which conflicts with their own traditional beliefs, then this mental dilemma might usefully provide the starting point for further critical examination. This awareness translates itself into the need for nurse practitioners to develop the skills of reflection and engage in reflective practice.

This argument is supported by the theory advanced by Benner (1984) in her work 'From Novice to Expert', which will serve as the main epistemological framework for this study.

1.6: The epistemological framework:

Benner's 'From Novice to Expert' (1984) is a classic study of professional knowledge. It is the application of the Dreyfuses' model of skill acquisition (1980) to nursing. Although it is called a 'model of skill acquisition', its emphasis is on perception and decision-making. The Dreyfus theory posits that in the acquisition and development of a skill, a student passes through five levels of proficiency: novice, advanced beginner, competent, proficient, and expert. By using this model, Benner (1984) was able to describe the performance characteristics at each level of the nurse practitioner's development, and to identify, in general terms, the teaching and learning needs at each level. Thus, Benner's main argument (1984) is that skill acquisition from novice to expert is about changes in perceptual ability from stage to stage. Essentially, there is a move from the novice to the expert stage characterised by the transition from explicit rule-governed behaviour
to intuitive, contextually determinate behaviour. Indeed, Benner (1984:5) says, ‘Often the perceptual grasp of a situation is context dependent; that is, the subtle changes take on significance only in the light of the patient’s past history and current situation.” Polanyi (1958) calls this perceptual, recognitional ability of the expert clinician, “connoisseurship”. Benner (1984) believes that the descriptive and interpretative recording of this connoisseurship uncovers clinical knowledge.

Essentially, Benner’s position is based on the difference between practical and theoretical knowledge. Using Kuhn (1970) and Polanyi (1958), as well as Heidegger (1962) as authorities, she argues that there is a distinction between ‘knowing how’ and ‘knowing that’. In fact, it was Ryle (1949) who originally coined the expression ‘know-how’ and made the distinction between ‘knowing that’ and ‘knowing how’. Therefore, for Benner, knowledge development in a practice discipline such as nursing depends on developing the ‘knowing that’ through scientific investigation and making explicit the ‘knowing how’ which Benner (1984:3) says, “develops through clinical experience in the practice of that discipline”. Thus, knowledge development is about developing the ‘knowing how’ alongside that of ‘knowing that’. This can be achieved by reflecting on the experiences of ‘knowing how’ and then being able to document these experiences in terms of what has been learned.

To return to her theory, at the novice stage, Benner (1984) argues that beginners have had no experience of the situations in which they are expected to perform. To give them entry to these situations and allow them to gain the experience necessary for skill development, they are taught about the situations in terms of objectifiable, measurable parameters of a patient’s condition. She adds that novices must be given rules to guide their performance, but that these rules are context-free. Thus, this rule-governed behaviour, typical of the novice, is limited and inflexible (Benner, 1984:21).

At the expert stage, Benner (1984) argues that the expert performer no longer relies on an analytic principle (rule, guideline, maxim) to connect her or his understanding of the situation to an appropriate action. The expert nurse, with a huge background of experience, now has an intuitive grasp of each situation. Expert decision-makers get a Gestalt of the situation. However, expert nurses know that in all cases, definitive evaluation of a patient’s condition requires more than vague hunches, but through experience they have learned to alter their perceptions to lead to corroborating evidence. In other words, hunches are treated as serious information and are followed up with a search for evidence to corroborate
that hunch. Indeed, Benner (1984:34) says, ‘...this is not to say that the expert never uses analytic tools. Highly skilled analytic ability is necessary for those situations with which the nurse has had no previous experience. Analytic tools are also necessary for those times when the expert gets a wrong grasp of the situation and then finds that events and behaviors are not occurring as expected.’

1.7: Benner’s later work:

In her later work Benner continued to look at intuitive experience, but in the critical care and community settings. Benner et al (1992) undertook a qualitative study in which they sought to explicate further the Dreyfus and Dreyfus (1980, 1986) model of skill acquisition within the field of critical care nursing. Essentially, Benner et al (1992), in their findings, discuss the ability of the expert to grasp a situation immediately and directly in an intuitive fashion. The characteristics of intuitive judgement identified by Dreyfus and Dreyfus (1980), such as sense of salience and pattern recognition, are particularly pertinent in their discussion of the expert practitioner. The nurses have an increased ability to use perception and emotion, which they have developed through learning from experiences, to facilitate expert judgment.

In the subsequent phenomenological study of Benner et al, ‘Expertise in Nursing Practice’ (1996), one of the major aims was to explain the practical knowledge embedded in expert practice. The findings showed that expert practice was characterised by increasing intuitive links between seeing the salient issues in the situation and ways of responding to them. They concluded that expert nurses’ practice is characterised by reasoning which is mature and practical in origin, accompanied by an intuitive grasp of the patient’s situation. The most recent study by Benner et al, ‘Clinical Wisdom And Interventions In Critical Care’ (1999) is an extension of the work begun in 1996 (Benner, Tanner & Chesla) and 1994 (Benner). In this study (1999), they advance the view that active reflection captures the nature of expert clinical judgement and comportment better than diagnosis and treatment models of clinical judgement. Thus, by the use of observational interviews and clinical narratives, they provide a thick description of nurses’ thinking-in-action and reasoning-in-transition. Benner et al (1999) argue that the approach they are presenting is close to Schön’s notion of artistry in practice. However, they differ from Schön’s belief that the expert
makes up new rules on the spot; they believe that experts are following tacit rules. They also use the term ‘thinking-in-action’ rather than ‘reflection-in-action’ because ‘thinking’ conveys the innovative and productive nature of the clinician’s active thinking in ongoing situations. Reflection connotes stepping back or being outside the situation. (Benner et al 1999:9). Both, however are important for knowledge development.

Thus, it can be seen that the argument raised within this study is rooted in that of Benner’s (1984) model. The argument being advanced is that nurse practitioners need at every stage to be increasing their perceptual abilities to enable them to become more aware of the different kinds of knowledge they use to inform their practice. The development of professional knowledge and experience becomes the basis for developing enhanced decision-making skills. Secondly, practitioners also need to be increasing their reflective abilities to critically examine those different kinds of knowledge, so that their decision-making becomes more informed as to whether or not practice should be research-based. Although it is now apparent that Benner (1999) prefers the term ‘thinking-in-action’ as opposed to ‘reflection-in-action’, nevertheless, the idea of thinking critically is commonly shared ground. As Benner (1984) argues, even at the expert stage, highly skilled analytic ability is necessary for those situations with which the nurse has had no previous experience. Even the expert can get a wrong grasp of the situation and then find that events and behaviours are not occurring as expected. ‘Snap judgements, tunnel vision, over generalisation, and fixation on certain problems to the exclusion of others are all possible sources of poor judgement’ (Benner et al, 1999:5).

Benner (1999:8) in her most recent work describes six aspects of what she considers to be clinical judgement and skilful comportment. These are:- 1) reasoning-in-transition; 2) skilled know-how; 3) response-based practice; 4) agency; 5) perceptual acuity and the skill of involvement; and 6) the links between clinical and ethical reasoning. She believes that the ability to reflect actively on each of these six areas of practice captures the nature of expert clinical judgement and comportment.

1.8: Critiques of Benner’s work - the ongoing debate:

Although Benner’s (1984) work has been identified as the main epistemological framework because of its significance for the argument being raised in this study, nevertheless, it has been criticised. There is an
ongoing debate about Benner’s work, particularly in relation to the role of intuition in her description of the expert nurse. This debate was originally fuelled by English’s article (1993). On the one hand, English (1993) concedes that the logical structure of Benner’s model is appealing in that it implies that progress in theory and practice occurs according to the nurse’s experience. This approach overcomes the limitation inherent in a modular system. On the other hand, English (1993) finds the concept of intuition in the expert practitioner ambiguous. However, his criticisms are not supported by the research evidence available on the subject. He disputes the use of intuition as an early warning signal and states that ‘whatever feelings intuition evokes, it is a subjective and questionable entity and hence, until empirically and unequivocally validated, has limited applicability in a nursing profession which is attempting to develop a research base to support its actions’ (English, 1993:390). However, in response to English’s view, had a more in-depth review of the literature been undertaken, it would have revealed research studies which do examine intuition in the context of practice. Indeed, Benner (1999:64) herself refutes the idea that intuition is about wild guesses or extrasensory perception. Rather, she claims that the term ‘intuition’ refers to pattern recognition, a sense of salience, and a sense of concern or heightened attentiveness based on experiential learning in whole past concrete situations. For Benner (1999:64) intuition is about clinical forethought which refers to the habits of thought that allow clinicians to anticipate likely clinical eventualities and take the actions warranted.

English (1993) also attempts to apply a model of cognitive psychology to Benner and Tanner’s (1987) description of intuition. He suggests such models can be used to redefine intuition and systematically critiques each of the Dreyfus’ (1986) six aspects of intuitive judgement. English (1993:392) expressed concern that the ‘intuitive grasp’ of the experienced nurse was being presented as an ‘esoteric talent available only to a few initiates’. In fact, this concern was raised because earlier researchers had found that intuition was experienced both by students and non-expert practitioners.

Darbyshire (1994), as an advocate of Benner, responded to English’s critique of Benner’s (1984) model and strongly criticised his attempt to objectify and measure the intuitive qualities of the expert through the use of cognitive models. Essentially, he accuses English of subscribing to a traditional notion of objective science and defends Benner’s ideas against what he describes as a ‘positivist’ attack.
Cash (1995) argues that Benner's work is coherent and well written, and strongly theoretically grounded. The attraction of her work is that she has moved the emphasis towards the clinical practitioner and clinical practice, a view also shared by English (1993). Cash (1995:534) also concedes that Benner has produced a powerful and seductive interpretation of expertise, which, on the surface, appears to empower the clinical nurse and to raise the status of her knowledge. In practice, however, Cash (1995) believes that Benner has produced a model of nursing which ignores issues of power and their influence on nursing epistemology. Cash (1995) reaffirms the difficulties experienced by nurses in using intuitive judgement because of the ever present difficulties of power relationships between nurses and doctors. He, too, is critical about Benner's (1984) focus on the use of intuition as being purely within the realm of the expert practitioner. Cash (1995: 534) argues that Benner's emphasis on intuition 'fossilises a nursing practice distorted by the unequal power relations with competing epistemologies such as medicine'. As such, Cash (1995) believes that Benner is a profoundly conservative force in nursing. Cash's argument seems to be related to what Popper called 'the myth of the interpretative framework', which implies that the latter makes research too conservative and uncritical. Thus, there is a need for continual criticism of all assumptions. Whilst I endorse to some extent this argument advanced by Cash, nevertheless, in view of the strongly social purpose of the nursing profession, and given that it is controlled by statutory bodies, it would be difficult to envisage how clients would benefit from the conflicts arising from a profession continually engaged in power struggles with competing epistemologies. Indeed, it could be further argued that Polanyi, who uses the concept of 'tacit knowledge' is, in political terms, conservative.

Paley's (1996) commentary adds to this debate on a philosophical level. He examines the rift between 'science' and 'phenomenology' in nursing theory through an examination of the critiques offered by English (1993) and Darbyshire (1994). However, like his predecessors, he ignores the developing empirical evidence which supports the legitimacy of intuition in nursing practice.

Rolfe (1997) argues that in Benner's work the expert is portrayed as a reflective practitioner who works intuitively, drawing almost unconsciously on a repertoire of context-specific paradigm cases. Rolfe (1997) has concern with Benner's (1984) argument that the aim of the expert is to act intuitively and that if experts are made to attend to the particulars, their performance actually deteriorates. He asserts that there are equal dangers in not attending
to the particulars (Rolfe, 1997:96). Jarvis (2000: 32) reaffirms this with reference to practitioners ‘who think that they know precisely what to do each time and their actions are presumptive, even ritualistic, and these are dangerous practitioners because the same water does not flow under the same bridge a second time’. Rolfe (1997), therefore, takes Benner’s model one stage farther and suggests that a sixth level beyond expertise exists, which is the reflexive practitioner. At this level, the nurse must be able to ‘think on her feet and synthesise personal, academic and scientific knowledge into a unique informal theory which can be tested out and modified’ (Rolfe 1997:97). The reflexive practitioner is concerned with reflection-in-action, not just reflection-on-action, and it is important that she is acutely aware of the clinical situation in which she finds herself, and this requires her to go beyond just expertise. Thus, the reflexive practitioner is both researcher and theory-builder. I would support Rolfe’s views since it implies that Benner is limiting the scope of what nursing could become by suggesting that the level of expert is the pinnacle to which nurses should aspire. The term itself seems to imply a terminal point in time. Nevertheless, it might be argued that it was not the fault of Benner, who was attempting to codify and make sense of the state of nursing in the 1980s and offer an understanding of the relationship between theory and practice at that time. However, as previously noted, Benner (1999) in her most recent work has moved a stage farther and actually rejected the term ‘reflection-in-action’ in favour of the terms ‘thinking-in-action’ and ‘reasoning-in-transition’. Benner (1999:570) defines the concept of ‘thinking-in-action’ as ‘the patterns and habits of thought and action that are directly tied to responding to patients and families and the demands of a changing situation and for noticing when clinical assumptions and expectations are not met. Benner (1999:569) defines ‘reasoning-in transition’ as practical reasoning where a clinician takes account of gains and losses in understanding a situation as transitions occur. She points out that a good clinician is always interpreting the present clinical situation in terms of the immediate past condition of the patient (Benner 1999:10).

Eraut (1999) argues that the strength of the Dreyfus model, as the basis of Benner’s work, lies in the case it makes for tacit knowledge and intuition as critical features of professional expertise in ‘unstructured problem areas’. Nevertheless, Eraut (1999) advances his concern that the process of learning from experience has been idealised and that psychological research in the fallibility of human judgement has been ignored.
1.9: A return to the main argument:

Having presented these critiques to highlight the ongoing debate surrounding Benner’s work, it is pertinent at this stage to return to my own argument and to offer some final justification for using Benner’s epistemological framework. The main thrust of my argument is that it is important for nurse practitioners to develop an awareness of, and through the development of reflective skills, critically examine the different sources of knowledge available to them so that their decision-making can be informed as to whether or not practice should be research-based. My argument implies that this is an important developmental learning process, from novice to expert, earmarked by the growth and development of knowledge, experience, intuition and critically reflective skills. Benner’s (1984) model is also developmental in that, from novice to expert, the acquisition of skills is about changes in perceptual ability enhanced by the development of practical and theoretical knowledge, and the growth of experience and intuition.

My argument also infers a developmental process as part of a lifelong professional learning process. The latter was discussed previously in this chapter in some detail with specific reference to the recommendations of the PREPP (1990) document. Indeed, Gately (1992b) identifies similarities between Benner’s model and the recommended structure of the Post Registration Education and Practice Project (UKCC, 1990) and suggests that the model provided by Benner and Dreyfus presents a coherent framework to support the lifelong learning of nurses promulgated by the UKCC.

Having presented the main argument and its epistemological basis, it is now pertinent to discuss the key concepts upon which the research questions are based to provide even more background to the study and further clarification for its rationale. In addition, for the ensuing part of the study, it will provide a basis for understanding the consistencies and inconsistencies which permeate the responses of the participants depending on their role within the nursing profession and the context of the work setting.
1.10: Some discussion of the key concepts:

1.10.1: Knowledge:

Knowledge is a complex concept. Nevertheless, it has been defined as 'essential information that is acquired in a variety of ways, is expected to be an accurate reflection of reality, and is incorporated and used to direct a person’s actions' (Kaplan, 1964). Within this definition, it might be argued that 'a variety of ways' incorporates the 'knowing that' and the 'knowing how' embodied within Benner’s (1984) model and theory. Also, knowledge 'used to direct a person’s actions' might be seen to relate to Benner’s practical knowledge. However, Benner (1999:569) makes explicit the relationship between knowing how and knowing that. She asserts that practical knowledge is that gained through directly practising skills.

1.10.2: Professional knowledge:

The concept of professional knowledge is similarly complex, since, as Jarvis (1983) suggests, professional knowledge may refer to the mastery of an academic discipline, or disciplines, that underlie the professional practice, and that the mastery of this knowledge is essential to the concept of professionalism. Nursing knowledge, as a body of professional knowledge, is also complex since it has been influenced by a multitude of academic disciplines such as philosophy, sociology, psychology, politics, medicine and education, and it might be argued that a nurse practitioner must have mastery of the knowledge of such disciplines in order to lay claim to professionalism. Yet, as Jarvis (1983) suggests, professional knowledge is a selection from the overall body of knowledge considered by members of a profession to be the foundation of their practice. Again, this sociological concept of control can be similarly applied to nursing knowledge and the practice of nursing. Eraut (1999:102) also concedes that determining the knowledge base of a profession is a difficult task since many areas of professional knowledge and judgement have not been codified and that experts often cannot explain the nature of their own expertise. Nevertheless, Eraut (1999) argues that all kinds of knowledge are necessary to professional performance, but that, thus far, a lack of attention has been given to those different kinds of knowledge. He adds that although philosophers, psychologists and sociologists have attempted to address those different kinds of knowledge, limitations are apparent in the methods
and approaches used (Eraut 1999:103). Essentially, Eraut (1999) advances three main kinds of knowledge employed in professional practice. These are propositional knowledge, personal knowledge, and process knowledge. Eraut (1999:103) distinguishes three subcategories of propositional knowledge, which are: 1) discipline-based theories and concepts, derived from bodies of coherent systematic knowledge (Wissenschaft), 2) generalizations and practical principles in the applied field of professional action and 3) specific propositions about particular cases, decisions and actions. He defines ‘process knowledge’ as ‘knowing how to conduct the various processes that contribute to professional action. This includes knowing how to access and make good use of propositional knowledge’ (Eraut, 1999:107). Thus, the propositional knowledge and process knowledge correspond to the ‘knowing that’ and ‘knowing how’ identified in Benner’s (1984) work.

1.10.3: Research, research knowledge, research-based practice:

Parahoo (1997:38) defines research as ‘the study of phenomena by the rigorous and systematic collection and analysis of data. Research is a private enterprise made public for the purpose of exposing it to the scrutiny of others to allow for replication, verification or falsification’. Overall, therefore, research is an attempt to increase available knowledge through a systematic process of enquiry. What is important is the approach to this process of enquiry, which might be described as being underpinned by either a positivist or an interpretative, phenomenological world view. Vaughan and Robinson (1993:11) claim that the basic premise of positivism is concerned with identifying cause and effect, and, in so doing, being able to identify generally applicable theories which can hold good in a multitude of circumstances. They further claim that positivism is based on fundamental beliefs. One is the notion of objectivity; the second is the notion of measurability. Whatever tests are applied to assess the subject, they have to be repeatable in a wide range of circumstances and many times so that error of judgement can be eliminated. The basic premise of phenomenology is that the nature of the outside world can never be fully known. All that can be known are people’s perceptions and interpretations of that world. In its strongest form, phenomenology asserts that reality is to be found in people’s minds, rather than in external objects (Cormack 1996:115). As Cormack (1996:115) points out, one of the consequences of this position is that reality is not a fixed entity. It changes and develops
according to people’s experiences, and the social context within which they find themselves. In terms of the approach to the process of enquiry, positivism represents a rigorous scientific enquiry approach, and phenomenology represents a social scientific enquiry approach. Thus, research has been defined as ‘an attempt to increase the sum of what is known, usually referred to as “a body of knowledge”, by the discovery of new facts or relationships through a process of systematic scientific enquiry, the research process’ (Clark & Hockey, 1989:4). The Task Force on Research in Nursing (Department of Health, 1993b) noted that the term ‘research’ was used to mean rigorous and systematic enquiry conducted on a scale and using methods commensurate with the issue being investigated, and designed to lead to generalisable contributions to knowledge. The Culyer Report (Department of Health, 1994b) emphasised the fact that the point of research was to promote beneficial change. These definitions reflect a quantitative research approach. On the other hand, Denzin & Lincoln (1994b) argue that research is conducted to interpret lived experiences in the natural context or to analyse communication patterns. It attempts to interpret phenomena in terms of the meanings which people bring to them. This reflects a qualitative research approach. Nevertheless, both represent scientific enquiry. Phenomenology is the science of phenomena, as opposed to positivism, which is the science of being. Any profession, such as nursing, which offers a service to others needs to develop the knowledge base through scientific enquiry. This knowledge base then forms the foundation of judgement and decision making. Research knowledge, therefore, might be seen to be knowledge gained to provide descriptions, explanations and predictions related to phenomena, or knowledge sought to illuminate the meaning of the world in the experiences of the individual concerned. Both kinds of knowledge have a place within nursing’s knowledge base. As Rose & Parker (1994) argue, scientific enquiry is viewed as the process by which theory for nursing is generated. Hence, the nursing profession regards scientific knowledge as being essential to have in the delivery of competent practice. On the other hand, Rose (1994) argues that by discovering the meaning of various phenomena for a series of individuals, a new understanding of the experience can be constituted by nurses, and thus facilitate assessment and care of future patients experiencing the same phenomenon, but all the time recognising that each individual will experience unique nuances. Clearly, the research knowledge derived from both approaches is needed by nurse practitioners to
ensure a holistic delivery of care to patients and should be used appropriately to form the basis of research-based practice. Thus, the demand for a practice-research interface comes from the need to account for practice and ensure that the knowledge base on which clinical decisions are made is sound (Vaughan & Edwards, 1995). The main purpose behind this approach is:

"...to ensure that practice is knowledge-based through the introduction and evaluation of research-based practice; to develop research and evaluation skills among clinical staff; to create an ethos of enquiry."

(Vaughan & Edwards, 1995:2)

Thus, to return to the main argument, it is essential that nurse practitioners develop an awareness of all the different kinds of knowledge, particularly research knowledge, so that when and where possible, after critical reflection and through informed decision-making, research knowledge might form the basis of practice. With reference to Benner's model (1984), this awareness of knowledge should be a gradual growth from the novice to the expert stage in the development of the practitioner.

1.10.4: Profession, professional, professionalism:

Eraut (1999) argues that the professions contribute a subset of occupations the boundary of which is ill-defined. He asserts that features such as length of training, licence to practise, code of ethics, self-regulation and monopoly feature in most discussions about the nature of professions, but do not provide a workable definition nor remain stable over time (Eraut, 1999:100). Eraut (1999:100) cites Johnson (1972, 1984) who argues that, instead of defining what constitutes a profession, we should regard 'professionalism' as an ideology and 'professionalization' as the process by which an occupation seeks to advance its status and progress towards full recognition within that ideology. Nevertheless, Goode (1973:355), from a functionalist perspective, identifies the common features of a 'profession' as '..a basic body of abstract knowledge and an ideal of service'. Certainly, nursing accords well with this definition in terms of its being a 'profession'. Jarvis (1983b:27) defines a 'professional' as 'one who continually seeks the mastery of the branch of learning upon which his occupation is based, so that he may offer a service
to his client'. It appears that the important idea within Jarvis’s definition is that of the practitioner continually seeking to master knowledge and understanding in relation to practice. This seems to imply that the professional practitioner needs to become fully immersed in his or her own work in an attempt to become self-fulfilled in professional practice. In considering this definition alongside the future advent of the ‘nurse consultant’ role, the nurse practitioner assuming this position might well be seen to be a true professional practitioner. Nevertheless, as Jarvis (1983:27) points out, it is recognised that the conflict caused by seeking to be a master of an academic branch of learning and endeavouring to serve clients may result in one or other of these aspects suffering. Thus, Jarvis (1983) argues that the concept remains an ‘ideal type’ to which some practitioners approximate.

Jarvis (1983) argues that the term 'professionalism' implies that there must be a commitment to the occupational organisation, and dedication to being a master of the knowledge and a skilful provider of service stemming from the knowledge upon which the occupation is based. In relation to the concept of professionalisation, it was previously highlighted that nursing is said to be in a process of professionalisation. However, Jarvis (2000:30) argues that professionalisation is a rather outdated idea, and that nursing is caught up in something far greater than merely the professionalisation of their occupation. The process in which the nursing profession is engaged is an indicator of the significance of the knowledge society. Earlier, Porter (1992) critiqued nursing’s attempts to appropriate the title of profession and dismissed them as rhetorical exercises. He concluded that nurses should abandon the ideology of professionalisation and concentrate on the more pertinent issue of maximising the efficiency of the occupation.

Despite these critiques of professionalisation, from the above discussion, it is clear that professionalism is an ideological concept and one which remains important for the nursing profession as can be seen in the recent Codes of Practice previously referred to in the discussion. It demands that the practitioner should have the knowledge necessary to be of service, and that she should be committed to using it to the benefit of those whom she defines as being in need. Clearly, nurse practitioners are accountable for their practice and are constantly having to make judgements about the delivery of care to their clients. Fundamental to this decision-making process, however, is that they possess and utilise the most appropriate knowledge available to be able to demonstrate the highest standard of
informed practice. The realisation that they do not have that knowledge might well be said to constitute an unprofessional approach.

1.10.5: Values:

Values and beliefs are linked. Hilgard & Atkinson (1979:527) define a 'belief' as '....a statement about the world that a person thinks is true.' Haralambos (1980:6) defines a 'value' as 'a belief that something is good and desirable.' It defines what is important, worthwhile and worth striving for.' Implicit within this latter definition is the notion that values are those principles which a community or society uses as guides for conduct; they are the fundamental beliefs of a group.

The 'principles' or 'fundamental beliefs' of the nursing profession are those embodied within the Code of Professional Conduct (UKCC, 1992). However, values and beliefs tend to become influenced and subsequently honed according to the ideology of the culture in which the individual is situated and practises. In this study the professional values of four subcultures of the nursing profession are being examined in relation to their influence on knowledge, research and practice.

1.11: An outline of the thesis:

Chapter 2 continues this thesis with the presentation of a literature review. Within this there will be a critical discussion of the main areas being addressed in the study: these are the utilisation of research in practice, the nature of knowledge, the concepts of professionalism, professionalisation and professional values, and the concept of discourse, discourse analysis and its underpinning psychology.

Chapter 3 documents the research design and the rationale for choice for this study. It examines the choice of research methods and the chosen sample before presenting a detailed critique of the methodology. Finally, the issues of reliability and validity are discussed in relation to the methodology used, and the correspondingly appropriate issues of credibility, fittingness and auditability specifically in relation to the use of qualitative methodology.

Chapter 4 is given over to the analysis of the data. It documents the use of a content analysis approach taken to analyse mainly the quantitative data obtained. A theoretical discussion of this approach is presented before
providing a practical application of its use and the findings from the main questionnaire.

**Chapter 5** is a discussion of the discourse analysis approach used to analyse 12 open-ended interviews, conducted in the later part of the study. Again, a theoretical discussion of this approach is embarked upon before presenting a practical application of this approach.

**Chapter 6** is a presentation of the research findings from the pre-pilot group discussion, the pilot and main questionnaires, and the open-ended interviews.

**Chapter 7** is a discussion and interpretation of the research findings. It commences with the findings from the discourse analysis as a basis for interpreting the findings overall. Subsequently, it discusses the research findings in relation to the main aims of the study and the research questions being asked.

**Chapter 8** presents the main conclusions and discusses the implications of the findings for nurse education, practice and management. A critique of the study is presented and suggestions for further research made. Finally, some main recommendations are made.

1.12: **Conclusion:**

This introductory chapter has sought to identify the main aims of this research study, the rationale for choice of the research topic, and the research questions upon which the study is based. The argument being advanced was then presented and supported by a discussion of its underpinning epistemological framework, identified in the work of Benner (1984). The ongoing debate surrounding Benner’s work was highlighted by the presentation and discussion of several critiques. Subsequently, there was a return to the main argument, and justification was given for the relevance and appropriateness of Benner’s (1984) model as a basis for this argument. Some preparatory discussion of the key terms and concepts contained within the research questions was given to provide a fundamental basis for understanding some of the respondents’ views being expressed in response to the questions being posed throughout the study. Finally, an outline of the subsequent structure and content of the thesis was presented.
2.1: Introduction:

In this chapter a discussion of the literature review conducted in the three main areas associated with the research questions will be presented. These areas were: (1) the utilisation of research in practice (2) the nature of knowledge and (3) professional issues. It was also at this stage that my interest was being directed towards discursive psychology and its relevance for the understanding of my research area and the questions being asked. I was interested to explore the concept of discourse and the role of discourse, specifically as it related to the professional practice of nursing, and the possibility of using discourse analysis as an approach to analysing the interview data. Thus, a literature review was also conducted in relation to these issues. All the above areas identified will now be discussed each in turn.

2.2: The utilisation of research in practice:

In reviewing the literature, to date no study has specifically investigated the significance of nurses’ perceptions of knowledge in relation to research utilisation in practice. Thus, my own study seeks to fill that gap. Nevertheless, much of the literature which does exist has significance, to a greater or lesser extent, for the main thrust of the argument being advanced within my work.

The problems of utilising research in practice have been well documented. Whilst research is producing increasing amounts of important new evidence for health care, this is not reflected in the care most patients actually receive (Haynes et al, 1995). Even where research findings are unambiguous, as in the case of preoperative fasting, nursing practice remains guided by a ritualistic approach due to nurses’ lack of awareness of such evidence (Chapman, 1996). This study’s findings confirm previous findings made in relation to nurses’ knowledge of the management of wound care (Koh,
1993). The problems highlighted in these studies relate significantly to my own argument that nurse practitioners need to develop their reflective skills to raise awareness of knowledge deficiencies, and then to examine critically current research evidence as a basis for utilising it in practice.

It is not known how wide non-utilisation of research is in nursing practice since many of the studies which explore research utilisation (Koh, 1993, Webb & Mackenzie, 1993, Chapman, 1996) are small and localised. However, these studies do illuminate the main concerns about the relationship between knowledge and research-based practice.

In contrast, a recent challenge to the view that nurses in the United Kingdom do not use research in practice has been made by Lacey (1994) using a questionnaire. Her findings indicate that nurses demonstrate a positive attitude towards research. She claims many instances of well-informed nurses questioning their practice and implementing research-based change. Overall, she claims that her study found that nurses tended to agree that they were utilising research in their practice. However, this was a pilot study, based on a sample of only 20 nurses, and, as such, can be criticised for being a small and localised study. Such a small sample also calls into question the overall reliability and generalisability of its findings. Nevertheless, the validity of this self-report was argued to be established by nurses giving examples of practices they used which were based on research during interviews. Its findings provided a useful springboard for further research studies to be undertaken. Indeed, Lacey (1996) in a later study found that 65% of nurses responding to a 6-month post-research course evaluation had in some way implemented proposals for change on the basis of research. However, no sample size was given and the response rate to the survey was only 52%. Camiah (1997) found that research-based practice was perceived to exist in only a very few areas. From the findings it was concluded that there appeared to be a wide gap between what was practised on the wards and what was research-based. A most recent study by Rodgers (2000) aimed to describe the extent of research utilisation by registered nurses in general medical and surgical wards in the Scottish Health Service. A postal survey was conducted for nurses to self-report their level of utilisation of 14 research-based practices. Scores on individual practices ranged from 60% (405/680) of nurses never having heard of a practice to 85% (574/680) always using a practice. However, the study does have some limitations. Firstly, the scoring system does not differentiate between being not able to use a practice and not wishing to use a practice. Another is that the findings may be generalised only to nurses in medical and surgical
wards. A further limitation is that there was only a very small proportion of registered nurses in the study who had qualified under the new training system (Project 2000).

Recently, research findings related to the factors which promote and act as barriers to research utilisation have dominated the literature. Most of the studies on research utilisation have been carried out in North America and therefore application to other countries must be made with some caution. These studies are also mainly surveys relying on self-reports of nursing practice, which may be unreliable, and, because the response rates are often low, this may give rise to a potential bias of sample responding. Nevertheless, in a review of the literature on barriers to and facilitators of research utilisation over the last twenty years in the USA, Funk et al (1995) have concluded that with some fluctuation in the numbers endorsing each barrier, the picture is quite stable across time and among nurses serving in different roles. Significantly, in support of my own argument, the major finding that nurses did not know about research findings was confirmed by Funk et al (1995) in their large-scale study. In the latter, American administrators were asked to rate the 3 greatest barriers to research utilisation using a questionnaire incorporating the Barriers to Research Utilisation Scale. The item rated by the largest number of respondents (77.2%) as a barrier was the nurse’s lack of awareness of relevant research through which to change practice.

Recently, a number of studies in the United Kingdom have used the Barriers Scale (Funk et al, 1991a) to survey British nurses. The findings from these studies currently indicate that the greatest barriers are that research is not reported clearly or readably, statistical analyses are not understandable, and the nurse does not feel that she/he has enough authority to change patient care (Walsh, 1997a, Walsh, 1997b, Dunn et al, 1998). The findings from Dunn et al’s (1998) study also rated insufficient time on the job to implement new ideas, and, physicians not co-operating with implementation, as major barriers. Again, these have been rated as the greatest barriers in the findings of a most recent large-scale study by Parahoo (2000). However, the overall generalisability of the findings from these U.K. studies can be called into question because they are small-scale surveys, and, the possibility of bias due to the use of small convenience samples. Even Parahoo’s (2000) Northern Irish study, although a large-scale survey based on a sample of 2600 respondents, nevertheless uses convenience sampling and, disappointingly, has only an average response rate (52.6%), again raising the issue of generalisability of the findings.
However, these studies might be seen to have validity since there is evidence of consistency in their findings because of the use of a well tried and tested measuring tool. Of significance for my own argument is the finding that the nurse does not feel that she/he has enough authority to change patient care. With reference to Benner's (1984) model, nurse practitioners will only gradually, on the journey from the 'novice' to the 'expert' stage, be able to assume a greater command over their knowledge base, and be able to function as autonomous practitioners exercising full professional accountability in the course of their decision-making about research-based care.

From this same large-scale survey, Parahoo (1999) had earlier used some of the data to make a comparison of the perceptions of pre-Project 2000 and Project 2000 qualified nurses of their research training, research needs, and the use of research in clinical areas. Of particular significance for my own study, are the findings related to research utilisation. From Parahoo's findings, the reported frequency of research utilisation for the majority (just over 50% in the case of pre-Project 2000 and 60% for Project 2000 nurses) of nurses was 'sometimes', while the proportion of those who reported using research 'frequently/all the time' was approaching one third. Parahoo (1999) claims that the overall picture of reported utilisation is not bleak, although a great deal remains to be done. Again, criticisms can be levelled at this comparative survey as part of the large-scale work. Indeed, Parahoo, acknowledges the limitations of the validity of this type of self-reporting and, it is also unclear whether the respondents included indirect forms of utilisation in their understanding of the question. With reference to the main argument and Benner's (1984) theory, these findings appear to indicate that, generally, nurses are becoming more aware of research knowledge, during the journey from 'novice' to 'expert'. They are also beginning to utilise research more often in their practice. Therefore, it might be argued that as nurses gain more knowledge and experience, and as they develop their critical thinking skills, the greater the likelihood exists of their being able to utilise research to improve practice.

2.3: The nature of knowledge:

Of the literature reviewed, Polanyi's (1959) concept of an interpretative framework, and his concepts of tacit knowledge and tacit integration, offer significance for the argument being pursued in my own study based on Benner's (1984) theory. Indeed, Eraut (1995:15) points out that although the
Dreyfuses call their model 'a theory of skills acquisition', its emphasis is on perception and decision-making. Polanyi (1959) argues that all judgements must take place within an interpretative framework and be understood and assessed only by reference to it. Brownhill (1997) describes an interpretative framework as a means of giving some stability to perceptions. With reference to Benner's (1999:5) most recent work, she claims that learning to develop the best account of a clinical situation to make the best clinical judgement under circumstances of uncertainty is an interpretative process. Polanyi's (1959) argument that the very process of thinking involves making judgements and that understanding the latter relies on looking at them in the context of different frameworks of ideas remains fundamental to Benner's (1999) current position. Benner (1999:8) claims that the expert practitioner is engaged in productive thinking-in-action based on a narrative understanding of the situation, rather than on rule-governed thinking. She makes reference to six aspects of clinical judgement and skilful comportment, which act as a guide for active reflection, and on which expert clinical judgement can take place (Benner, 1999:8). This might be seen to serve as an interpretative framework.

Subjectivity, however, is identified as the main problem in using an interpretative framework. I accept the criticism offered by Brownhill (1997:38), who points out that subjectivity lies at the heart of this approach because of its self-confirming nature, its protection against falsifiability, its uncritical nature and its failure to get to grips with reality except through the interpretation of the framework. Nevertheless, Brownhill (1997), also concedes that discovery comes about through passion, obsession and commitment controlled by the desire to get at the truth, although they may not necessarily lead to discovery. It is a matter of human judgement and such judgement can be fallible and open-ended. I would accept this argument because nursing as a professional practice is subjective since an individual interpretation of the various frameworks is involved, which is based on both individual and professional values and belief systems. Nevertheless, it would be difficult for a nurse to be an objective, impersonal practitioner during her engagement with fellow human beings. Marks-Maran (1997:106) adds another dimension to the debate on judgements. She uses the term 'wisdom' to demonstrate the nurse's ability to use her experience and knowledge to make sensible decisions or judgements. She sees 'wisdom' as relying on an extended scope of enquiry, knowledge and experience. Marks-Maran (1997) further argues that
scientific knowledge alone is not sufficient for the development of wisdom. This latter argument accords with Benner’s (1999) view that clinical judgements cannot be as certain or predicted and controlled to the degree that scientific experiments can. Wisdom in clinical decision-making relies on practice which reflects all types of knowledge and all types of decision-making. Of significance for the main argument is the fact that it is the perceptual awareness of different kinds of knowledge which provides the basis for more informed decision-making about practice. Polanyi’s (1959) concepts of tacit knowledge and tacit integration also give further insight into the nature of knowledge and the development of our understanding. Polanyi (1959) argues that all of our explicit knowledge exists within a tacit framework, which provides the framework for our judgement. Although we can make some of this tacit knowledge explicit, we can never make it all known. This is pertinent to nurses since they find it difficult to articulate and justify their tacit knowledge. The problem of articulating knowledge is reflected in the findings of Eraut’s (1995) published study. Student nurses were asked to reflect on their practice and consider what knowledge they had used to guide it. One main category of replies was that they did not try to understand what was happening, or felt unable to describe what knowledge they were using in practice. In her early work, Benner (1984) argues that a wealth of untapped knowledge is embedded in the practices and the ‘know-how’ of expert nurse clinicians, but this knowledge will not expand fully unless nurses systematically record what they learn from their own experience. In her most recent work, she claims that the best way to capture “practical knowledge”, everyday understanding, or “know-how?” is in narrative or “story” form that includes all the feelings of risk, opportunity, concerns, meaning, chronology, and changing relevance, complete with puzzles. This way, “know-how” can be charted, even though “knowing that” or theoretical knowledge may be incomplete or even non-existent (Benner, 1999: 564-565).

2.4: Professional issues:

In reviewing the literature related to professional issues the areas of professionalisation and professional values were found to provide significance for the argument being presented in this study. It is clear, however, from the literature that there is a contest concerning professionalism. In fact, the most recent literature claims that it is outmoded
as a concept (Jarvis, 2000). Nevertheless, professionalism remains an important issue for nursing. The statutory bodies continue to strive for the recognition of nursing as a profession in its own right, and currently, nursing is said to be in the stages of professionalisation. For the purpose of this study, the concept of professionalism is being taken to mean, firstly, a practitioner who is accountable for practice and ensures that the knowledge base on which clinical decisions are made is sound (Vaughan & Edwards, 1995). Secondly, it is being taken to mean a practitioner who maintains skills, reinforces a critical attitude to work and who keeps up to date with developments and research (PREPP 1990).

The concept, however, receives little support from Porter (1992) who, from a sociological perspective, argues that the professionalisation model is inappropriate because the rise of managerialism is anti-professional since it restricts the autonomy of individual practitioners. Patient autonomy, however, is a crucial concept in contemporary ethical debate. Harris (1985) has loosely defined autonomy as 'self-government'. By this, he means that people are autonomous to the extent to which they are able to control their own lives. Aveyard (2000) points out that although the term is widely used within nursing ethics, its meaning is often unclear. Aveyard (2000) argues that if nurses use the concept of autonomy as a rationale for proceeding with certain nursing care procedures, it is crucial that their approach is both consistent and ethically defensible. By this, she means that nurses need to be clear that patients who are sufficiently autonomous to make their own decisions are given the right to do so, and those who are not can be cared for in their best interests.

In returning to Porter's (1992) work, he argues that occupational autonomy implicitly entails authority over patients and as such is incongruous with the increasing emphasis that nurses are placing on the need for co-operation with patients. However, it appears that Porter has overlooked the fact that, firstly, nursing has a strong social purpose, and, secondly, that it is a statutorily controlled occupation, and, as such, is governed by codes of practice within which professional and ethical standards are implicit. However, as already highlighted by Aveyard (2000), Porter has also overlooked those situations where patients cannot always co-operate and therefore the exercise of the nurse's autonomy is deemed essential in being able to make the most appropriate decision on behalf of, and in the best interests of, the patient. This approach has been well illustrated in Benner's work (1984, 1996, 1999) where the main focus has been in the area of critical care nursing. With reference to my own argument and Benner's
theory, the gradual acquisition of professional knowledge, and the
development of critical reflective skills from the experiences of clinical
practice, will allow the practitioner to make decisions based on the best
available evidence, especially in those circumstances where the facilitation
of self-care is denied. Indeed, Benner (1999) points out that essential
ethical concerns such as patient autonomy, informed consent, justice,
beneficence and non maleficence must be translated into visions for
excellent practice, since they do not in themselves create concrete visions
for excellent practice. Benner (1999:17) asserts ‘Nursing.............depends on
the professional standards of beneficence and non maleficence for helping
people during periods of vulnerability and distress.......’. Professionalisation
is deemed to be an appropriate ideology.

Another issue raised in relation to professionalisation strategies is that of
clinical elitism. Again, Porter (1992) argues that the ‘Project 2000’ nurse
training is a professionalising strategy which will produce a clinical élitism
by reducing the number of registered nurses within the nursing work force.
This has also been confirmed by Hart (1996) who asserts that
professionalising strategies have been criticised on the grounds that the
achievement of professional status is premised on the creation of a nursing
élite with the associated de-skilling of the rank and file. In response to these
arguments, whilst it may be conceded that professionalisation has given rise
to a clinical élitism, it is debatable whether the rank and file have been
de-skilled. Indeed, it could be argued that attempts have been made to
improve their skills and status. One strategy which has achieved this is the
introduction of the conversion course training, which has allowed the
up-skilling of enrolled nurses so that they can become registered nurse
practitioners.

From an educational viewpoint, professionalisation has also been criticised
for determining the educational process, preventing progressive humanist
argues that the humanist ‘process’ model of education is less attractive to
nurse education because it encourages a view of knowledge as ‘tentative’
rather than as ‘certain’. It might be argued that this ‘tentative’ view of
knowledge accounts to some extent for the current scepticism about
research knowledge, which does not appear to practitioners to have any
permanency thereby compromising its credibility. Nevertheless, nurse
practitioners can be encouraged to learn how to accommodate tentative
knowledge. It might also be argued that nurse educators for the future
should be able to explain how knowledge can be viewed as tentative,
uncertain, changing and evolving whilst at the same time not necessarily being seen as relative, subjective, personal and incapable of being expressed in any generally agreed form. Interestingly, Purdy (1997) has also produced a critique of humanist ideology and nurse education. He claims that the need to produce safe practitioners compromises the humanist model. He points to the limitations as being the tensions between independent learning and required course content, and he queries the appropriateness of student-centred learning to the professional education of nurses (Purdy, 1997:196). It is possible to accept the limitations highlighted by Purdy (1997) in his critique. Nursing is a statutorily controlled professional practice with public accountability. Therefore, the primary aim of a nurse education programme must be to produce safe and competent nurse practitioners, who are accountable. In this respect, Benner’s (1984) model might be seen to serve as the appropriate basis for a nurse training programme since it is a model of professional knowledge development alongside the acquisition of skills which produces competent, and beyond this stage, proficient and then expert practitioners.

In the area of professional values and nursing I was able to identify some significance in Kelly’s (1991) study with regard to my own study. The findings in this study revealed that informants (English nursing undergraduates) perceived two concepts as being central to their professional values, namely, respect for patients and ‘caring about little things’. Her findings indicated that the undergraduates expected their values would be in conflict with hospital practice. They valued ‘fitting in’ and ‘going along’, but retained their own ideas and values until such time as these could be implemented. These findings reflected the first stage of Benner’s (1984) model in that these students were undergoing professional nursing socialisation, and their behaviour therefore was very much rule-governed. However, values become revisional because, from the ‘novice’ to the ‘expert’ stage (Benner, 1984), nurses gain professional knowledge and experience through working and interacting with colleagues, patients and their relatives. The findings of a more recent Norwegian study (Fagermoen, 1997), exploring the values underlying nurses’ professional identity, indicate that nurses hold both other-oriented (moral) and self-oriented (work) values. Human dignity and altruism are the most prominent moral values, whereas the most significant work values are intellectual and personal stimulation. In relation to this study and its main argument, both sets of values are important in the relationship between knowledge and research-based practice. For nurse practitioners, caring is a
moral value, but caring in the most informed way based on research evidence is a self-oriented value. The latter is dependent on the practitioner’s personal commitment to best practice through the most informed decision-making.

2.5: Issues related to discourse:

Of most significance for my own study was the work of Harré and Gillett (1994). This allowed me initially to gain an understanding of the philosophical roots and scientific applications of discursive psychology, and the concept of discourse. This also allowed me to appreciate the relevance of using discourse analysis as a data analysis tool for the interview data.

The concept of discourse was made even more significant in analysing the definitions given by Gee (1989) and Mitchell (1992) respectively. Firstly, Gee (1989) makes the distinction between ‘Discourses’ with a capital ‘D’, which he argues are saying (writing) - doing- being- valuing- believing combinations and discourses with a small ‘d’, which are connected stretches of language which make sense. Thus, for Gee (1989:6-7) Discourses are ‘ways of being in the world; they are forms of life which integrate words, acts, values, beliefs, attitudes and social identities as well as gestures, glances, body positions and clothes’. From this definition, I was able to argue that nursing was also a way of being in the world, in which the wearing of a uniform conferred social identity and access to nursing culture, and the undertaking of a professional nurse training programme bestowed professional knowledge and nursing philosophy. The most pertinent section of Mitchell’s (1992:7) definition is the point at which she claims that discourse ‘allows things to be said, but also contains what can be said’. Thus, whatever position is occupied by the nurse practitioner, and, whatever Discourse she finds herself in, will determine what can and cannot be said. Again, with reference to Benner’s (1984) model, each stage from novice to expert might be seen to represent a Discourse in which nurse practitioners’ discourse is similarly governed by values, beliefs, attitudes, and behaviour in the developmental process of gaining professional knowledge and skills.

In relation to undertaking the process of discourse analysis, Smith, Harré and Langenhove (1995) give guidance on how to conduct a discourse analysis. However, of most benefit for my own study was Potter & Wetherell’s (1994) work which provides a detailed, but clearly
understandable, and most useful practical guide to using such an approach. Essentially, their work is a comprehensive introduction to the theory and application of discourse analysis within the field of social psychology. Although grounded in the field of social psychology, their work is also applicable to the practice of nursing and the relationship between knowledge and research-based practice. Chapter eight is particularly helpful since it presents the ten practical stages of conducting a discourse analysis. As an approach, it has been criticised for its radicalism since there is no method to it, but just a broad theoretical framework concerning the nature of discourse and its role in social life. From a quantitative research perspective, it would be criticised for lacking rigour as a research method. It is also very subjective and requires the researcher to be versed in how to be reflexive about interpretations being put on the data. This then calls into question the overall reliability of the findings, and the validity of using such a technique. Nevertheless, Potter and Wetherell (1994) do discuss the issue of validity and offer four techniques for validating the findings from discourse analysis as a means of examining and justifying claims.

Since there is no specific method, approaching discourse analysis for the first time is a challenging experience. Lupton’s (1992) work, however, was most useful in offering some suggestions as to how to incorporate some structure.

For Lupton (1992), discourse analysis is a methodology focusing on the sociocultural and political context in which text and talk occur. It is concerned with a critical analysis of the use of language and the reproduction of dominant ideologies in discourse. Thus, Lupton (1992) advances the idea that discourse analysis is composed of two dimensions - the textual and the contextual. The textual are those which account for the structures of discourse. The contextual relate the structural descriptions to various properties of the social, political or cultural context in which they take place. Both dimensions are important for examining the role and function of discourse within the practice of nursing. Lupton (1992) also emphasises the importance of validating one’s assertions by the extensive use of the actual textual material used in the analysis. She argues that by doing this, it allows others to assess the researcher’s interpretations and follow the reasoning process from data to conclusions. I accept Lupton’s view and concede that although it is a time consuming activity, it is nevertheless a worthwhile one in being able to argue for overall validity. Interestingly, Lupton (1992) defines discourse analysis as a post-structuralist activity, differing from traditional content analysis, in its
goal in identifying cultural hegemony and the manner by which it is reproduced. I found this concept was also relevant to Benner’s (1984) work and the main argument she raises, which is that the perceptual awareness of the different kinds of knowledge informing practice, and the experience of decision-making is a gradual development from the stage of novice to that of expert. This development also takes place and is controlled within an overarching cultural hegemony. Lupton (1992), however, points out that discourse analysis might also be seen to be a strategy of resistance. It seeks to display the reproduction of ideology and the more subtle forms of control and persuasion in the meanings inherent in discourse.

2.6: Conclusion:

This chapter has sought to discuss a review of the literature identified in the areas of the utilisation of research in practice, the nature of knowledge, and professional issues including professionalisation and professional values. It has also sought to discuss the most significant literature surrounding the areas of discursive psychology, discourse and discourse analysis. Thus, in undertaking such a review, it was intended to provide a detailed background to this study and to offer some further clarification of the research questions and the main reasons for asking them in the light of current literature.

In summary, in relation to the utilisation of research in practice, the emphasis has been on exploring the factors which act as barriers to research utilisation. Thus far, the findings from the United Kingdom surveys, using the Barriers Scale (Funk et al, 1991a) literature indicate that the current overall barriers which exist are research not being reported clearly or readably, incomprehensible statistical analyses, and, most importantly, the nurse practitioner feeling that she does not have enough authority to change patient care (Walsh, 1997a, Walsh, 1997b, Dunn et al, 1998, Parahoo, 2000).

In relation to the nature of knowledge, the issues of most relevance for the main argument of this study and Benner’s (1984) model were the concepts of an interpretative framework, tacit knowledge and tacit integration respectively (Polanyi, 1958). Discussion of these issues emphasised the importance of the relationship between the perceptual awareness of knowledge and informed decision-making about research-based practice.

In relation to professional issues, professionalisation as a strategy both for nursing practice and nurse education has received substantial criticism (Porter, 1992, Hart, 1996, Purdy, 1994, Purdy, 1997). In respect of nursing
practice, the overall problem seems to reside in the dichotomy between professional autonomy implicitly entailing authority over patients and current nursing philosophy which places emphasis on the need for co-operation with patients (Porter, 1992). In nurse education, professionalisation has been viewed as reinforcing a rationalist education (Purdy, 1994). Although Purdy (1994) argues for a humanist ‘process’ model of education, he has since critiqued the humanist ideology, pointing out that the main limitation is that for a profession such as nursing, there is the need to produce safe practitioners. This, in itself, compromises it (Purdy, 1997). In respect of professional values, little literature of salience for this study was found. However, Kelly’s (1991) study raised the issue of student nurse values and Fagermoen’s (1997) study made the distinction between moral and work values. With reference to my own study, a nurse practitioner’s values are important, since from being a novice to becoming an expert values become revised through the development of professional knowledge and experience in relation to practice. More significantly, both the moral and work values should be applied optimally to provide the best possible decisions about evidence-based care.

In reviewing the definitions of discourse (Gee, 1989; Mitchell, 1992), their relevance for Benner’s (1984) model became clear. Each stage of her model could be viewed as a discourse. The transition from novice to expert is a gradual developmental process during which the practitioner is expected to acquire the appropriate knowledge and skills to be able to think and act in a way expected of the stage reached and the discourse occupied. By reviewing the literature on discourse analysis, it provided some insight into using discourse analysis as a methodological tool for analysing the talk, culture and practices of nurse practitioners in relation to their perceptions of knowledge and research-based practice.

The way in which the research questions were incorporated into the overall research framework for this study will be discussed in the following chapter, which considers in detail the research setting, the research design and methodology used. It also provides a critique of the methodology.
Chapter 3

Research Methodology

3.1: Introduction:

This chapter will discuss the research methodology adopted to undertake this study. It will offer a rationale for the choice of research design and the research methods used to obtain the data before discussing their application within the context of the study. Initially, a methodological strategy was devised which subsequently had to be abandoned in favour of one which was deemed to be more realistic and appropriate in view of the research topic being pursued. The rationale for this methodological change will be addressed prior to a detailed discussion of the final chosen methodology. This will be followed by a critique of that methodology. The ethical responsibilities of the researcher will then be considered before finally discussing the important issues of reliability and validity as applied to quantitative research, and credibility, fittingness, auditability and confirmability in relation to qualitative research.

3.2: The research site: gaining access

The research site is the term used to describe a wide variety of settings within which research may take place and the research data collected (Cormack, 1996). My research study took place within two large health authorities in London and involved six hospital sites and three education centres. Gaining access to a research site can be fraught with problems particularly for the researcher who is not part of the organization in which the data are to be collected. However, as a researcher I found access to the research site relatively easy since I was either a part of, or, at least, affiliated with the organizations already referred to.

3.3: The research design:

My decision regarding the research design of this study preceded a selection of the data collection methods and I decided that the overall research design would be descriptive. Cormack (1996:44) points out that research design is selected on the grounds that it is the most suitable to answer the research
question. Indeed, I had several research questions, but I felt that a descriptive research design met the criteria for suitability in being able to answer these questions.

Descriptive research design:

The aim of descriptive research is to discover new facts about a situation, people, activities or events, or the frequency with which such events occur. This is achieved through the systematic collection of information about the phenomenon of interest and forms an essential phase in the development of nursing knowledge in that it provides the basis for future nursing research (Cormack, 1996:179).

Best (1970 cited in Cohen & Manion, 1992: 70 ) asserts that descriptive research is concerned with conditions or relationships that exist; practices that prevail; beliefs, points of view, or attitudes that are held; processes that are going on; effects that are being felt; or trends that are developing. Cormack (1996:179) also reinforces this definition by pointing out that the focus of descriptive studies is on the situation as it is and no attempt is made to manipulate variables. Cormack (1996:179) asserts further that the data obtained can then be used to justify and assess current conditions and practice, or to make plans for improving them.

Descriptive research begins with the identification of a problem or problematic situation. It is then followed by the description and analysis of that situation, which may reveal relevant factors or relationships thus far undetected which, in turn, could form the basis for further research (Cormack, 1996:179).

3.4: Rationale for the choice of research design:

It might be argued that within the overall framework of descriptive research I was pursuing an exploratory research design. Cormack (1996) argues that this type of design is appropriate for areas about which nursing has little theoretical or factual knowledge. Normally, in descriptive studies the research question presupposes a prior knowledge of the problem and it might be argued that, as the researcher, I was making assumptions about the relationship between nurses’ perceptions of knowledge and research-based practice. Clearly, as previously discussed in Chapter 2, nursing does possess a substantial body of research evidence about the non-utilisation of research in practice. However, it was also found that there is no theory or evidence in relation to nurses’ perceptions of knowledge. Therefore, I feel justified in identifying the design as an exploratory descriptive approach and also as the most appropriate one for the area which I was addressing. As the researcher, I was exploring a particular area to find out what was there, the meanings attached to this area and how
these could then be organised. Thus, in my research I was aiming to explore the relationship between nurses’ perceptions of knowledge and research-based practice and describe and interpret the meanings attached to their perceptions of knowledge in relation to their practice. I was also examining relationships between research-based knowledge and professionalism, and professional values and research-based practice and was aiming to explore the beliefs which existed within those relationships. Cormack (1996) argues that this type of study calls for intuition and insight on the part of the researcher. It also calls for a degree of flexibility so that any new leads can be followed up, so moving the study into new areas as the researcher proceeds and knowledge of what is being studied increases. Best (1970 cited in Cohen & Manion, 1972:70) also argues that descriptive research is concerned with how what is or what exists is related to some preceding event that has influenced or affected a present condition or event. Again, in this research study I was considering nurses’ perceptions of knowledge and the past and existing influences on the development of nursing knowledge, which might be seen to offer an explanation for some of the confusion and uncertainty surrounding it and the current scepticism about research-based knowledge and the lack of utilisation of research findings in practice.

3.5: The research methodology:

Within this overall exploratory descriptive research design a combined qualitative and quantitative approach was taken to allow the subject area to be studied from more than one perspective. I felt that a combined approach was an appropriate one for my study because nursing might be seen to be both an art and a science. Indeed, Mason (1993) argues that a nursing-focused study contains aspects of scientific and artistic study, and, therefore, qualitative and quantitative methods may be used appropriately to answer different questions.

3.5.1: Research methods:

The research methods used included a small group discussion, questionnaires, and open-ended interviews. These methods will subsequently be discussed in more detail.

3.5.2: The sample:

My sample population consisted of nurse practitioners, who were divided into the sub-categories of 1) qualified clinical practitioners, 2) clinical / educational
managers, 3) student nurses, and 4) nurse lecturers. The reason for this subdivision within the sample was to attempt to gain a wider-ranging set of data from practitioners working at different levels within the nursing profession. My aim in doing this was to obtain a broader perspective on the subject area.

A purposive sampling technique was used to obtain the sample groups. Eleven student nurses undertaking a traditional registered general nurse training were chosen from one education centre for conducting a pre-pilot study. Sixteen nurses, consisting of four ward-based qualified practitioners, four nurse managers, four student nurses undertaking a Diploma in Higher Education in Nursing (Project 2000) training and four nurse lecturers were selected from two education centres, based on two hospital sites, for conducting a pilot questionnaire. The main questionnaire was distributed to two hundred nurse practitioners, consisting of fifty ward-based qualified practitioners, fifty nurse managers (clinical and educational), fifty student nurses and fifty nurse lecturers from four hospital sites and two education centres. Of the fifty student nurses taking part, ten were undertaking a Diploma in Higher Education in Nursing training course, twenty were undertaking a pre-registration BSc. degree in Nursing Studies, ten were undertaking a Registered Mental Health Nurse training, five were post-registration students undertaking a BSc. degree in Nursing Studies, and five were undertaking an MA. degree in Midwifery Practice. Twelve nurses, three from each of the four sub-categories, were selected for the purpose of doing the open-ended interviews.

3.6: Changing the initial methodological strategy: the rationale

Before proceeding to give a detailed critique of the methodology used, it is important to discuss briefly the need to change my original methodological strategy. Initially, my data collecting tools were to be taped unstructured interviews, the use of a repertory grid technique and the distribution of questionnaires. After considerable reflection, however, I had to abandon this strategy due to my unease about the underlying assumptions that I was making about nurses and my subject area. I discovered that the approach that I was wanting to take would be too subjective. By choosing a repertory grid technique I was wrongly assuming that I would be able to elicit quite easily from nurses at all levels spontaneous information about knowledge, quite apart from its relationship to research-based practice. In trying to devise a repertory grid I realised that gaining all the elements and constructs would be a long, arduous and possibly unachievable task. Thus, I had to make a fundamental change to my methodological strategy.

Essentially, Kelly (1955) devised repertory grid technique as a method for exploring personal construct systems. He argued that it was an attempt to stand
in others' shoes to see their world as they saw it, to understand their situation and their concerns. Kelly (1955) believed that we strive to make sense of out of our universe, out of ourselves, out of the particular situations we encounter. He further argues that each of us invents and re-invents an implicit theoretical framework which is our personal construct system. Certainly, I was wanting to see how nurses saw their world of knowledge and to understand how they made sense out of it in relation to the situations they encountered. What I doubted, however, was whether nurses had a sufficient awareness of this complex world to be able spontaneously to articulate about its relationship and application to practice, particularly research-based practice. I also doubted whether nurses were aware of the idea of their practice being guided by implicit theoretical frameworks.

Fransella & Bannister (1990) argue that the grid is best looked on as a particular form of structured interview. They also argue that it assigns mathematical values to the relationships between a person's constructs. However, I did not want to take such a scientific approach in exploring another person's construct system, but wanted to engage nurses in conversation to find out what their perceptions of the world of knowledge were, their awareness of the different sources of knowledge in their world, and why and how each of those sources was used in their practice. Using a grid would have formalised this process and basically I wanted to adopt a more qualitative approach underpinned by a discursive psychology.

One of the problems of using this technique lies in whether the constructs should be elicited or provided. Generally, a person regards his/her own constructs as being more important to him/her than those that have been provided (Isaacson & Landfield, 1965). However, I felt that in my own study constructs would probably not be able to be wholly elicited or provided because of the nature of the world of knowledge. Therefore, this approach would not have provided me with a tool for examining such a complex area and all the issues surrounding it. Finally, grids measure relationships between constructs and then predictions can be derived from the measurements. My intention was not to measure the relationship between knowledge and research-based practice, but to examine it and tell the story as it was. Indeed, Kelly (1969) argued that accurate prediction could scarcely be taken as evidence that one had pinned down a fragment of ultimate truth.

3.7: A critique of the methodology:

3.7.1: A combined qualitative and quantitative approach:

As already stated, a combined qualitative and quantitative approach was adopted. The main reason for this was that by using a mixed approach it
allowed me to study the subject area from more than one perspective. Although there is general support for the separateness of the quantitative-qualitative paradigm in the literature, I would argue that for the purpose of my study this approach provided me with a fuller understanding of nurses as human beings and some of the problems associated with their perceptions of knowledge in relation to practice. It has been argued that nursing is a combination of art and science and thus the methodology should be able to reflect these dual theoretical perspectives. Indeed, Donaldson & Crowley (1978) claim that the discipline of nursing has both scientific aspects and aspects akin to the arts. It cannot be slotted into a neat polar category or even a neat polar research perspective. An opposing argument, however, is that there is an apparent lack of epistemological rigour when quantitative and qualitative methods are combined in the same study because they reflect opposing positive and interpretative perspectives. The latter are apparently incompatible and encompass differing assumptions (Rist, 1977; Smith, 1983). However, the argument has also been advanced that the research perspective becomes the master of the researcher rather than the servant and is an end in itself rather than a means to ontological study (Cuff & Payne, 1985; Feyerabend, 1975a). Methodological pluralism has been said to provide both increased flexibility to study dynamic phenomena (Huck et al, 1974) and data relevant to different kinds of questions (Bond & Bond, 1986). Two other advantages of a combined approach are that, firstly, it increases comprehensiveness and, secondly, it allows for cross-validation of findings (Goodwin & Goodwin, 1984). Mason (1993), however, has argued that data from combined methodology can be contradictory and their analysis problematic. This in itself may contradict the validity of either of them. However, he suggests that analysis needs to incorporate the notion that the data which people provide are situated in the context of the diverse methods used.

The integration of quantitative and qualitative methods of research, however, also calls into question whether qualitative or quantitative should take precedence in a research study. In this particular study a decision was made to use a qualitative approach prior to a quantitative one. Duffy (1985) suggests that quantitative techniques are the most appropriate source for corroborating findings initially derived from qualitative methods and qualitative methods are best used to provide richness or detail to quantitative ones when clarifying the direction of inquiry. Bryman (1992) has argued that quantitative researchers have tended to view it as an essentially exploratory way of conducting social investigations and that they have seen it as useful at the preparatory stage of a research project. Importantly, the main intention in doing this research study was to develop knowledge and it might be argued that there is no one best method of doing that. Quantitative and qualitative methods are different, but neither is superior
to the other. Both have recognised strengths and weaknesses and are used ideally in combination.

Duffy (1985) argues that choosing one methodology narrows a researcher's perspective and deprives one of the benefits of building on the strengths inherent in a variety of research methods. Atwood (1985), however, argued that nursing should adopt quantitative approaches to build nursing into a science, providing it with a useful theory base with practical applications. Clearly, there is a bipolar debate about methodology, but this might be seen to be advantageous to nursing. Duffy (1985) argues that it is encouraging researchers to consider the controversial issues of each methodology. For this, they need to have an in-depth knowledge of epistemology and methodology and must not feel constrained by the tradition of the physical sciences. Moccia (1988) points out that deciding on a specific research strategy is not just a technical choice, it is an ethical, moral, ideological and political activity.

In this study, a decision was made to collect data via a group discussion, a pilot questionnaire and a main questionnaire, and from open-ended interviews. The data would be collected from four groups of nurse practitioner, namely, qualified clinical practitioners, clinical /educational managers, student nurses and nurse lecturers. Thus, the intention behind approaching it in this way was to discover the extent to which perceptions were similar or dissimilar across those four different groups. Overall, however, the main goal in using these different methods was to increase the validity of the findings.

3.7.2: Ethical considerations:

During the process of research the researcher has certain moral obligations towards the subjects involved. For nurse researchers the criteria for the safe and ethical conduct of research are documented in the UKCC’s Code of Professional Conduct (1992) and The Scope of Professional Practice (1992). The main issues for consideration, however, are about the informed consent and protection of subjects, particularly patients, in the case of nursing research, and confidentiality and anonymity. As this study did not involve patients who would be exposed to unacceptable risks, there was no requirement to seek permission from the Research Ethics Committee to undertake the research. The most important aspect of obtaining consent was by providing and sharing information with the participants either by letter or in conversation. Participants gave their consent either verbally or by demonstrating their co-operation in the study.

As Cormack (1996) argues, researchers may be told much that is confidential during the course of data collection and so they are required to give assurances of confidentiality and anonymity. Indeed, in many cases, it is only because of these assurances that a high quality of data may be obtained. In this study
assurance was given to the participants about confidentiality of any information which they might give. Also they were assured that their anonymity in the research study would be protected. It was also made clear that, as participants, they had an absolute right to decline to participate in the study or withdraw from it at any time.

3.7.3: Data Collection:

Pilot work:

The research study was initiated by the undertaking of some pilot work. Oppenheim (1993:47) refers to pilot work as 'a process of designing and trying out questions and procedures.' In effect, it allows for the trying out of instruments, the making of any necessary revisions and then the retrying of instruments. Initially, the pilot work was exploratory in that I conducted a pre-pilot group discussion; this was followed by a pilot questionnaire. Oppenheim (1993: 51) points out that the earliest stages of pilot work will be primarily concerned with the conceptualisation of the research problem. It would have been difficult for me to devise a pilot questionnaire about the relationship between nurses' perceptions of knowledge and research-based practice without first exploring the feelings about the main issues underlying this relationship. I also had to take into consideration the fact that 'knowledge' as a concept has, thus far, only been addressed superficially in the nursing curriculum and, therefore, the wording of questions in a questionnaire would require careful thought.

The pre-pilot study: a group discussion.

Data collection was commenced by conducting a pre-pilot group discussion which took place on August 24th, 1994. Oppenheim (1993) infers that in exploratory pilot work, interviews or talks with key informants should be unstructured and tape-recorded. Thus, a decision was made to audio-tape the group discussion (see Appendix 6 for a complete transcription of the group discussion).

It was conducted with eleven third-year student nurses undertaking a traditional registered general nurse training in one education centre within one major Health Authority in London. A letter was sent to each member of the group explaining the nature and purpose of the research study, and inviting them to take part in a small group discussion which would last for 45 minutes.
approximately. It was possible to gain verbal consent from all members of the group.
The main purpose of this group discussion was twofold; firstly, I was aiming to examine the extent to which nurses’ perceptions of knowledge and professional values related to research-based practice and, secondly, I was aiming to look at the relationship between professional self-concept and practice. Although my intention was not to be directive in the process, I decide to devise just a short and simple discussion guide (See Appendix 1). It was circulated to all members of the group five days prior to the arranged discussion date. It highlighted four main areas for discussion which I felt to be little known and infrequently addressed in nurse training. I felt that spontaneous discussion about ‘knowledge’ as a concept might prove to be a difficult undertaking without providing some support to the participants. However, as the facilitator of this group discussion, the intention was not to be too directive, but at the same time it was important to be mindful of the need to maintain some control among the group participants during the course of the discussion. Adequate control is important since a group interview might provide the forum for a lively discussion, which could become a source of bias if one group member is allowed to dominate the discussion or if the group splits into sub groups. Oppenheim (1993: 67) points out that the purpose of an exploratory interview is heuristic. This also supported my rationale for choice of method since I was concerned to find out and understand how nurses felt and thought about the issues of ‘knowledge’, ‘research-based practice’, and ‘professionalism’.

Whether I should have chosen to do individual interviews was debatable since it could be argued that an insufficient depth of information was obtained about the ideas being discussed within the group. It is also usual to conduct several group interviews as opposed to one. However, as Oppenheim (1993) argues, individual in-depth interviews are expensive, time-consuming and not easy to arrange and conducting several group interviews can use up more subjects. What might also be debatable is whether I should have used a focus group interview technique as a method of obtaining the preliminary data as opposed to a group discussion. Patton (1990) points out that a focus group interview is an interview with a small group of people on a specific topic and that groups are typically six to eight people in size. Krueger (1988) argues that often a major research goal for researchers is to learn more about the range of opinions or experiences that people have. They also argue that focus groups have a strong advantage because the interaction in the group can provide an explicit basis for exploring this issue. Clearly, it might be seen that my main research goal was to find out about nurses’ opinions and experiences of knowledge related to practice and that this approach would have provided me with the necessary information which I was seeking. Krueger (1988) also argues that it is important to consider the use of focus groups when wishing to learn more
about the degree of consensus on a topic. However, it was not my intention at this stage of data collection to learn more about the degree of consensus on the subject area. Thus, this was my reason for not choosing a focus group technique. I was wanting to obtain a baseline set of data on which to build further strategies for data collection and, therefore, I felt that a group discussion would be the most effective means of achieving this relatively quickly. Clearly, Krueger (1988) points out that the myth that focus groups can be done cheaply and quickly has led to many inappropriate uses of this technique, based more on expediency than on the appropriateness of the method for the purposes at hand. Focus groups require planning, effort, and resources. I felt that a realistic assessment of time at the beginning of the project was a good way of avoiding any future problems. A major problem of this approach is attendance and the potential for non-attending must be taken into account. Importantly, however, there is a growing interest in and enthusiasm for the use of focus groups both in nurse education and research. As MacIntosh (1993) argues, the curriculum revolution in nursing has promoted significant changes in nursing education. Nursing is currently in the process of a paradigm shift, which implies the need for more interactive learning opportunities for students to reflect on their own values and beliefs. Indeed, MacIntosh (1993) in her study concluded that the use of focus groups as an interactive learning strategy was encouraging and that as a teaching strategy provided an opportunity to build on the strengths of adult learners.

Pilot Study: a pilot questionnaire.

The second stage of my research was a pilot questionnaire. Sixteen questionnaires were distributed together with a letter explaining the nature and purpose of the my research study among the four listed sub-categories of nurse practitioner, using two hospital sites and one education centre within one Health Authority in London. Eleven questionnaires were returned, giving an overall response rate of 68.7%.

The sample:

A purposive sample was used both for the pre-pilot and pilot study. De Poy & Gitlin (1993: 173) state that purposive sampling ‘involves the deliberate selection of individuals by the researcher based on certain predefined criteria’. Black (1993:49) defines the technique as ‘the hand-picking of subjects on the basis of traits to give what is felt or believed to be a representative sample’. I chose four different categories of nurse practitioner and by doing this I felt that I had ensured a cross-section of the nursing population in a small sample. Black (1993) suggests that the main limitations of this approach are that a
researcher may not have identified all the contributing variables and characteristics, or individual bias may prevail when carrying out the selection. Treece & Treece (1986) argue that random sampling is the ideal technique in providing truly representative populations and De Poy & Gitlin (1993:170) state ‘simple random sampling means that theoretically each and every element in the population has an equal chance of being included in the sample’. It also permits generalisation from the sample to the population it represents. However, De Poy & Gitlin (1993) also argue that this technique can be time-consuming and difficult to complete when one is drawing a very large sample. Nevertheless, the fact that I chose a small sample size for what, I feel, is an essentially qualitative study does not automatically mean that the sampling strategy should not be random. Indeed, Patton (1990) argues that random sampling, even of small samples, will substantially increase the credibility of the results. Generally, the purpose of random sampling is to achieve representativeness and sample size is a function of population size and desired confidence level. Patton (1990) indicates that purposive sampling selects information-rich cases for in-depth study and that size and specific cases depend on the purpose of the study. The sampling technique used in my own study might be seen to be a purposive sampling and was chosen for the purpose of illustrating the characteristics of the four sub-categories of nurse practitioner in relation to their perceptions of knowledge and research-based practice. It also allowed me to make comparisons across the four groups. Convenience sampling is probably the most common sampling strategy, but the least desirable. I did use a convenience sample for my pre-pilot group discussion, but the main reason for this approach was that I was eager to start data collection and the availability of a group of third-year student nurses was, I felt, an ideal opportunity to provide me with some interesting and essential baseline information as a starting point for my research. Convenience sampling saves time, money and effort, but Patton (1990) argues that whilst convenience and cost are real considerations, they should be the last factors to be taken into account after deciding how to get the most information of the greatest value from a limited sample. Although convenience sampling is said to have the poorest rationale, low credibility and to yield poor information, nevertheless, I would argue that the information I gained from the group discussion was useful, valuable and credible.

Rationale for conducting a pilot questionnaire:

The main reason for conducting a pilot questionnaire was to provide me with data which would give me a more comprehensive view and understanding of the research area being examined and to form the basis for devising a main questionnaire. It also allowed me to make the necessary adjustments in relation
to question wording, sequencing and overall structuring of the questionnaire. I sought feedback from each of the pilot study respondents as to any problems or difficulties they had encountered while completing it. Their suggestions were very helpful and were subsequently incorporated in the devising of the main questionnaire.

The pilot questionnaire:

In the pilot questionnaire, I used a combination of closed-ended and open-ended questions to obtain data (See Appendix 2 for reference). Polit & Hungler (1991) have argued that the information obtained from questionnaires tends to be more superficial than interview data because of the use of too many closed-ended questions. However, the same researchers also suggest that open-ended questions often cause some resentment among respondents because they dislike having to compose and write out a reply. I felt that by using both types of question, respondents did not find completing the questionnaire too arduous a task and the response rate of 69% also supported this.

Generally, questionnaires tend to be more cost-effective and less time-consuming than interviews. Youngman et al (1978) argue that a questionnaire can bring in a lot of information quickly and analysis is comparatively easy. I used interpretative and numerical analysis to interpret the data obtained from the pilot work. Polit & Hungler (1991) also suggest that group-administered questionnaires are the least expensive and time-consuming of any procedure and that mailed questionnaires can provide a more geographically diverse sample. Another advantage is that questionnaires offer the possibility of complete anonymity and sometimes this is of the essence in obtaining candid responses. Similarly, the absence of an interviewer ensures that there will be no interviewer bias. However, this is not to deny that researcher bias can still be present in a questionnaire. It manifests itself often in the types of question being asked.

The disadvantages of using questionnaires are also well documented. The response rate for questionnaires tends not to be as high as for interviews. Polit & Hungler (1991) argue that a well designed and properly conducted interview normally achieves a response rate in the region of 80% to 90%. Another disadvantage is that questionnaires can contain ambiguous or confusing questions whereas in an interview the interviewer can determine whether questions have been misunderstood and, if so, give any necessary clarification. Similarly, however, some questions which are misinterpreted may go undetected by the researcher and lead to incorrect conclusions.
The main questionnaire:

The main questionnaire was the third stage of data collection. Questionnaires were distributed to a sample of two hundred nurses, fifty to each of the listed sub-categories, using four hospital sites and two education centres. One hundred questionnaires were returned, giving an overall response rate of 50%. The response rate data are given in Table 1 below:

Table 1: Response rate data:

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<tr>
<th>Response rate</th>
<th>Practitioner subcategory</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall response rate</td>
<td>Combined practitioner sub-categories</td>
<td>50</td>
</tr>
<tr>
<td>Response rate to the questionnaire overall</td>
<td>Qualified practitioners</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>Nurse managers</td>
<td>4.5</td>
</tr>
<tr>
<td></td>
<td>Student nurses</td>
<td>9.5</td>
</tr>
<tr>
<td></td>
<td>Nurse lecturers</td>
<td>20</td>
</tr>
<tr>
<td>Contribution to the overall response rate</td>
<td>Qualified practitioners</td>
<td>64</td>
</tr>
<tr>
<td></td>
<td>Nurse managers</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>Student nurses</td>
<td>38</td>
</tr>
<tr>
<td></td>
<td>Nurse lecturers</td>
<td>80</td>
</tr>
</tbody>
</table>

Therefore, it is important at this stage to comment on the issue of response rate, which is significant for researchers in terms of making claims for the reliability and validity of their findings. It is documented in the literature that a response rate of 65% and above is deemed to be a reasonably good one. The response rate for the group discussion and open-ended interviews was 100% and 69% for the pilot questionnaire, but only 50% for the main questionnaire, which it might be argued was inadequate. However, what had to be borne in mind was the current climate in which constant change, pressure of workload, lack of resources and time often precluded practitioners from completing a questionnaire. Measures can be taken to increase the response rate, one of which is to follow up non-returns. However, this becomes problematic when the questionnaire is based on an anonymous return. Another strategy for overcoming the difficulty is to send out more questionnaires, which is, in fact, what I chose to do in order to improve
the response rate. As Oppenheim (1993) suggests, it is necessary to maximise the response rate, since the main issue of concern is not the number or proportion of non-respondents, but the possibility of bias. Importantly, the researcher needs to ascertain whether the reasons for non-response were connected to the research topic. The questionnaire itself consisted of a mixture of mainly open-ended, but also some closed-ended questions (See Appendix 4 for reference). The data obtained from the main questionnaire helped to provide more clarification on the research area, and furnished me with a basis for conducting twelve open-ended interviews.

Interviewing:

Patton (1990) argues that the purpose of interviewing is to find out what is in and on someone else’s mind and that qualitative interviewing begins with the assumption that the perspective of others is meaningful, knowable and able to be made explicit. Patton (1990:279) states ‘The task for the interviewer is to make it possible for the person being interviewed to bring the interviewer into his or her world------’. Three basic approaches have been described in relation to collecting qualitative data through open-ended interviews. These are (1) the informal conversational interview (2) the guided interview and (3) the standardised interview. I chose to adopt the guided interview approach as being the most appropriate in respect of the complex nature of the subject area under review.

Open-ended interviews:

This was the fourth stage of data collection. I interviewed twelve practitioners, three from each of the four listed sub-categories. I approached each practitioner, explaining the nature and purpose of my research study and inviting them to take part in an audio-taped interview. I gained the verbal consent of each practitioner and dates and times for interviewing were then arranged at the interviewee’s convenience. I mentally formulated an interview schedule for myself as the interviewer and verbally informed the interviewees beforehand that I wanted them to talk to me about their work and role, and how knowledge fitted into that. By talking to the interviewees in advance it allowed them to reflect on the subject area and helped to increase the comprehensiveness of the data. It also made the collection of data more systematic whilst still allowing the interviews to be conversational and situational. This approach, however, has been criticised as being one which may allow for omission of relevant and important topics and one which reduces the comparability of responses because the
interviewer can be flexible about the sequencing and wording of questions (Patton, 1990). It might be argued that interviewing is one of the most effective means of allowing the interviewer to enter into the other person’s world of experience and perceptions and it provides in-depth data. However, it has also been argued that they are a limited source of data because participants can only report their perceptions and perspectives related to their experiences (Patton, 1990). Indeed, Youngman et al (1978) claim that the interview has low reliability and it is hard to deny that a person’s perspectives and perceptions are sometimes influenced by personal bias. Interviews, however, do afford the interviewer the opportunity to ensure that he or she understands what the respondent means and allows interesting comments to be explored in more depth.

Transcribing the interviews:

The interviews were audio tape-recorded and the transcribing of them was a lengthy process (see Appendix 7 for a sample of 4 interview transcriptions). Watts (1980) points out that transcribing a tape is an extremely slow and time-consuming process. He argues that researchers vary in the amount of detail they feel necessary for analysis and that the more they need, the longer it takes. Watts (1980) pinpoints the difficulty of trying to convey the actual emphasis in the respondents’ words in terms of the person’s gestures, faltering, pausing, voice quality, facial expressions, posture and positioning. The outcome could be that the respondent conveys the opposite of what he or she is saying. Other problems are that the transcriber may often have difficulty tracing the sequence of the conversation and the presence of a tape-recorder may affect the interviewee who may become aware of it momentarily during the course of the interview. A final problem is that the transcription can only be an interpretation by the transcriber of the recording. The transcriber will be selective about what to write down and in this sense the data represent the transcriber’s own view of the actual event. I endeavoured to overcome this problem by asking the respondents to validate the transcription data. The analysis of qualitative data also raises issues of accuracy and rigour, which will be subsequently addressed.

3.7.4: Issues of Reliability and Validity:

This research study used a combined quantitative and qualitative approach and it was previously highlighted that quantitative and qualitative research methodologies complemented each other. However, a fundamental problem exists in that nurse researchers have tried to judge the rigour of qualitative research by using the criteria for quantitative research. Primarily, however, the
underlying assumptions of qualitative inquiry are different from those of quantitative inquiry. Thus, different criteria are needed to evaluate reliability and validity in the context of qualitative studies. The quantitative terms ‘internal validity’, ‘external validity’, and ‘reliability’ can be referred to as credibility, fittingness and auditability respectively. It was Guba & Lincoln (1981) who suggested the renaming of the former scientific terms to the latter naturalistic ones, which they believed were more appropriate to qualitative research. According to Guba & Lincoln (1981), credibility is the criterion against which the truth value of a qualitative study should be judged. Fittingness is the criterion against which the applicability of qualitative studies should be evaluated. Auditability is the suggested criterion for evaluating consistency and confirmability is the criterion of neutrality.

3.7.5: Credibility:

In quantitative research, internal validity measures whether or not the manipulation of the independent variable really makes a significant difference in the dependent variable. In qualitative research, credibility measures how vivid and faithful the description of the phenomenon is. Guba & Lincoln (1981) suggest that a qualitative study is credible when it presents such faithful descriptions or interpretations of an experience that the people having that experience would immediately recognise it as their own.

In relation to my own study, I would argue that the participants would recognise the experience, that is, descriptions of their perceptions of knowledge and research-based practice as their own, since I tried to remain true to the data obtained and reflect as accurately as possible what was being written and stated. I would also argue that readers would view the findings as meaningful and applicable in terms of their own experiences as nurses involved in reflecting on the use of their knowledge in practice. This argument is supported by Psathas (1973) who also suggests that a study is credible when other researchers can recognise the experience when confronted with it after having only read about it in a study.

A major threat to the truth value of a qualitative study lies in the closeness of the investigator-subject relationship (Miles & Huberman, 1984). As the researcher, I did not keep in-depth field notes about my relationships with the 12 interviewees since I did not intend to prolong contact with them through an ongoing series of interviews. However, after each interview I did reflect on my actions, interactions and subjectivity and documented thoughts and feelings, which I felt were significant at the time, in my research experience diary. The latter was used for this purpose throughout the study. The other important issue as a researcher was trying to keep my own experiences separate from those of the people being interviewed. I often tried to make a conscious
effort to be aware of the effects of my presence on people and what they were saying, and, conversely, the effects on me of what other people were saying. Finally, in support of making a claim for the credibility of this study, I did validate the findings with the informants and also provided, what I felt to be, many significant excerpts from the interviewees’ transcripts. Importantly, I used triangulation in relation to data collection methods and data analysis strategies to determine the congruence of the findings from and across the four sub-categories of nurse practitioner.

The analysis of qualitative data also raises the two important issues of accuracy and rigour. Some other important issues will be examined in the next chapter which presents a discussion of data analysis. It is important for the researcher to represent and analyse accurately the experiences of individuals. Secondly, the researcher must ensure that the themes and taxonomies are not personal interpretations and biases. Thirdly, it is important that the findings reveal meanings that would be shared by others if conducting the same set of interviews (De Poy & Gitlin, 1993). Lincoln & Guba (1981) have expressed concern with the truth value, accuracy and the credibility of the researcher’s findings and interpretations. However, Sandelowski (1986) argues that since the threat to the truth value of a qualitative lies in the closeness of the researcher-subject relationship, the credibility of qualitative research is enhanced when the researcher can deliberately focus on how he or she influenced and was influenced by the subject.

3.7.6: Fittingness:

In quantitative research, external validity refers to the extent to which the results of a study can be generalised to other populations. In qualitative research, the concept of fittingness is more appropriate (Beck 1993). Guba & Lincoln (1981) argue that fittingness measures how well the working hypotheses or propositions fit into a context other than that from which they were generated. In relation to my own study, it might be argued that the findings were applicable outside of the study situation and that the results would be meaningful to individuals not involved in the research. Although the specific focus of the study was about nurses’ perceptions of knowledge and research-based practice, there were also other influential issues being addressed in the findings such as professional culture, socialisation processes and professionalism, which might be seen as lending a universality to the findings in relation to knowledge and practice in nursing.

Other important issues in relation to fittingness are the typicality of the respondents and their responses, and the representativeness of the data as a whole. Denzin (1978) suggests that any subject belonging to a specified group is considered to represent that group. The respondents in my study were all
nurse practitioners, but because they were chosen from four different sub-categories, represented different levels of knowledge and experience, in relation to practice. Since I was also using a discourse analysis approach to analyse the responses, it was also seen that the individual responses within each of these categories were for the most part typical of that particular Discourse. Thus, I would make a claim for the representativeness of the data as a whole although the size of the sample for the interviews was small. Clearly, in quantitative research, certain conventions are observed to ensure representativeness and generalisability, such as random sampling technique and a sufficiently large sample size. In qualitative research, however, sample sizes are typically smaller because of the larger volume of data which has to be analysed. Additionally, sampling is often theoretical rather than statistical because subjects are selected on the basis of being able to illuminate the focus of the study. Thus, the intention behind using a purposive sampling technique was to choose four groups of subjects specifically to represent four different discourses, which, in turn, represented the nursing profession as a complex mass of contradictions due to the existence of multiple discourses.

3.7.7: Auditability:

In quantitative research, reliability measures how consistently an instrument obtains similar results over repeated testing periods. In qualitative research, the criterion of auditability is deemed to be more fitting (Beck 1993). Guba & Lincoln (1981) refer to auditability as the ability of another investigator to follow the decision trail which consists of all the decisions made by the researcher at every stage of data analysis. In other words, another researcher could arrive at the same or comparable conclusions given the researcher’s data, perspective and situation. I would argue that because I documented the stages of the research process, any reader or researcher would be able to follow the thinking behind the research, the progression of events in the study and understand their logic. Each stage of the research process was discussed in detail and in-depth descriptions of the strategies used to collect and analyse the data were provided. I also endeavoured to give as much description, explanation and justification in relation to my interest in the subject matter, the specific purpose of the study and how all the subjects were approached and included in the study.

3.7.8: Confirmability:

Finally, neutrality refers to the freedom from bias in the research process and product. In quantitative research, objectivity is the criterion of neutrality and it
is achieved when reliability and validity are established (Sandelowski, 1986). In qualitative research, Guba & Lincoln (1981) suggest that confirmability is the criterion of neutrality. As such, it refers to the findings themselves as opposed to the subjective or objective stance of the researcher. Qualitative research emphasises the meaningfulness of findings by reducing the distance between researcher and subject and by eliminating artificial lines between subjective and objective reality. I would argue that the findings in this study are meaningful and that the use of a discourse analysis approach helped to reduce researcher bias to some extent.

3.8: Conclusion:

This chapter has discussed at length the research methodology adopted for this study and the rationale for its choice whilst at the same time providing an in-depth critique of this strategy. It also presented rationale for rejecting the initial methodological strategy which had been selected. The ethical considerations of engaging in research were discussed, and, finally, the overall issues of reliability and validity were considered, both in the context of quantitative and qualitative research. Therefore, the equivalent issues of credibility, fittingness, auditability and confirmability were specifically addressed in relation to qualitative research and in the context of my own study. The next chapter will present a theoretical discussion of the content analysis approach chosen to analyse the data obtained from the pre-pilot group discussion, and the pilot and main questionnaire respectively. The full reporting of the findings from the main questionnaire will also be given in the next chapter.
Data Analysis I: The use of content analysis

4.1: Introduction:

This chapter will firstly give the rationale for selecting content analysis as a method for analysing data from the pre-pilot group discussion, the pilot questionnaire, and the main questionnaire. Secondly, discussion will focus on the theoretical underpinnings of the content analysis approach. Thirdly, a brief outline will be given of the overall approach taken to analyse data from the pre-pilot group discussion, and pilot questionnaire. Finally, a complete content analysis of the data from the main questionnaire will be presented.

4.2: Content analysis - rationale for choice of approach:

Since both quantitative and qualitative data were gained in the early part of the study, an appropriate data analysis method was required to encompass the two kinds of data. After reviewing several methods, a content analysis approach was chosen, because it is a method which can be used for analysing both quantitative and qualitative data within a research study. Secondly, the use of this approach would allow me to test theoretical issues to enhance my understanding of the data. Importantly, however, the way this approach was used was shaped by the overall research methodology, which I discussed in detail in the previous chapter. In quantitative research, content analysis is fundamentally about counting in terms of the researcher’s categories. In qualitative research, it is essentially about understanding the participants’ categories. I knew that my own study would yield both quantitative and qualitative data and I felt that the former would lend itself to a simple statistical analysis in terms of the categories identified and that the latter would produce a more detailed understanding of the categories.

4.3: Content analysis - the approach:

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Patton (1990:381) states ‘Content analysis is the process of identifying, coding and categorising the primary patterns in the data’. He also stresses that simplifying the complexity of reality into some manageable classification scheme is the first step of analysis. Downe-Wamboldt (1992) argues that content analysis provides systematic and objective means to describe and quantify phenomena. It is more than a counting game; it is concerned with meanings, intentions, consequences and context. Central to the methodology is the distillation, through analysis, of words into fewer content-related categories (Weber, 1995). Indeed, Cavanagh (1997:9) points out that the purpose of creating and defining categories is to provide a means of describing the phenomenon under investigation, to increase understanding, and to generate knowledge. Thus, quantitative researchers use content analysis in which they establish a set of categories and then count the number of instances which fall into each category. The essential requirement is that the categories are sufficiently precise to enable different coders to arrive at the same results when the same material is examined (Silverman, 1994). Silverman (1994) also emphasises that when used quantitatively, it pays particular attention to the issue of the reliability of its measures, ensuring that different researchers use them in the same way and to the validity of its findings through precise counts of word use. However, critics in the quantitative field have criticised this approach as being a simplistic technique which does not lend itself to detailed statistical analysis and in the qualitative field it has been felt not to be sufficiently qualitative in nature. (Morgan 1993). However, Tesch (1990) argues that a qualitative and quantitative form of content analysis is the start of a process of exploring information, identifying relationships between data and understanding the meaning emerging from the data. Yin (1989) suggests that quantitative analysis ends with answers to counting questions compared to the explanatory answers to the questions of qualitative analysis. Weber (1995) argues that simplistic procedures do not have to be put to simplistic uses and that the use of content analysis techniques has been shown to produce symbolic content which is both valid and reliable. Qualitative researchers analyse data for a very different purpose. Their aim is to understand the participants’ categories and to see how these are used in concrete activities. In relation to the reliability of the analysis, this is less frequently addressed. Instead, as Silverman (1994) points out, qualitative researchers make claims about their ability to reveal the local practices through which given ‘end-products’, such as stories and descriptions are
assembled. He further argues that authenticity rather than reliability is often the issue in qualitative research and its data analysis. The aim is to gather an 'authentic' understanding of people's experiences and it is believed that 'open-ended' questions are the most effective route towards this end. Importantly, too, audio-recordings are of the essence in qualitative research to facilitate the process of data analysis. Transcripts provide an excellent record of naturally occurring interaction. Again, Silverman (1994) argues that compared to the field notes of observational data, recordings and transcripts can offer a highly reliable record to which researchers can return as they develop new hypotheses.

4.4: Group discussion (Pre-pilot study):

I began by reading through the transcription of the pre-pilot group discussion (see Appendix 6 for reference) and then making comments on a separate sheet of paper about how I could organise the data. I decided that I would take the four main topic areas, on which the discussion had been based, and identify categories and units of analysis, for example, the use of different words, phrases and sentences occurring within each area.

4.5: Pilot questionnaire:

The pilot questionnaire (see Appendix 2 for reference) consisted of eight questions, five of which were purely open-ended questions, which yielded qualitative data. Three questions consisted of two parts; the first part consisted of a closed-ended question, which produced quantitative data in the form of a 'YES' or 'NO' answer. The second part consisted of an open-ended question, and this yielded qualitative data (the complete pilot questionnaire data can be referred to in Appendix 3). A simple numerical analysis was applied to the quantitative responses, and a creating and defining of categories was undertaken for the qualitative responses.

4.6: The main questionnaire:

The main questionnaire (see Appendix 4 for reference) consisted of twelve questions, two of which were purely open-ended thus giving qualitative data. The remaining ten questions consisted of two parts; the first part produced quantitative data, which were analysed quantitatively and the...
second part produced qualitative data, which were analysed qualitatively (see Appendix 5 for a sample of the data obtained). In my approach to the main questionnaire (see Appendix 4 for reference). I chose to analyse separately the specific data obtained from each of the four groups of practitioner as I was now wanting to begin to identify any similarities and dissimilarities in the data not only within each group, but also across the total sample. A practical application of the content analysis approach is now given.

4.7: A content analysis of the data from the main questionnaire:

Question 1:

(1) Qualified practitioners:

<table>
<thead>
<tr>
<th>Statements offered</th>
<th>Number of practitioners (%)</th>
<th>None of the statements offered</th>
<th>Own meaning preferred</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>13 (41%)</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>b</td>
<td>15 (47%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c</td>
<td>0 (0%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d</td>
<td>7 (22%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Own meanings:

The following 4 categories of knowledge emerged:

(1) Knowledge is facts and information

'Sum of information which is known by an individual'.
'The sum of what is known to mankind'.
'The total of what is known, through experience or association'.
'The capacity of one's brain to seek and contain information'.
'Information learnt - includes formal and informal learning experience'.
'Data, facts, information'.

(2) Knowledge is related to beliefs and experience

'Knowledge is the body of beliefs held as a result of previous experience,.....knowledge is gained as the result of learning experiences both theoretical and practical'.

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'A set of beliefs, developed over time and held by more than one person'.

'I believe that knowledge is gained by experience, having theoretical and practical understanding, being well informed and at an individual person's level; "a range of information". It is not an opinion'.

(3) Knowledge is related to theory, research and opinion

'A body of theories based on research and a consensus of established opinion'.

(4) Knowledge is subjective

'"Knowledge" is a subjective term which cannot be accurately quantified or defined'.

(2) Managers:

<table>
<thead>
<tr>
<th>Statements offered</th>
<th>Number of practitioners (%)</th>
<th>None of the statements offered</th>
<th>Own meaning preferred</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>3 (33%)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>b</td>
<td>3 (33%)</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>c</td>
<td>0 (0%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d</td>
<td>5 (55%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Own meanings:

The following 2 categories of knowledge emerged:-

(1) Knowledge is facts

'Facts, concepts, ideas (etc.) which either arise theoretically and are applied to nursing (or life in general) or which are generated from practice (or life in general) from which theory is generated.[I also like Carper's four patterns of knowing as a way of classifying knowledge]'.

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(2) Knowledge as intuition

‘Practical knowledge/intuition (perceptual awareness) / know how.’

(3) Student nurses:

<table>
<thead>
<tr>
<th>Statements offered</th>
<th>Number of practitioners (%)</th>
<th>None of the statements offered</th>
<th>Own meaning preferred</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>9 (47%)</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>b</td>
<td>1 (5%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c</td>
<td>0 (0%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d</td>
<td>4 (21%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Own meanings:

The following 3 categories of knowledge emerged:-

(1) Knowledge is facts and information.

‘An organised body of information. To be knowledgeable of all kinds of information’.

‘Knowledge is a collection of facts’.

‘Facts that we acquire to increase our beliefs in a particular topic/subject’.

‘Knowledge is information gained through systematic research/study. However, it can be affected by culture, class, gender, intuition etc., (Very difficult to define !!)’.

(2) Knowledge is belief and experience.

‘Knowledge is a justified true belief based on scientific proof’.

‘Knowledge is something learnt from education or from practice that is justified. It is something learnt through time and is what one believes in’.

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'Knowledge is the state reached by a variety of routes:
- by reading i.e. theoretical
- by experience through practice
- by intuition
- by common sense'

(3) Knowledge is learning through observation and research.

'Knowledge is a result of learning through observation and research and ending in a change of behaviour'.

4) Lecturers:

<table>
<thead>
<tr>
<th>Statements offered</th>
<th>Number of practitioners (%)</th>
<th>None of the statements offered</th>
<th>Own meaning preferred</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>18</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>b</td>
<td>11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d</td>
<td>16</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Own meanings:

The following 3 categories of knowledge emerged:-

(1) Knowledge is fact and understanding.

'Something that can be taught and learnt and provide understanding'.

'Understanding of subjects/objects - everyday life and the application of that understanding to the individual's world. Context can be global or specific'.

'An understanding based on fact'.
Knowledge is based on fact, it usually should increase with professional development. It is influenced by experience and changes throughout life. It is something that can be lost or gained.

Don't know. Difficult to define because of its multifaceted nature. Best guess "All that is known and understood at this time"!

Understanding, comprehension, wisdom.

(2) Knowledge is belief and experience.

It is almost a combination of all the above as knowledge (right or wrong), comes from a variety of sources and can be derived from beliefs, opinions, institutions, groups of professionals, experience.

The use of the terms 'belief' and 'truth' are problematical, though knowledge must contain elements of these. I take a more epistemological approach....i.e. it is derived from experience and evidence.

One's own interpretation of one's own experience. Acquiring new information through research.

A justified belief.

(3) Knowledge is awareness.

Current awareness based on evidence.

Question 2:

The following tables give details of the frequency of the type of knowledge identified by each of the 4 groups of nurse practitioner:
(1) Qualified practitioners:

<table>
<thead>
<tr>
<th>Type of knowledge identified</th>
<th>Number of practitioners (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practical</td>
<td>12 (37%)</td>
</tr>
<tr>
<td>Experiential</td>
<td>12 (37%)</td>
</tr>
<tr>
<td>Research-based</td>
<td>9 (28%)</td>
</tr>
<tr>
<td>Reading books</td>
<td>4 (12%)</td>
</tr>
<tr>
<td>Lectures</td>
<td>4 (12%)</td>
</tr>
<tr>
<td>The Establishment</td>
<td>5 (16%)</td>
</tr>
<tr>
<td>Nursing</td>
<td>5 (16%)</td>
</tr>
<tr>
<td>Skill-based</td>
<td>4 (12%)</td>
</tr>
<tr>
<td>Courses</td>
<td>3 (9%)</td>
</tr>
<tr>
<td>Theoretical</td>
<td>3 (9%)</td>
</tr>
<tr>
<td>Medical</td>
<td>3 (9%)</td>
</tr>
<tr>
<td>Educational</td>
<td>3 (9%)</td>
</tr>
<tr>
<td>General</td>
<td>3 (9%)</td>
</tr>
<tr>
<td>Common sense</td>
<td>3 (9%)</td>
</tr>
<tr>
<td>Management</td>
<td>3 (9%)</td>
</tr>
<tr>
<td>Information</td>
<td>3 (9%)</td>
</tr>
<tr>
<td>Reflective practice</td>
<td>2 (6%)</td>
</tr>
<tr>
<td>Scientific</td>
<td>2 (6%)</td>
</tr>
<tr>
<td>Anecdotal</td>
<td>2 (6%)</td>
</tr>
<tr>
<td>Political</td>
<td>1 (3%)</td>
</tr>
<tr>
<td>Personal</td>
<td>1 (3%)</td>
</tr>
<tr>
<td>Philosophical</td>
<td>1 (3%)</td>
</tr>
<tr>
<td>Language</td>
<td>1 (3%)</td>
</tr>
</tbody>
</table>

1 respondent cited:  
'Human anatomy, physiology, behaviour, pharmacology'.

1 respondent cited:  
'Models of care - Orem, Lang's 3 system. Cognitive Behavioural Therapy'.
(2) Managers:

<table>
<thead>
<tr>
<th>Type of knowledge identified</th>
<th>Number of practitioners (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research-based</td>
<td>4 (44%)</td>
</tr>
<tr>
<td>Empirical</td>
<td>2 (22%)</td>
</tr>
<tr>
<td>Experience</td>
<td>2 (22%)</td>
</tr>
<tr>
<td>Reflective practice</td>
<td>2 (22%)</td>
</tr>
<tr>
<td>Consensus</td>
<td>2 (22%)</td>
</tr>
<tr>
<td>Personal</td>
<td>2 (22%)</td>
</tr>
<tr>
<td>Ethical</td>
<td>2 (22%)</td>
</tr>
<tr>
<td>Aesthetic</td>
<td>2 (22%)</td>
</tr>
<tr>
<td>Accepted theory</td>
<td>1 (11%)</td>
</tr>
<tr>
<td>Colleagues</td>
<td>1 (11%)</td>
</tr>
<tr>
<td>Clients</td>
<td>1 (11%)</td>
</tr>
<tr>
<td>Managerial</td>
<td>1 (11%)</td>
</tr>
<tr>
<td>Educational</td>
<td>1 (11%)</td>
</tr>
</tbody>
</table>

(3) Student nurses:

<table>
<thead>
<tr>
<th>Type of knowledge identified</th>
<th>Number of practitioners (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experiential</td>
<td>10 (53%)</td>
</tr>
<tr>
<td>Research-based</td>
<td>8 (42%)</td>
</tr>
<tr>
<td>Reading books</td>
<td>8 (42%)</td>
</tr>
<tr>
<td>Practical</td>
<td>5 (26%)</td>
</tr>
<tr>
<td>Intuitive</td>
<td>4 (21%)</td>
</tr>
<tr>
<td>Consensus knowledge</td>
<td>4 (21%)</td>
</tr>
<tr>
<td>Theoretical</td>
<td>3 (16%)</td>
</tr>
<tr>
<td>Scientific</td>
<td>2 (10%)</td>
</tr>
<tr>
<td>Educational</td>
<td>2 (10%)</td>
</tr>
<tr>
<td>Common sense</td>
<td>2 (10%)</td>
</tr>
<tr>
<td>Personal</td>
<td>2 (10%)</td>
</tr>
<tr>
<td>Management knowledge</td>
<td>2 (10%)</td>
</tr>
<tr>
<td>Medical</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>Nursing</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>Professional</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>Reflection</td>
<td>1 (5%)</td>
</tr>
</tbody>
</table>
(4) Lecturers:

<table>
<thead>
<tr>
<th>Type of knowledge identified</th>
<th>Number of practitioners (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establishment knowledge</td>
<td>13 (32%)</td>
</tr>
<tr>
<td>Research-based</td>
<td>11 (27%)</td>
</tr>
<tr>
<td>Experiential</td>
<td>10 (25%)</td>
</tr>
<tr>
<td>Theoretical</td>
<td>8 (20%)</td>
</tr>
<tr>
<td>Professional</td>
<td>6 (15%)</td>
</tr>
<tr>
<td>Knowledge of people</td>
<td>3 (7%)</td>
</tr>
<tr>
<td>Empirical</td>
<td>3 (7%)</td>
</tr>
<tr>
<td>Nursing</td>
<td>3 (7%)</td>
</tr>
<tr>
<td>Practical</td>
<td>3 (7%)</td>
</tr>
<tr>
<td>Philosophical</td>
<td>2 (5%)</td>
</tr>
<tr>
<td>Reflective</td>
<td>2 (5%)</td>
</tr>
<tr>
<td>Medical</td>
<td>2 (5%)</td>
</tr>
<tr>
<td>Intuitive</td>
<td>2 (5%)</td>
</tr>
<tr>
<td>Personal</td>
<td>2 (5%)</td>
</tr>
<tr>
<td>Textbooks</td>
<td>2 (5%)</td>
</tr>
<tr>
<td>Spiritual</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Ethical</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Aesthetic</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Common sense</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>General knowledge</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Knowledge of change</td>
<td>1 (2%)</td>
</tr>
</tbody>
</table>

Question 3:

Section (a)

The following tables indicate the types of knowledge most often used:

(1) Qualified practitioners:

3 respondents did not state which types of knowledge were most often used.
2) Managers:

2 respondents did not state the types of knowledge most often used.

<table>
<thead>
<tr>
<th>Types of knowledge most often used</th>
<th>Number of practitioners (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Empirical</td>
<td>3 (33%)</td>
</tr>
<tr>
<td>Personal</td>
<td>3 (33%)</td>
</tr>
<tr>
<td>Ethical</td>
<td>1 (11%)</td>
</tr>
<tr>
<td>Aesthetic</td>
<td>1 (11%)</td>
</tr>
<tr>
<td>Clinical</td>
<td>1 (11%)</td>
</tr>
<tr>
<td>Professional</td>
<td>1 (11%)</td>
</tr>
<tr>
<td>Experiential</td>
<td>1 (11%)</td>
</tr>
<tr>
<td>Theoretical</td>
<td>1 (11%)</td>
</tr>
</tbody>
</table>

3) Student nurses:

<table>
<thead>
<tr>
<th>Types of knowledge most often used</th>
<th>Number of practitioners (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Factual</td>
<td>10 (53%)</td>
</tr>
<tr>
<td>Practical</td>
<td>10 (53%)</td>
</tr>
<tr>
<td>Experiential</td>
<td>11 (58%)</td>
</tr>
<tr>
<td>Research-based</td>
<td>2 (10%)</td>
</tr>
<tr>
<td>Reflective</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>Common sense</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>Management knowledge</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>Evidence-based</td>
<td>1 (5%)</td>
</tr>
</tbody>
</table>
1 respondent stated that she did not feel that any one type of knowledge was used more or less than the others.

4) Lecturers:

<table>
<thead>
<tr>
<th>Types of knowledge most often used</th>
<th>Number of practitioners (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional</td>
<td>20 (50%)</td>
</tr>
<tr>
<td>Theoretical</td>
<td>20 (50%)</td>
</tr>
<tr>
<td>Educational</td>
<td>20 (50%)</td>
</tr>
<tr>
<td>Experiential</td>
<td>20 (50%)</td>
</tr>
<tr>
<td>Research-based</td>
<td>9 (22%)</td>
</tr>
<tr>
<td>Establishment knowledge</td>
<td>3 (7%)</td>
</tr>
<tr>
<td>Recognition</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Interpersonal</td>
<td>2 (5%)</td>
</tr>
<tr>
<td>Medical</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Reflective</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Sociological</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Semantic</td>
<td>1 (2%)</td>
</tr>
</tbody>
</table>

Question 3:

Section (b)

The following tables indicate the types of knowledge least often used:

(1) Qualified practitioners:

<table>
<thead>
<tr>
<th>Types of knowledge least often used</th>
<th>Number of practitioners (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional</td>
<td>5 (16%)</td>
</tr>
<tr>
<td>Experiential</td>
<td>5 (16%)</td>
</tr>
<tr>
<td>Knowledge from peers</td>
<td>5 (16%)</td>
</tr>
<tr>
<td>Research-based</td>
<td>2 (6%)</td>
</tr>
<tr>
<td>Common sense</td>
<td>2 (6%)</td>
</tr>
<tr>
<td>Practical</td>
<td>2 (6%)</td>
</tr>
<tr>
<td>Philosophical</td>
<td>1 (3%)</td>
</tr>
<tr>
<td>General</td>
<td>1 (3%)</td>
</tr>
<tr>
<td>Political</td>
<td>1 (3%)</td>
</tr>
<tr>
<td>Pharmacological</td>
<td>1 (3%)</td>
</tr>
<tr>
<td>Theoretical</td>
<td>1 (3%)</td>
</tr>
</tbody>
</table>
Some respondents also gave reasons for the type of knowledge least often used:

The following are some of the reasons given:

1. **Knowledge from peers**
   "because I am very sceptical of other people's 'knowledge' if I don't personally know them".

2. **Research-based knowledge**
   "because there were no resources available on site and because of motivating staff to change their practices and time factor".

(2) **Managers:**

4 respondents did not state the type of knowledge least often used.

<table>
<thead>
<tr>
<th>Types of knowledge least often used</th>
<th>Number of practitioners (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research-based</td>
<td>2 (22%)</td>
</tr>
<tr>
<td>Aesthetic</td>
<td>1 (11%)</td>
</tr>
<tr>
<td>Management knowledge</td>
<td>1 (11%)</td>
</tr>
<tr>
<td>Justified true beliefs</td>
<td>1 (11%)</td>
</tr>
</tbody>
</table>

Some of the reasons given:

1. **Research-based:**
   "because I'm not always up to date with the latest research."

2. **Aesthetic:**
   "because I don't take as much time for people as I feel I'd like."

3. **Managerial:**
   "because of my change of role into education."
4. Justified true belief:
"Have learned the hard way here! Very difficult to say what is "the truth".

(3) Student nurses:

4 respondents stated that they used all types of knowledge equally.

<table>
<thead>
<tr>
<th>Types of knowledge least often used</th>
<th>Number of practitioners (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research-based</td>
<td>3 (16%)</td>
</tr>
<tr>
<td>Scientific</td>
<td>3 (16%)</td>
</tr>
<tr>
<td>Intuitive</td>
<td>2 (10%)</td>
</tr>
<tr>
<td>Theoretical</td>
<td>3 (16%)</td>
</tr>
<tr>
<td>Establishment knowledge</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>Management knowledge</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>Professional</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>Traditional</td>
<td>1 (5%)</td>
</tr>
</tbody>
</table>

Some of the reasons given:

1. Research-based:

"...which can be difficult to introduce without strong commitment and determination....Also, good relevant research is difficult to identify without the appropriate education. However, this is improving."

2. Intuitive:

"Probably as a student nurse I rely on 'intuitive' knowledge least - I don't believe I yet have the experience to rely on my own intuition".

"Although I do get a 'feeling' about something -must be able to justify...."
3. Scientific:

No reasons were given.

4. Theoretical:
   "...because generally too rigid for day to day use and difficult to remember".

5. Establishment knowledge:
   "As such, traditional modes of nursing practice are rapidly becoming a thing of the past (thank goodness)"

6. Management knowledge:
   "used too often...it smacks of dishonesty."

7. Professional:
   "I have not reached that stage in my training - I do not have the experience."

8. Traditional:
   "This type of knowledge relies on ritualistic practices and does not allow for questioning and justification of why things are done a certain way."

(4) Lecturers:

12 respondents did not answer this question and no reasons were given.
<table>
<thead>
<tr>
<th>Types of knowledge least often used</th>
<th>Number of practitioners (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research-based</td>
<td>4 (10%)</td>
</tr>
<tr>
<td>Establishment knowledge</td>
<td>4 (10%)</td>
</tr>
<tr>
<td>Justified true beliefs</td>
<td>3 (7%)</td>
</tr>
<tr>
<td>Intuitive</td>
<td>2 (5%)</td>
</tr>
<tr>
<td>Experiential</td>
<td>3 (7%)</td>
</tr>
<tr>
<td>Consensus of opinion</td>
<td>2 (5%)</td>
</tr>
<tr>
<td>Traditional</td>
<td>2 (5%)</td>
</tr>
<tr>
<td>General knowledge</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Professional</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Ethical</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Practical</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Economic</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Information</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Empirical</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Students' knowledge</td>
<td>1 (2%)</td>
</tr>
</tbody>
</table>

Some of the reasons given:

1. Research-based knowledge:

"These may not always be accepted by our colleagues and managers and thus no support."

"...because it has to do with change and adaptation."

2. Establishment knowledge:

"It is often hidden and difficult to draw out as a particular form of knowledge from, for example, experience, opinion, consensus."

"....may not be your own views or you may not agree."

"The power of the establishment over even the most informed and assertive practitioner cannot be overstated."
3. Justified true beliefs:

"...because this knowledge is only really applicable to teaching facts eg. in physiology - and I no longer really teach such subjects -however, it does come in when I speak to groups about facts eg. the history of philosophy."

"If there is not consensus with the organization, (it is) very difficult to 'fight' on one's own."

4. Intuitive:

"The rationality model rules in this domain."

5. Experiential:

"... For me this has value, but we cannot put the clock back. Situations are now."

"I have not had sufficient experience to base practice on experience."

6. Consensus of opinion:

"My role does not promote consensus decision-making."

7. Traditional:

"No rationale behind practice -sometimes effective, sometimes not.... e.g. cabbage leaves for engorged breasts."

8. General knowledge:

"Need to use other types more frequently due to my role."

9. Professional:

"I don't feel I have enough professional knowledge."

10. Ethical:

"...value judgements not needed all of the time."

11. Economic:

"I find it boring."
Question 4:

(1) Qualified practitioners:

<table>
<thead>
<tr>
<th>Statements offered</th>
<th>Number of practitioners (%)</th>
<th>None of the statements offered</th>
<th>Own meaning preferred</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>17 (53%)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>b</td>
<td>25 (78%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c</td>
<td>22 (69%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d</td>
<td>21 (66%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The one respondent who preferred to state their own meaning said:

"Nursing knowledge I feel represents, on the whole, outdated matriarchal beliefs about practice based on tradition and fallacies rather than anything more plausible."

(2) Managers:

<table>
<thead>
<tr>
<th>Statements offered</th>
<th>Number of practitioners (%)</th>
<th>None of the statements offered</th>
<th>Own meaning preferred</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>2 (22%)</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>b</td>
<td>7 (78%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c</td>
<td>6 (67%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d</td>
<td>4 (44%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(3) Student nurses:

<table>
<thead>
<tr>
<th>Statements offered</th>
<th>Number of practitioners (%)</th>
<th>None of the statements offered</th>
<th>Own meaning preferred</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>6</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>b</td>
<td>17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c</td>
<td>13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d</td>
<td>11</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The one respondent who preferred their own meaning said:

"A body of scientific knowledge which can be put into practice with knowledge of what it does and affects."
4) Lecturers:

<table>
<thead>
<tr>
<th>Statements offered</th>
<th>Number of practitioners (%)</th>
<th>None of the statements offered</th>
<th>Own meaning preferred</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>20 (50%)</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>b</td>
<td>29 (72%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c</td>
<td>29 (72%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d</td>
<td>24 (60%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The following are the preferred meanings given by the 3 respondents:

"Knowledge about the role of the nurses, nursing practice and research. It is influenced by beliefs and experience."

"Nursing knowledge is the state of information, ideas, research, theory and discussion that is currently occurring and forming practice, management, policy, professional statements and it is not static but continues to grow and become more defined over time."

"Knowledge gained through the experience of nursing practice and theoretical scientific knowledge."

Question 5:

(1) Qualified practitioners:

<table>
<thead>
<tr>
<th>Statements offered</th>
<th>Number of practitioners (%)</th>
<th>None of the statements offered</th>
<th>Own meaning preferred</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>0 (0%)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>b</td>
<td>31 (97%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c</td>
<td>1 (3%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d</td>
<td>13 (41%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The one respondent who preferred their own meaning said it was:

"when you take a group of clients on and a “tool” eg. Incontinence pads and measure and document findings thus coming to a documented proof."
(2) Managers:

<table>
<thead>
<tr>
<th>Statements offered</th>
<th>Number of practitioners (%)</th>
<th>None of the statements offered</th>
<th>Own meaning preferred</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>0 (0%)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>b</td>
<td>9 (100%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c</td>
<td>0 (0%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d</td>
<td>6 (67%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(3) Student nurses:

<table>
<thead>
<tr>
<th>Statements offered</th>
<th>Number of practitioners (%)</th>
<th>None of the statements offered</th>
<th>Own meaning preferred</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>0 (0%)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>b</td>
<td>18 (95%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c</td>
<td>0 (0%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d</td>
<td>7 (37%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(4) Lecturers:

<table>
<thead>
<tr>
<th>Statements offered</th>
<th>Number of practitioners (%)</th>
<th>None of the statements offered</th>
<th>Own meaning preferred</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>0 (0%)</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>b</td>
<td>37 (92%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c</td>
<td>5 (12%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d</td>
<td>18 (45%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The one respondent who preferred to give their own meaning said:

"Knowledge gained through systematic enquiry coupled with the ability to reflect on practice."

Question 6:

The following tables indicate the extent to which the respondents perceived the use of research knowledge in practice:
(1) Qualified practitioners:

4 did not answer this question. No reasons were given.

<table>
<thead>
<tr>
<th>The extent to which research-based knowledge is used in practice</th>
<th>Number of practitioners (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>To a great extent</td>
<td>6 (19%)</td>
</tr>
<tr>
<td>To a limited extent</td>
<td>15 (47%)</td>
</tr>
</tbody>
</table>

The following are a sample of the comments made in relation to this question:

"90% of the time."

"To a very great extent. Gives appropriate direction."

"80% used in practice....."

"In my everyday work in NDU to maintain the required standardised outcome."

"Frequently."

"To quite a limited degree- new changes take a long time to filter through but some of the old practices have been changed through knowledge."

"...A great deal of nursing practice is still based on what "works best" in a certain situation. This, however, is not bad practice as changes and adaptations to skills, techniques, procedures etc., are made in the light of 'new information' or experiences but more often this is anecdotal rather than researched."

"-less than we would like to think. Although many of us know the outcomes of a few pieces of nursing research, these are not often applied because either they do not seem relevant or would be difficult to apply or we habitually do things in a different way or hold different beliefs. I think perhaps we are creatures of habit."

7 respondents did not necessarily indicate the extent, but made their own comments. A sample is given below:

"Used when relevant to clinical area. Time factor prevents nurses undertaking research."
“Research-based knowledge is used by medical/nursing staff who have attended various lectures/study days based on knowledge from research.”

“I believe that as more and more practitioners are going through further education programmes, research is being slowly incorporated into practice.”

(2) Managers:

<table>
<thead>
<tr>
<th>The extent to which research-based knowledge is used in practice</th>
<th>Number of practitioners (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>To some extent</td>
<td>4 (44%)</td>
</tr>
<tr>
<td>Not often</td>
<td>2 (22%)</td>
</tr>
</tbody>
</table>

The following are a sample of the comments made in relation to this question:

“...often the research-based knowledge does not reflect the knowledge needed in the swamps!“

“Particularly in the area of wound care because the nursing press has a plentiful supply of research. Some practice is not always research based by the literature, but has a measured rationale.”

“As much as possible in each given field of nursing but reflective nursing knowledge is possibly used more on percentage by 30%.”

“At this time I think research-based knowledge is only used by nurses who are on courses and have access to information. However, I feel the hospital is making every effort to increase nurses’ knowledge on research-based practice.”

“I think that nurses are not able to keep up with all available research. Therefore, it is incorporated haphazardly and generally only by those exposed to it i.e. study days etc.,“
"More so than before but still a battle. Some students become change agents and their questioning encourages practitioners to practise more on evidence than before."

(3) Student nurses:

<table>
<thead>
<tr>
<th>The extent to which research-based knowledge is used in practice</th>
<th>Number of practitioners (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>To a reasonable extent</td>
<td>4 (21%)</td>
</tr>
<tr>
<td>To a limited extent</td>
<td>10 (53%)</td>
</tr>
</tbody>
</table>

The following are a sample of the comments made in relation to this question:

"In some clinical placements I think research-based knowledge is used up to 75% of the time."

"Generally - on a nation wide basis. It is increasingly used more and more in recent years (past 5 or so). But it depends on ward/placement. On current placement - approximately 50-60%.

"It is used for drugs, dressings, mattresses etc., but nursing behaviour i.e. approaches to patients etc., are slow to catch on."

"More so now than in the past, but nursing is still a very "traditional" setting. Many nurses do not respond well to change and this reflects on research-based knowledge."

(4) Lecturers:

<table>
<thead>
<tr>
<th>The extent to which research-based knowledge is used in practice</th>
<th>Number of practitioners (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>To a reasonable extent</td>
<td>12 (30%)</td>
</tr>
<tr>
<td>To a limited extent</td>
<td>19 (47%)</td>
</tr>
</tbody>
</table>

The following are a sample of the comments made in relation to this question:
“Only where there is policy change.”

“Sometimes used i.e. dressings.”

“With policy to measure performance, accountability, standard setting, application of reflective practice, every aspect of care is geared towards providing rationale for practice and hence the way forward is research-based knowledge.”

Question 7:

(1) Qualified practitioners:

<table>
<thead>
<tr>
<th>Whether the application of research-based knowledge to practice presented difficulties</th>
<th>Number of practitioners (%)</th>
<th>Difficulties identified</th>
<th>Number of practitioners (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO</td>
<td>13 (41%)</td>
<td>Lack of knowledge</td>
<td>6 (19%)</td>
</tr>
<tr>
<td>YES</td>
<td>19 (59%)</td>
<td>Difficulty in changing</td>
<td>8 (25%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Adhering to ritualistic practice</td>
<td>4 (12%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Financial cost</td>
<td>3 (9%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Little support from managers</td>
<td>2 (6%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lack of staff</td>
<td>2 (6%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Conflict with policy</td>
<td>2 (6%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medical domination</td>
<td>2 (6%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lack of confidence</td>
<td>2 (6%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lack of interest</td>
<td>2 (6%)</td>
</tr>
</tbody>
</table>
(2) Managers:

<table>
<thead>
<tr>
<th>Whether the application of research-based knowledge to practice presented difficulties</th>
<th>Number of practitioners (%)</th>
<th>Difficulties identified</th>
<th>Number of practitioners (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO</td>
<td>4 (44%)</td>
<td>Applying educational research to teaching and learning</td>
<td>1 (11%)</td>
</tr>
<tr>
<td>YES</td>
<td>5 (55%)</td>
<td>Lack of time to study research</td>
<td>2 (22%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lack of resources to implement it</td>
<td>1 (11%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Making frequent changes</td>
<td>1 (11%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Changing established beliefs</td>
<td>1 (11%)</td>
</tr>
</tbody>
</table>

3) Student nurses:

<table>
<thead>
<tr>
<th>Whether the application of research-based knowledge to practice presented difficulties</th>
<th>Number of practitioners (%)</th>
<th>Difficulties identified</th>
<th>Number of practitioners (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO</td>
<td>10 (53%)</td>
<td>Resistance to change</td>
<td>4 (21%)</td>
</tr>
<tr>
<td>YES</td>
<td>9 (47%)</td>
<td>Medical dominance</td>
<td>3 (16%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Time-consuming</td>
<td>1 (5%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Staff ratios</td>
<td>1 (5%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lack of resources</td>
<td>1 (5%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Role conflict</td>
<td>1 (5%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Scepticism</td>
<td>1 (5%)</td>
</tr>
</tbody>
</table>
(4) Lecturers:

<table>
<thead>
<tr>
<th>Whether the application of research-based knowledge to practice presented difficulties</th>
<th>Number of practitioners (%)</th>
<th>Difficulties identified</th>
<th>Number of practitioners (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO</td>
<td>21 (66%)</td>
<td>Tradition</td>
<td>5 (12%)</td>
</tr>
<tr>
<td>YES</td>
<td>19 (59%)</td>
<td>Change</td>
<td>3 (7%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lack of resources</td>
<td>3 (7%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lack of staff</td>
<td>3 (7%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lack of staff</td>
<td>2 (5%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Time constraints</td>
<td>2 (5%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Clinical links</td>
<td>2 (5%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reluctance to evaluate research-based knowledge</td>
<td>2 (5%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No guidelines to apply research knowledge</td>
<td>2 (5%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Unawareness of research findings</td>
<td>1 (2%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Opposition from other health professionals</td>
<td>2 (5%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Keeping up to date</td>
<td>1 (2%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lack of reading time</td>
<td>1 (2%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Constraint by social infrastructures</td>
<td>1 (2%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lack of follow-up replication and validation</td>
<td>1 (2%)</td>
</tr>
</tbody>
</table>

Question 8:
The following tables indicate the extent to which the respondents agreed with the meaning of the term ‘professional’:
(1) Qualified practitioners:

<table>
<thead>
<tr>
<th>Statements offered</th>
<th>Number of practitioners (%)</th>
<th>None of the statements offered</th>
<th>Own meaning preferred</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>6 (19%)</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>b</td>
<td>1 (3%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c</td>
<td>18 (56%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d</td>
<td>4 (12%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The following are a sample of the respondents' own meanings:

'Someone with sufficient skill in an occupation.'

'A person who has achieved a level of qualification/competence that can be tested and proved in the particular profession and has kept up to date with developments within the profession.'

'"Professional" is a term, I feel, which is only used by people to impose their own beliefs as to their perceived self-importance. It is an ego mechanism.'

'One who has trained for that type of work and passed an examination set for that type of work by an examining body.'

(2) Managers:

<table>
<thead>
<tr>
<th>Statements offered</th>
<th>Number of practitioners (%)</th>
<th>None of the statements offered</th>
<th>Own meaning preferred</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>1 (11%)</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>b</td>
<td>0 (0%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c</td>
<td>5 (55%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d</td>
<td>1 (11%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The following are a sample of the respondents' own meanings:

'A professional is a person who makes informed decisions/judgements, can justify those decisions/judgements and can articulate that justification.'

'Professional is a term given to someone who has studied a given subject and is an expert. Pay is not necessarily part of it.'
'I think the term professional means to be able to practise as an experienced practitioner and with autonomy within the guidelines set by the “governing bodies”.'

(3) Student nurses:

<table>
<thead>
<tr>
<th>Statements offered</th>
<th>Number of practitioners (%)</th>
<th>None of the statements offered</th>
<th>Own meaning preferred</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>0 (0%)</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>b</td>
<td>0 (0%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c</td>
<td>10(53%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d</td>
<td>0 (0%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The following are a sample of the respondents' own meanings:

'A professional is someone with a body of knowledge based on research who puts his/her clients first, who shares his/her knowledge with others and is regulated by a code of ethics.'

'A person who, having trained for several years, has expertise in providing a service in a particular field - who regularly updates his/her skills and conforms to a “high standard” code of conduct and is autonomous in practice - although well capable of being part of a multidisciplinary team framework.'

'Professional - working with a supportive, caring, respectful manner, practice based on evidence. Able to promote choice and control for those s/he is caring for.'

'Have pride in your work.
Have a mature outlook.
Abide by the Professional Code of Conduct.'
4) Lecturers:

<table>
<thead>
<tr>
<th>Statements offered</th>
<th>Number of practitioners (%)</th>
<th>None of the statements offered</th>
<th>Own meaning preferred</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>10 (25%)</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>b</td>
<td>2 (5%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c</td>
<td>23 (57%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d</td>
<td>4 (10%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The following are a sample of the respondents' own meanings:

'.....indicates a person who belongs to a defined career group who have respect and status because the group audits, evaluates and confers membership to courses, and people, so that a quality of service is obtained and maintained. It needs to be self-regulating with defined characteristics for entry.'

'The term 'professional' also encompasses not only expert knowledge, but also a set of values which places the client in a relationship with the professional which should be above the importance of money, power, status - but based on altruism, high standards, not doing harm.'

'“Professional” is a term which applies to members of particular professions i.e. law, medicine and which is generally misused to include footballers, accountants, nurses and anyone who works hard and conscientiously.'

'A person who joins with others who have similar expertise in a particular field which is need by the public. It has its own knowledge, criteria for joining eg. exams. A professional can expect to get a good wage from selling his/her services and expertise.'

Question 9:

The following tables indicate whether the respondents perceived nurses as professional practitioners:
(1) Qualified practitioners:

<table>
<thead>
<tr>
<th>Is it appropriate to state that nurses are professional practitioners</th>
<th>Number of practitioners (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>24 (75%)</td>
</tr>
<tr>
<td>NO</td>
<td>8 (25%)</td>
</tr>
</tbody>
</table>

5 respondents gave reasons for stating ‘YES’.

'They undertake 3 years of training and develop further - through specialised courses. They are professionally accountable for their actions - therefore are responsible professional practitioners.'

'Although in reality most are not. CNS's (Community Nursing Sisters) in the true sense of the term are indeed professionals with autonomy and specialist knowledge. However, it's also possible for all (professional practitioners) registered nurses to function at this level regardless of grade.'

'Nurses are able to recognise problems in patients because of the knowledge they have. Health Care Assistants are able to do 'observations', but do not have the knowledge to interpret them or to recognise early warning signs.'

'Gone through training. Code of practice. Continuous development.'

'They have the knowledge, skills and expertise which are mostly research-based. The professional has its ethical and legal constraints within which they practise.'

5 respondents gave reasons for stating ‘NO’.

'The "so called" body of knowledge and skilled practice has been given to other grades eg. nursing auxiliaries. I do not believe it is possible for a profession to discard its original function and take on the work of another profession and expect to remain a profession.'
'Nurses are 'practitioners' who would like to be perceived as a 'professional' for their own ego. The term 'professional practitioner' is a divisive phrase which is deflecting many nurses away from their true status.'

'Most nurses still experience an apprenticeship type training. We have no body of knowledge that is our own.'

'At present, I believe that nurses are not seen as professionals by the public and this lack of social status is important. Nurses are still not implementing research and other 'good practice' to improve patient care - this is important if we are to be seen as professionals.'

'There are too many constraints within which we practice - UKCC, District or Trust policy, following doctors' 'wishes'.'

(2) Managers:

<table>
<thead>
<tr>
<th>Is it appropriate to state that nurse are professional practitioners</th>
<th>Number of practitioners (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>5 (55%)</td>
</tr>
<tr>
<td>NO</td>
<td>4 (44%)</td>
</tr>
</tbody>
</table>

3 respondents gave reasons for stating 'YES'.

'Paid to use expertise and keep learning. Willing to make changes to practice depending on knowledge gained. Thought and pride in what is done.'

'Yes, because they do fulfil the criteria for professionalism.'

'Nurses are trained people who have varied amounts of expertise and knowledge dependent on experience. They have often extended their roles by taking on added competency-based practice. They deserve to be called 'professional practitioners'.'
2 respondents gave reasons for stating ‘NO’.

‘My experience tells me that few nurses can behave as professionals.’

‘Semi-professional - do not take enough high decisions.’

(3) Student nurses:

<table>
<thead>
<tr>
<th>Is it appropriate to state that nurses are professional practitioners</th>
<th>Number of practitioners (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>15 (79%)</td>
</tr>
<tr>
<td>NO</td>
<td>4 (21%)</td>
</tr>
</tbody>
</table>

6 respondents gave reasons for stating ‘YES’.

‘All qualified nurses have to abide by a code of conduct and have certain duties to adhere to. Also have a duty to keep educated. Although staff nurses are not paid a professional wage !!!’

‘In the ideal world nursing practice is supposed to be based on research and has the UKCC Code of Conduct. Teaches students.’

‘Whilst the debate regarding professionalism continues to rage I believe we have to be seen as part of the “ professions “, otherwise we will be set back 100 years in relation to status etc.,’

‘It is a distinct health care profession which is necessary in virtually all spheres of health care needs/services. Along with the advance of nursing knowledge, nurses are becoming increasingly autonomous and adhering to a Code of Conduct.’

‘Nurse education has moved into universities and nurses continue to strive to increase their body of knowledge and base their clinical practice on research findings and to initiate research.’
'We are regulated by the UKCC which lays down our Code of Conduct and calls us to account for our actions. We have a long history which leads us from the image of the handmaiden to the highly skilled professionals we are today.'

2 respondents gave reasons for stating 'NO'.

'At present they do not have a 'job description' and on the whole do the jobs/tasks that others do not want to do.'

'I don't think nursing has received 'true' professional status as yet. However, I believe many nurses practise in a professional manner.'

(4) Lecturers:

<table>
<thead>
<tr>
<th>Is it appropriate to state that nurses are professional practitioners</th>
<th>Number of practitioners (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>15 (37%)</td>
</tr>
<tr>
<td>NO</td>
<td>25 (62%)</td>
</tr>
</tbody>
</table>

6 respondents gave reasons for stating 'YES'.

'It puts them above a health care assistant. Implies a body of knowledge behind their actions/decisions.'

'Nurses have their own knowledge base/
Nurses have their own research base.
Skills and techniques specific to nursing, own Code of Conduct and professional body and nurses are autonomous practitioners.'

'Nurses, like the professionals, go to college for 3/4 years, learn special skills for that profession and so have training for a particular job. As such we should be recognised as professional people, but, of course, we're not -maybe because of our pay - the higher your wage, the more status you seem to have - lawyers, for example, are highly regarded and earn a fortune. Nurses will never be seen as a true profession as long as we continue to be treated like skivvies and doctors' handmaidens.'
On the basis of accountability issues and the development/growth of the profession in relation to research-based knowledge for practice.

Nurses spend 3 years and more learning their knowledge which then becomes a skill. Also, nurses are guided by a Code of Professional Conduct and Practice.

They use a body of knowledge. Have now become more orientated to using research-based knowledge. Skilled practitioners.

7 respondents gave reasons for stating 'NO'.

Nursing is an occupation, not a profession. Nurses generally have little autonomy, are poorly paid and nursing is not considered by society as a status job. However, we can be described as 'professional' if this term is used loosely to describe those who work conscientiously.

Not all nurses are. There is still a resentment in accepting change or updating personal knowledge.

We are not an independent body.

Majority of nurses do not demonstrate facets of professionalism i.e. research knowledge base to practice, expertise, control of practice, autonomy, accountability.

We won't ever be recognised as a profession unless we get more pay.

Nurses are trying to become professional.

If professional means the way in which they provide the care and skills they offer -YES . However, if nursing is considered a profession - no, due to the hierarchical and political power base that entraps nursing within the NHS.

Question 10:

The following tables indicate whether the respondents think that nurse practitioners should use research-based knowledge in practice:
(1) Qualified practitioners:

<table>
<thead>
<tr>
<th>Should nurse practitioners use research-based knowledge in practice</th>
<th>Number of practitioners (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>32 (100%)</td>
</tr>
<tr>
<td>NO</td>
<td>0 (0%)</td>
</tr>
</tbody>
</table>

Of the reasons given for stating ‘YES’, the following have been selected:

‘In some cases, yes, as it’s proved to work i.e. certain ways of lifting and handling.’

‘The use of research-based knowledge helps us to ensure that our practice is meaningful and effective. It enables us to determine whether our interventions are effective in meeting our goals and are the best use of our resources.’

‘In order to be recognised as a profession all knowledge acquired should have research and theory based. It also reflects the outcome.’

‘The only way to become more knowledgeable and to give better care to clients is by knowing about research and then using it appropriately.’

‘It’s no longer acceptable for nurses to do things because they have always done them like that or ‘Sister likes it done that way!‘. If we wish to be acknowledged as professional practitioners, we must be able to justify ourselves by means of research-based practice and not ‘professional opinion‘.

‘Research proves and justifies the knowledge acquired leading to improvement of standards of practice.’

88
(2) Managers:

<table>
<thead>
<tr>
<th>Should nurse practitioners use research-based knowledge in practice</th>
<th>Number of practitioners (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>9 (100%)</td>
</tr>
<tr>
<td>NO</td>
<td>0 (0%)</td>
</tr>
</tbody>
</table>

Of the reasons given for stating ‘YES’, the following have been selected:

'To dispel myths, old wives' tales etc., still used in nursing practice. Increases measurable outcomes - the intention is to give clients the best care available !!'.

'To strive for autonomy and professionalism nurse practitioners should use research-based knowledge. However, they need to be better equipped to do this.'

'(1) Only if and when the research has been critiqued and judgements made about the suitability for use in their clinical area.
(2) Only when practice demands a rationalistic decision rather than an intuitive, empathic decision.'

'Evidence-based knowledge is important though intuition still has a role when working with individuals.'

(3) Student nurses:

<table>
<thead>
<tr>
<th>Should nurse practitioners use research-based knowledge in practice</th>
<th>Number of practitioners (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>19 (100%)</td>
</tr>
<tr>
<td>NO</td>
<td>0 (0%)</td>
</tr>
</tbody>
</table>

Of the reasons given for stating ‘YES’, the following have been selected:

'When appropriate. Public may feel more confident if aware that methods are from reliable research methods. However, nursing needs a lot of common sense and intuition. e.g. patients' emotions.'
Research provides high standards of care by eliminating bad practice and providing accountability for good practice.'

'Such knowledge is vital for good patient care as well as for the advancement of the nursing profession (and job satisfaction).'</n
'(1) To enhance the care and treatment of their patients.
(2) To understand the level of nursing care given and why appropriate actions/care/treatment are given.
(3) To ensure the care is effective and therapeutic for the patient.'

'To promote their [nurses] position and status.'

'To advance the profession.'

'Because it challenges routine practice and leads to the development of innovative questioning of practice. Nursing needs to develop knowledge based on its own records.'

'Is important to advance the practice of nursing. Nurses using research-based knowledge will be able to justify their actions and improve standards of patient care.'

(4) Lecturers:

<table>
<thead>
<tr>
<th>Should nurse practitioners use research-based knowledge in practice</th>
<th>Number of practitioners (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>40 (100%)</td>
</tr>
<tr>
<td>NO</td>
<td>0 (0%)</td>
</tr>
</tbody>
</table>

Of the reasons given for stating 'YES', the following have been selected:

'Yes - both for professional development and improved patient care.'

'Nurses should be able to justify and rationalise their practice to other caring professions i.e. the medical profession. It should encourage progress.'

'In order to inform practice and develop it.'
'Otherwise, they cannot call themselves professionals.'

'In order to add to the knowledge/care base.
In order to have a rationale for action.
In order to ensure no harm is committed.
In order to give appropriate care.'

'So that harmful practices can be eliminated and practices which can be proven to benefit patients can be used with justification. However,.....there is often a clash between what the research recommends and what the practitioner is able to do given the restraints of time, staffing levels, workloads etc., thereby making the research redundant and in effect a waste of money.'

'Research-based knowledge should be used in practice in order to improve patient care.'

'Would improve/enhance their theoretical and practical understanding, skills and competence.'

'It helps them (nurses) become advocates for their patients.'

'To prove practice is efficient and effective, providing research has been analysed and judged to be valid and reliable.'

Question 11:

The following tables indicate the respondents’ perceptions of the term ‘professional values’:

(1) Qualified practitioners:

<table>
<thead>
<tr>
<th>Statements offered</th>
<th>Number of practitioners (%)</th>
<th>None of the statements offered</th>
<th>Own meaning preferred</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>22 (69%)</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>b</td>
<td>15 (47%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c</td>
<td>11 (34%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d</td>
<td>7 (22%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The following are the respondents' preferred meanings:

'I think statements a - d apply but also believe that ensuring my practice is 'up to date' and based on sound rationale and research (where available) is an important aspect of 'professional' values.'

'The term 'professional values' is irrelevant as the term 'professional' is not a term which is definable. A 'moral' and 'ethical' set of uniform values may be more appropriate in this type of environment.'

(2) Managers:

<table>
<thead>
<tr>
<th>Statements offered</th>
<th>Number of practitioners (%)</th>
<th>None of the statements offered</th>
<th>Own meaning preferred</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>7 (78%)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>b</td>
<td>8 (89%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c</td>
<td>0 (0%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d</td>
<td>0 (0%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The one respondent who gave a preferred meaning said:

'I don't believe there is such a thing as professional values. I believe in moral responsibility as human beings. The same moral responsibility that governs our personal lives should govern our professional lives. Moral responsibility is not behaving how anyone else tells us is right to behave. Moral responsibility is applying our personal value system to our lives and our work, justifying this and articulating it.'

(3) Student nurses:

<table>
<thead>
<tr>
<th>Statements offered</th>
<th>Number of practitioners (%)</th>
<th>None of the statements offered</th>
<th>Own meaning preferred</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>17 (89%)</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>b</td>
<td>9 (47%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c</td>
<td>6 (31%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d</td>
<td>10 (53%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The one respondent who gave a preferred meaning said:

'Professional values can be all of the above combined.'
(4) Lecturers:

<table>
<thead>
<tr>
<th>Statements offered</th>
<th>Number of practitioners (%)</th>
<th>None of the statements offered</th>
<th>Own meaning preferred</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>32 (80%)</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>b</td>
<td>21 (52%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c</td>
<td>12 (30%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d</td>
<td>14 (35%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The 3 respondents who gave their own meanings said:

'I do not believe that in practice you can separate personal from professional values. Therefore, each individual has their own professional values which may be influenced by current debates within nursing, but are not anchored/founded in them.'

'Nursing has become a very subjective occupation. Divisions within nursing are apparently based on the individual differences in that which constitutes nursing.'

'It is all of the above statements - but it is more. It is to do with altruism, and a way of thinking - which encompasses doing no harm to the patient, striving to do one's best.'

Question 12:

The following tables indicate whether respondents think that professional values place constraint on their practice:

(1) Qualified practitioners:

<table>
<thead>
<tr>
<th>Do professional values place constraints on your practice</th>
<th>Number of practitioners (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO</td>
<td>23 (72%)</td>
</tr>
<tr>
<td>YES</td>
<td>9 (28%)</td>
</tr>
</tbody>
</table>

Of those respondents stating 'YES', the following examples of such constraints were given:
'Because in the real world professionalism can demand resources which aren't always available.'

'Time - where quick turnover is all important. Selling health as a commodity when professional values and job requirements clash.'

'Resources (not able to give appropriate care due to resources).'

'Nurses have to act within certain guidelines and constraints which may prevent innovation. There are endless procedures to follow which ensure continuity, yet prevent developing practice.'

(2) Managers:

<table>
<thead>
<tr>
<th>Do professional values place constraints on your practice</th>
<th>Number of practitioners (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO</td>
<td>6 (67%)</td>
</tr>
<tr>
<td>YES</td>
<td>3 (33%)</td>
</tr>
</tbody>
</table>

Of those respondents stating 'YES', the following examples of such constraints were given:

'It ignores personal responsibility for values and moral action. It "passes the buck" onto Codes, the law, management policy etc., and stops us from developing a sense of personal moral responsibility.'

'This becomes a problem in ethical or moral dilemmas when professional opinion may dictate a certain course of action but humane, personal beliefs may suggest otherwise.'

(3) Student nurses:

<table>
<thead>
<tr>
<th>Do professional values place constraints on your practice</th>
<th>Number of practitioners (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO</td>
<td>15 (79%)</td>
</tr>
<tr>
<td>YES</td>
<td>4 (21%)</td>
</tr>
</tbody>
</table>
Of those respondents stating ‘YES’, the following examples of such constraints were given:

‘Ethical dilemmas.’

‘I think that ‘professional values’ may devalue the use of intuition - seeing as this is not scientific or objective.’

‘All the documentation involved takes you away from the side of the patient. Time is a constraint.

‘This may cause conflicts because of the lack of resources at times - due to financial cutbacks.’

(4) Lecturers:

<table>
<thead>
<tr>
<th>Do professional values place constraints on your practice</th>
<th>Number of practitioners (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO</td>
<td>28 (70%)</td>
</tr>
<tr>
<td>YES</td>
<td>12 (30%)</td>
</tr>
</tbody>
</table>

Of those respondents stating ‘YES’, the following are examples of such constraints:

‘It’s called boundaries and they are very important.’

‘E.g. Telling students about the dangers of smoking (Health Education) and yet preferring them to smoke to ease stress rather than turn to other avenues for release.’

‘Conflict between demands of the patient and demands of managers, doctors etc.,’

‘Sometimes there are situations where a preferred response might be compromised by professional values such as when establishing a rapport with a client.’
‘One’s best might conflict with the present ethos in the NHS which might carry efficiency savings too far and affect practice.’

4.8: Conclusion:

This chapter has sought to offer rationale for choosing a content analysis approach as a method for analysing data from the pre-pilot group discussion, pilot questionnaire, and main questionnaire. Firstly, the theoretical underpinnings of the content analysis approach were presented. This discussion was then followed by a brief outline of the overall approach used to analyse the data from the pre-pilot group discussion, and the pilot questionnaire. Subsequently, a complete content analysis of the data from the main questionnaire was provided and the findings were reported. In the next chapter, the discourse analysis approach will be presented and discussed as the means taken to analyse the research findings from the twelve open-ended interviews.
Chapter 5

Data analysis II: A discourse analysis approach

5.1: Introduction:

In this chapter there will be an examination of the discourse analysis approach, chosen as a means of analysing the data from the 12 open-ended interviews. The rationale for choosing this method, and its theoretical underpinnings, will be discussed prior to presenting a practical application of the discourse analysis approach. Discussion of the latter will document how I analysed the data using the broad guidelines given by Potter and Wetherell (1994), and with special reference to the interview stage. I began each of the interviews with the same question, which was essentially inviting the interviewees to talk about themselves as practitioners and their perceived role and knowledge base in the work setting. For the purpose of this chapter, the 3 student nurse interview transcriptions will be taken as the main example of how I analysed the data. It will then be demonstrated how I undertook a comparative analysis of the data with both the qualified practitioner and nurse manager discourses.

5.2: Rationale for choice of approach:

My rationale for choosing a discourse analysis approach was primarily because of its appropriateness as a method for examining practitioners’ perceptions of knowledge in relation to their practice within a social, professional and cognitive context. Thus, I felt that the concept of discourse, particularly as it was interpreted in the definitions given by Gee (1989) and Mitchell (1992), would provide me with a framework for trying to understand the data obtained from the four groups of nurse practitioner in my sample. Each of the groups would be viewed as ‘Discourse’ within the overall ‘Discourse’, which was the nursing profession. It would, therefore, enable me to understand that whatever practitioners were saying (their discourse) would be governed by their roles, values, beliefs, the context and their sense of social and personal identity within that particular ‘Discourse’.
Secondly, discourse analysis was being used as a means of validating the findings from the earlier data collection methods used and of trying to provide some overall validity within the research study itself.

Thirdly, during the study I made an ontological shift from a Newtonian ontology whereby things in space and time are explained by causal relationships, to a discursive ontology which considers people and the stories they tell, and the rules that they follow. Harré & Gillett (1994:29) compare the Newtonian view of reality with that of discourse psychology and identify the main differences in the two ontological approaches (see Figure 1 below).

**Figure 1: The two ontological approaches:**

<table>
<thead>
<tr>
<th>Ontology</th>
<th>Locative Systems</th>
<th>Entities</th>
<th>Relations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newtonian</td>
<td>Space and Time</td>
<td>Things and Events</td>
<td>Causality</td>
</tr>
<tr>
<td>Discursive</td>
<td>Arrays of People</td>
<td>Speech Acts</td>
<td>Rules and Story lines</td>
</tr>
</tbody>
</table>

The emphasis in discourse psychology is on people and what they say, and its meaning can be grasped by the rules they follow and the stories they tell. This approach fits in well with the characteristics of qualitative research. This approach is also appropriate for my own study because it demonstrates that different groups of people will have different views about the same reality. In my study, the reality being looked at is the relationship between knowledge and research-based practice. Thus, this approach can be applied to the four different groups of nurse practitioner to discover what they perceive the reality to be and what they are able to say about it. What is important is that there will be differing views expressed about this reality. This is to be expected because each group of nurse practitioner represents a different stage reached in terms of professional knowledge development and and past experiences of the reality.

### 5.3: Discursive psychology as an ontology:

Harré (1994:36) states that discursive psychology is an ontology in which utterances, interpreted as speech-acts, become the primary entities in which minds become personalised as privatised discourses. This was relevant for
my own analysis as I was viewing nurse practitioners as locations for discourses, both public and private. Harré’s idea of fluid positionings, instead of fixed roles, and the importance of subjectivity were also relevant because they were important contributions which would allow me to understand the diverse and changing rights and obligations which influence and explain nurse practitioners’ behaviour as discursive agents.

5.4: Theoretical underpinnings:

In choosing a discourse analysis approach I was influenced by the work of Rom Harré and Grant Gillett and their theory about the emergence of a new cognitive psychology, a discursive psychology, which they refer to as ‘The Second Cognitive Revolution’; a detailed and comprehensive discussion of this forms the basis of their work ‘The Discursive Mind’ (Harré & Gillett, 1994). They reject the Cartesian view of human beings, which is that there is a distinction between the mind and body and argue that the workings of the mind are accessible and available to us in what we jointly create conversationally (1994:27).

Harré (1994) argues that the mind is a social construction and our concepts arise from our discourse and shape the way we think. The way we conceptualise the mind is a product of the concepts available within our discourse. Discourse is the person and the subject is discursive in that s/he uses symbols whose meaning is a function of their use in discourse. Discourse is private (thought) and public (behaviour) and thinking (individual/private use of symbolic systems) is derived from interpersonal discursive processes. Harré (1994) argues that many psychological phenomena may be interpreted as properties or features of discourse. The production of psychological phenomena such as emotions, decisions, attitudes and personality displays depends upon the individual’s skills, relative moral standing in the community and the story lines that unfold. Importantly, as previously highlighted, the workings of each other’s minds are available to us in what we jointly create conversationally.

There were two issues which had particular significance for the analysis of my own data. Firstly, it was that the structure of discourses was under the control of conventions of right and wrong performances - emotions, attitudes, responsibility. Secondly, both the idea of fluid positionings, instead of fixed roles, and the importance of subjectivity as important contributions to understanding the diverse and changing rights and
obligations which influence and explain our behaviour as discursive agents, became meaningful to me in trying to understand the data. Indeed, nurse practitioners are judged by the professional conventions of right and wrong actions and do at any particular point in time speak and behave according to their position and the context within the Discourse. Having reviewed the theoretical background to using a discourse analysis approach by discussing the role of discourse within the context of discursive psychology, it is now pertinent to examine the approach more specifically.

5.5: The Method:

Potter & Wetherell (1994:160-175) indicate that discourse analysis is neither theory-driven nor method-driven, but that a broad theoretical framework exists concerning the nature of discourse and its role in social life. There are ten stages, which can be said to act as a springboard. These are:- 1) research questions 2) sample selection 3) collections of records and documents 4) interviews 5) transcription 6) coding 7) analysis 8) validation 9) the report 10) application. Before specifically discussing the interview stage, a brief explanation of the other stages will be given to provide an overview of the approach.

5.6: Stages within the approach:

1) Research questions:

Research questions can be many and varied, but importantly, participants’ discourse or social texts are approached in their own right, not just as a secondary route to things ‘beyond ‘the text such as attitudes, events, or cognitive processes. Research questions ask about the way discourse is constructed in relation to its function.

2) Sample selection:

Issues surrounding sample selection and size have been incorporated into the forthcoming discussion of the interview stage (Stage 4) as a separate section.
3) Collection of records and documents:

An important advantage of collecting naturalistic records and documents is the almost complete absence of the researcher’s influence on the data. Potter & Wetherell (1994: 162-163) argue that collecting documents from many sources, recording interactions and combining this with more directive interviewing enables the researcher to build up a much fuller idea of the way the participants’ linguistic practices are organised compared to one source alone. However, this process raises the practical problem of tape recording, since high quality recordings are needed. There is also an ethical problem involving the morality of taking surreptitious recordings.

4) Interviews:

This stage will subsequently be discussed under a separate heading.

5) Transcription:

A good transcript is essential for a discourse analysis since it involves repeated readings of sections of data. The process makes the transcriber read the discourse closely (Potter & Wetherell, 1994:165-166). In relation to the detail of the transcription, some writers stress the importance of the intonational features of discourse (Brazil, 1981; Jefferson, 1985; Kreckel, 1982). However, transcription is a very labour-intensive and time-consuming task and attempting to use a Jeffersonian style of transcription may exceed the resources of the particular research project. In any case, for many research questions, details of timing and intonation are not crucial. Potter & Wetherell (cited in Smith et al., 1995:86) argue that a great deal depends on how the study is oriented in relation to discourse practices and resources. If the focus is on interpretative repertoires and ideological practices, then a reduced transcription scheme may be sufficient, but not if the focus is regularities in discursive practice or the use of a particular device. If the interest is in the latter, it is preferable to do fewer interviews but spend more time on transcribing them.
6) Coding:

Coding serves as a preliminary process to the analysis and the main objective is to use it to organise the data into manageable chunks. The categories used are related very much to the research questions of interest. Initially, the process involves searching through the data for a number of themes. Potter & Wetherell (1994) argue that coding is pragmatic and should be done inclusively. The aim is to produce a body of instances, rather than set limits to that body.

7) Analysis:

This is made up of two closely related phases:-

**Phase 1:**

(1) a search for pattern in the data. This takes the form of variability (differences in either the content or form of accounts) and consistency (the identification of features shared by accounts).

(2) a concern with function and consequence.

**Phase 2:**

This consists of forming hypotheses about these functions and effects and searching for the linguistic evidence. Discourse analysis is based on the argument that people’s talk fulfils many functions and has varying effects.

8) Validation:

This is discussed in a separate section addressing some of the issues related to the overall validation of discourse analysis.
9) The report:

Potter & Wetherell (1994) argue that the final report constitutes part of the confirmation and validation of the discourse analysis approach. The aim is to present the analysis and conclusions in such a way that the reader is able to assess the researcher’s interpretations. A representative set of examples from the area of interest must be included along with a detailed interpretation which links analytic claims to specific parts of the extracts (Potter & Wetherell, 1994:173-174). The extracts are not characterisations or illustrations of the data, but are examples of the data itself.

10) Application:

Miller (1980 cited in Potter & Wetherell, 1994:174) suggests there are various models for the application of discourse analysis, but one possibility is popularisation, in which knowledge is given away as freely as possible. The second possibility is to open up a dialogue with the people who have been researched.

5.7: The interview stage:

Interviews in discourse analysis differ from conventional interviews in three ways. Firstly, variation in response is as important as consistency. Interviews are a very different tool for discourse analysts than for orthodox social researchers (Brenner, 1985; Cannell & Kahn, 1968). However, in a personal communication from Eraut (2001), this point was refuted. The goal of traditional interviews is to obtain or measure consistency in participants’ responses. Consistency is valued because it is taken as evidence of a corresponding set of actions or beliefs. It is argued that if the interview talk is consistent, it must reflect a consistent reality beyond. Consistent discourse demonstrates that the interviewer has found some genuine phenomena and not biased or distorted responses (Potter & Wetherell
Consistency, however, is also important for the discourse analyst, but specifically in relation to being able to identify regular patterns in language use (1994:164). It has been suggested that analyses which identify only the consistent responses are sometimes uninformative in that they fail to provide the full range of accounting resources used by respondents to construct the meaning of their social world and reveal the function of the respondents' construction less clearly (1994:164).

Secondly, techniques which allow diversity rather than eliminate it are emphasised. The idea is that the interview should be a much more interventionist and confrontative arena than is normal. Potter & Wetherell (1994 cited in Smith et al, 1995:84) point out that ideally, the traditional interview's status as a piece of social interaction should be minimal, and having asked clear and unambiguous questions in the correct manner the interviewer's contribution should be of no further interest.

Thirdly, interviewers are seen as active participants rather than like speaking questionnaires. The interview is not viewed as a research instrument for producing an accurate account of an unbiased set of opinions, but is seen as a conversational encounter in which the researcher's questions are just as much a topic for analysis as the interviewee's answers.

Indeed, the researcher's questions are seen as active and constructive, not passive and neutral (Potter & Wetherell, 1994:164-165). Interviews, therefore, are treated as a piece of social interaction in their own right. The interviewer is contributing just as much as the interviewee, and often the interviewer's talk is just as interesting as that of the interviewee. The interviewer's role is not a neutral one and it might be more analytically revealing for the interviewer to express views or even argue with the interviewee (Potter & Wetherell cited in Smith et al, 1995:85).

In relation to sample size, Potter & Wetherell (1994:161) also point out that small samples or a few interviews are generally adequate for investigating an interesting and practically important range of phenomena. For discourse analysts, the success of a study is not in the least dependent on sample size. Indeed, Potter & Wetherell (1994:161) argue that if one is interested in discursive forms, ten interviews might provide as much valid information as several hundred responses to a structured opinion poll. Thus, I felt that twelve interviews had provided me with an adequate sample size and enough data to explore the issues surrounding knowledge, practice and research-based practice.
5.8: Analysing the data:

Before commencing analysis, I also had to give consideration to two other main dimensions, namely, the textual and the contextual. Lupton (1992) argues that the textual accounts for the structure of discourse and contains the micro elements, such as the use of grammar, rhetorical devices, syntax and the overt meaning and content matter of words and sentences of a text or talk. The contextual accounts for the macro structures of discourse such as the topics and themes. This dimension examines the production and reception processes of discourse and the reproduction of ideology and hegemony in such processes. It also examines the links between discourse structures and social interaction and situations. The emphasis is not so much on the 'message' itself, but on the elements and influences in the discourse process as a whole. Thus, I decided to utilise these two dimensions in my analysis to examine the influence of ideology and hegemony on the discourse of each of the four groups of nurse practitioner.

Initially, however, in approaching the analysis of my data, I was looking for and coding instances of consistency, inconsistency, excuses, justification, blaming, and disclaiming. Whilst I felt sure about the difference between instances of consistency and inconsistency, I needed further clarification in relation to what constituted an excuse, a justification and a disclaimer. Potter & Wetherell (1994:75-77) point out that excuses are accounts admitting a relevant act was bad in some way, but which claim that performance was influenced or caused by some external agency. Justifications do not involve the denial of responsibility, but claim that certain actions are, in fact, good, sensible, or, at least, permissible in the circumstances. Disclaimers are pre-accounts which attempt to ward off anticipated negative attributions in advance of an act or a statement.

In examining the data from the four groups of practitioner, it was found that there were just as many instances of consistency as there were inconsistency both within and across the groups. There were also instances of excuses, justification, blaming and disclaiming across the groups.
5.9: The discourse analysis approach applied:

Stage 1: Reading the transcriptions and identifying appropriate data

With reference to my main research questions, I read through the interview transcription data and identified and examined those parts of the text which I deemed appropriate to each of the research question areas being explored.

Stage 2: Devising a coding system

As previously discussed, I was looking for instances of consistency, inconsistency, justification, disclaiming, blaming, and excuses. I therefore devised a coding system in which these instances were categorised alphabetically in the following way. I then made appropriate recordings in the left-hand margin of the transcription on identification of such instances in the text.

The coding key:

(a) = represented instances of consistency.
(b) = represented instances of inconsistency.
(c) = represented instances of justification.
(d) = represented instances of disclaiming.
(e) = represented instances of blaming.
(f) = represented instances of excuses.

Stage 3: Analysing data from the nurse practitioner groups

The interview transcriptions were then taken and analysed separately according to the specific nurse practitioner group. Initially, within each of the four groups, I conducted an individual analysis followed by a comparative analysis of the transcription data.
Stage 4: Taking an example: Student nurse discourse:

The following extracts from the student nurse interview data have been selected to demonstrate how I performed a discourse analysis and how, during the interpretation stage, I related the data overall to the main research questions being asked.

No 1: Student nurse interview (Paula):

Extract 1

Coding:

Paula:

(d) .... I am enjoying it here. I think that there’s always room for improvement. I time the sort of questions that I ask to different staff. I mean I have questioned a few of the things I don’t necessarily agree with, but, and that fits into knowledge....where it comes from....how it is practised....why is it practised...um...I mean, for example, not many people on this ward are on intravenous infusions but the people that are.... I’m constantly amazed....they say, oh it’s running very late and I say, but why?.. you know, when you have facilities like the pump to monitor.... If a bag has got to go in twelve hours...you know...why is it running eight hours late...you know....that’s not good enough... ....a lot of the time you do pick up on things and there’s other things you just take for granted because that’s the way we’ve done it, you know, and you can see that that’s the way it’s done because it’s always been done like that but then I like to say,

(e) well, you know, perhaps there is a better way or another way or what about this, but...um...well, you know, I think it’s about getting on with staff and not upsetting the apple cart too much...
Extract 2

(a) ....it’s building up a rapport with the people you’re working with and using your judgement and how people respond to you and seeing how you get on with people.....I’m very much one to ask questions....and I think it’s the way you ask questions, you know,

(a) you can be very diplomatic about things that you might not necessarily agree with and, you know, have the staff say ‘no... that’s a good point’, or ‘we need new ideas, we need people to be asking things’ and I’ve noticed as well, a lot of the staff have said that when you have students that are asking questions it makes them question their practice and a lot of them as well enjoy teaching....I’ve found people very willing to teach and explain why and often I’ve asked a couple of different staff the same thing just to see whether, you know,... some people have a different way of explaining things and are much better teachers than others. No, I ask lots of questions.

Grouping:

After coding the text, I grouped the instances according to the identified categories.

(a) Consistency:

* I have questioned a few of the things I do not necessarily agree with......and that fits into knowledge....where it comes from...how it is practised....why is it practised.....

* I like to say.... perhaps there is a better way or another way or what about this...

* I think it’s about getting on with staff.....

* it’s building up a rapport with the people you’re working with

* I’m very much one to ask questions...
* it’s the way you ask questions

* when you have students that are asking questions it makes them [the staff] question their practice....

* I ask lots of questions.

(b) Inconsistency

* and there’s other things you just take for granted because that’s the way we’ve done it.....and you can see that that’s the way it’s done because it’s always been done like that......

(c) Justification

* I’ve found people very willing to teach and explain why...

(d) Disclaiming

* I am enjoying it here. I think there’s always room for improvement.

(e) Blaming

* why is it running eight hours late.... you know....that’s not good enough.

Interpretation:

Having grouped the instances according to the identified categories, I then attempted to place an interpretation on some of the patterns which seemed to be emerging in the discourse. Thus, from an examination of the above extracts, it appeared that there was consistency being expressed about the role of questioning to challenge
traditional knowledge. Some ritualistic practice is taken for granted due to the constraint of professional values, but where practice is not deemed to be good enough, because it is based on excuses rather than informed justification, then it needs to be questioned. Equal consistency, however, appeared to be given to the importance of adopting a positive attitude, of building up a rapport with others, and of establishing relationships as a means of being able to ask questions ‘without upsetting the apple cart too much’ and in an attempt to overcome the constraints of professional values on the notion of research-based practice. This idea of having to address professional values and learn how to get on with other staff concurs with the views already expressed by the students in the pre-pilot group discussion. Indeed, it is reflected in similar colloquial syntax such as ‘don’t rock the boat’ and ‘don’t stick your head out’. Furthermore, it concurs with Rom Harre’s notion of learning how to function and how to argue within a discourse as part of the ongoing development of knowledge and of a social and personal identity.

Extract 3

Sue: What about research knowledge? How does that feature in the work on this ward?

Paula:

(a) Um....I think it depends on individual staff to a certain extent, but I do think they’re getting more geared up towards constantly looking at research and seeing how we can improve patient care. I mean, for example, the ...team nursing and the Named Nurse concept. Now that’s only recently been introduced on this ward and ...they say - well, it’s not really working for this, that, and the other reasons and I think that there is a reluctance in introducing new research, but at the same time....I don’t know..... I’ve noticed that the younger, the more recently qualified staff tend to be more keen on reading research and implementing it but.... I don’t think it’s a very dynamic area for research-based practice to be quite honest...um
I don’t know whether that’s because this is Care of the Elderly. I hope it’s not because of that. I think may be it’s because a lot of people have been here quite a long time and they’re more, I’d say traditionally trained and that to do with knowledge.... this is the way we’ve always done it kind of thing, but that comes down from the top.... I’m not naming anybody, but I think that the person that’s in charge can very much...um...set about a dynamic structure for the ward and that doesn’t really happen here.

Extract 4

Paula:

I’ve had one teaching session on this ward and that wasn’t research-based...um...nobody has actually on this ward spoken to us about any recent research....um...but then.....I think it’s as much down to us to be saying, ‘Have you read this or...you know...as I said before there are so many other factors that come into your training....struggling just to get by as it is...um...and I think it’s a shame.... I think it’s as much my fault....I could or should be saying while I’m here ‘Have you read this or what about this, or how can we improve on this and I’ve read such and such that could.....so I don’t think I would point the finger at anyone..... I think it’s everybody and nobody.... ....in the beginning I didn’t really see the importance of it[research] enough but that’s because we weren’t on the wards and only since a lot of clinical practice can I see where it all fits in. You need to be in the clinical setting to really understand the importance of it[research]...and ..research is dynamic....it questions what we’re doing and I don’t think there’s enough importance put on our practice....it[nursing] is a practical-based training.

...part of the role of the nurse is to question her practice and to underpin all nursing practice with research-based knowledge.. and studies that have been done...but from my own experiences I don’t see that being done all the time.....it’s not linked enough to nursing.....I just think that it’s been with us
from the start so as nursing continues to develop I see it becoming more important......

I don’t see research in people’s minds as being linked to nursing.....people think that nursing research is just a sort of follow-on from medical research....that it’s sort of mimicking medical research in nurses’ quest to be considered as a profession.....we’re striving to be a profession therefore we sort of have to do research.... and I...I don’t think it will......I don’t know whether it’s taken seriously by a lot of people. I can’t imagine the general public would associate research with nursing.

Grouping:

(a) Consistency

* I do think they’re getting more geared up towards constantly looking at research and seeing how we can improve patient care.

* You need to be in the clinical setting to really understand the importance of it [research].

* research is dynamic....it questions what we’re doing and I don’t think there’s enough importance put on our practice.. it [nursing] is a practical-based training.

* part of the role of the nurse is to question her practice and to underpin all nursing practice with research-based knowledge

* ..it’s been with us from the start so as nursing continues to develop I see it becoming more important.

(b) Inconsistency

* ..they say - well, it’s not really working for this, that, and the other reasons and I think that there is a reluctance in
introducing new research....

* I’ve had one teaching session on this ward and that wasn’t research-based

* ...nobody has actually on this ward spoken to us about any recent research.....

* and I think it’s a shame...I think it’s as much my fault.....

* ...but from my own experiences I don’t see that being done all the time....

* ...we’re striving to be a profession therefore we sort of have to do research...and I...I don’t think it will...I don’t know whether it’s taken seriously by a lot of people.

(c) Justification

* ..I’ve noticed that the younger, the more recently qualified staff tend to be more keen on reading research and implementing it

* ..I don’t think it’s a very dynamic area for research-based practice to be quite honest...

* I don’t know whether that’s because this is Care of the Elderly.

* I think may be it’s because a lot of people have been here quite a long time and they’re more...traditionally trained...

* ..it’s just as much down to us to be saying,'Have you read this or....as I said before there are so many other factors that come into your training...struggling just to get by as it is.....

* ..so I don’t think I’d point the finger at anyone....
*..it’s not linked enough to nursing....

(d) Disclaiming

* I think it depends on individual staff to a certain extent...

* I’m not naming anybody but, I think that the person that’s in charge can very much..um...set about a dynamic structure for the ward...

Interpretation:

From the above extracts, it appears that justification is being offered for the current situation in which, overall, there is a reluctance to introduce new research. This is achieved by expressing a positive attitude towards staff who are looking at research to see how patient care can be improved, particularly the more recently qualified staff who are seen to be more keen on reading research and implementing it. Nevertheless, the student has only received one teaching session from a newly qualified staff nurse, which was not research-based, and nobody on the ward has spoken about any recent research. These views concur with those expressed by the students in the pre-pilot group discussion.

This clinical area is also deemed not to be a dynamic one for research-based practice, for which further justification is offered by suggesting that this may be due to the fact that it is a Care of the Elderly ward, or that there are more traditionally trained people who have been on the ward for a long time. However, research is everybody’s responsibility. Again, these views concur with those expressed by the students in the pre-pilot group discussion.

This nurse respondent is very consistent in her view that role of the nurse is to question her practice and to underpin all nursing practice with research-based knowledge. However, the collective behaviour of the hospital is not. Doubt is expressed as to whether it is taken seriously by many people and certainly the undertaking of research is not seen as a guarantee for becoming a profession. There needs to be more linkage between research and practice as a basis for improving it.
Extract 5

**Sue:** What do you think about reflection?

**Paula:**

(d) Um..... it's talked about a lot...um ...but I don’t think it’s actually done. I think you can reflect a lot without actually thinking, I am engaged in a reflection session, but as regards to staff on various wards I haven’t noticed it being done at all.

(a) ..and I think nursing...you do experience so many different things and you need to learn something from those experiences.... I think you’re constantly trying to be a better nurse in lots of different areas and I think that your experiences enable you to do that and you do gain certain knowledge every day from the tiniest little things....things that you can’t even quantify....um...you gain valuable experience and I think if you reflect on those experiences you can accept that you have gained some knowledge from that.... it’s hard to actually explain a lot of things but I think we all gain, you know, from our experiences and I think...only by sharing them you can...we can all learn something from them. ...

(a) I think students probably need to be aware that that is a tool for self-development.... and becoming more self aware and using reflection and improving your practice.....

Extract 6

**Sue:** What are you going to be doing at the end of your course when you’ve qualified?

**Paula:**

I haven’t really decided yet......I would like to work somewhere that’s more dynamic than here......I think I need more stimulation and I need to be working with people that I
(a) Consistency

*..and I think nursing...you do experience so many different things and you need to learn something from those experiences....

*..I think your experiences enable you to do that[be a better nurse] and you do gain certain knowledge every day from the tiniest little things...things that you can’t even quantify..

*..if you reflect on those experiences you can accept that you have gained some knowledge from that....

*..it’s hard to actually explain a lot of things but..we all gain from our experiences...only by sharing them....we can all learn something from them.

*..using reflection and improving your practice.....

*... I would like to work somewhere that’s more dynamic than here

*..and I need to be working with people that I consider are more dynamic that are keyed up on things like research.....
that don’t want to have some static practice that is perhaps more traditional...that want to question things.....

(d) Disclaiming

* Um...it’s talked about a lot...um...but I don’t think it’s actually done.

Interpretation:

Emphasis is consistently placed on the value of experience as a source of knowledge to be gained from a constant reflection on practice with a view to sharing that knowledge, improving practice and becoming a better nurse. This tacit knowledge, gained on a daily basis, is difficult both to quantify and explain. The student believes that in reality reflection is not practised. The consistent use of the word 'dynamic' seems to conjure up the image of a practitioner who is young, research-minded, and prepared to question and challenge decisions related to practice. This view of having dynamic nurses was also expressed by the students in the pre-pilot group discussion in which they referred to nurses as belonging either to the ‘old school’ or the ‘new school’.

No. 2: Student nurse interview (Linda)

Extract 1

Linda:

(a) ...I think knowledge is a vital part in almost everything in life and coming to this nursing programme has really opened my eyes to many things. When we come into college and learn theoretical bits we go out on the wards and try to put it into practice, which I think is very good. At the moment in mental
health I’m having to, like, get to know people, get to know why they behave the way they do......

(a) The staff have been quite helpful because they’ve encouraged me to ask questions and given me the opportunity to let me put my hands on the job and do what I am able to do ,like, I mean... giving out medication.

(a) I think the theoretical bit...coming into college is quite interesting, but actually going out there to put it into practice is really much more, you know....

(a) Research is something that is completely new to me, but, on the whole I think I’ve enjoyed research because before I started research I just read articles and just left them....after doing my research critique...I mean, I found I started going into, like, Nursing Standard and Nursing Times more and trying to see the way people wrote and how I would have actually written the same thing... I think that’s been quite interesting.

Sue:

How do you think research knowledge is viewed by people working in the clinical areas?

Linda:

(b) I think most people are really....from my experience, I think most people are more challenged about it. Probably, may be the ward managers and probably the senior staff nurses think much about it, but so far the junior staff nurses are more for it because when I started my research critique assignment I took it on the ward and I said to one of the staff nurses there “Could you help me out with this?”. She said “What is this? I mean I’m not used to doing this, so take it to somebody else”......so I think research is not being used much on the wards.

(c) I think most nurses probably have been used to their...I mean... traditional way of nursing. I think research is, like, something new to them that really has to...they need more, like, education towards it to be able to use it.
(a) Consistency

*I think knowledge is a vital part in almost everything in life...

* When we come into college and learn the theoretical bits we go out on the wards and try to put it into practice, which I think is very good.

* The staff have been quite helpful because they’ve encouraged me to ask questions...

* I think the theoretical bit...coming into college is quite interesting, but actually going out there to put it into practice is really much more, you know.....

* Research is something that is completely new to me, but, on the whole I think I’ve enjoyed research because before I started research I just read articles and just left them...

(b) Inconsistency

*...from my experience, I think most people are challenged about it.

(c) Justification

*..when I started my research assignment I took it and I said to one of the staff nurses...” Could you help me out with this?” She said “...I’m not used to doing this, so take it to somebody else.....so I think research is not being used much on the wards.

* I think most nurses probably have been used to their....traditional way of nursing. I think research is something....new to them....they need more education towards it to be able to use it.
Interpretation:

There appears to be a consistently held view about the importance of learning theory and trying to put that into practice. Similarly, communicating with others, asking questions, and being encouraged by others to ask questions are also important in gaining knowledge and experience. Learning by doing is essential. These views are consistent with those of the first student. However, there is inconsistency about research knowledge. Although the student can appreciate the usefulness of learning about research, nevertheless, she believes that generally people feel challenged by it. This is justified by reference to the staff nurse's response to the request for help with a research critique. The junior staff nurses are 'more for it', but, even so, research is not really being used much on the wards. Justification is offered in terms of traditional nursing (and the professional values implicit within that) and a lack of education about research. Again, these views are consistent with those of the first student and also confirm the earlier findings from the pre-pilot study, pilot and main questionnaires.

Extract 2

Sue:

Do you think it [the situation] will change with the generation of Project 2000 students when they become qualified practitioners?

Linda:

(a) Yes, I do see that coming with my generation and the generation after me of Project 2000 nurses...having been taught research at college... I think we'll be able to use it more in our clinical areas

(b) ....it's been quite good having to study research, but, ...I think we need much more time to go into it to have an in-depth knowledge about it.

(a) I think it [getting knowledge] has to do with research. I mean, as a student, I think to be able to really know much about mental health problems... and things that make people end up in mental units I have to do a lot of research into reading past articles.....
if I can read up everything about schizophrenia and find out what makes a schizophrenic behave the way he does, then I’ll have a better insight and be able to deal with that person much more.

(b) I think I still need more theory-based knowledge at college and then much more practice to be able to know what some of these articles are about.

(a) I think for the year 2000 and beyond nursing is going to go places anyway because nurses are widely needed everywhere...
(b) so I think nurses need to be treated much better than what they are having right now, which will encourage those after me to want to come into nursing.

(a) ....if more teaching and more encouragement is given to research, I feel it’s going to be quite useful for the future.....it’s really going to change the face of nursing, so I just think that a lot of concentration and education is needed in research for the nurses to be able to use it.

Grouping:

(a) Consistency

* ....having been taught research at college...I think we’ll be able to use it more in our clinical areas...

* ...it’s been quite good having to study research.....

* I think it [getting knowledge] has to do with research.

* I think for the year 2000 and beyond nursing is going to go places.....because nurses are widely needed everywhere.....

* ...if more teaching and more encouragement is given to research.....it’s really going to change the face of nursing

* ...a lot of concentration and education is needed in research for the nurses to be able to use it.
(b) Inconsistency

*...I think we need much more time to go into it [research] to have an in-depth knowledge about it.

*...I still need more theory-based knowledge at college and then much more practice to be able to know what some of these articles are about.

*...so I think nurses need to be treated much better than what they are having right now.....

**Interpretation:**

Consistently positive views are expressed by the student about the teaching of research, literature searching and critiquing skills to Project 2000 nurses whom, it is felt, will be able to use research more in the clinical areas for the future. These views are consistent with those of the first student. However, more time to gain a more in-depth knowledge of research would increase an understanding of its application to practice. There is no direct reference to nurses being viewed as professional practitioners, but implicit within the statement that ‘nursing is going to go places...’ might be the notion that Project 2000 students are being equipped with the necessary skills to advance practice through the utilisation of research knowledge. Nevertheless, the statement ‘...I think nurses need to be treated much better than what they are having right now...’ appears to be offering some justification for a current inconsistency.

**No 3: Student nurse interview (Arnold)**

**Extract 1**

Arnold:

I spent my first three days very scared and every time I did something they would say ‘Arnold, why are you doing this?... and, I don’t know, I was completely lost and they were constantly saying to me ‘Right...you need to go back and look and find out why. These are the books you can read ‘....I came
home and said to my friends, I said, ‘I’ve decided I’m a very good carer, but I’m a bad nurse because I’m not... I haven’t been rationalising. I haven’t been questioning enough.

I think a lot of the community nurses, especially, were saying to me ‘these are the books you need to read, things you need to look at....’. They were actually getting me to question...starting then to learn a little bit more. We weren’t given a lot of insight really in the college to inspect our own views....

In orthopaedics I was very spoilt, I think. I had very very good mentors, newly qualified staff... And they would say to me ‘Right, Arnold, there’s somebody going upstairs for a procedure. Are you going to go and watch it? ’ I would say ‘ Well, I’ve got my four patients’. They would say ‘No, you are a student, you’re supernumerary, you go’, and I’ve never come across that before because in Care of the Elderly, you were just...almost counted into the numbers, but not officially.

Sue: Why do you think that kind of approach was taken in the orthopaedic ward and not in Care of the Elderly?

Arnold: I think it was the staff who were quite young, quite dynamic.

They had a new Sister, but I think it was the staff who were quite young. I had a young mentor in Care of the Elderly, but she wasn’t on very often because she was on night duty and on annual leave. You know, she went away, she was doing a course, so the staff just tended to be a little bit older. You find that they don’t really tend to come up to you and talk to you and explain what they’re doing, they just do it and if you’re there to see it then that’s fine, but they wouldn’t actually call you over to acknowledge your knowledge....

Grouping:
(a) Consistency

* ..but I’m a bad nurse because I’m not.... I haven’t been rationalising. I haven’t been questioning enough.

* They [the community nurses] were actually getting me to question....starting then to learn a little bit more.

* In orthopaedics........ I had very very good mentors, newly qualified staff.... They would say, ‘No, you are a student, you’re supernumerary.....

*..... I’ve never come across that before because in Care of the Elderly, you were just...almost counted into the numbers, but not officially.

* I think it was the staff who were quite young, quite dynamic.

* They had a new Sister, but I think it was the staff who were quite young.

*...so the staff just tended to be a little bit older.

* You find that they don’t really tend to come up to you and talk to you and explain what they’re doing......they wouldn’t actually call you over to acknowledge your knowledge.

(b) Inconsistency

* I had a young mentor in Care of the Elderly, but she wasn’t on very often because she was on night duty and on annual leave. You know, she went away, she was doing a course......

Interpretation:
There is consistency about the idea of questioning to order to learn, a view firmly held by the first student, but also about being encouraged by qualified nurses to ask questions. The community nurses, in particular, were highlighted as practitioners who got the student to question. This idea of being taught to question is also consistent with the views expressed by the second student.

There is also consistency about the idea of dynamic and non-dynamic areas and the difference between young and older nurse practitioners. Young qualified staff are seen to be more dynamic. This view is shared directly by the first student and indirectly by the second student, and this finding is confirmed in the pre-pilot group discussion. Project 2000 students might be seen to be a threat to older staff because ‘...they don’t really tend to come up to you.... they wouldn’t call you over to acknowledge your knowledge...’.

The student also appears to be trying to offer some justification for an inconsistency related to his mentor in Care of the Elderly who indeed was young, but, in fact, who was not often present for various reasons.

**Extract 2**

Sue:

How well do you think the college has prepared you for going out into the clinical areas?

Arnold:

(a) ...at first, we couldn’t see the relevance and I think everybody says that....but, I admit, when we first started research, I was thinking....
(a) what has this got to do with anything, and I was thinking, I really didn’t...I couldn’t... and then it was only when somebody said,’
(a) you know, you need to question everything you do’. I’d never thought about it. It has taught me to question a lot of stuff even in my normal life....I think I was always quite easy to accept what people said rather than to go back and look it up and to find out why.
Arnold:

I find this a lot of the time...when you get to a ward, it’s your attitude and what you’ve learnt and what you’ve...I try to read up a little bit....this is what I think happened with the aseptic technique because the Matron said ‘Do you have any previous experience?’ I said, ‘Yes, I do..... and I’ve been trying to read up about it’ and I think her attitude changed......

so it is largely, a lot of it, up to you to make sure you’re actually gaining from the experience and not just doddling through and walking around....

Sue: Where do you think most of your learning has actually come from?

Arnold:

...I think probably 70% of what I have learnt has been....from the lectures, definitely....um...sitting down and writing notes and going home and reading through those notes and maybe 30% of it is going to the library afterwards, getting out books.....and reading chapters on those books.....sometimes not even from the lectures, sometimes from the ward staff themselves, which I think sometimes is more relevant because ...the lectures don’t always tie in with what you’re having at that time.......
* ...it was only when somebody said, '......you need to question everything you do'...... It has taught me to question a lot of stuff even in my normal life......

* I find this a lot of the time...when you get to a ward it's your attitude and what you've learnt....I try to read up a little bit.

* ...Matron said, 'Do you have any previous experience?'. I said, 'Yes, I do.....and I've been trying to read up about it' and I think her attitude changed......

* ...so it is largely..... up to you to make sure you're actually gaining from the experience.....

(b) Inconsistency

*...sometimes not even from the lectures, sometimes from the ward staff themselves, which I think sometimes is more relevant because the lectures don't always tie in with what you're having at that time.....

**Interpretation:**

The student in general is highlighting the problem of relating theory to practice during training, particularly of the research knowledge given in college and its application to practice. However, this research knowledge gradually begins to make sense and research is then seen as an important means of being able to question everything. These views are certainly consistent with those of the first student.

The student also indicates that communication is important for learning to take place by adopting the appropriate attitude towards other qualified practitioners. This means taking some of the responsibility for learning and demonstrating a willingness to read the relevant literature and being prepared to discuss previous experiences. This accords with Harré’s view that an individual (in this case, the student nurse) has to learn not only
about the Discourse (i.e. the ward and the type of nursing), but also how to function and learn effectively within it by communicating and establishing good rapport with others.

Learning is seen mainly to come from college lectures but the student appears to place more value on the learning derived from clinical practitioners and justifies this apparent inconsistency in terms of its being more relevant due to a mismatch between theory and practice.

Extract 4

Sue:

Where do you think nursing is going for the year 2000 and beyond?

Arnold:

(a) I have a friend who thinks that nurses will never be professionals.

(a) Um...this is why trying to become professionals we’re undermining ourselves. Um... we’re trying to take on other roles which undermine nursing and the fact that we’re trying to take on too much theory...um...and not actually practising the skills which

(a) nursing started at.....I had an “old school” sister working there and she thought things like patient care and comfort came first maybe with theory behind....she was more interested in going out there, seeing her patients, looking after her patients and not so much why she was using certain procedures.....whereas now I think

(b) nurses are starting to question a lot more...um...we’re taking on

(b) more roles. A lot of people say we’re taking junior doctors’

(b) work...um...and things like nurse prescribing...if we can take on

(b) more roles, that means, nurse prescribing.....I think that’s a positive thing. Um....why should we wait or ask for a doctor to come down and prescribe Paracetamol when you can buy them over a counter.......Um.... I think nursing’s definitely heading towards acute hospitals with fewer beds and community-based care...um...rightly or wrongly, I’m not sure. I haven’t really made up my mind yet. I saw some very good care in the community and I also saw some very bad care.
Grouping:

(a) Consistency

* I have a friend who thinks that nurses will never be professionals.

* ... this is why trying to become professionals we’re undermining ourselves...we’re trying to take on other roles which are undermining nursing...and we’re trying to take on too much theory ...um...and not actually practising the skills which nursing started at.

* ... I had an “old school” sister working there and she thought things like patient care and comfort came first maybe with theory behind....

(b) Inconsistency

* ...whereas now I think nurses are starting to question a lot more... um...we’re taking on more roles.

* A lot of people say we’re taking junior doctors’ work...um... and things like nurse prescribing...

* ....if we can take on more roles.....nurse prescribing....I think that’s a positive thing.

Interpretation:
The student raises other people’s views concerning the debate about whether nurses are becoming professionals and seems to couch it in terms of the ‘old school’ versus the ‘new school’ of nurses. From the findings of this study this view of nurse practitioners appears to have been generally endorsed by the students. This particular student views the “old school” nurses as individuals for whom patient care and comfort come first ‘with theory behind’. The ‘new nurses’, however, are seen as people starting to question a lot more because they are taking on more roles. However, this student’s discourse is also inconsistent in respect of whether nurses are becoming professionals. On the one hand, with reference to a friend’s thoughts, the view is advanced that nurses will never become professionals because they are trying to take on other roles which are undermining nursing and trying to take on too much theory. On the other hand, the student is also condoning the taking on of more roles, such as nurse prescribing, judging it in a positive way, and even challenging why it should not happen. Arguably, for this student, these are some of the aspects which constitute being a ‘professional’ practitioner.

Extract 5

Sue:

What about nurses in research?

Arnold:

Nurses in research. I think more nurses are doing research......but I think it’s taught me to question a lot more and I think if nurses actually start to go on a ward and think - Why are we using this pain scale because it doesn’t fit in with all pressure area scores?

(a) I saw this in orthopaedics...um...the Sister was saying that they use a completely different system because a nurse would say,’it’s fine, but it doesn’t take into account orthopaedics....’......so why
don’t we find out what we can do to change that.....and if people are starting to think like that, then it’s for the best. Why should we rely on other people to do the research for us....um....we should be doing more of it ourselves. It’s quite an easy task for nurses. It seems very hard at first and I think anybody can do research provided they’re given the funding and that’s the big issue, I think. But who’s going to be able to say.....here’s the time and here’s the money to do it?

**Grouping:**

(a) **Consistency**

* ..but I think it’s [research] taught me to question a lot more.

*...and I think if nurses actually start to go on a ward and think - Why are we using this pain scale because it doesn’t fit in with all pressure area scores ?

*..and if people are starting to think like that, then that’s for the best.

* Why should we rely on other people to do the research for us... um...we should be doing more of it ourselves.

(b) **Inconsistency**

* It’s quite an easy task for nurses. It seems very hard at first and I think anybody can do research provided they’re given the funding...

* But who’s going to be able to say...here’s the time and here’s the money to do it ?
Interpretation:

This student consistently expresses the view that research has taught him to question a lot more and that nurses generally should start to think more about their nursing practice and ask questions about it. This concurs with the views expressed by the first student about the importance of reflecting on practice, but that, in reality, it was not being practised. The student believes that nurses have a responsibility for doing their own research and perhaps that thinking is the first important stage in the process. However, this positive approach is contradicted when he identifies time and money as being the major constraints to nurses’ doing research.

Stage 5: Producing a summary of a collective analysis of student discourse

Having demonstrated how I conducted a discourse analysis of each of the students’ interview data on an individual basis, the next stage will show how I then produced a summary of their collective discourse, indicating essentially the extent to which instances of consistency, inconsistency, justification, disclaiming, blaming and making excuses had occurred, again with reference to the main research question areas being examined.

Questioning:

There was consistency across all three student interviews about the importance of adopting the right attitudes towards qualified practitioners in order to form meaningful relationships in which questioning could take place and serve as an essential means of gaining knowledge and learning. The student was either self motivated to question qualified practitioners, or in many instances, was encouraged by qualified practitioners to question.

Knowledge, research knowledge and the theory-practice gap:

There was consistency about the difficulties experienced in trying to relate theory to practice and of appreciating the relevance of the theory received in the initial stages of their training. The same difficulties were experienced
equally in relation to research knowledge and its application. However, all three students agreed that gradually during their training they were able to translate theory into practice and, indeed, viewed the learning about research as a means of enabling them to question a lot more. Nevertheless, in relation to research knowledge and its application to practice, there was some inconsistency expressed by the first two students, who also offered some justification for it. Clearly, they felt there was a reluctance to introduce new research knowledge into practice because practitioners felt challenged by it, and they could not identify research being used much in the wards. They attempted to justify this by adopting a positive attitude towards staff who were at least looking at research and seeing how patient care could be improved.

**Dynamic versus non-dynamic nurses:**

There was consistency about expressing the word ‘dynamic’, which was used as a means of being able to distinguish between an ‘old school’ nurse and a ‘new school’ nurse. Clearly, stimulation from colleagues was important for learning to take place and having ‘dynamic’ nurses was instrumental in achieving this. The younger nurse practitioners, such as the newly qualified staff nurses and younger ward sisters were perceived to be more dynamic and committed to the idea of research knowledge and research-based practice.

**Learning:**

There was consistency in the views expressed by the first two students about the main sources of learning. Clearly, learning came from doing and getting ‘hands on’ experience. They were indirectly referring to the tacit knowledge which builds up from ongoing experiences. The first student significantly remarked ‘...you do gain certain knowledge every day from the tiniest little things....the things you can’t even quantify..’ The first student also highlighted reflection as a means of learning, particularly as a tool for appraising nursing practice. However, she also conceded that it was not actually being practised.

The third student, in contrast, made no reference to learning by experience. The major sources of learning were via college lectures, visits to the library,
and ward staff. The willingness to read and take some responsibility for learning were important issues for him.

**Project 2000 culture:**

There was consistency across all three students about the importance of getting, and also wanting to get knowledge. They were a culture willing to read and take responsibility for learning; they felt that they were equipped with the necessary literature searching and research critiquing skills to be able to gain knowledge and critically review it. They concede that their culture is underpinned by the 'nurses becoming professionals debate' and are aware that the 'old school' nurses place more emphasis on patient care and comfort than on questioning the theory underpinning nursing practice and its procedures. It might be implied from the discourse of all three students that questioning is a characteristic feature of the Project 2000 culture. They believe that nurses are starting to question much more now because nursing is becoming more complex, nurses are taking on more roles, and they are accountable for their practice. Some inconsistency is expressed by the second student who justifies it by arguing that if nursing is going to develop for the future with a continuation of a Project 2000 culture, then nurses need to be valued much more than is currently in evidence.

**Contextual and textual dimensions:**

As previously discussed, I also analysed the discourse from both a contextual and textual dimension. Firstly, in examining the discourse from a contextual dimension, it was possible to identify an apparent prevailing ideology and hegemony within the student nurse Discourse. Overall, it might be argued that the ideology was seen to be a positive one in that students appeared to be able to defend assuredly the attributes of the Project 2000 educational culture. From a textual dimension, the use of the words 'dynamic' and 'non-dynamic' seemed to embrace a hegemony in which their generation as the 'new school' of staff nurses of the future would, through their knowledge of research, research critiquing skills, and their willingness to question practice, be seen to be able to advance the frontiers
of nursing knowledge and research-based practice and thus establish their own power base.

This approach was taken for each of the four groups of nurse practitioner. It might now also be interesting to show how at this stage it was possible to provide a comparison with the emerging collective analyses of the other three nurse practitioner groups. For the purpose of illustration within the remit of this chapter, the qualified practitioner group will be taken as an example.

Stage 6 : Undertaking a comparative analysis with the Qualified Practitioner discourse

Knowledge and their role:

All three qualified practitioners interviewed were ward sisters. In this Discourse, there appeared to be consistency about the way in which they viewed themselves as role models. To be an effective role model, current knowledge, skills, understanding and experience related to their specific area of clinical practice were deemed to be essential. They were also consistent about expressing their fears in respect of keeping up to date with changes in practice and the knowledge associated with that. Knowledge for safe practice and for taking responsibility for their own scope of professionalism was viewed as being essential. Thus, the pressure of current expectations seemed to be significant for this group of practitioners. There was some consistency about the value of intuition and experience in the scenarios which were recalled by the two older and more experienced ward sisters. There was no reference to intuition or experience by the younger ward sister.

Research and research-based practice:

Although there was consistency about the need for research-based practice, there were also statements made which constituted excuses, justification and disclaimers. The younger ward sister thought that the majority of her clinical skills were research-based and felt that there was so much research-based nursing being introduced into the wards. However, she also
felt that self-awareness, communication skills and reflective practice were equally as important as research. One of the experienced ward sisters also thought that research-based practice was operational in her clinical area and also felt that the ward-based nurse’s role in the undertaking of research was important. This view was shared by the student nurses. However, time and resources were the major constraints in allowing nurses to do this. This view was also upheld by one of the student nurses. In any event, research related to practice was controlled by the Trust. Overall, her discourse might be seen to represent some resistance to the ‘top-down’ approach to research-based practice. In contrast, the other experienced ward sister felt that not enough research was being done in view of all the changes in clinical practice.

Reflection and reflective practice:

There was inconsistency here. One of the experienced ward sisters made no reference to it at all. This, to some extent, endorses the student nurse’s perception that reflection and reflective practice were not practised at all. The other experienced ward sister did not deny the existence of reflective practice, but felt that it depended on how you reflected and how up to date your knowledge base was. The younger ward sister thought that reflective practice was very much about what it was you were doing and what you could be doing, and generally raising awareness about it.

Project 2000 training and research:

There was inconsistency here. One of the experienced ward sisters made no direct reference to the Project 2000 training, but, indirectly, indicated that in relation to nursing she believed in principles and regulations, and that it was necessary to enforce consistent regulations. These were her professional values. Some contradiction was expressed by the other experienced ward sister who, seemed, to some extent, to demonstrate a positive attitude towards the Project 2000 training by conceding that the students were reading far more and trying to improve the care they were offering to the patient, and that she felt there would be a lot more research in the future. Yet, she expressed concern that the younger nurses received too much theory in school and lacked the essential ‘Old School’ nurses’ experience.
The younger ward sister made no reference to the Project 2000 training, but expressed doubts as to whether student nurses really grasped the concept of research-based practice during their training. Indeed, this view is partly shared by the student nurses who did express difficulty in relating research knowledge to practice in the early stages of their training.

Contextual and textual dimensions:

From a contextual dimension, it might be seen that the prevailing ideology is a less positive one, in which ongoing changes both in practice and knowledge appear to be challenging the qualified practitioners. The changes are also serving to undervalue intuition and experience as part of an outdated belief system, which is represented by the two experienced ward sisters. The latter appear to be experiencing the pressures of the current discourse and some negative feelings are emerging as a result of this.

In contrast, the apparent willingness to manage change, represented by the less experienced ward sister, might be seen to herald a more positive ideology for the future of this group of practitioners.

From a textual dimension, the use of the words 'experience' and 'intuition' by the older ward sisters is significant in conveying their importance when effective decisions about patient care have to be made. Phrases such as 'I just know something is going to happen...I did not know what sort of knowledge this was' and 'Well, I can't really tell you how I know but I just know that.....' highlight the value of tacit knowledge when nursing action is required.

Stage 7: Undertaking a comparative analysis with the Nurse Manager discourse

Knowledge and their role:

All three managers were consistent about the wide remit of their role. Primarily, they saw themselves as role models who were there to lead, manage and support staff, and who were essentially involved in quality issues, standards and auditing. Communication skills were regarded as a
very important part of the role, particularly in relation to change management, and to be a successful manager, business skills were just as essential as nursing skills. There was inconsistency about the role of knowledge. One manager made no reference to it, and from this it might be implied that in order to function at this level as a manager the possession of appropriate knowledge must be assumed. One manager conceded the need for a broad knowledge base, although boasted a fairly good knowledge of management issues, and the remaining manager conceded a reliance on tacit knowledge, particularly where knowledge of management issues was ‘a bit rusty’. In contrast to the student nurse group, knowledge does not seem to play such an important or significant role, and in contrast to the qualified practitioners, the problem of trying to keep up to date with knowledge certainly does not seem to hold the same fears or anxieties.

Research and research-based practice:

As with the student nurses and qualified practitioners there was inconsistency about research. One manager felt that generally medical research was taking place, but that only layman’s research was being conducted in relation to nursing. Clinical practice, however, was research-based because of the use of models of care and nursing theories. The other managers perceived research and research-based practice to be very high on the agenda although they felt that research was not seen as being important to nurses. This is in contrast to the perceptions of the student nurses who do view research as being important and who also believe that although many qualified practitioners share the same view, nevertheless, they fail to implement research knowledge into clinical practice. Managers believe, however, that it is their responsibility to introduce and implement research in practice by having such strategies as quality forums, quality facilitators, and regular auditing practices in place. Managers also see the commissioning of research projects and employing the services of research and development consultants as being instrumental in achieving research-based practice. Thus, this represents a corporate-led approach to the problem, in which the provision of management knowledge and expertise is seen to be the most effective strategy for advancing the idea of research-based practice. This perception is in complete contrast to that of
the student nurse group who clearly view an individual practitioner-led approach as being the basis for developing research-based practice.

**Reflection and reflective practice:**

Doubts were expresses about reflection and reflective practice. Indeed, the student nurses felt that it was not practised at all on the wards. One manager had tried to use a model of reflective practice unsuccessfully and had found the setting up of a support and discussion group to be of more value to clinical practitioners. One manager made no reference to it. In contrast, one manager felt that reflective time marked the beginnings of research. This perception was also shared by one of the qualified practitioners. Practice could be reviewed, discussed and then appropriate steps taken to develop or change it. This constituted learning through research and taking action through learning.

**Project 2000 training and research:**

Managers generally support the Project 2000 approach to the education and training of student nurses. They believe that nurses need degree status to become professionals, which is important for their credibility, and need to become more autonomous. Nursing is not just a vocation and nurses are not doctors’ handmaidens. This latter perception is clearly shared by student nurses. Managers believe that the student nurses have a thorough academic grounding and acquire a much broader outlook on health. They have the skills to seek knowledge, they learn more quickly, and they are exposed to more open dialogue.

In relation to research, managers feel that the student nurses have a real concept of what research is about and are research-minded. However, it’s also about striking the balance between theory and clinical skills, because students feel extremely anxious at the end of their training in relation to their practical experience deficit. This view is endorsed equally by the qualified practitioners and the students themselves.

**Nursing and the future:**

Managers seem to demonstrate a positive attitude about the future of nursing. Generally, there appears to be support for a professionalisation strategy in which advancing nursing practice is deemed to be essential.
Nursing has to continue to develop and move forward, but this can only be achieved with degree nurses. Importantly, however, the priority for nursing is for nurses to be ever mindful of the patient’s presence and to remain committed to the giving of care. This view is endorsed by the qualified practitioners.
The two managers based in the field of mental health, offered two more perspectives. Firstly, a more therapeutic, psycho social approach in nursing should be undertaken. Secondly, mental health students should undertake a specialist three year training with a shared focus on mental health, community support, and rehabilitation. Nurses would emerge with both nursing and social work knowledge.

**Contextual and textual dimensions:**

From a contextual dimension it might be seen that the prevailing ideology is a positive one in relation to the future of nursing. The nurse managers emerge as confident, knowledgeable practitioners who regard themselves primarily as role models and leaders in relation to the management of change and the development of nursing for the future. They support the professionalisation strategy as a means of advancing nursing practice and view research-based practice as being a managerially-led initiative and responsibility.

From a textual dimension, such phrases as ‘move away from old routines, rituals, and regulations...’, ‘nursing has to develop and move forward...it cannot go back’, and ‘nursing can only move forward with degree nurses’ seems to reflect an urgency to seize the opportunity to make a break with the past and take forward nursing’s new agenda for the future.

**The final stage:**

The final stage in this process was a collective summary of professional discourse which was subsequently used to compare and validate the earlier findings from this study. A discussion of the research findings is presented in Chapter 7.

**5.10: Conclusion:**

This chapter has sought to examine the discourse analysis approach as the method selected to analyse that data from the open-ended interviews. After
presenting the rationale for its choice, and discussing the theoretical underpinnings, a practical application of the method was given using the student nurse interview transcriptions as the main example. The stages undertaken in this process were identified and then illustrations were given of how data were selected from the text with reference to the main research questions being asked. The data were then analysed according to a coding system. Subsequently, by taking the qualified practitioner and nurse manager groups as examples, it was demonstrated how a comparative analysis was conducted across these Discourses before attempting to achieve a final collective analysis. This chapter has also served to highlight the context-related variability within professional discourse and the fluidity of positioning within individual groups. It attempted to show how discourse is constructed out of the context of experiences and governed by the values and beliefs of the individual. It might also be seen how the individual’s discourse was very much dependent on the stage reached in the practitioner’s professional knowledge development and experience. The findings from this discourse analysis will be revisited in the next chapter, which will consider the overall findings from the study.
Chapter 6

Research Findings

6.1: Introduction:

The following chapter presents an interpretation of the findings gained from the pre-pilot group discussion, pilot questionnaire, main questionnaire and open-ended interviews. Appropriate reference will be made to Benner’s (1984) model and theory, as the epistemological framework, and to relevant current literature and research evidence to support the ongoing discussion. Conclusions will also be drawn in relation to the findings from each of the data collecting methods used. Discussion will also focus on the use of a discourse analysis method to analyse the open-ended interviews, and how, as a method, it provided a means of validating the data obtained from the group discussion and pilot and main questionnaires, which were analysed using a content analysis approach.

6.2: The pre-pilot group discussion:

The pre-pilot group discussion guide is given in Appendix 1, and the complete transcription of the pre-pilot group discussion is given in Appendix 6 for reference. An interpretation of the findings will be given according to the main areas discussed. The pre-pilot group comprised only student nurses.

Nurses’ perceptions of knowledge and commitment to research-based practice.

Essentially, the meanings attached to the term ‘knowledge’ were ‘understanding’, ‘gaining information and using it’, ‘wisdom’, ‘fact’, and ‘direct learning into certain areas’. The overall meaning of ‘research-based practice’ was practice which had been investigated and proved to work.
In relation to research-based practice, the view was expressed that nurses were committed to research-based knowledge in name only. It was felt that nurses needed to be aware of research and committed to research-based knowledge, but very few of them put it into practice. The most recent research findings (Walsh, 1997a, Walsh, 1997b, Parahoo, 2000) suggest that one of the main reasons for the latter is that nurses do not feel that they have enough authority to change patient care. The idea of individual and collective responsibility was discussed. It was argued that nurses should read a nursing journal weekly and introduce current research findings to colleagues. It was also argued that qualified staff should take more responsibility by discussing and sharing research findings at ward meetings and displaying research articles on notice boards. One student nurse remarked 'Everything changes so quickly'. It was felt that everyone had a duty to communicate relevant research knowledge to others in the clinical areas.

One of the fundamental obstacles to applying research findings was the fear of causing trouble. This obstacle can also be seen as a perceived lack of authority to change patient care (Walsh, 1997a, Walsh, 1997b, Parahoo, 2000). Laziness and stubbornness about using research-based knowledge, the fear of change, and an unwillingness to accept new and better ways of caring for patients were stated. Other obstacles associated with application were disbelief about research nurses because of their absence from the clinical areas, the problem of having to take 'a leap of faith' where no proof of the research findings had been given, or where the value of the research had not been indicated. Another obstacle stated was time constraint. This finding is also supported by Dunn's (1998) study which rates insufficient time on the job to implement new ideas as one of the major barriers to research-based practice. The other two obstacles stated were lack of staff, and 'not feeling good about it'.

**The concept of knowledge within the nursing profession.**

Differing views were expressed in relation to whether nurses thought about the kinds of knowledge they used in practice. Some group members clearly thought not. This latter view is borne out in Eraut et al's (1995) study. Here, when students were asked to reflect on their practice and consider what knowledge they had used to guide it, they responded that they didn't try to understand what was happening or felt unable to describe what knowledge they were using in practice. Other group members categorised the different
kinds in terms of theory and how to care for a patient, practical skills, and knowledge acquired in the wards and from the ward staff.

It was indicated that a greater appreciation of research-based knowledge had been gained in the clinical setting rather than from the school of nursing. This manifested itself in being able to identify an improved quality of life for patients given research-based care. Even so, research knowledge was still not seen as a priority and was therefore accorded no authority. In fact, it was often ignored, regardless of its proven worth. There was a general wariness of research knowledge because it was changing so rapidly, and because it was producing conflicting knowledge. Generally, new knowledge and research nurses were viewed as threatening.

It emerged that the respect given to research knowledge depended on the clinical area. For example, on an orthopaedic ward, research knowledge had low priority because practical knowledge was more esteemed, whereas on an Aids/HIV ward it had high priority. Generally, research knowledge needed to be trendy to command respect and stimulate enthusiasm. Respect also depended on ward leadership. Young nurse leaders were seen to be more keen, energetic, and enthusiastic about research knowledge. The ‘old school’ leaders were unwilling to change, and maintained a social control over ‘new knowledge’. Challenging the ‘old school’ had no effect. Student nurses needed the confidence to empower themselves to make an effective challenge.

**Nurses’ perceptions of themselves as individuals.**

Differing views were expressed as to whether nurses perceived themselves as professionals. Overall, however, they did not. They indicated that a professional nurse was a practitioner with complete responsibility. The innovative, career nurses were seen to be professional because they strove to change practice.

It was felt that nursing was a job and that nurses were striving to be something they were not. The word ‘professional’ was overused. Porter (1992) also suggested that the ideology of professionalisation be abandoned and more emphasis placed on maximising the efficacy of the occupation. It was also felt that nursing was not of the standard of a traditional professional training. They argued that degree and diploma nurses probably saw themselves as more professional than traditional nurses because of the acquisition of more knowledge by the end of their training. A greater body
of knowledge meant better understanding and the ability to change. Such nurses would also be better able to look at research critically. Nurses did not keep themselves updated, and did not behave in a professional way in practice by adhering to the Code of Professional Conduct. It was conceded that the change to professionalism would take a considerable period of time, mainly because it was being hindered by the ‘old school’.

It also emerged that nurses did not see themselves as professionals because, in general, society did not. A ‘professional’ was described as one who ‘drove a BMW car, had a nice house, and had a good income’. Unlike lawyers and doctors, nurses did not have these things. Money and power were always associated with being professional from the lay person’s viewpoint. Lawyers and doctors functioned at a higher level than the public. Nurses, however, were viewed by the public as functioning at the public’s level. It was concluded that nurses had to appreciate themselves as a prerequisite for other people’s appreciation of them.

The influence of professional values.

It was felt that nursing practice was dictated by personalities, ‘stand-offish ward sisters’, and ward reports. Basically, nurses were taught not to question authority. This latter view may provide some rationale for the most recent findings in relation to the main obstacles to research utilisation (Walsh, 1997a, Walsh, 1997b, and Parahoo, 2000). However, in reality there were conflicting messages. In theory, they were told to challenge; in practice, they were urged not to. The official line was to criticise with one hand.

Professional values were about learning to be diplomatic and about ‘not rocking the boat’. This latter view is confirmed by the findings of Kelly’s (1991) study in which English undergraduate nurses valued ‘fitting in’ and ‘going along’, but retained their own ideas and values until such time as these could be implemented. Therefore, nothing ever changed and the status quo was maintained. It was argued that professional values dictated people’s behaviour; attitudes towards and perceptions of research-based practice were moulded by nurse education. Young people coming into the nursing profession were judged on their personality, personal opinions, upbringing and education, and were then shaped by the profession.
Conclusions:

Overall, these respondents perceived knowledge as a process of gaining information and using it, and as understanding. In principle they felt that nurses were committed to the concept of research knowledge, but few put it into practice. The main constraint on utilising research knowledge in practice was perceived as a fear of causing trouble. These respondents tended not to think about the types of knowledge used in practice. Essentially, they were sceptical about research knowledge because it changed rapidly and produced conflicting knowledge. They did not perceive themselves as professional practitioners, and believed that professional values were about being diplomatic. Professional values also influenced attitudes towards research. In relation to Benner’s (1984) model, these student nurses represent having reached the competent stage. At this point they can be said to have gained sufficient knowledge and skills to be able to practice as competent practitioners. They will have, as Benner (1984:27) points out, ‘a feeling of mastery and the ability to cope with and manage the many contingencies of clinical nursing’. However, they will need to gather more knowledge and experience to enable the acquisition of a more flexible and holistic approach towards understanding situations.

6.3: The pilot questionnaire:

A copy of the pilot questionnaire is given in Appendix 2, and the complete data from the pilot questionnaires are given in Appendix 3 for reference. An interpretation of the findings will be made according to the questions asked.

Question 1: What do you understand by the term ‘knowledge’?

The meanings attached to ‘knowledge’ were still fairly broad although perhaps just a little more specific than those elicited during the group discussion. This was to be expected since four different groups of nurse practitioner had been addressed. Nevertheless, knowledge overall was still understood in terms of the gaining and understanding of information. Below some direct quotations are given:
'understanding about a particular subject'.

'the reception, understanding and internalisation of information'.

'the collection of information retained during life'.

'a personal collection of thoughts (through experience and study)'

'information through reading, learning, seeing, experiencing, senses interpreted as 'facts', or 'experiences', or 'learning'.

'facts, feelings, awareness gained by formal learning and experience of self and others'.

Other respondents expressed different thoughts about 'knowledge'. The following are direct quotations:

' a personal belief system'.

'something which can be used and applied appropriately'.

'acquired in practice'.

'theoretical reading - definitions, models, propositions'.

Question 2: What type of knowledge do you use in your nursing/educational practice?

4 respondents mentioned practical knowledge, and for which they used the terms 'practical', 'technical', and 'clinical'. One respondent mentioned aesthetic knowledge. One respondent stated intuitive knowledge. 3 respondents stated theoretical knowledge. One respondent mentioned empirical knowledge.
5 respondents referred to experiential knowledge. One respondent stated social knowledge, and 2 referred to moral knowledge (ethics). 2 mentioned research-based knowledge. One respondent mentioned personal knowledge, one respondent stated professional knowledge, and one stated scientific knowledge.

Question 3: Do you think some types of knowledge more important than others. If so, which types?

5 respondents stated ‘YES’, 5 stated ‘NO’. One respondent did not answer either ‘YES’ or ‘NO’, but stated:

‘All knowledge is important. It helps us to exist on a day to day personal and professional basis. The basis of the knowledge itself can influence its use and give it more credence’.

In answer to which types of knowledge were more important and why:

One respondent stated technical knowledge because ‘good nursing practice technique meant patient care was of a higher standard’.

One respondent stated research-based knowledge because ‘it could be analysed and used for further teaching’.

Of the 2 respondents who stated empirical/theoretical knowledge:

one said because ‘it (theoretical knowledge) formed the basis of good practice and justified why specific care may have to be given’.

the other who had stated empirical knowledge as ‘that which could be measured, assessed, described according to criteria’ also conceded that ‘the culture and custom of individuals engaged in the exchange of ‘knowledge’ almost defied empirical methods’.

One respondent stated experiential knowledge because ‘it enabled reflection on the experience and the gaining of confidence and understanding’.
Question 4: How do you view research-based knowledge?

6 respondents implied that research-based knowledge was a means of updating existing knowledge and creating new ideas through a systematic and scientific inquiry and that it was essential for the development of nursing. Supporting knowledge by research was thought to be more professional.

One respondent commented 'it could be analysed and used for further teaching'.

One respondent referred to it as 'the “in” phrase'.

2 respondents expressed some misgivings and implied that knowledge gained through research only represented the sample from which it emerged and should not always be assumed to be definitive. One of the respondents, in particular support of this view, stated 'Especially in the field of Mental Health! (I am not keen on having American ideas thrust upon me)'.

One respondent implied that research-based knowledge depended on the quality of research and determined whether new ideas could be explored, or current practices reinforced or improved.

One respondent felt it was important in clinical practice and that reflection was made easier by research awareness.

It appeared that these views reflected both positive attitudes as well as an implicit scepticism about research-based knowledge, thus reinforcing some of the findings from the pre-pilot group discussion. Importantly, in relation to Benner’s (1984) model, these views represent practitioners at different stages in their professional development, from novice to expert, and thus reflect different levels of knowledge, experience, and attitude development in relation to research-based knowledge.
Question 5: Does the application of knowledge to practice present you with any difficulties? If so, what kinds of difficulties?

5 respondents said ‘NO’ and 5 said ‘YES’. One respondent gave no answer.

Of those respondents who answered ‘YES’, the reasons given for the difficulties in applying knowledge to practice were threefold:

Firstly, resistance to change and preference for traditional ways made it difficult to change and apply new knowledge. One respondent described the difficulty as ‘Disbelief/myths - perpetrated by the “service side” !......’.

Secondly, the cost and time involved in implementing research-based knowledge were cited. One respondent said, ‘Implications such as the cost of changing to a new dressing item......’.

Thirdly, one respondent highlighted a difficulty in planning care to suit a particular model of nursing in use in the area of practice.

Question 6: What do you understand by the term ‘professional self-concept’?

2 respondents did not understand the term. 2 respondents understood it in terms of how individuals perceive themselves as professionals at work. One respondent stated, ‘.....the individual has to have a picture of one’s physical self, personality, how he/she would like people to think about him/her, and his/her sense of control and self-esteem’.

A similar view held by 2 respondents was that it meant what one perceived as a professional role model, and how one viewed his/her own profession and what it entailed.
Another view expressed was that of a thinking practitioner able to reflect upon his/her own practice thus enabling professional development by the identification of personal strengths and weaknesses.

One respondent felt it meant adherence to the Code of Conduct and described it as ‘Personal responsibility to “update” - underpinned by continually striving to achieve the highest degree of self-awareness - to provide the best possible therapeutic use of ‘self’-‘.

Another respondent, however, pointed out that although there were professional guidelines in practice, individuals still held their own views and that it was about the practitioner’s own understanding of professional practice.

Other views were that it was about people believing that they possessed a unique body of knowledge and were confident to carry out their work in an autonomous way.

A different perspective was offered by one respondent who said that it was ‘What the individual thinks is good/bad about the profession’.

Question 7: Do you think that nurses perceive themselves as being professional?

9 respondents stated ‘YES’. No one stated ‘NO’, but 2 respondents stated they did not know.

Reasons given for stating ‘YES’ included recognition from the public, the governing of nursing practices by a body of authority and the wearing of uniforms which promoted professional identity.

Other reasons were that nurses were autonomous, accountable for their practice and acted as the patient’s advocate. This latter view, however, is refuted by Porter (1992).

One interesting comment was ‘It validates the amount of mental effort invested in the practicalities of dealing with the human condition’.

Another respondent felt that there was more awareness of being professional ‘in the recent graduates’. This view was also expressed by the third year student nurses in the group discussion. They felt that students
undertaking Diploma nursing courses would probably feel more professional because they would have more knowledge. Another reason identified was that nurses passed a recognised examination and obtained a certificate.

Comments made by the 2 respondents who answered ‘DON’T KNOW’ suggested that some nurses perceived themselves as being professional, whilst others did not. Additionally, the amount of change taking place in nursing caused some nurses to feel that it was a vocation. Where nurses were allowed to use their knowledge to full capacity, they would feel more professional.

**Question 8: What are your views about the influence of professional values on practice?**

One respondent expressed no views. Other views were that all practice was influenced by professional values, which formed the foundation of nursing on which extra knowledge was built. Professional values made nurses autonomous and accountable for their own practice, which, in turn, should lead to the implementation of a high standard of care. One respondent thought that it would also increase the nurse’s standing in the wider multidisciplinary team. It was felt that the Code of Conduct was the basis for professional values and that the latter provided for efficiency in the quality of care.

One respondent also expressed the view that ‘a wise professional is guided by the responses from the client and assists the client to express their wants as well as what are perceived as Needs’. This view was also supported by another respondent who felt that it gave the patient the opportunity to participate in their own care.

**Conclusions:**

Essentially, knowledge was perceived as the gaining and understanding of information through study and experiences. However, some respondents were able to give more expanded definitions of the term. The main types of knowledge used in practice were practical, intuitive and theoretical. Theoretical knowledge was viewed as being more important than the others. (Interestingly, only two respondents mentioned research- based knowledge).
Having research-based knowledge was seen to be more professional and essential for the development of nursing. However, applying research to practice was difficult because of the resistance to change and the cost involved.

In relation to the meaning of 'professional self-concept' generally respondents indicated that it was about how individuals perceived themselves as professionals at work. In contrast to the group discussion finding respondents did view themselves as professionals.

Lastly, professional values were seen to influence all aspects of professional practice. They were the foundation of nursing and instrumental in providing a quality of care.

6.4: The main questionnaire:

A copy of the main questionnaire is given in Appendix 4, and a sample of the data from the main questionnaires is given in Appendix 5 for reference. I decided to adopt a more specific approach with the main questionnaire and the data have therefore been interpreted according to the four different groups of nurse practitioner in order to be able to highlight any differences or similarities in relation to perceptions of knowledge and research-based practice across the groups.

Question 1: The meaning of the term ‘Knowledge’:

In relation to the meaning of 'knowledge' there were strong similarities across the qualified practitioner and student nurse groups in terms of the choice made from the given statements. 'A justified true belief' and 'a consensus of opinion' were the two most frequently chosen statements reflecting the meaning of knowledge. There was some similarity across the manager and lecturer groups in that the statement 'the stage reached in our professional discourse' was felt to reflect the meaning of knowledge. There were also similarities across the qualified practitioner, student nurse and nurse lecturer groups that knowledge was information gained through research. Research was not mentioned by the nurse managers, but they stated that knowledge was practical, and that it was intuition.
Question 2: The types of knowledge used in practice:

As for the types of knowledge used in practice, the two most frequently identified across the four groups were *experiential* and *research*. The other frequently mentioned types were *practical knowledge* by the qualified practitioners, *knowledge from books* by the student nurses and *justified true belief* by the lecturers.

One lecturer commented, 'In my teaching I would like to say I use only research-based knowledge, but, of course, personal opinion, beliefs, experience and institutionalism always invade research-based knowledge'. This comment was significant since it seemed to highlight the argument advanced by Purdy (1994) that professionalisation prevents progressive humanist education and reinforces traditional rationalist education, which encourages a view of knowledge as 'certain' rather than as 'tentative'.

Question 3: The types of knowledge most often used:

There were similarities across the qualified practitioner, student nurse and lecturer groups in that the types of knowledge most often used were *experiential* and *theoretical*. *Practical knowledge* was also frequently stated by qualified practitioners and student nurses. In the manager group, *empirical* and *personal knowledge* were most often used.

Question 3: The types of knowledge least often used:

*Research-based knowledge* was the type least often used in all four groups. Respondents gave the following reasons:

'because there were no resources available on site and because of motivating staff to change their practices and time factor' (Qualified practitioner).

'because I'm not always up to date with latest research' (Manager).

'I know the importance of research-based practice, however, I do not have the time or energy most of the time to conduct literature searches and read' (Student nurse).

'because it has to do with change and adaptation' (Lecturer).
Question 4: The meaning of the term ‘nursing knowledge’:

In response to this question, there was strong consensus across the four groups that nursing knowledge was 'experience gained through practice' and 'a body of scientific knowledge', and almost as many practitioners thought that nursing knowledge was ‘knowledge of caring behaviour’. However, in returning to the former consensus view, this seems to sum up what Benner (1984) refers to as the clinical dialogue. In her most recent work, Benner (1999: 4-5) clearly asserts that scientific research must be continually developed and critically evaluated to enable clinicians to keep abreast of the current state of the science. She also points out that theory guides clinicians and enables them to ask the right questions, but that any nurse experienced in working with these theories finds differences that the formal theory fails to express. Therefore, it is this clinical dialogue with theory which makes refinements accessible or possible for the experienced nurse (Benner, 1984:36).

Question 5: The meaning of the term ‘research-based knowledge’:

There was consensus across the four groups in relation to the chosen statements about the meaning of research-based knowledge. It was indicated that research-based knowledge was’ knowledge gained through a systematic enquiry’.

Question 6: The extent to which research-based knowledge is used in practice:

However, inconsistency about the extent to which research-based knowledge was used in practice existed in all four groups. Whilst approximately fifty per cent of respondents in each group indicated that it was used to a great extent, fifty per cent indicated that it was used to a limited extent.
Question 7: Difficulties associated with applying research-based knowledge to practice:

Again, inconsistency about whether the application of research-based knowledge to practice presented any difficulties existed across the four groups. In each group approximately half the respondents answered 'No' whilst half answered 'Yes'. The main difficulties identified were: 'a lack of knowledge' (qualified practitioner), a 'lack of time to study research', (manager), 'resistance to change' (student nurse), and 'tradition', (lecturer). Difficulties such as nurses’ lack of awareness of research evidence, and the pursuit of ritualistic practices have been confirmed in the findings of Chapman's (1996) study about preoperative fasting. Chapman (1996) found that even where research evidence was unambiguous, tradition continued to dominate nursing practice.

Question 8: The meaning of the term ‘professional’:

The meaning of the term 'professional' also gave rise to inconsistency across the groups. Of the meanings provided, approximately half of the respondents in each group indicated that a professional was a person with expertise who was paid, whilst half chose to offer their own meaning.

Of the meanings given, the following appeared to have most significance:

'One who has trained for that type of work and passed an examination set for that type of work by an examining body ' (Qualified practitioner). This statement might be seen to represent a rationalist view of nurse education whereby certain knowledge is deemed essential for safe practice. The U.K.C.C. and the National Boards, therefore, might be seen to represent the value of safe nursing practice (Purdy, 1994).

"Professional" is a term, I feel, which is only used by people to impose their own belief as to their perceived self-importance. It is an ego mechanism' (Qualified practitioner). This view is supported by Porter (1992), who argues that professionalism contradicts genuine advocacy because of the gap between the professional and client in terms of knowledge and power.
'A professional is a person who makes informed decisions/judgements, can justify those decisions/judgements and can articulate that justification' (Manager). This view of a professional might be seen to equate with Benner's (1984) view of what constitutes an expert practitioner.

'A professional is someone with a body of knowledge based on research who puts his/her clients first, who shares his/her knowledge with others and is regulated by a code of ethics' (Student nurse). This view seems to represent a textbook definition voiced by a practitioner occupying the novice stage (Benner, 1984) of training. Here the practitioner appears to be adhering firmly to what has been taught.

'The term 'professional' also encompasses not only expert knowledge, but also a set of values which places the client in a relationship with the professional which should be above the importance of money, power, status - but be based on altruism, high standards, not doing harm' (Lecturer). Again, this view appears to conform to Benner's (1984) concept of an expert practitioner.

Question 9: Are nurses professional practitioners?:

There appeared to be consensus across the qualified practitioner, manager, and student nurse groups that nurses were professional practitioners. However, the majority of lecturers disagreed. One reason given as to why nurses were not professional practitioners was:

'Nursing is an occupation, not a profession. Nurses generally have little autonomy, are poorly paid and nursing is not considered by society as a status job. However, we can be described as 'professional' if this term is used loosely to describe those who work conscientiously' (Lecturer).

This view is supported by Porter (1992), who argues that the ideology of professionalisation should be abandoned and more emphasis placed on maximising the efficacy of nursing as an occupation. This view was also expressed by the third year student nurses in the group discussion.
Question 10: Should nurse practitioners use research-based knowledge in practice?:

There was consensus across all groups that practitioners should use research-based knowledge in practice. The two commonly identified reasons were that research-based knowledge would allow the advancement of the practice of nursing, and enable its recognition as a profession.

Question 11: The meaning of the term 'professional values':

In relation to the meaning of the term 'professional values', two thirds of all practitioners thought it was about 'adhering to the Code of Professional Conduct', whilst 42% thought it was about 'having a set of beliefs about nursing'.

Question 12: Do professional values place constraints on your practice?:

Only 28% of practitioners felt that professional values did place constraints on their practice. The remaining percentage of respondents felt that professional values did not place any constraints on their practice. However, where constraints were identified, they related mainly to time, money and a lack of resources.

6.5 The open-ended interviews:

The data from the interviews were analysed using a discourse analysis approach, as previously stated, to provide a means of validating the findings from the pre-pilot group discussion, and the pilot and main questionnaires. The discourse method was also used to highlight the context-related variability which occurs within professional discourse. Complete transcriptions of a sample of four of the interviews are given in Appendix 7 for reference.
Qualified practitioners (Ward sisters)

In analysing their discourse, there appeared to be consistency in viewing themselves as role models. However, to be role models within ward management, current knowledge, skills, understanding and experience related to their area of practice (Care of the Elderly) were deemed to be instrumental. Because their area of practice was changing, the underlying nursing knowledge was also developing, which made it difficult to keep up to date because the latter required a lot of time. Having knowledge for safe practice (one respondent referred to it as 'good knowledge') and taking responsibility for one's own scope of professionalism were seen to be essential. Thus, the pressure of current expectations seemed to be significant for this discourse.

Two of the ward sisters were consistent in their belief about the value of intuition, although they expressed it in an indirect way.

One respondent said, 'I just know something is going to happen ....I did not know what sort of knowledge this was .....I just looked at her'.

The other said, '...you can't beat the eye ...that you can give a patient from experience because you will know straight away that something is not right'.

Firstly, it is important that these two statements are seen as representing the personal feelings of the interviewees. Nevertheless, from their discourse, it appeared that there was consistency about the need for research-based practice. However, one respondent felt that not enough research was being done. Another felt that the steps taken forwards in research-based practice for nurses would be smaller anyway. Another felt that the Trust controlled research related to practice and that there was no time for nurses to do their own research projects. One respondent saw self-awareness, communication skills and reflective practice as being equally as important as research. Thus, the findings seemed to indicate that there were some pressures and constraints being felt by the practitioners within this discourse. The findings also served to reinforce to a marked extent those from the pre-pilot group discussion and pilot and main questionnaires.
Nurse managers:

There was consistency about the wide remit and complexity of the nurse manager's role within a setting of constant change and developments. This might also partly account for the overall poor response rate obtained in the pilot and main questionnaires for this group of practitioners. Two managers clearly saw themselves as role models, whilst the other saw himself as someone who gave direction and set the parameters.

There was some inconsistency about perceptions of knowledge and their role. One manager conceded that her management knowledge was a bit rusty, but that she could rely on some tacit knowledge, which was already there, and which could help her to get through. Another manager made no mention of knowledge. The third manager boasted a fairly good knowledge of managing budgets and conceded that there was a need for a broad knowledge base of audits and quality issues. It appeared, therefore, that these perceptions of knowledge were providing a contrast to those of the ward sisters.

In relation to research-based practice, all three managers agreed that there was a need for this. Indeed, this view has been reinforced throughout this study's findings. However, it was also felt that research should be controlled and introduced into practice by specialist practitioners and groups such as the quality facilitator and quality forum, the research and development consultant, the senior research nurse, or via clinical audit recommendations. This is consistent with the view previously expressed that Trusts control research related to practice as there is no time for nurses to do their own research projects. Two managers agreed that reflection time and reflective practice were the beginnings of research and learning through research, and then taking action through learning. This view is consistent with that of one of the ward sisters.

The finding related to the importance of the association between knowledge, research-mindedness and professionalism was reconfirmed by two of the managers. They made positive statements about the Project 2000 training and emphasised that nurses needed degree status to become professionals. They agreed that nursing was not just a vocation and that nurses should be more autonomous. However, they also conceded that anxiety was felt by student nurses about their clinical skills and lack of experience at the end of training. The other manager was less positive about Project 2000 and preferred a specialist course rather than a generic one, particularly in relation to mental health training.
The view that there was a strong need to advance nursing practice and move away from ritualistic practice was reconfirmed. Nursing had to develop and move forward; it could not go back. However, nurses had always to remember the existence of the patient, a doubt consistent with one ward sister's view, 'I just hope it [nursing] doesn't go down the pan as fast as it is going now'.

Student nurses:

There was consistency about the importance of questioning. Students were taught and encouraged to ask questions. Learning took place through questioning and communicating with staff and patients. Equally important, however, was the idea of learning through the adoption of appropriate attitudes in their relationships with staff.

In relation to discourse theory, these views are echoed in the argument advanced by Gee (1989) that an individual moves from a position of knowing about a Discourse to knowing in a Discourse. Nurses have to become located within a Discourse and, therefore, must say or write the right thing in the right way whilst playing the right social role and appearing to hold the right values, beliefs and attitudes. Dialoguing effectively within relationships also relies on learning to question.

Two of the student nurses were consistent in their belief that learning occurred by doing and getting "hands-on" experience, and that tacit knowledge built up from that. This view was particularly consistent with that of the qualified practitioner group's discourse. The other student nurse made no reference to learning by doing.

All three student nurses referred to a theory-practice gap and highlighted the initial difficulty of appreciating the relevance of theory and research knowledge in practice. They conceded that understanding was gradual and acknowledged that research taught nurses to question much more. They tried to justify an expressed inconsistency about the reluctance of staff to introduce new research into practice by claiming that staff were positive about looking at research and seeing how patient care could be improved. However, they pointed out that people felt challenged by it and that research was not really being used much on the wards. These student nurses, in fact, might well be said to have been at the advanced beginner stage of Benner's model (1984). Therefore, it might have been difficult for them to distinguish between the existence of research-based and non-research-based practice.
from their own experience since, at this stage, situational perception is still somewhat limited. They all viewed having dynamic nurses as being important in providing stimulation. Clearly, for them, it was perceived as a situation of the young members of staff versus the older members of staff. The junior staff nurses were seen to be more enthusiastic about research. Again, the same findings were made in the pre-pilot group discussion. They were all consistent in their views about Project 2000 culture. It was about wanting to get knowledge and knowing how to do that through literature searching. It was also about critiquing skills, a willingness to read and taking responsibility for learning. For the future, nurses would question more and take on more roles, and the 'nurses becoming professionals' debate would continue. One student nurse said, 'Nursing is going to go places...', but, '...I think nurses need to be treated much better than what they have right now...'. Although this appears to be inconsistent, it is not because the student nurse is talking both about the future as well as the present. This sentiment was also expressed by one of the ward sisters.

**Nurse Lecturers:**

They were consistent in their views about the uncertainty of their knowledge base and, therefore, the importance, but also the pressures, of trying to keep up to date. The demands of workload resulted in superficial reading and no in-depth knowledge emerging. There was an apparent anxiety about striking a balance between the breadth and depth of knowledge needed by students in a real world setting. It was also apparent that lecturers felt obliged to give concrete knowledge which was felt by students to equip them to practice and speak the same language as doctors. This confirms the view advanced by Purdy (1994) that nurse education is based on a rationalist model of education, the aim of which is to certain as opposed to tentative knowledge. Thus, nurse educators are obliged to operate within the constraints imposed by the professionalisation, which determines the educational process. Similarly, in relation to students and research knowledge, they all believed that the extent to which students made the connection between clinical practice and research knowledge depended on the way they approached their studies. It was an 'open, enquiring, critically-minded student versus a pragmatic student' situation which determined what they wanted to accept.
Indeed, this is mirrored in the argumentative versus narrative stance debate advanced by Mitchell (1992). The former resists the closing down of debate, keeping open the possibility of change, whilst the latter avoids questioning and disruption of given information and conserves rather than changes. They all believed that every nurse should have clinical knowledge and take some sort of role in the practice area to maintain credibility. However, getting back to the clinical areas to update knowledge and skills seemed a remote possibility in some areas of nursing. An important aspect of knowledge and teachers in higher education was seen to be that of facilitating practice research. They all felt that there was a missing link between education and research and that practitioners should take the responsibility to make the connection between knowledge and research-based practice. Research was about giving people confidence to realise what they did or did not know, and research should be part of everyone's thinking and practice.

In relation to Project 2000 and the future there was inconsistency across this group. The most optimistic view was that nurse education needed to be at the forefront of developing practice, but the overall problem to overcome was getting universities to value and acknowledge practice. Another view was that Trusts would take some control over nurse education, Project 2000 nurse education would essentially become elitist, but that this would be good for nurse education. The most pessimistic view was that nurse education would be totally Trust led, which would have a negative influence on students.

6.6: Conclusions from the discourse analysis:

Knowledge was important for nurse practitioners in the four groups. For student nurses, it was about wanting to gain more and more knowledge. Learning took place through doing and getting experience. Tacit knowledge built up from this process. For qualified practitioners and nurse lecturers, it was about keeping up to date with their knowledge base, and the associated anxiety in trying to achieve this. For managers, it was about using their knowledge to effect change and develop practice.

In relation to research-based practice, practitioners across the four groups conceded that there was a need for research-based practice, and that research knowledge should be utilised in practice where appropriate. In relation to professionalism, there was inconsistency in the views expressed by practitioners across the four groups. From their discourse, it
appeared that there was an ongoing debate about the ideology of professionalism.

6.7: Conclusion:

This chapter has sought to present an interpretation of the findings from this study. The pre-pilot group discussion, the pilot and main questionnaires, followed by the open-ended interviews, were taken each in turn and conclusions drawn from a discussion of the interpretation of the data. Discussion of the latter was supported with reference to Benner’s (1984) model and theory, as the main epistemological framework, and with appropriate reference to current literature.

Overall, in relation to the areas of knowledge, research-based practice, professionalism and professional values, it was concluded that there was consistency about the importance of knowledge in relation to safe practice, and for the development of practice. There was also consistency about the need for research-based practice, although the extent to which practitioners utilised research knowledge in practice remained a debatable issue. There was inconsistency about whether nurses were professional practitioners, and the influence of professional values on practice. These issues remained contentious within the ideology of professionalism. Using a discourse analysis approach to analyse the interview data helped to validate to some marked extent the earlier data. As an approach it also demonstrated that nursing as a professional discourse is characterised by as much consistency as inconsistency. However, wherever possible, this area of consistency and inconsistency was discussed with reference to Benner’s (1984) model as a process for understanding and explaining the characteristics of professional knowledge development. A discussion of these findings will now be presented in the next chapter.
Chapter 7

Discussion of Findings

7.1: Introduction:

In this chapter, a return will be made to the main aims of this research study, which will be discussed in the light of the inferences made from the findings. Again, the discussion will be supported by reference to Benner’s (1984) model, as the epistemological framework, and to current research evidence and literature. The discussion also provides an assessment of Benner’s (1984) model as a theory about the acquisition of knowledge, skills and experience as a gradual progression. Furthermore, it assesses the acquisition of knowledge, skills and experience as being demonstrated according to the stage which has been reached by the nurse practitioner. In terms of this study, the logical progression from novice to expert also represents the gradual acquisition of different sources of knowledge, of which research knowledge is recognised as one having potential for improving practice.

The aims of this study were: (1) To examine the relationship between nurses’ perceptions of knowledge and research-based practice (2) To examine the extent to which nurses view themselves as professional practitioners and (3) To examine the relationship between professional values and research-based practice. Before addressing these main aims, it will be necessary to present a discussion of the findings made from the discourse analysis, which has been used as an interpretative framework to provide a basis for understanding the inferences made overall. By using a discourse analysis approach to analyse the data from twelve open-ended interviews, an attempt has been made to substantiate to some considerable extent the findings from the earlier data collection methods used in the study.

7.2: The findings from discourse analysis:

Essentially, in attempting to understand the findings from the discourse analysis, each of the four groups of nurse practitioner had to be regarded as a discourse in its own right, but also as part of the overall discourse of nursing. Fundamentally, therefore, it was important to take into consideration the fact that the individual’s discourse would signify to some extent the prevailing ideology and hegemony of each of the four groups of nurse practitioner. With
reference to discourse analysis theory, each group was contextualised and an attempt was made to indicate its relationship with the dominant discourse of nursing.

Upon examination of the data from the four groups of nurse practitioner, it was found that there were just as many instances of consistency as there were inconsistency both within and across the groups. Each of the four groups will now be taken in turn for the purpose of discussing the findings.

**Student nurse discourse:**

In this discourse there was consistency expressed by all three students about areas such as the importance of questioning and communication in relation to gaining knowledge. There was also consistency about trying to put theory into practice, the existence of dynamic and non-dynamic nurses, and the nature of a Project 2000 education. However, there was inconsistency, as well as some justification for the inconsistency about areas such as research knowledge and research-based practice, sources of student learning and the future of nursing and Project 2000. Benner’s (1984) model serves well as a means for explaining and offering justification for the existence of this inconsistency. Indeed, each stage of Benner’s (1984) model, from novice to expert, might be regarded as a separate discourse. Thus, the stage reached in the practitioner’s professional development is demonstrated by their level of knowledge, understanding, skills, experience, and attitudes. There will be differing expectations of what they should know, say, and how they should behave. For the most part student nurses will occupy the novice and advanced beginner stages before eventually progressing towards the competent stage. However, their level of knowledge and experience will be gradually developing between the advanced beginner and competent stages. A third year student nurse, for example, should be able to demonstrate that developing knowledge and experience. Therefore, it might be argued that inconsistency about research knowledge and research-based practice is to be expected because of the stage reached by these student nurses in terms of how much knowledge, understanding and experience they have acquired in relation to the application of research knowledge to practice. Although they will have been taught about research in their nursing programme, it might be conceded that their understanding of its application in practice will be limited until sufficient experience has been gained. As Benner (1984) points out, at the novice and advanced beginner stages, behaviour is very much rule-governed, particularly at the novice stage, and practitioners manifest limited situational perception and discretionary judgement about clinical practice.
From the perspective of discourse theory, in examining the findings from a contextual dimension, it seemed possible to offer some insight into the prevailing ideology and hegemony of this discourse. Overall, the ideology might be seen to be a positive one in that students appeared to be able to offer a strong defence in respect of the attributes of the Project 2000 educational culture. From a textual dimension the use of the words ‘dynamic’ and ‘non-dynamic’, referring to young and old practitioners respectively, seemed to embrace a hegemony in which their generation as the staff nurses of the future would, through their knowledge of research and effective literature searching and learning skills, be able to advance the frontiers of nursing and research-based practice and thus establish their own power base. Although this statement represents a positive outlook, nevertheless, it is a narrative which is being told within the discourse of student nurses. At the student nurse stage, it might be conceded that there tends to be a positive expectation expressed that the new generation of qualified practitioners will be able to change future practice. However, this is often not possible. Lack of knowledge and experience of clinical reasoning at this stage precludes a realistic insight into the obstacles which serve to constrain their power and authority to effect change as qualified practitioners.

Qualified practitioner discourse:

Of the three ward sisters interviewed, two were very experienced and the other less experienced and recently appointed to this nursing role. All three ward sisters were practising within the same Care of the Elderly unit. In examining the findings there was consistency in the way in which the ward sisters viewed themselves as role models, for which current knowledge, understanding, skills, and experience related to their area of practice, were essential. They also appeared to be consistent in their fears about keeping up to date with changes in practice and the knowledge alongside it. Knowledge for safe practice and for taking responsibility for their own scope of professionalism was deemed essential. This view indicates the influence of a rationalist model of nurse education on practitioners, where certain knowledge is valued above tentative knowledge (Purdy, 1994). However, it might be argued that a rationalist model is the most appropriate and valuable one to utilise. Nurse practitioners are accountable for their practice and, therefore, the acquisition of certain knowledge for safe and competent practice is deemed an essential aim. Indeed, Benner (1984:184) confirms this when she says, ‘...the risks inherent in poor judgement indicate that strong educational preparation in the biological and psycho-social sciences and in nursing arts and science is the necessary base for advanced skill acquisition, because this knowledge provides
the basis for safe care and gives the most advantageous position for gaining a sense of salience.’

There was some consistency about the value of intuition and experience in the examples given by the two experienced ward sisters. For Benner (1984), experience is important. She points out that experience does not refer to the mere passage of time, but that it is the refinement of preconceived notions and theory through encounters with many actual practical situations that add nuances or shades of difference to theory (Benner, 1984:36). She adds that any nurse experienced in working with theories finds differences that the formal theory fails to express (Benner, 1984:36). A nurse who has dealt with many people acquires a rich basis on which to interpret new situations, but that this multifaceted knowledge cannot really be put into abstract principles or explicit guidelines (Benner, 1984:37). In relation to Benner’s model (1984), therefore, it might be argued that these practitioners have reached the proficient stage of knowledge and skill acquisition. Here, practitioners see situations holistically rather than in terms of aspects and can see what is most important in a situation. This holistic understanding improves the decision-making process, which becomes less laboured (Benner, 1984:28-29).

Although there was consistency about the need for research-based practice, there were also statements made which constituted excuse, justification and disclaimers. In fact, the less experienced ward sister saw self-awareness, communication skills and reflective practice as being as important as research. From a contextual dimension, it appeared that the prevailing ideology was a mixture of both positive and negative aspects, the latter being represented more by the two experienced practitioners and the former represented by the less experienced practitioner. Ongoing changes both in practice and knowledge appeared to be challenging the senior ward sisters who felt that there was an undervaluing of their intuition and experience as part of an outdated belief system. However, the apparent willingness of the younger practitioner to manage change seemed to indicate a more flexible approach to the changes taking place.

Nurse manager discourse:

Of the three nurse managers interviewed, two practised within the same mental health unit and the other was based in a general hospital.

In this discourse, there appeared to be consistency about the fact that they viewed themselves as acting as role models. The two senior ward sisters also viewed themselves as role models. However, as role models in management, they were there to demonstrate the skills of management, change management,
and of supporting staff. There was some inconsistency about the knowledge base in relation to their role. One nurse manager mentioned that her management knowledge was ‘a bit rusty’, but that her tacit knowledge could ‘always be relied upon’. Another nurse manager conceded a fairly good knowledge base, and the other nurse manager made no mention of knowledge. These views were in contrast to the three ward sisters, all of whom were consistent in indicating the importance of an up to date knowledge base in relation to their role. The nurse managers appeared to be consistent about the fact that there was constant change, but also that change was an enabling agent. The reality of research-based practice was viewed as a top-down approach achievable through management strategies such as a quality facilitator, a quality forum, a senior research-based nurse, a research and development consultant, and auditing. The two mental health nurse managers placed emphasis on reflection as the starting point for research. There was no mention of reflection by the general hospital nurse manager. These nurse managers, however, produced disclaimers about the Project 2000 training. Essentially, this had to be the course for the future, but that student anxiety about their clinical skills and lack of experience was considerable. This view was also shared by the two senior ward sisters. Indeed, the mental health nurse managers stated that they preferred a separate training for psychiatric nurses. In discussing their own training it was emphasised how nursing had moved from a practical base to a theoretical base. One nurse manager emphasised the importance of raising change and business skills.

From a contextual dimension, it appeared that the overall ideology was a positive one. Change was the biggest issue for all three nurse managers, but it did not appear to pose a threat to them, unlike the two senior ward sisters. These nurse managers appeared to be confident in discussing the potential of management strategies to support practitioners through change. Thus, from a contextual stance, it seemed to suggest the existence of a confident and dominant hegemony within the overall discourse of the nursing. From a textual dimension, the most frequently used words were change, change management, communication skills, role model, auditing, quality, and supporting staff, all of which seemed to summarise management discourse.

**Nurse lecturer discourse:**

All three nurse lecturers were practising within the same university department. Overall, the ideology was a mixture of optimism and pessimism about the future of Project 2000 and nurse education. Pessimism was expressed in terms of nurse education being led by Trusts, contracts and finance rather than sound
educational principles. They felt that this was also having a negative influence on students. However, optimism was couched in terms of nurse education needing to, and having the potential to be at the forefront of developing clinical practice, and that this could be its key role for the future. There was agreement that they felt uncertainty about their personal aims, alongside those of their students in relation to what constituted the knowledge base. The difficulty was trying to decide what knowledge the students needed and how best to deliver it. However, it was felt that students wanted concrete, theoretical knowledge to enable them to speak the same language as doctors or psychologists. There was also consistency about the problem of keeping up to date with a rapidly changing knowledge base and the demands of workload. It was unanimously stated that nurses needed to have clinical knowledge in order to demonstrate credibility. In relation to research, it was everyone’s responsibility to ensure the link between knowledge and research-based practice. As for students and research, it was stated that students essentially lacked critical abilities. Their enthusiasm for research depended on how they approached their studies and what they wanted and needed. The nurse lecturers seemed to suggest that students were either open, inquiring, and critically minded, or they were pragmatic. From a textual dimension the frequent use of words such as knowledge, knowledge base, clinical knowledge, theoretical knowledge and research-based practice indicated their awareness of the importance of the whole area of knowledge and research-based practice, which was to be expected. With the exception of the nurse managers, they expressed the same fears, doubts and anxieties about knowledge and research-based practice as the student nurses and qualified practitioners.

7.3: The main aims of the study:

Having discussed the findings from discourse analysis, the main aims of this study will now be revisited. These are:-

To examine the relationship between nurses’ perceptions of knowledge and research-based practice:

In examining the relationship between nurses’ perceptions of knowledge and research-based practice the findings from the pre-pilot group discussion, and pilot and main questionnaires, indicated that practitioners’ perceptions of knowledge and research-based practice were determined by their cognitive level and stage of professional development. Thus, the expectations about
practitioners' level of knowledge and its application to practice correlated to those identified within the stages of Benner's model (1984).
In relation to knowledge, the types most often used were theoretical and experiential. Practical knowledge was frequently mentioned by the qualified practitioners, and, knowledge from books by the student nurses. Again, this confirms what Benner (1984) points out in her model about the difference in the kind of knowledge required to perform at the novice stage from that required at the later stages of professional practice and development.
In terms of nursing knowledge, there was a consensus that it was experience gained through practice and a body of scientific knowledge. As for research-based knowledge, there was consensus among practitioners that it was that gained through a systematic enquiry and that there was a need for research knowledge and research-based practice as a means of developing nursing for the future. This consensus appeared to represent the professional ideology of nursing. Nevertheless, there was some disbelief and scepticism about research knowledge and research-based practice. The relationship was dominated by nurses' beliefs and what worked best in certain situations in clinical practice.
Changes and adaptations to skills, techniques and procedures were made in the light of 'new information' or experiences, but this was not necessarily research knowledge. This view is endorsed by Benner's theory (1984) that as practitioners become more advanced, they should be able to reflect more critically on their knowledge, based on their own experiences of practice. Thus, clinical expertise is about the ability to make a judgement about the best available knowledge to apply in practice, and which is known to work in the light of personal experience.
In conducting a discourse analysis, the earlier findings were validated. The relationship between knowledge and research-based practice was found to be the same. There was disagreement being expressed by practitioners about the need for research-based practice and the extent to which it was in existence. The findings from the main questionnaire indicated that the majority of respondents in each group of practitioners thought that research-based knowledge was used to a limited extent. This disagreement, however, is confirmed in the literature. Rodgers' (2000) study found that nurses' scores on individual research practices ranged from 60% of nurses never having heard of a practice to 85% always using a research practice. Similarly, Parahoo (1999), in examining and comparing the extent to which pre-Project 2000 and Project 2000 trained nurses utilised research in their practice, found that 2.8% of pre-Project 2000 nurses and 1.9% of Project 2000 nurses reported 'never' using research, whilst 6.9% of pre-Project 2000 nurses and 4.5% of Project 2000 nurses reported using research 'all the time'.

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There was also inconsistency about whether there were any difficulties associated with applying research-based knowledge to practice. Again, in the findings from the main questionnaire, in each group, with the exception of the qualified practitioner group, approximately 50% of the respondents indicated that there were difficulties, whilst 50% indicated that there were none. In the qualified practitioner group, 59% of the respondents indicated that there were difficulties, whilst 41% indicated that there were no difficulties. The main difficulties identified were: a lack of knowledge of research, a lack of time to study research, resistance to change, and tradition. Difficulties such as a lack of awareness of research evidence and the pursuit of ritualistic practices have been confirmed recently in the literature (Chapman, 1996).

The relationship appeared to be constrained by ongoing changes both in knowledge and practice, which particularly threatened senior qualified practitioners because it undervalued their intuition and experience as part of an outdated belief system. Younger qualified practitioners and student nurses appeared to represent a more positive approach to this relationship and they were more flexible about the changes taking place within different professional contexts. Student nurses undertaking the Project 2000 course of training seemed to imply that their knowledge of research was growing as a result of having research studies as part of their training programme. Thus, their awareness of the need for research was developing. However, they also implied that because of a lack of autonomy as student nurses, this served to act as a constraint to research utilisation. Again, these views have been confirmed in the findings of Parahoo (1999, 2000). In the Parahoo (2000) study, the results showed that the top barrier to research utilisation was ‘The nurse does not feel she has enough authority to change patient procedures’.

Change was perhaps the most significant factor affecting this relationship. The older generations of practitioners were tying to resist change and maintain some stability by exercising a social control over ‘new knowledge. The younger generations of practitioners were more willing to negotiate and develop with the changes. It was made explicit that it was everyone’s responsibility to ensure the link between knowledge and research-based practice, but it was also implied that this might only be achieved infrequently.

In relation to perceptions of knowledge, basically, knowledge was about facts, gaining information and understanding and using it, direct learning into certain areas, knowledge for how to care for a patient, beliefs and experience. Knowledge was needed to get the job done. What was required was certain knowledge for safe and competent practice. Other perceptions of knowledge were more wide ranging. Knowledge was identified as being research-based, reflection, personal, ethical, aesthetic, intuitive, philosophical, sociological, spiritual, political, medical, semantic and discursive.
From a discourse analysis, it appeared that knowledge was being viewed in a much more holistic way for the future due to a rapidly changing professional environment. Research knowledge and research-based practice were gradually gaining more credibility. Younger practitioners were becoming more research-minded and more skilled in literature searching due to an emphasis placed on research studies in the current educational programme.

To examine the extent to which nurses view themselves as professional practitioners:

In examining the extent to which nurses viewed themselves as professional practitioners, findings indicated differing views. There was debate as to the meaning of the term 'professional'. Approximately 50% of the respondents in each group in the main questionnaire thought that a professional was a person with expertise who was paid. The other 50% offered different meanings. Nevertheless, overall, there was consensus among the qualified practitioner, manager, and student nurse groups that nurses were professional practitioners. The number of changes taking place in nursing caused many nurses to feel that nursing was just a vocation. Where nurses were allowed to use their knowledge to full capacity, they would feel more professional. Interestingly, the pre-Project 2000 trained third year student nurses in the group discussion viewed degree and diploma nurses as being more professional than traditional nurses because of the acquisition of more knowledge by the end of training. Thus, more knowledge was equated with better understanding, with being more research-minded, and with having the power to effect change.

It was believed that many nurses practised in a professional manner but that, in reality, nursing had still not received ‘true’ professional status. Thus, nurses lacked social status in the eyes of the public. This view was expressed by the third year student nurses in the group discussion and also endorsed by the nurse lecturers in the main questionnaire. Indeed, the main reason advanced by the lecturers for this was that nursing was an occupation, not a profession. This view is also advanced and supported in the literature (Porter, 1992).

It was held by many nurses that there was a relationship between research-based practice and being professional. Nurses felt that they were still not implementing research and other ‘good practice’ to improve patient care and this was important if they were to be seen as professionals. One of the main reasons for believing that nurses were professional practitioners was that nurse education had moved into higher education. Nurses were striving to increase their body of knowledge and base their clinical practice on research findings, and they were continuing to initiate research. Another main reason was that
nurses were guided by a Code of Professional Conduct and were autonomous practitioners. From a discourse analysis it was made explicit in the qualified practitioner group that being a professional practitioner was very much related to having updated knowledge and skills, and understanding and experience relevant to the area of practice. In the manager group it was felt that nurses needed to become professionals and depart from the image of being 'handmaidens to the doctors'. In this sense, it was felt that Project 2000 was the training course for the future because it could help nurses to achieve professional status. In the student nurse group, only one of the students made some reference to the professionalism debate although his personal view was not made explicit. No specific reference was made to being professional in the nurse lecturer group. Thus, in relation to the student nurse group and with reference to Benner's (1984) model, it might be inferred that at the novice and advanced beginner stages, although students may have received some knowledge about the concept of professionalism, nevertheless, they lack the understanding and experience of its application to practice to be able to express personal views about it.

To examine the relationship between professional values and research-based practice:

In examining the relationship between professional values and research-based practice, professional values were linked to maintaining the status quo and they dictated people's behaviour. They formed the foundation of nursing on which extra knowledge was built. In relation to the meaning of the term 'professional values' the four groups of practitioner in the main questionnaire indicated that essentially it was about adhering to the Code of Professional Conduct. For many practitioners, however, the term 'professional values' was irrelevant and the idea of moral responsibility as human beings was more significant. Moral responsibility was about the application of a personal value system to practice, being able to justify this and articulate it. Only one statement was identified which indicated a relationship between professional values and research-based practice. It was expressed in this way. 'It is about ensuring your practice is up to date and based on sound rationale and research where available'. Otherwise, no direct reference was made to research-based practice, although it might be inferred that striving to do one's best for the patient might involve the use of research knowledge in practice. In relation to professional values placing constraints on practice, the majority of respondents among the four groups in the main questionnaire felt they did not. However, where constraints were identified, they related mainly to time, money, and a lack of resources.
From a discourse analysis, the learning of professional values was very important for student nurses. This was achieved by knowing how to communicate and form relationships with others and learning how to adopt appropriate attitudes towards others. The incorporation of research studies in the nurse education curriculum helped students to learn how to question much more. They were willing to embrace research and demonstrate a positive attitude towards looking at research and seeing how patient care could be improved.

For the older and more experienced qualified practitioners, professional values were about principles, enforcing consistent regulations and getting the job done efficiently. The managers reflected positive attitudes towards research and the need for nurses to become professionals. For nurse lecturers, every practitioner should take responsibility for making the connection between knowledge and research-based practice. An important aspect of the lecturer's role in higher education was to facilitate practice research.

7.4: Discourse analysis: an ongoing critique.

In this chapter, in discussing the main aims of the study in the light of the inferences made from the findings, reference has been made to Benner's (1984) model. This has served both as an epistemological framework and an interpretative framework. Discourse analysis has also been used as another interpretative framework. However, because of the recognised subjective nature of a discourse analysis approach, and because it has been used both as an interpretative framework and a narrative, it is necessary to provide some critique of it at this stage.

Firstly, Benner's (1984) model, as an interpretative framework, can be related to discourse analysis as an interpretative framework. The stages from novice to expert in Benner's (1984) model might be seen to correspond to the concept of 'discourses', in which power struggles and hegemony exist. Benner's (1984) model represents the development of professional knowledge and skills, and through experience, the development of expertise in clinical decision-making. Similarly, discourse analysis shows how individuals gain the knowledge, skills and experience to be able to work with other people and perform to acceptable standards. It also shows how people can improve and negotiate their situation and become experts in their own area of study and practice by developing and using their knowledge. It also shows how people gain experience in the power struggles within nursing. Thus, discourse analysis, as an interpretative framework, was used in this way to interpret the findings.

Secondly, however, it was used to present a story, or narrative, which served as a basis for a contextual analysis of the respondents in the open-ended interviews. The contextual dimension was felt to be important since it was
locating nurse practitioners and their discourse within a social, political and cultural context. Thus, it was examining the reproduction of ideology and hegemony within the four groups of nurse practitioner. A problem with combining the two approaches is that the story or narrative itself becomes an interpretative framework. The implication of this is that the researcher can produce a biased interpretation through allowing personal experience to form the basis of further reconstruction of the data. Subjectivity remains a problem in using a discourse analysis approach. Nevertheless, an effort was made to be as objective as possible in approaching the interpretation of the data. This might be seen to have manifested itself in that it was possible using this approach validate to some marked extent the findings from the earlier data collection methods.

7.5: Conclusion:

This chapter has sought to discuss the main aims of this research study in the light of the inferences made from the findings. The discussion was supported by reference to Benner’s (1984) model, as the epistemological framework, and to current research evidence and literature. Before addressing the main aims, a discussion of the findings made from the discourse analysis was presented as a basis for understanding the inferences made overall. By using a discourse analysis approach to analyse the data from the twelve open-ended interviews, it was shown how this approach served as a means of validating to some considerable extent the findings from the earlier data collection methods used in the study. However, because discourse analysis was being used as an interpretative framework and also because, as a framework, it was being used in two ways, it was deemed necessary to offer some ongoing critique of the approach in relation to its subjective nature. In the final chapter, several conclusions will be drawn in relation to these main aims in the light of the discussion of the findings.
Chapter 8

Conclusion

8.1: Introduction:

This research study set out to examine the relationship between nurses’ perceptions of knowledge and research-based practice, the extent to which nurses viewed themselves as professional practitioners and to examine the relationship between professional values and research-based practice. Several conclusions will now be drawn in relation to these main aims in the light of the discussion of the findings in Chapter 7. These conclusions will be presented with reference to the research findings from this study, and supported, where appropriate, with reference to Benner’s (1984) model which has served as the main epistemological framework for this study. The implications of the findings will then be discussed with reference to nurse education, management, and clinical practice. Some suggestions for further research will be made, based on the research findings, and several major recommendations for nurse education and practice will be advanced. The study will then be concluded overall.

8.2: Conclusions:

The findings from this study provide research evidence of the complexity of professional knowledge development. The research-based findings from this study are distinct from the evidence-based findings provided by Benner’s work in respect of professional knowledge development. However, they are also complementary to Benner’s evidence-based findings in that they reveal the complex nature of professional knowledge development by a different approach. The contribution of the research findings from this study to the development of knowledge is that it has been shown that the complexity of professional knowledge development has a significant influence on the relationship between nurses’ perceptions of knowledge and research-based practice with reference to the utilisation of research in practice. From these research findings, the complexity of professional knowledge development has emerged as another factor influencing the non-utilisation of research knowledge in practice. This is a very substantial factor which has not previously been documented in the literature, although many other contributory, though less significant, factors are to be found. The research
findings from this study indicated that, in the course of developing professional knowledge, nurse practitioners’ perceptions of knowledge with respect to research-based practice were dominated by as much consistency as inconsistency about the need for and the extent to which research-based practice existed, respectively. Whilst the views of practitioners were consistent about the need for research-based practice, there was disagreement about the extent to which it existed. With reference to Benner’s (1984) model as the epistemological framework, it was possible to offer some explanation and provide some rationale for the disagreement being expressed.

1) The relationship between nurses’ perceptions of knowledge and research-based practice.

Firstly, nurse practitioners express overall the need for research knowledge and research-based practice as ways of developing nursing practice. This expression may be seen to represent a professional ideology which views nursing as being a profession underpinned by a scientific knowledge base and research-based practice. However, the decision-making skills required to put research knowledge into practice very much depends on the stage reached in terms of the practitioner’s professional knowledge development. It depends on the practitioner’s level of professional knowledge and understanding, and the skills and experience gained. Alongside the development of professional knowledge, understanding and experience, there emerges a perceived authority for the nurse practitioner to initiate research-based practice. Parahoo (2000) has most recently confirmed ‘a lack of authority’ as being the top barrier to research utilisation among student nurses.

Secondly, As nurse practitioners advance and gain more knowledge, understanding, and experience, they should become more reflective. However, to place this expectation on student nurses in the early stages of their training, that is at the novice stage, could almost be counterproductive because of their limited understanding of the knowledge being acquired and its application to practice. Nevertheless, as nurse practitioners gain more experience of observing the application of knowledge to practice, they can then begin to reflect on those experiences. The gradual development of their reflective skills will then enable them to make judgements about practice with reference to the most appropriate sources of knowledge available, which includes research knowledge. More importantly, as they develop their reflective skills, they will need to make the results of their reflection explicit so that the grounds for judgement can be laid. This might be achieved by the use of reflective models, which offer a structured approach to the organisation of thoughts in defined areas. As the practitioner
becomes more advanced, the capturing of reflective thoughts might be achieved by the writing of clinical narratives.

**Thirdly,** On closer examination of the relationship between nurses’ perceptions of knowledge and research-based practice, it was found that there was disagreement about the extent to which research-based practice existed. However, this can be explained in terms of the complexity of professional knowledge development. The disbelief and scepticism expressed about research knowledge and research-based practice are to be expected as nurse practitioners become more advanced in their professional knowledge and understanding, and in their experience of the application of research knowledge to practice. More importantly, it is to be expected in the light of practitioners who are constantly engaged in critically examining the experiences of their own practice and the knowledge underpinning those experiences. Research knowledge may not necessarily be the best or most appropriate knowledge to use in practice.

2) The extent to which nurses view themselves as professional practitioners.

**Firstly,** differing views were expressed about the extent to which nurses viewed themselves as professional practitioners. In the qualified practitioner and student nurse groups, there was a clear indication that these respondents viewed nurses as professional practitioners. In the nurse manager group, it was found that nearly as many respondents did not view nurses as professional practitioners as those who did. In the nurse lecturer group, there was more a much more marked tendency not to view nurses as professional practitioners, and generally to view nursing as an occupation, rather than a profession. However, again, these inconsistent views can be explained in that professionalism is another ideological concept. This ideological concept was voiced by many nurse practitioners who indicated that there was a relationship between research-based practice and being professional.

**Secondly,** it was indicated that nurse practitioners could be described as ‘professional’ if the term was being used loosely to describe those who work conscientiously. It was also indicated that although nurse practitioners did practise in a professional manner, nevertheless, in reality, nursing had still not received ‘true’ professional status because nurses lacked social status in the eyes of the public. They lacked autonomy and were poorly paid.
Thirdly, it was indicated that nurse practitioners were professional because nurse education had moved into higher education. Nurses were striving to increase their body of knowledge and base their clinical practice on research findings. They were continuing to initiate research. Furthermore, nurse practitioners believed that they were professional because they were guided by a Code of Professional Conduct and were autonomous practitioners.

Fourthly, it was indicated that nurse practitioners believed that being a professional practitioner was very much related to having updated knowledge and skills, and understanding and experience relevant to the area of practice.

3) The relationship between professional values and research-based practice.

Firstly, the majority of views expressed did not indicate a direct relationship between professional values and research-based practice, and, overall, professional values did not place constraints on research-based practice. Where constraints were identified, they related to time, money, and resources.

Secondly, professional values were viewed both as being about adhering to the Code of Professional Conduct and having a set of beliefs about nursing. However, professional values were revisional, and, again, this was influenced by the complexity of professional knowledge development and the gaining of experience. For student nurses in the early stages of professional knowledge development, the learning of professional values was very important. This was achieved by learning how to establish professional relationships, and how to learn and communicate in practice by adopting appropriate professional attitudes.

8.3: Implications:

Some implications for the findings of this study will be presented. The conclusions of this study focus on the three important areas of knowledge, research-based practice and professionalism, which directly concern practitioners in education, clinical practice and management. In relation to these areas, the education of practitioners for the future will be significant. It will need to enable them to develop their decision-making skills to the extent of being able to judge whether or not clinical practice should be research-based.
Thus, the implications for education, practice and management will now be discussed.

8.4: Implications for education:

The implications of the findings from this study are significant for nursing education in terms of the approach to teaching students, curriculum content, implications for teachers, and students' expectations of professional knowledge development in relation to clinical nursing practice.

The teaching of students for the future will be significant for the relationship between knowledge and research-based practice. Teachers need to give more priority to the whole area of knowledge and its philosophical underpinnings.

Student nurses need to examine in some detail the different kinds of knowledge which are used to inform nursing practice. Importantly, they also need to be able to critically appraise different kinds of knowledge in order to determine the most appropriate kind to use in practice. Clearly, with the advent of research studies into nurse education curriculum, the opportunity has been taken not only to introduce the concept of sources of knowledge with specific reference to research knowledge, but also the concept of critical appraisal of research studies.

However, this subject area needs to be more fully integrated and developed within the modular system of training.

Experiential learning might be seen as a valued teaching and learning approach to introducing students to the concepts of thinking, critical thinking, and reflection. Although the concepts of reflection and reflective practice were introduced into the curriculum with the advent of the Project 2000 nurse training, they have tended only to be superficially addressed and not developed or integrated sufficiently within the curriculum. If reflection and reflective practice were undertaken on an ongoing basis, it might be conceded that the ability to write clinical narratives would develop.

Experiential learning is deemed to be important and best seen as being structured narratively. Benner et al (1999) posit that a good teaching/learning strategy is to dwell in and with stories that capture clinical understandings of situations. Thus, narratives might be seen as a means of nursing knowledge development and its documentation. A narrative will enable a practitioner to make explicit his or her knowledge, what he or she did, and what led to a certain judgement. Indeed, Benner (1999) believes that developing the skills of narrative reflection on practice is particularly helpful in developing expert clinical judgement.

This approach to teaching and learning allows a view
of how clinical reasoning unfolds over a period of time. Thus, teachers need to help students to develop clinical reasoning. This means that then students will be able to make the best possible use of knowledge to make sound, defensible decisions about clinical practice. Students need to develop habits of clinical enquiry in practice to enable them to question existing ritual, habit and tradition, which have been well documented in the literature, particularly in relation to factors impeding the implementation of research-based practice.

In relation to curriculum content, communication studies have long been part of the nurse education curriculum in an attempt to enable students to learn about and develop effective interpersonal skills. However, communication has not been necessarily been viewed as a means of knowledge development and has been addressed too narrowly in relation to knowledge and practice development. The concept of dialogue is pivotal to the process of communication and knowledge development and, therefore, the dialogical relationship in clinical practice must be seen to be important and given due weighting within the curriculum. One of the significant findings from this study was that for student nurses, the forming of relationships was important in enabling them to learn within a context. Knowing how to adopt appropriate attitudes towards others and knowing how to question to gain information was crucial to their cognitive development. As Benner (1999) argues, learning to make good clinical judgements and be a good practitioner requires experiential learning, reflection, and dialogue with patients and their families.

8.5: Implications for teachers:

If experiential learning is to form the basis for the approach to teaching and learning within the curriculum, then the teacher would be required to become proactive in the teaching and learning process. Experiential learning is an approach which links process and content in terms of the curriculum. As Benner (1999:19) indicates, experiential learning does not occur without active participation, nor is it guaranteed by the mere passage of time. Thus, experiential learning requires engagement in the situation. Benner (1999:19) adds that it ‘involves a “turning around” of preconceptions, recognition of patterns, or sensing something disquieting or puzzling that generates a problem search’. Such a relationship is based on an ongoing enquiring dialogue.

Teachers will also need to be mindful of students’ expectations of professionalism, professional knowledge development and clinical nursing practice. It is essential that student nurses are helped to gain some clear understanding of the concept of professionalism. A significant finding from the pilot questionnaire, in response to a question seeking an understanding of the
term ‘professional self-concept’, was that practitioners were vague in their answers, or gave answers which related to their personally perceived aspects of being a professional in nursing. No official definitions of ‘professional self-concept’ were given.

Nursing is firmly rooted in practice and student nurses need to be clear that seeking to become a professional practitioner involves a continuous striving to gain mastery over the different kinds of knowledge which both inform and improve practice. A wealth of knowledge is derived from reflecting on the experiences of clinical practice. In conjunction with this, therefore, student nurses also need to be clear about the role of research and research-based practice as being another means of contributing to the improvement of clinical nursing practice. Reflecting on the experiences of practice can often give rise to research questions which then become the basis for a research study and further knowledge development. At the same time, an abundance of research knowledge exists alongside other kinds of knowledge. It is a question of deciding which kind of knowledge constitutes the best available knowledge to utilise in clinical practice to the benefit of the client.

One of the main aims of nurse education for the future will be to produce professional practitioners who can contribute to professional knowledge development and practice through active reflection or, according to Benner (1999), a thinking-in-action approach. In order to achieve this, greater emphasis will need to be placed on a consideration of professional knowledge development through an experiential learning approach. This will serve as a basis for allowing students to develop the skills necessary to make the most informed decisions about the delivery of best practice, which might also appropriately include research-based practice.

8.6: Implications for clinical practitioners:

Clinical nurse practitioners need to become more aware of the different kinds of knowledge which inform their practice and this includes research knowledge. They also need to critically examine these different kinds of knowledge by reflecting on their own experiences of clinical practice. This will then enable them to make decisions about the best available kind of knowledge to utilise in practice and again this includes research knowledge. Patient care is not linear and orderly and, therefore, a linear and orderly framework for explaining it will never be effective. Nevertheless, nurse practitioners need to provide justification for the decisions made about the evidence underpinning their clinical practice.
Clinical practitioners need to distinguish between evidence-based practice, which includes evidence which is patient-specific, and research-based practice, which is underpinned by research evidence which may not necessarily be patient-specific. Currently, randomised controlled trials are deemed to be a very legitimate form of research evidence for nursing decisions. However, it has been estimated that only 12% of clinical and management decisions in nursing can be informed by research evidence from randomised controlled trials (Marks-Maran, 1997). As Benner (1999) argues, good clinicians must be able to draw on the best scientific evidence available to make sound clinical judgements. However, as clinicians, they can also contribute to the development of scientific knowledge through discoveries made directly in practice. Benner (1999) further argues that in addition to scientific knowledge, the clinician needs that essential clinical wisdom to interpret a particular patient’s clinical situation and respond to demands and possibilities in a timely manner.

8.7: Implications for management:

The same issues previously discussed in relation to the implications for education and practice apply equally to management. Importantly, the clinical setting is significant because nursing is a practice discipline and the knowledge of nursing cannot be separated from its practice. The responsibility of nurse management is to encourage co-operation between nurse educators, nurse practitioners and themselves as nurse managers. They are also responsible for ensuring the facilitation of an effective professional learning environment which affords appropriate learning experiences for all nurse practitioners, depending on the stage reached between ‘novice’ to ‘expert’. Nurse managers have a responsibility for ensuring that there are opportunities for effective communication within the clinical learning environment. Critical reflection at all levels should be encouraged. For qualified clinical practitioners, in particular, critical reflection on clinical experiences can provide the basis for striving towards becoming an expert practitioner. This is achieved by a continuing development of knowledge and decision-making skills as a basis for advancing practice.

It is also important for nurse managers to support the notion of professionalism. One of the important findings from this study is that many nurse practitioners believe that being professional is about striving to increase their body of knowledge so that they can base their clinical practice on research findings. Nurse managers, therefore, must also be seen to be professional role models and seek to ensure that the relationship between professional knowledge and practice, particularly research-based practice, continues to be nurtured. This
means that practitioners must be encouraged to develop their professional knowledge and clinical experiences with a view to advancing their level of practice in caring for patients. Thus, an awareness of the importance of the relationship between professional knowledge and practice, particularly research-based practice, should guide management decisions about the appropriateness of initiating research-based practice and thus provide the resources necessary to achieve this.

8.8: A critique of the study:

The rationale for undertaking this study based on the chosen research topic was discussed fully at the outset and the main aims of the study were stated clearly and explicitly. This study set out to examine the relationship between nurses’ perceptions of knowledge and research-based practice. It was also examining the influence of professional values on this relationship and the extent to which nurses perceived themselves as professional practitioners. The use of Benner’s (1984) model served as a significant epistemological framework for this study.

Since the approach to the study was mainly qualitative, a number of research questions were asked and, again, these were stated clearly and explicitly. These questions were subsequently clarified during discussion with reference to supporting literature. The research approach taken was that of obtaining data from qualified clinical practitioners, student nurses, nurse managers, and nurse lecturers. These four groups were chosen to reflect four different levels of nursing. With reference to Benner’s (1984) model, they represented different stages of professional knowledge development along the spectrum from novice to expert. Having four groups also enabled a broader range of views to be elicited about the relationship between knowledge and research-based practice within the nursing profession.

Three areas will be discussed in relation to providing a critique of this study. These are 1) the complexity of the phenomena involved 2) the nature of the subject and 3) the limitations of the methodology.

The complexity of the phenomena:

It was the complexity of the phenomena involved in the study which made the exploration of the relationship between knowledge and research-based practice an insightful and exciting, yet difficult undertaking. However, having taken Benner’s (1984) model as the main epistemological framework facilitated a
better understanding of the complexity of this relationship by being able to offer rationale.

Knowledge itself is a complex concept. The main problem for nurse education is that knowledge as a subject in its own right has still not been sufficiently addressed and explored within the curriculum. The dearth of literature related to nursing knowledge has confirmed this. Traditionally, the nursing profession has adopted a pragmatic approach to the relationship between professional knowledge and practice. Fundamentally, nurses need a sufficient amount of theoretical knowledge to deliver the care required. There has been no recognition of the need to conduct a deeper awareness and analysis of the different kinds of knowledge which exist and might be used to promote a more informed approach to nursing care.

Research is also a complex phenomenon. Although it is a subject which has become integrated within the curriculum in nurse education in recent years, nevertheless, there tends to be a lack of understanding as to what purpose research serves. There is also scepticism about its application to nursing care. Certainly, it was found that the non-utilisation of research in practice was well documented in the literature. However, again, much of this scepticism could be explained with reference to Benner’s (1984) model.

The issues of what constitutes a profession and professionalism require much more debate since the nursing community remains unsure as to what is meant by the term ‘professional’ and whether nurses view themselves as professional practitioners. Professionalism appears not to be discussed explicitly. Certainly, there was a paucity of literature which addressed directly the relationship between nursing and professionalism.

The nature of the subject:

The nature of this relationship presented a challenge from the point of view of undertaking a research study on it. Knowledge, research, and research-based practice are regarded by many practitioners as being abstract concepts. They sometimes feel threatened by and alienated from such issues. It could not therefore be assumed that these concepts were an integral part of the cognitive repertoire of nurse practitioners regardless of their stage of career and professional knowledge development.

Consequently, some practitioners found it difficult to respond to some of the questions pertaining to knowledge and research in the pilot and main questionnaires although consideration had been given to the construction of the questions by offering, in many cases, the choice of a possible combination of answers to the question being asked. The reason for this difficulty was most probably due to the fact that, as practitioners, they were unaccustomed to
thinking specifically about such topics as knowledge, which, it appears, is subsumed within practice and for which there is no time to articulate it. Even when the opportunity was provided, respondents did not voluntarily wish to express their own written views on these areas. Perhaps this attitude indicates that nurse practitioners experience difficulties generally when asked to articulate about knowledge. However, as Benner (1984:11) argues, there is a wealth of untapped knowledge embedded in the practices and “know-how” of expert nurse clinicians, but this knowledge will not expand or fully develop unless nurses systematically record what they learn from their own experience. This also implies that nurse practitioners need to increase their whole awareness of the importance of knowledge.

In the open-ended interviews, encouraging respondents to talk about their own area of nursing practice and to what extent their knowledge and skills helped them to perform their work did allow them to articulate more easily their views about knowledge and practice.

Limitations of the methodology:

A combined quantitative and qualitative approach was taken within this descriptive research study. However, the greater emphasis was on the qualitative approach. The qualitative approach, however, can be criticised on the grounds of being subjective, biased and lacking in rigour. Discussion has already taken place about the complexity of the phenomena being explored within the relationship between knowledge and research-based practice in this study. It can be argued that it would have been difficult to measure such fundamentally complex phenomena totally by using a quantitative approach. It might be argued that complex people and experiences cannot be reduced to a series of numbers with no regard for context. Nevertheless, quantitative research is seen as being hard science, reliable, structured, outsider, distant, and objective in approach. However, it has been argued that there is nothing in the physical world which uniquely determines scientists’ conclusions. As Mulkay (1979) argues, scientists construct their own accounts of the world, and variations in social context influence the formation and acceptance of scientific assertions. However, it might be argued that using qualitative and quantitative methods in combination can be beneficial in providing the opportunity for exploring the research question more fully. Indeed, in the earlier part of this study, the quantitative approach was used specifically for the purpose of establishing a baseline of information in relation to the main research questions being asked. The information gained then served as a basis for a more in-depth exploration using a qualitative approach.
The qualitative research method was also chosen because the domains of personal and aesthetic knowledge are central to it, and are essential in helping to elicit the type of knowledge required for understanding human perceptions and experiences. It was important to search for meaning in the different perceptions of knowledge being expressed, rather than measure them. Thus, there was a need to interpret the respondents’ perceptions, with reference to Benner’s (1984) model, according to the stage reached in their professional knowledge development and level of experience.

**The discourse analysis approach:**

Because a search for meaning was required, a discourse analysis approach was used to analyse the interview data. As Lupton (1992) argues, discourse analysis has the potential to lay bare the ideological dimension of phenomena. Thus, in this study, the approach was a valuable way of trying to understand the meanings which nurse practitioners attached to such phenomena as knowledge, research knowledge, research-based practice, and professionalism, and thus, to discover the underlying ideologies. One of the goals of discourse analysis is to identify cultural hegemony and the manner by which it is reproduced. Discourse analyses, however, are undoubtedly subjective because they rely almost entirely on the researcher’s reading of the text with little regard for how others might interpret the same text. Nevertheless, by analysing the data and presenting the findings of this study with reference to Benner’s (1984) model as the main epistemological framework, it is possible to argue that the discourse analysis approach was a means of demonstrating that the development of professional knowledge and experience from novice to expert is also determined and influenced by the concept of cultural hegemony and the manner by which that is reproduced.

Discourse analysis theory openly acknowledges the inevitability of a theoretical position being context- and observer- specific. However, Lupton (1992:148) points out that it is important for the researchers to validate their assertions. This can be achieved by the extensive use of the actual textual material used in the analysis. By doing this, it allows others to assess the researcher’s interpretations and follow the reasoning process from the data to the conclusions. In this study, a practical application of the discourse analysis approach was illustrated in Chapter 5. Transcribed data from the 3 student nurse interviews were presented as textual material for this purpose. A comparative analysis was then made with the qualified practitioner and nurse manager groups. Thus, a substantial amount of data was disclosed and analysed. The broad pattern and the micro aspects of the discourse were explained as thoroughly as possible, and rationale was given to support the conclusions drawn.
Interviews conducted for the purpose of discourse analysis differ from others in that respondents are allowed greater rein to talk around a subject. The interview is seen as a conversational encounter with the researcher’s questions becoming as important as the interviewee’s answers. Because the researcher is seen as an active and purposeful individual, not just as a tool to gather and analyse data, the issue of reflexivity is a concern. The researcher is an integral part of the field being studied. As Schutz (1994) argues, nurse researchers need to establish a common ‘being’ with those they seek to study. It might be argued that this is far removed from the objective distance which is conventionally the cornerstone of validity in nursing research. However, according to Benner & Wrubel (1989), answers to the question of being precede answers to the question of knowing, and thus the establishment of this in-depth understanding of each other would be a prerequisite to the generation of theory from the research exercise.

It might be argued that if research is a learning experience then it must be interactive, and this is an indication of the need for a reflexive approach. Discourse analysis is a reflexive approach. It views the understanding of human behaviour as involving interpretation and empathy rather than prediction and control. Therefore, the researcher and subject are co-participants in the process of making sense of the world and their experiences of it. This will necessarily result in more than one construction of those experiences.

8.9: Suggestions for further research:

This study has presented an analysis of the relationship between nurses’ perceptions of knowledge and research-based practice using a combination of quantitative and qualitative methods. The conclusions drawn and the implications presented are based on an interpretative examination of the main concepts using both a content analysis and discourse analysis. As no previous research could be identified which looked specifically at this area, this study’s findings might be said to offer some new perspectives on the relationship between knowledge and research-based practice with particular reference to Benner’s (1984) model. The study itself could now serve as a springboard for further research which could be examined and conducted from different perspectives. These will now be considered.

Firstly, further research could be conducted by looking at this relationship in other professional health care fields of practice such as those of medicine, physiotherapy, occupational therapy, radiography and social work. Clearly, the concepts of knowledge, research knowledge and research-based practice are fundamental to all professional health care practitioners, including nurses, in
helping them to achieve the highest possible standards of practice in the interests of their clients. If such research were undertaken, it might provide the platform for sharing some of the universal problems which exist in relation to the utilisation of research findings in professional health care practice. Thus, through a collaborative approach, it might also seek to overcome some of the difficulties involved.

It might also be interesting and beneficial to conduct a comparative study to explore the similarities and differences which exist between the student nurse and qualified nurse practitioner relationship and its medical counterpart in relation to perceptions of knowledge and research-based practice. This undertaking could provide some explanation and a better understanding of the current conflicts and tensions which arise concerning the credibility and acceptance of nursing research knowledge by the medical profession.

Secondly, a perspective which might be pursued is the exploration of other professional health care practitioners’ views of the relationship between nurses’ knowledge and their practice, with particular reference to research-based practice. Thus, a research study of this nature would be on a much larger scale, since it might include participants, not only from the already mentioned fields of professional health care practice, but might also include patients and clients.

8.10: Recommendations:

In relation to the overall conclusions drawn from the findings of this study, it is now necessary to propose some recommendations for nurse education and practice concerning the area of knowledge and research-based practice.

Nurse education curriculum:

It would seem to be beneficial to promote more understanding of Benner’s (1984) model, as a teaching and learning model. A better understanding of the development of professional knowledge and experience could be seen to provide the springboard for the greater utilisation of research knowledge in nursing practice for the future. The nurse practitioner’s level of awareness of the different kinds of knowledge available and the level of decision-making skills based on previous experience will determine the extent to which research knowledge is utilised in practice. This approach to teaching and learning might also lead to a clearer understanding of the notion of professionalism. Nurse practitioners are accountable and, therefore, must be able to justify the
decisions they make about utilising the best available knowledge to underpin clinical practice to the benefit of the patient. Importantly, professional knowledge develops largely through experiential learning by reflecting on practice. This is made explicit throughout Benner’s (1984) model. Therefore, there needs to be a continuing emphasis placed on reflection and reflective practice. A thinking-in action approach, as described recently by Benner (1999), might offer an even more advanced cognitive approach to the area of reflective practice. This would involve practitioners learning how to respond more effectively to patients and to the demands of a changing situation, and for recognising when clinical assumptions and expectations are not being met. It would provide the basis for developing clinical judgement and the ability to reason. Thus, this approach to experiential learning could be facilitated within the area of communication studies in the curriculum. This would necessitate the introduction of the concept of narrative, its role in experiential learning, and the concept of clinical narrative writing.

**Interdisciplinary practice:**

In the current climate of interdisciplinary collaboration and partnerships in relation to the delivery of professional health care, it would seem that communication is instrumental to the ongoing struggle to achieve some shared multi-professional understanding of knowledge in relation to research-based practice.

The nursing profession, therefore, must be seen to be an integral part of the interdisciplinary concept. Nurse practitioners need to be versed in the art of interdisciplinary communication and skilled in the delivery of their own arguments in order to change the future health care agenda in the interests of clients. They can achieve this by documenting their own professional clinical knowledge development.

Communicating with other health care professionals could take the form of regular meetings to discuss issues and events concerning patients and areas of practice. They could also serve as a forum for constructing collaborative strategies to address any major problems or concerns which have been identified. However, this would need to be a health care Trust led policy initiative, which would be seen as lending support and credibility to the procedures required to be undertaken by practitioners within a multidisciplinary team at clinical ward level.
Nursing practice:

Similarly, nurse practitioners need to arrange their own regular meetings in which discussion can take place based on their own reflections on practice. This might be approached through the sharing of clinical narratives, or the presentation of case conferences. The aim would be to discuss and identify concerns related to clinical practice and formulate some ideas for overcoming the perceived difficulties. Generally, these approaches would serve as a basis for raising awareness about current research knowledge, current standards of practice, and the need to change and develop practice for the future. Again, this would need to be a health care Trust led policy initiative to lend support to the importance of practitioners' carrying out such procedures.

8.11: Conclusion:

The main aims of this study were to examine the relationship between nurses' perceptions of knowledge and research-based practice, to examine the extent to which nurse view themselves as professional practitioners, and to examine the relationship between professional values and research-based practice. This was achieved by obtaining data from four main groups of nurse practitioner representing student nurses, clinical practitioners, nurse managers, and nurse lecturers. Using Benner's (1984) model, these four groups were seen to represent different stages between the novice to expert stages, and, as such, demonstrated different levels of professional knowledge, understanding, skills and experience in relation to their perceptions of knowledge and research-based practice. Several conclusions were drawn from the research data and their implications for future education and practice discussed.

There were three main conclusions drawn. Firstly, the relationship between nurses' perceptions of knowledge and research-based practice is underpinned by a professional ideology and significantly influenced by the complexity of professional knowledge development. Thus, nurse practitioners will express an overall need for research knowledge and research-based practice because both are perceived as being ways of developing nursing practice, which should be the aim of a professional nurse practitioner. However, this perception is part of a professional ideology. On further examination, this relationship between nurses' perceptions of knowledge and research-based practice is dominated by disagreement about research-based practice and the extent to which it exists. In reality, the research findings from this study have shown that perceptions about knowledge, and research-based practice will depend on the stage reached in the nurse practitioner’s professional knowledge development, their experience, and the level of their decision-making skills in terms of the need for research-based practice. Secondly, there is disagreement about the extent to which nurse
practitioners regard themselves as professional practitioners. Again, the inconsistent views of the respondents can be explained in that professionalism is also part of a professional ideology. Thirdly, although respondents did not express a direct relationship between professional values and research-based practice, nevertheless, it is influenced by the stage reached in the nurse practitioner’s development in terms of the professional knowledge, skills, and experience gained. This will influence decision-making about nursing practice generally, but also the need for research-based practice. Overall, these conclusions might be seen to be indicative of the complexity of professional practice and culture and the way in which nurse practitioners acquire professional knowledge, skills, and experience within their practice and culture. A critique of the study was presented and discussed and some suggestions for further research were offered. Finally, some major recommendations were made for the future of nurse education and practice. In conclusion, by examining the relationship between nurses' perceptions of knowledge and research-based practice, this study has highlighted the need for a more serious consideration of professional knowledge development and its implications for research-based practice. In respect of the concept of professionalism, as the clinical careers of nurse practitioners develop, nurse practitioners themselves should change their intellectual orientation, integrate and sort out their knowledge, and refocus their decision-making on a different basis. What has to be ensured, however, is that practitioners are encouraged to engage in reflective practice, or adopt a thinking-in-action approach to their clinical practice. This, in turn, could lead to an increasing awareness of the different kinds of knowledge available based on their experiences and upon which future decisions about the need for research-based practice can be made.
APPENDICES
APPENDIX 1
4th August 1994

Dear Colleague,

I am currently undertaking an MPhil/PhD course at the University of Surrey and my research study is examining the extent to which nurses’ perceptions of knowledge and their professional values are related to research-based practice.

I would like to invite you to take part in a small group discussion which will be taped and last 45 minutes, approximately. It will constitute a pre-pilot study and also the initial stage of my study.

I should like to reassure you that you will remain anonymous in any report made by me and that your response during the group discussion will be treated in strict confidence. I am very happy to replay the tape for you to listen to your responses after the recording.

Thanking you in advance for your co-operation in this study.

Yours sincerely

Sue Watkinson

Acting Principal Lecturer
Research Studies
APPENDIX 2
Pre-pilot Study

Group Discussion Guide

Introduction
The main purpose of the research study which I am undertaking is twofold. Firstly, it aims to examine the extent to which nurses' perceptions of knowledge and professional values are related to research-based practice; secondly, it aims to examine the relationship between professional self-perception and practice.

Areas for discussion:

a) Nurses' perceptions of knowledge and commitment to research-based practice.

b) The concept of knowledge within the nursing community.

c) Nurses' perceptions of themselves as individuals.

d) The influence of professional values.

Thank you for taking part in this discussion.
Dear Colleague,

Re: Pilot Questionnaire

I am currently undertaking an MPhil/PhD course at the University of Surrey and my research study is examining the extent to which nurses’ perceptions of knowledge are related to research-based practice.

My reasons for asking you to complete this pilot questionnaire, which is the second stage in the design of the study, are twofold. Firstly, I hope to gain a broader span of information about nurses’ perceptions of knowledge and its application to practice, and, secondly, I hope to elicit views about the relationship between professional self-concept and practice.

I should like to reassure you that you will remain anonymous in any report made by me and information given will be treated in confidence. An addressed envelope has been provided for return of the completed questionnaire.

Thanking you in advance for your co-operation in this study.

Yours sincerely

Sue Watkinson
Senior Lecturer - Research
PILOT QUESTIONNAIRE

Would you please answer the following questions:

1. What do you understand by the term 'knowledge'?

2. What type of knowledge do you use in your nursing/educational practice?

3. Do you think that some types of knowledge are more important than others?

   [ ] YES  [ ] NO  
   Please tick the appropriate box.

   If you have answered 'YES', please state which type(s) of knowledge and why?

4. How do you view 'research-based knowledge'?
5. Does the application of knowledge to practice present you with any difficulties?

Yes [ ] No [ ]

Please tick the appropriate box.

If you have answered ‘YES’, please state what kinds of difficulties.

6. What do you understand by the term 'professional self-concept'?

7. Do you think that nurses perceive themselves as being professional?

Yes [ ] No [ ]

Please tick the appropriate box.

Please state the reasons for your answer.

8. What are your views about the influence of professional values on practice?

Thank you very much for completing this questionnaire.
APPENDIX 3
PILOT QUESTIONNAIRE

Would you please answer the following questions:

1. What do you understand by the term 'knowledge'?

   facts, feelings, awareness gained by formal learning, experience of self and others.

2. What type of knowledge do you use in your nursing/educational practice?

   - Experiential Learning
   - Formal Teaching
   - Experience of others
   - Research

3. Do you think that some types of knowledge are more important than others?

   [ ] YES [ ] NO

   Please tick the appropriate box.

   If you have answered 'YES', please state which type(s) of knowledge and why?

4. How do you view 'research-based knowledge'?

   Essential for the development of nursing if we are to develop and go forward
5. Does the application of knowledge to practice present you with any difficulties?

[ ] YES [ ] NO

Please tick the appropriate box.

If you have answered 'YES', please state what kinds of difficulties.

I consider myself as a Manager now not a Nurse. However in this role I do not have any difficulties. I have undertaken the 'formal learning' to prepare this role and have very good experience to back it up.

6. What do you understand by the term 'professional self-concept'?

7. Do you think that nurses perceive themselves as being professional?

[ ] YES [ ] NO

Please tick the appropriate box.

Please state the reasons for your answer.

More and more awareness in the recent graduates.

"Old school" trained like myself certainly felt it but I feel there are still some in the wilderness.

8. What are your views about the influence of professional values on practice?

Crucial. It is essential to have the appropriate professional values in order to practice.

Thank you very much for completing this questionnaire.
PILOT QUESTIONNAIRE

Would you please answer the following questions:

1. What do you understand by the term 'knowledge'?

   Knowledge directly relates to understanding and learning. Once comprehension has occurred, new knowledge can be assimilated into daily practice.

   There are many aspects to knowledge.

2. What type of knowledge do you use in your nursing/educational practice?

   Theoretical and practical knowledge. Theory gained from reading. Practical knowledge from observation and experience. Knowledge helps me make moral judgements in practice with nursing students and help them identify what they need to know.

3. Do you think that some types of knowledge are more important than others?

   PLEASE TICK THE APPROPRIATE BOX.

   YES [ ]  NO [ ]

   If you have answered 'YES', please state which type(s) of knowledge and why?

   Theoretical knowledge must be good practice to justify why specific care may be given.

4. How do you view 'research-based knowledge'?

   Very important to develop a knowledge base for nursing. But methodology must be well grounded for study.

   ...
5. Does the application of knowledge to practice present you with any difficulties?

[YES] [NO]

Please tick the appropriate box.

If you have answered 'YES', please state what kinds of difficulties.

6. What do you understand by the term 'professional self-concept'?

A thinking practitioner who is able to develop professionally by identifying our strengths and weaknesses and focusing on weakness by setting action plan.

A practitioner able to reflect to enhance our practice.

7. Do you think that nurses perceive themselves as being professional?

[YES] [NO]

Please tick the appropriate box.

Please state the reasons for your answer.

I think that nurses often use the term professional without exploring the true meaning of the term. When they explore the definition, they will often say we are working towards being a profession.

8. What are your views about the influence of professional values on practice?

I consider the Code of Conduct essential to base professional values so that the trained nurse is accountable for her actions. Being accountable for own practice should lead to the implementation of a high standard of care.

Thank you very much for completing this questionnaire.
PILOT QUESTIONNAIRE

Would you please answer the following questions:

1. What do you understand by the term 'knowledge'?

   Knowledge directly relates to understanding and learning. Once comprehension has occurred new knowledge can be assimilated into daily practice. There are many aspects to knowledge.

2. What type of knowledge do you use in your nursing/educational practice?

   Theoretical and practical knowledge. Theory gained from reading. Practical knowledge from observation and experience. Knowledge helps me make moral judgements in practice with nursing students and help them identify what they need to know.

3. Do you think that some types of knowledge are more important than others?

   Please tick the appropriate box.

   ![YES](✓)  ![NO](☐)

   If you have answered 'YES', please state which type(s) of knowledge and why?

   Theoretical knowledge must be good practice to justify why specific care may be given.

4. How do you view ‘research-based knowledge’?

   Very important to develop a knowledge base for nursing. But methodology must be well grounded for study.
5. Does the application of knowledge to practice present you with any difficulties?

[YES] [NO]

Please tick the appropriate box.

If you have answered 'YES', please state what kinds of difficulties.

6. What do you understand by the term 'professional self-concept'?

A thinking practitioner who is able to develop professionally by identifying our strengths and weaknesses and focusing on weaknesses by setting action plans.

A practitioner able to reflect to enhance our practice.

7. Do you think that nurses perceive themselves as being professional?

[YES] [NO]

Please tick the appropriate box.

Please state the reasons for your answer.

I think that nurses often use the term 'professional' without exploring the true meaning of 'profession'. When they explore true definition they often say we are working towards being a profession.

8. What are your views about the influence of professional values on practice?

I consider the code of conduct essential to base professional values so that the trained nurse is accountable for her actions. Being accountable for own practice should lead to the implementation of a high standard of care.

Thank you very much for completing this questionnaire.
PILOT QUESTIONNAIRE

Would you please answer the following questions:

1. What do you understand by the term ‘knowledge’?
   - Information obtained by reading, discussing, learning, seeing, experiencing, and understanding and applying this knowledge.

2. What type of knowledge do you use in your nursing/educational practice?
   - All of the above.

3. Do you think that some types of knowledge are more important than others?
   - [ ] YES  [ ] NO
   - Please tick the appropriate box.
   - If you have answered ‘YES’, please state which type(s) of knowledge and why? Experience, understanding, you are able to reflect on the experience, gaining confidence and understanding.

4. How do you view ‘research-based knowledge’?
   - Important part of use of information and knowledge. It allows the knowledge to relate to fact.
5. Does the application of knowledge to practice present you with any difficulties?

[YES] [NO] Please tick the appropriate box.

If you have answered 'YES', please state what kinds of difficulties.

6. What do you understand by the term ‘professional self-concept’?

What one perceives as a role model within a profession.

7. Do you think that nurses perceive themselves as being professional?

[YES] [NO] Please tick the appropriate box.

Please state the reasons for your answer.

Because they obtain knowledge and skills, for which they pass a recognised exam and obtain a certificate.

8. What are your views about the influence of professional values on practice?

Essential part of care.

Thank you very much for completing this questionnaire.
PILOT QUESTIONNAIRE

Would you please answer the following questions:

1. What do you understand by the term 'knowledge'?

   KNOWLEDGE IS THE ACQUISITION AND UNDERSTANDING OF NEW INFORMATION. KNOWLEDGE CAN BE GAINED FROM EXPERIENCE, TRANSFER OF KNOWLEDGE FROM TEACHERS TO STUDENTS.

2. What type of knowledge do you use in your nursing/educational practice?

   WE USE EXPERIENCED BASED KNOWLEDGE AND RESEARCH - BASED KNOWLEDGE.

3. Do you think that some types of knowledge are more important than others?

   YES [ ] NO [ ]

   Please tick the appropriate box.

   If you have answered 'YES', please state which type(s) of knowledge and why?

   RESEARCH - BASED KNOWLEDGE CAN BE ANALYSED AND USED FOR FURTHER TEACHING, EXPERIENTIAL KNOWLEDGE IS TOO INDIVIDUALISED TO BE PUT TO WIDER USE.

4. How do you view 'research-based knowledge'?

   RESEARCH BASED KNOWLEDGE IN MY VIEW IS WHAT ULTIMATELY SHOULD UNDERPIN ALL THE PRACTICE OF NURSES. IT IS THE BASIS OF A PROFESSIONAL BODY OF KNOWLEDGE, KNOWLEDGE AND INFORMATION THAT CAN BE DRAWN UPON.
5. Does the application of knowledge to practice present you with any difficulties?

[ ] YES  [ ] NO  Please tick the appropriate box

If you have answered 'YES', please state what kinds of difficulties.

Knowledge base to practice of any profession presents difficulties. The practice of nurses depends very much on the workload that presents itself to them. So the application of pure knowledge is not always easy to do when faced with practice.

6. What do you understand by the term 'professional self-concept'?

[ ] YES  [ ] NO  Please tick the appropriate box.

Please state the reasons for your answer.

Professionally, yes, but nurses understanding concept of what being professional is, is possibly not generally what is thought when people refer to a profession.

7. Do you think that nurses perceive themselves as being professional?

[ ] YES  [ ] NO  Please tick the appropriate box.

8. What are your views about the influence of professional values on practice?

Professional values can only enhance the practice of qualified nurses. It will increase the nurses' approach and standing in the wider multi-disciplinary team.

Thank you very much for completing this questionnaire.
PILOT QUESTIONNAIRE

Would you please answer the following questions:

1. What do you understand by the term 'knowledge'?
   Information - received by the senses, interpreted as "facts" or "experiences" as "learning", supported by the mental phenomena of a personal belief system - the whole knowledge base is open to adaptation as required.

2. What type of knowledge do you use in your nursing/educational practice?
   The "knowledge" model seems to divide into 4 areas - (to quote my turn - many years ago)
   "Art" of science of nursing, temperament by my "personae, experiences", governed by an "ethical code" supported by feedback from "learners".

3. Do you think that some types of knowledge are more important than others?
   YES
   NO
   Please tick the appropriate box.
   If you have answered 'YES', please state which type(s) of knowledge and why?
   Such knowledge e.g. empiricism, that can be measured/ assessed/ described etc. according to criteria.
   However - culture is custom of individuals engaged in exchange of 'knowledge' - almost defies empiric method!

4. How do you view 'research-based knowledge'?
   With some misgivings, if the results are presented as applicable to all situations & circumstances! Especially within the mental health! (I am mildly keen on having American ideas thrust upon me -)
5. Does the application of knowledge to practice present you with any difficulties?

[ ] YES  [ ] NO  Please tick the appropriate box

If you have answered 'YES', please state what kinds of difficulties.

[ ] Difficulty/performance by the service side
[ ] They now discover that cash can be saved by changing practice - a significant issue!
[ ] But the patient is not often told (e.g. TPR B/P obs.)
[ ] They were neglected

6. What do you understand by the term 'professional self-concept'?

- Adherence to high code of conduct
- Personal responsibility to "update"
- Undertake to continually strive to achieve the highest degree of self-awareness
- To pursue the best possible therapeutic use of 'self'

7. Do you think that nurses perceive themselves as being professional?

[ ] YES  [ ] NO  Please tick the appropriate box.

Please state the reasons for your answer.

If you believe the amount of mental effort invested in the practicalities of dealing with the human condition.

8. What are your views about the influence of professional values on practice?

- That the 'professional' choice do the patient/clients "no harm" - The "norm" does not exist!
- He/She/Nurse in a continuum - a more professional is quicker by the response from the client is assist the client to Thank you very much for completing this questionnaire, express their wants as well as what are perceived as words.
PILOT QUESTIONNAIRE

Would you please answer the following questions:

1. What do you understand by the term 'knowledge'?
   The term 'knowledge' to me means having an understanding about a particular subject.

2. What type of knowledge do you use in your nursing/educational practice?
   Practical, intuitive and theoretical knowledge.

3. Do you think that some types of knowledge are more important than others?
   [YES] [NO]
   Please tick the appropriate box.
   If you have answered 'YES', please state which type(s) of knowledge and why?

4. How do you view 'research-based knowledge'?
   I view 'research-based knowledge' as a means of updating existing knowledge and also to create new ideas. Unfortunately, in most instances this knowledge is not implemented in practice.
5. Does the application of knowledge to practice present you with any difficulties?

[ ] YES  [ ] NO

Please tick the appropriate box.

If you have answered 'YES', please state what kinds of difficulties.

- Difficulties in phrasing and documenting actual care given on the care plan
- Difficulties in planning care to suit the particular nursing model in use at that area of practice.

6. What do you understand by the term 'professional self-concept'?

Professional self-concept is the practitioner's own understanding about professional practice. Although there are professional guidelines in practice, individuals still perceive their own view.

7. Do you think that nurses perceive themselves as being professional?

[ ] YES  [ ] NO

Please tick the appropriate box.

Please state the reasons for your answer.

From the recognition they get from the public.
Their practice by the profession is endorsed by nurses and this makes nursing a body of its own.
Wear of uniforms makes the nurse unique and different hence the identity of a professional.

8. What are your views about the influence of professional values on practice?

- Provides for efficiency in the quality of care.
- Provides for autonomy, accountability.
- Gives patient the opportunity to participate in their care.

Thank you very much for completing this questionnaire.
PILOT QUESTIONNAIRE

Would you please answer the following questions:

1. What do you understand by the term 'knowledge'?
   Knowledge is acquired in practice and also theoretical reading. Theoretical reading consists of definitions, models and propositions.

2. What type of knowledge do you use in your nursing/educational practice?
   Nursing knowledge which consists of four types mainly empirical, esthetics, personal and ethical moral knowledge. These form a body of knowledge which is unique and distinct from particular discipline.

3. Do you think that some types of knowledge are more important than others?
   [YES] [NO]  Please tick the appropriate box.

   If you have answered 'YES', please state which type(s) of knowledge and why?

4. How do you view 'research-based knowledge'?
   Knowledge that contains up-to-date facts through systematic and scientific inquiry. This knowledge can be defended on scientific grounds.
5. Does the application of knowledge to practice present you with any difficulties?

[YES] [NO]

Please tick the appropriate box

If you have answered ‘YES’, please state what kinds of difficulties.

Some knowledge-practice areas are not grasped and it makes it difficult to change and apply own knowledge. They are resistant to change and prefer traditional ways.

6. What do you understand by the term ‘professional self-concept’?

Professional self-concept includes physicality and how someone views his profession and what it entails. First of all the individual has to have a picture of one's physical self, personality, and so on. People tend to think about him/her, his/her sense of control and self-esteem.

7. Do you think that nurses perceive themselves as being professional?

[YES] [NO]

Please tick the appropriate box.

Please state the reasons for your answer.

Nursing practice has changed a lot during the past five years. There is more research, making nurses more autonomous and accountable for their practice. Nurses have to advocate for people. It involves great responsibility and nurses view themselves as being professionals by doing all these.

8. What are your views about the influence of professional values on practice?

It makes you have a framework in your mind and acts as a guidance in practice. It is making nursing a profession in its own right.

Thank you very much for completing this questionnaire.
PILOT QUESTIONNAIRE

Would you please answer the following questions:

1. What do you understand by the term "knowledge"?
   It is the collection of information that one amasses and is able to retain during one's life both in terms of education, work experience, and social interaction.

2. What type of knowledge do you use in your nursing/educational practice?
   Acquired knowledge both in terms of technical/practical knowledge relating to the professional aspects of nursing along with social knowledge obtained both from within and externally to the profession.

3. Do you think that some types of knowledge are more important than others?
   Please tick the appropriate box.

   YES  NO

   If you have answered 'YES', please state which type(s) of knowledge and why?
   Technical knowledge - good nursing practice means patient care is of a higher standard.

4. How do you view 'research-based knowledge'?
   Depends on quality of research, as to ability either to explore new areas or re-iterate, improve current practices. Question of cost v benefit.
5. Does the application of knowledge to practice present you with any difficulties?

   YES   NO  

Please tick the appropriate box

If you have answered 'YES', please state what kinds of difficulties.

6. What do you understand by the term 'professional self-concept'?

I think this means how we perceive ourselves as professionals.

7. Do you think that nurses perceive themselves as being professional?

   YES   NO  

Please tick the appropriate box.

Please state the reasons for your answer.

We are a profession because we have a body of authority governing our practices, and as a qualified practitioner we are answerable for our own actions.

8. What are your views about the influence of professional values on practice?

Professional values ensure we carry out our practices to the highest possible standard, because we know if we don't then there are bodies of authority that will discipline us.

Thank you very much for completing this questionnaire.
PILOT QUESTIONNAIRE

Would you please answer the following questions:

1. What do you understand by the term 'knowledge'?
   Anything that an individual "knows or seeks. Something which can be used to applied as the individual sees appropriate.

2. What type of knowledge do you use in your nursing/educational practice?
   - Theoretical knowledge, found in a textbook.
   - Knowledge gained from other colleagues, patients, students, researchers.
   - Knowledge that I instinctively learned from my life experience.

3. Do you think that some types of knowledge are more important than others?
   
   **YES**  **NO**
   Please tick the appropriate box.

   If you have answered 'YES', please state which type(s) of knowledge and why?
   All knowledge is important. It helps us to exist on a day-to-day personal and professional basis. The basis of the knowledge itself can influence its use and give it more "take evidence."

4. How do you view 'research-based knowledge'?
   Research-based knowledge is in "in" phrase. Naturally, as a professional, I expect to follow research-based practice, but it should be remembered that knowledge gained through research only represents the sample from which the research was taken. It should not always be assumed to be "definitive."

PILOT QUESTIONNAIRE

Would you please answer the following questions:

1. What do you understand by the term 'knowledge'?
   A personal collection of encyclopaedia that I have gained enough experience and study which I can apply to appropriate situations.

2. What type of knowledge do you use in your nursing/educational practice?
   Professional and specific knowledge and a bit of scientific knowledge.

3. Do you think that some types of knowledge are more important than others?
   
   YES  NO
   Please tick the appropriate box.
   If you have answered 'YES', please state which type(s) of knowledge and why?

4. How do you view 'research-based knowledge'?
   Can be an accurate form of knowledge depending on who has done the research and whether they have a bias or not.
   It is good to be able to back up knowledge by research - more professional.
5. Does the application of knowledge to practice present you with any difficulties?

[ ] YES  [ ] NO  Please tick the appropriate box

If you have answered 'YES', please state what kinds of difficulties.

6. What do you understand by the term 'professional self-concept'?

- How one considers themselves as a professional.
- What the individual thinks is good/bad about profession.
- A collection of ideas about themselves from a professional point of view.

7. Do you think that nurses perceive themselves as being professional?

[ ] YES  [ ] NO  Please tick the appropriate box.

Please state the reasons for your answer.

I cannot say yes or no. The amount of change arising out the moment suggests that some feel professional - more recent qualified staff and some feel that it is a vocation. I know in places where nurses are given space to use their knowledge to the capacity learnt they learnt they would feel more professional.

8. What are your views about the influence of professional values on practice?

Thank you very much for completing this questionnaire.
PILOT QUESTIONNAIRE

Would you please answer the following questions:

1. What do you understand by the term 'knowledge'?
   Knowledge to me means reception and internalisation of information and an understanding of that internalised information.

2. What type of knowledge do you use in your nursing/educational practice?
   - Theoretical knowledge
   - Clinical knowledge

3. Do you think that some types of knowledge are more important than others?
   - [ ] Yes
   - [x] No
   Please tick the appropriate box.
   If you have answered 'Yes', please state which type(s) of knowledge and why?

4. How do you view 'research-based knowledge'?
   When used in clinical based contexts it is essential. Research on knowledge essential in order to develop knowledge base. Research made easier by research awareness
5. Does the application of knowledge to practice present you with any difficulties?

[YES] [NO] Please tick the appropriate box.

If you have answered 'YES', please state what kinds of difficulties.

Situations: Implications such as cost of changing to new dressing item for example. Also time needed to implement research based change.

6. What do you understand by the term 'professional self-concept'?

Don't understand it.

7. Do you think that nurses perceive themselves as being professional?

[YES] [NO] Please tick the appropriate box.

Please state the reasons for your answer.

Nurses are on a continuous learning quest from day 1 and need to be so in order to fulfill roles. I perceive themselves as professionals.

8. What are your views about the influence of professional values on practice?

All practice is influenced by professional values. These form the foundation of nursing on which extra knowledge is built.

Thank you very much for completing this questionnaire.
APPENDIX 4
Would you please answer the following questions:

Q1. Which of the following statements reflects the meaning of the term "knowledge"?

(a) a justified true belief
(b) a consensus of opinion
(c) What the establishment thinks
(d) the stage reached in our professional discourse
(e) none of the above statements

Please tick the appropriate box (you may tick more than one)

If you have ticked the box (e), please state your own meaning.

Q2. Which types of knowledge do you use in your nursing/educational/management practice?

Q3. Of the types you have stated, which do you use most often? (Please state your reasons)
Q4. Which of the following statements indicates what 'nursing knowledge' is?

(a) a set of beliefs about caring
(b) experience gained through practice
(c) a body of scientific knowledge
(d) a knowledge of caring behaviours
(e) none of the above statements

If you have ticked box(e), please state what you think 'nursing knowledge' is.

Q5. Which of the following statements indicates the meaning of 'research-based knowledge'?

(a) useless rubbish
(b) knowledge gained through a systematic enquiry
(c) medical knowledge
(d) knowledge gained from reflecting on practice
(e) none of the above statements
Q8. Which of the following statements indicates the meaning of the term 'professional'?

(a) a career-minded person
(b) a person with a smart appearance
(c) a person with expertise who is paid
(d) a person who has social status and earns a high salary
(e) none of the above statements

Please tick the appropriate box (you may tick more than one).

If you have ticked box (e), please state what you mean by this term.

Q9. Is it appropriate to state that nurses are 'professional practitioners'?

Please tick the appropriate box

☑ YES ☐ NO

Please give reasons for your answer.
Q10. Should nurse practitioners use research-based knowledge in practice?

Please tick the appropriate box

☐ YES ☐ NO

Please state the reasons for your answer.

Q11. Which of the following statements reflects the meaning of the term 'professional values'?

(a) adhering to the Code of Professional Conduct
(b) having a set of beliefs about nursing
(c) having a philosophy about practical procedures
(d) basing care on models of nursing and theories of care
(e) none of the above statements

Please tick the appropriate box (you may tick more than one)

If you have ticked box(e), please give your own meaning.

...
Q12. Do you think that 'professional values' might place constraints on your practice?

Please tick the appropriate box

☐ YES  ☐ NO

If you have answered 'YES', please give some examples of such constraints.

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE
Dear Colleague

I am currently undertaking an MPhil/PhD course at the University of Surrey and my research study is examining the extent to which nurses' perceptions of knowledge are related to research-based practice.

My reasons for asking you to complete this main questionnaire which is the third stage in the design of the study are twofold. Firstly, I hope to gain a broader span of information about nurses’ perceptions of knowledge, research-based knowledge, professionalism, and the application of knowledge to practice. Secondly, I want to gather more information about the relationship between professionalism and practice.

I should like to reassure you that you will remain anonymous in any report made by me and information given will be treated in confidence.

I should appreciate a return of the completed questionnaire by the 29th July 1995.

Thanking you in advance for your co-operation in this study.

Yours sincerely

Sue Watkinson
Senior Lecturer-Research
Wolfson School of Health Sciences
Thames Valley University.
APPENDIX 5
**MAIN QUESTIONNAIRE**

Would you please answer the following questions:

Q1. Which of the following statements reflects the meaning of the term “knowledge”?

(a) a justified true belief

(b) a consensus of opinion

(c) What the establishment thinks

(d) the stage reached in our professional discourse

(e) none of the above statements

Please tick the appropriate box

(you may tick more than one)

If you have ticked the box (e), please state your own meaning.

Q2. Which types of knowledge do you use in your nursing/educational/management practice?

Medical knowledge
Nursing knowledge
Knowledge of research
General knowledge

Q3. Of the types you have stated, which do you use

(a) most often? (Please state your reasons)

Nursing knowledge - I am a practicing nurse working in the clinical area.
Medical knowledge - 970.
Q4. Which of the following statements indicates what 'nursing knowledge' is?

(a) a set of beliefs about caring
(b) experience gained through practice
(c) a body of scientific knowledge
(d) a knowledge of caring behaviours
(e) none of the above students

If you have ticked box(e), please state what you think 'nursing knowledge' is.

Q5. Which of the following statements indicates the meaning of 'research-based knowledge'?

(a) useless rubbish
(b) knowledge gained through a systematic enquiry
(c) medical knowledge
(d) knowledge gained from reflecting on practice
(e) none of the above statements
If you have ticked the box (e), please state what you mean by 'research-based knowledge'.

Q6. To what extent do you think that research-based knowledge is used in practice?

I believe that as more and more practitioners are going through further education programmes, research is being slowly incorporated into practice.

Q7. Please state whether the application of research-based knowledge to your own area of practice might present you with any difficulties?

Please tick the appropriate box

☑ YES ☐ NO

If you have answered 'YES', please give some examples of such difficulties.

Economic - more expensive yet more effective wound care products.
Professional - difficulty in changing peoples' beliefs and practices.
Q8. Which of the following statements indicates the meaning of the term `professional'?  

(a) a career-minded person  
(b) a person with a smart appearance  
(c) a person with expertise who is paid  
(d) a person who has social status and earns a high salary  
(e) none of the above statements  

Please tick the appropriate box (you may tick more than one)  

If you have ticked box (e), please state what you mean by this term.  

A person who has undertaken extensive training and experience in their chosen area, who demonstrates this with skill, confidence and expertise.  

Q9. Is it appropriate to state that nurses are `professional practitioners'?  

Please tick the appropriate box.  

☐ YES  ☐ NO  

Please give reasons for your answer.  

Nurses—especially graduate nurses—undertake extensive training and experience before qualifying and are legally bound by codes of professional conduct.
Q10. Should nurse practitioners use research-based knowledge in practice?

Please tick the appropriate box

☑ YES ☐ NO

Please state the reasons for your answer.

Ensures the highest possible care, and the most effective treatments. There should be a logical reason for any nursing procedure.

Q11. Which of the following statements reflects the meaning of the term 'professional values'?

(a) adhering to the Code of Professional Conduct
(b) having a set of beliefs about nursing
(c) having a philosophy about practical procedures
(d) basing care on models of nursing and theories of care
(e) none of the above statements

Please tick the appropriate box.

☑ ☐ Please tick the appropriate box.

(you may tick more than one)

☑ ☐ ☐

If you have ticked box(e), please give your own meaning.

[Blank space]
Q12. Do you think that 'professional values' might place constraints on your practice?

Please tick the appropriate box

☑️ YES  ☐ NO

If you have answered 'YES', please give some examples of such constraints.

Nurses have to act within certain guidelines and constraints which may prevent innovation. There are endless procedures to follow which ensure continuity, yet prevent developing practice.
MAIN QUESTIONNAIRE

Would you please answer the following questions:

Q1. Which of the following statements reflects the meaning of the term "knowledge"?

(a) a justified true belief        ☐ Please tick the
(b) a consensus of opinion        ☐ appropriate box
(c) What the establishment thinks ☐ (you may tick more
(d) the stage reached in our professional discourse ☐ than one)
(e) none of the above statements   ☑

If you have ticked the box (e), please state your own meaning.

The sum of what is known

to mankind.

Q2. Which types of knowledge do you use in your nursing/educational/management practice?

Research based information

Some anecdotal where there is no verifiable body of research.

Q3. Of the types you have stated, which do you use

(a) most often? (Please state your reasons)

About 50/50

We are discouraged (it is an offence in the opinion of the Trust to give anything but research based advice) in the letters
Q4. Which of the following statements indicates what ‘nursing knowledge’ is?

(a) a set of beliefs about caring
(b) experience gained through practice
(c) a body of scientific knowledge
(d) a knowledge of caring behaviours
(e) none of the above statements

If you have ticked box (e), please state what you think ‘nursing knowledge’ is.

Q5. Which of the following statements indicates the meaning of ‘research-based knowledge’?

(a) useless rubbish
(b) knowledge gained through a systematic enquiry
(c) medical knowledge
(d) knowledge gained from reflecting on practice
(e) none of the above statements
If you have ticked the box (e), please state what you mean by 'research-based knowledge'.

Q6. To what extent do you think that research-based knowledge is used in practice?

Because there is a lack of good research the answers must reflect areas 3. (50/50)

Q7. Please state whether the application of research-based knowledge to your own area of practice might present you with any difficulties?

Please tick the appropriate box

☐ YES

☐ NO

If have answered 'YES', please give some examples of such difficulties.

research conflicts with policy or case w.i.
research is often ignored
use of sterile gauze pads for cord care
use of Kamillacen cream for n. p.p.l.
Q8. Which of the following statements indicates the meaning of the term 'professional'?

(a) a career-minded person
(b) a person with a smart appearance
(c) a person with expertise who is paid
(d) a person who has social status and earns a high salary
(e) none of the above statements

Please tick the appropriate box (you may tick more than one).

If you have ticked box (e), please state what you mean by this term.

Q9. Is it appropriate to state that nurses are 'professional practitioners'?

Please tick the appropriate box.

☐ YES   ☐ NO

Please give reasons for your answer.

9 have reservations if some are yes. Possibly some are.
Q10. Should nurse practitioners use research-based knowledge in practice?

Please tick the appropriate box

☐ YES  ☐ NO

Please state the reasons for your answer.

Time for custom practice cannot be part
Certainty is based on research
Based knowledge provides us care
Critical analysis is good to what is not

Q11. Which of the following statements reflects the meaning of the term 'professional values'?

(a) adhering to the Code of Professional Conduct
(b) having a set of beliefs about nursing
(c) having a philosophy about practical procedures
(d) basing care on models of nursing and theories of care
(e) none of the above statements

Please tick the appropriate box (you may tick more than one)

If you have ticked box(e), please give your own meaning.
Q12. Do you think that 'professional values' might place constraints on your practice?

Please tick the appropriate box.

☐ YES  ☐ NO

If you have answered 'YES', please give some examples of such constraints.

purposes
provision
contextual decisions
effects of market forces or health provision

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE
MAIN QUESTIONNAIRE

Would you please answer the following questions:

Q1. Which of the following statements reflects the meaning of the term “knowledge”?

(a) a justified true belief
(b) a consensus of opinion
(c) What the establishment thinks
(d) the stage reached in our professional discourse
(e) none of the above statements

If you have ticked the box (e), please state your own meaning.

"Knowledge is a subjective term which cannot be accurately quantified or defined."

Q2. Which types of knowledge do you use in your nursing/educational/management practice?

A mixture of professional knowledge, personal knowledge of good situations and life experiences.

Q3. Of the types you have stated, which do you use

(a) most often? (Please state your reasons)

"Personal knowledge is based on self-beliefs as they are not tried and trusted by myself. I am very sceptical of other people’s knowledge if I don’t personally know them (and trust them)."
Q4. Which of the following statements indicates what 'nursing knowledge' is?

(a) a set of beliefs about caring
(b) experience gained through practice
(c) a body of scientific knowledge
(d) a knowledge of caring behaviours
(e) none of the above statements

If you have ticked box (e), please state what you think 'nursing knowledge' is.

Q5. Which of the following statements indicates the meaning of 'research-based knowledge'?

(a) useless rubbish
(b) knowledge gained through a systematic enquiry
(c) medical knowledge
(d) knowledge gained from reflecting on practice
(e) none of the above statements
If you have ticked the box (e), please state what you mean by 'research-based knowledge'.

Q6. To what extent do you think that research-based knowledge is used in practice?

I use research very rarely from research evidence. There is a mixture of formal, political and anecdotal evidence.

Q7. Please state whether the application of research-based knowledge to your own area of practice might present you with any difficulties?

Please tick the appropriate box

☑ YES  ☐ NO

If have answered 'YES', please give some examples of such difficulties.

I could have difficulty in practice if changes in practice are then implemented from sexual units to the trust I work for, regardless of the request of our clients.
Q8. Which of the following statements indicates the meaning of the term 'professional'?

(a) a career-minded person
(b) a person with a smart appearance
(c) a person with expertise who is paid
(d) a person who has social status and earns a high salary
(e) none of the above statements

Please tick the appropriate box (you may tick more than one).

If you have ticked box (e), please state what you mean by this term.

'Professional' is a term I feel which is only used by people to impose their own belief on to their perceived self-importance. It is an ego mechanism.

Q9. Is it appropriate to state that nurses are 'professional practitioners'?

Please tick the appropriate box

☑ YES ☐ NO

Please give reasons for your answer.

Nurses are 'practitioners' and would like to be perceived as be as 'professional' for their own ego's. The term 'professional practitioner' is a devious phrase which is directing many nurses away from their true status.
Q10. Should nurse practitioners use research-based knowledge in practice?

Please tick the appropriate box

☐ YES  ☐ NO

Please state the reasons for your answer.

If it is essential to their clients.

Q11. Which of the following statements reflects the meaning of the term 'professional values'?

(a) adhering to the Code of Professional Conduct
(b) having a set of beliefs about nursing
(c) having a philosophy about practical procedures
(d) basing care on models of nursing and theories of care
(e) none of the above statements

If you have ticked box(e), please give your own meaning.

The term 'professional values' is irrelevant as the term 'professional' is not a legal term which is definable. A moral and ethical set of common values may be more appropriate to this type of statement.
Q12. Do you think that 'professional values' might place constraints on your practice?

Please tick the appropriate box

☐ YES  ☐ NO

If you have answered 'YES', please give some examples of such constraints.

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE
MAIN QUESTIONNAIRE

Would you please answer the following questions:

Q1. Which of the following statements reflects the meaning of the term "knowledge"?

(a) a justified true belief
(b) a consensus of opinion
(c) What the establishment thinks
(d) the stage reached in our professional discourse
(e) none of the above statements

If you have ticked the box (e), please state your own meaning.

I believe that knowledge is gained by experience, having theoretical and practical understanding, being well-informed and at an informed person being a range of information. It is not an opinion.

Q2. Which types of knowledge do you use in your nursing/educational/management practice?

Acquired/learned through practice and theoretical experiences in all the above situations.

Q3. Of the types you have stated, which do you use

(a) most often? (Please state your reasons)

This is difficult to answer as I believe we use all our knowledge, practical and theoretical, past experiences, and now in all situations regardless of whether it is nursing, education or management practice.
Q4. Which of the following statements indicates what 'nursing knowledge' is?

(a) a set of beliefs about caring  ✔
(b) experience gained through practice  ✔
(c) a body of scientific knowledge  ✔
(d) a knowledge of caring behaviours  ✔
(e) none of the above statements  

If you have ticked box(e), please state what you think 'nursing knowledge' is.

Q5. Which of the following statements indicates the meaning of 'research-based knowledge'?

(a) useless rubbish  
(b) knowledge gained through a systematic enquiry  ✔
(c) medical knowledge  
(d) knowledge gained from reflecting on practice  
(e) none of the above statements  

Please tick the appropriate box

(you may tick more than one)
If you have ticked the box (e), please state what you mean by 'research-based knowledge'.

Q6. To what extent do you think that research-based knowledge is used in practice?

I think that nurses are not able to keep up with all available research therefore it is incorporated haphazardly and generally only by those exposed to it. It is study days etc.

Q7. Please state whether the application of research-based knowledge to your own area of practice might present you with any difficulties?

Please tick the appropriate box

☑ YES  ☐ NO

If you have answered 'YES', please give some examples of such difficulties.

Would need nurse to be allocated to monitor changes in practice and be responsible for keeping all up to date. Possible difficulties with changes as research is often superseded by new studies.
Q8. Which of the following statements indicates the meaning of the term 'professional'?

(a) a career-minded person  
(b) a person with a smart appearance  
(c) a person with expertise who is paid  
(d) a person who has social status and earns a high salary  
(e) none of the above statements

If you have ticked box (e), please state what you mean by this term.

Q9. Is it appropriate to state that nurses are 'professional practitioners'?

Please tick the appropriate box

☑ YES  ☐ NO

Please give reasons for your answer.

I would like to believe that all the level nurses who have undergone training to achieve this and have continued to develop their knowledge and experience in both theory and practice throughout their career, should be known as 'professional practitioners'. Sadly this hasn't always been the case but hopefully with the introduction of mandatory PEP, things will change for the better.
Q10. Should nurse practitioners use research-based knowledge in practice?

Please tick the appropriate box

☑ YES    □ NO

Please state the reasons for your answer.

It is no longer acceptable for nurses to
or even because they base all their
is that a "sister makes it and then says she
"we must be encouraged to professional
practitioners. We must be able to justify
our nurses by means of evidence-based practice,
not just professional opinion."

Q11. Which of the following statements reflects the meaning of the term 'professional values'?

(a) adhering to the Code of Professional Conduct    ☑
(b) having a set of beliefs about nursing
(c) having a philosophy about practical procedures
(d) basing care on models of nursing and theories of care
(e) none of the above statements

Please tick the appropriate box

☑ (you may tick more than one)

e

If you have ticked box(e), please give your own meaning.
Q12. Do you think that 'professional values' might place constraints on your practice?

Please tick the appropriate box

☐ YES  ☑ NO

If you have answered 'YES', please give some examples of such constraints.

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE
Would you please answer the following questions:

Q1. Which of the following statements reflects the meaning of the term “knowledge”?

(a) a justified true belief  
(b) a consensus of opinion  
(c) What the establishment thinks  
(d) the stage reached in our professional discourse  
(e) none of the above statements

Please tick the appropriate box (you may tick more than one).

If you have ticked the box (e), please state your own meaning.

Q2. Which types of knowledge do you use in your nursing/educational/management practice?

Knowledge gained from:

- experience
- research
- colleagues
- clients
- (studies)

Q3. Of the types you have stated, which do you use most often? (Please state your reasons)

We all use all of the above in an eclectic manner - but all is generally based on (e)
Q4. Which of the following statements indicates what 'nursing knowledge' is?

(a) a set of beliefs about caring
(b) experience gained through practice
(c) a body of scientific knowledge
(d) a knowledge of caring behaviours
(e) none of the above statements

Please tick the appropriate box (you may tick more than one)

If you have ticked box(e), please state what you think 'nursing knowledge' is.

Q5. Which of the following statements indicates the meaning of 'research-based knowledge'?

(a) useless rubbish
(b) knowledge gained through a systematic enquiry
(c) medical knowledge
(d) knowledge gained from reflecting on practice
(e) none of the above statements

Please tick the appropriate box (you may tick more than one)
If you have ticked the box (e), please state what you mean by 'research-based knowledge'.

Q6. To what extent do you think that research-based knowledge is used in practice?

I think that nurses are not able to keep up with all available research therefore it is incorporated haphazardly and generally only by those exposed to it. 

Q7. Please state whether the application of research-based knowledge to your own area of practice might present you with any difficulties?

Please tick the appropriate box

☑ YES  ☐ NO

If you have answered 'YES', please give some examples of such difficulties.

Would need nurse to be allocated to monitor changes in practice and be responsible for keeping all up to date. Possible difficulties with changes as occur so frequently and sometimes research is then superseded by more recent studies.
Q8. Which of the following statements indicates the meaning of the term 'professional'?

(a) a career-minded person
(b) a person with a smart appearance
(c) a person with expertise who is paid
(d) a person who has social status and earns a high salary
(e) none of the above statements

If you have ticked box (e), please state what you mean by this term.

Q9. Is it appropriate to state that nurses are 'professional practitioners'?

Please tick the appropriate box

Please give reasons for your answer.

Paid to use expertise and keeps learning. Willing to make changes to practice depending on knowledge gained. Thought and pride in what is done.
Q10. Should nurse practitioners use research-based knowledge in practice?

Please tick the appropriate box

☐ YES  ☐ NO

Please state the reasons for your answer.

To dispel myths, old wives tales etc. still used in nursing practice, increased measurable outcomes intention is to give client best care available.

Q11. Which of the following statements reflects the meaning of the term 'professional values'?

(a) adhering to the Code of Professional Conduct
(b) having a set of beliefs about nursing
(c) having a philosophy about practical procedures
(d) basing care on models of nursing and theories of care
(e) none of the above statements

Please tick the appropriate box

☑ (you may tick more than one)

If you have ticked box(e), please give your own meaning.

Each nurse needs to be able to define and articulate their own philosophy in order to base a working system which they believe to be ethical.
Q12. Do you think that 'professional values' might place constraints on your practice?

Please tick the appropriate box

☑ YES  ☐ NO

If you have answered 'YES', please give some examples of such constraints.

Yes, however these constraints need to be in place to ensure professional safety of clients and practitioners. i.e. relationships outside of work.

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE
MAIN QUESTIONNAIRE

Would you please answer the following questions:

Q1. Which of the following statements reflects the meaning of the term "knowledge"?

(a) a justified true belief
(b) a consensus of opinion
(c) What the establishment thinks
(d) the stage reached in our professional discourse
(e) none of the above statements

If you have ticked the box (e), please state your own meaning.

Practical knowledge/knowledg I know how

Q2. Which types of knowledge do you use in your nursing/educational/management practice?

Q3. Of the types you have stated, which do you use

(a) most often? (Please state your reasons)
(b) least often? (Please state your reasons)

Q4. Which of the following statements indicates what 'nursing knowledge' is?

(a) a set of beliefs about caring
(b) experience gained through practice
(c) a body of scientific knowledge
(d) a knowledge of caring behaviours
(e) none of the above students

If you have ticked box (e), please state what you think 'nursing knowledge' is.

Knowledge generated by nurses
Knowledge adapted from the discipline of nursing

Q5. Which of the following statements indicates the meaning of 'research-based knowledge'?

(a) useless rubbish
(b) knowledge gained through a systematic enquiry
(c) medical knowledge
(d) knowledge gained from reflecting on practice
(e) none of the above statements
If you have ticked the box (e), please state what you mean by 'research-based knowledge'.

Q6. To what extent do you think that research-based knowledge is used in practice?

Some extent - Often No research-based knowledge does not reflect the knowledge needed in the workplace.

Q7. Please state whether the application of research-based knowledge to your own area of practice might present you with any difficulties?

Please tick the appropriate box

☐ YES  ☑ NO

If have answered 'YES', please give some examples of such difficulties.
Q8. Which of the following statements indicates the meaning of the term 'professional'?

(a) a career-minded person
(b) a person with a smart appearance
(c) a person with expertise who is paid
(d) a person who has social status and earns a high salary
(e) none of the above statements

If you have ticked box (e), please state what you mean by this term.

Additionally, I would add professionals are providing a public service.

Q9. Is it appropriate to state that nurses are 'professional practitioners'?

Please tick the appropriate box.

[ ] YES  [ ] NO

Please give reasons for your answer.

Yes, because they also fulfill the criteria for professionalism.
Q10. Should nurse practitioners use research-based knowledge in practice?

Please tick the appropriate box

☑ YES  ☐ NO

Please state the reasons for your answer.

This is not the only knowledge I would use - it is very much 'Know Not' knowledge.

Q11. Which of the following statements reflects the meaning of the term 'professional values'?

(a) adhering to the Code of Professional Conduct  ☐
(b) having a set of beliefs about nursing ☑ (you may tick more than one)
(c) having a philosophy about practical procedures  ☐
(d) basing care on models of nursing and theories of care  ☐
(e) none of the above statements  ☐

If you have ticked box(e), please give your own meaning.
Q12. Do you think that 'professional values' might place constraints on your practice?

Please tick the appropriate box

☐ YES       ☑ NO

If you have answered 'YES', please give some examples of such constraints.

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE
MAIN QUESTIONNAIRE

Would you please answer the following questions:

Q1. Which of the following statements reflects the meaning of the term “knowledge”?

(a) a justified true belief
(b) a consensus of opinion
(c) What the establishment thinks
(d) the stage reached in our professional discourse
(e) none of the above statements

Please tick the appropriate box (you may tick more than one)

If you have ticked the box (e), please state your own meaning.

Q2. Which types of knowledge do you use in your nursing/educational/management practice?

- Nursing knowledge
- Medical knowledge
- Classroom
- General knowledge
- Political

Q3. Of the types you have stated, which do you use most often? (Please state your reasons)

a sort of everything depending on which field you are doing.
Q4. Which of the following statements indicates what 'nursing knowledge' is?

(a) a set of beliefs about caring
(b) experience gained through practice
(c) a body of scientific knowledge
(d) a knowledge of caring behaviours
(e) none of the above students

If you have ticked box(e), please state what you think 'nursing knowledge' is.

Q5. Which of the following statements indicates the meaning of 'research-based knowledge'?

(a) useless rubbish
(b) knowledge gained through a systematic enquiry
(c) medical knowledge
(d) knowledge gained from reflecting on practice
(e) none of the above statements
If you have ticked the box (e), please state what you mean by 'research-based knowledge'.

Q6. To what extent do you think that research-based knowledge is used in practice?

If it is getting more common now compared to years ago.

Q7. Please state whether the application of research-based knowledge to your own area of practice might present you with any difficulties?

Please tick the appropriate box

☐ YES  ❑ NO

If you have answered 'YES', please give some examples of such difficulties.

Q8. Which of the following statements indicates the meaning of the term 'professional'?

(a) a career-minded person
(b) a person with a smart appearance
(c) a person with expertise who is paid
(d) a person who has social status and earns a high salary
(e) none of the above statements

If you have ticked box (e), please state what you mean by this term.

Q9. Is it appropriate to state that nurses are 'professional practitioners'?

Please tick the appropriate box

[ ] YES  [ ] NO

Please give reasons for your answer.

Especially if one you've been through 3 years of training, practice and theory and then pass all examinations. If a profession that has our life regardless of age, race and culture.
Q10. Should nurse practitioners use research-based knowledge in practice?

Please tick the appropriate box

☐ YES    ☐ NO

Please state the reasons for your answer.

[Written理由]

Q11. Which of the following statements reflects the meaning of the term 'professional values'?

(a) adhering to the Code of Professional Conduct  ☐
(b) having a set of beliefs about nursing  ☐
(c) having a philosophy about practical procedures  ☐
(d) basing care on models of nursing and theories of care  ☐
(e) none of the above statements  ☐

If you have ticked box(e), please give your own meaning.

[Written理由]
**MAIN QUESTIONNAIRE**

Would you please answer the following questions:

Q1. Which of the following statements reflects the meaning of the term "knowledge"?

(a) a justified true belief
(b) a consensus of opinion
(c) What the establishment thinks
(d) the stage reached in our professional discourse
(e) none of the above statements

If you have ticked the box (e), please state your own meaning.

Q2. Which types of knowledge do you use in your nursing/educational/management practice?

- Acquired through practice
- Taught through lectures/reading/courses

Q3. Of the types you have stated, which do you use most often? (Please state your reasons)

- Acquired (because of long practice)
(b) least often? (Please state your reasons)

Taught (there is a lot you have forgotten).

Q4. Which of the following statements indicates what 'nursing knowledge' is?

(a) a set of beliefs about caring
(b) experience gained through practice
(c) a body of scientific knowledge
(d) a knowledge of caring behaviours
(e) none of the above students

If you have ticked box(e), please state what you think 'nursing knowledge' is.

Q5. Which of the following statements indicates the meaning of 'research-based knowledge'?

(a) useless rubbish
(b) knowledge gained through a systematic enquiry
(c) medical knowledge
(d) knowledge gained from reflecting on practice
(e) none of the above statements

Please tick the appropriate box (you may tick more than one)
If you have ticked the box (e), please state what you mean by ‘research-based knowledge’.

Q6. To what extent do you think that research-based knowledge is used in practice?

Some extent - often No research-based knowledge does not reflect the knowledge needed in the swamp.

Q7. Please state whether the application of research-based knowledge to your own area of practice might present you with any difficulties?

Please tick the appropriate box

☐ YES  ☑ NO

If you have answered 'YES', please give some examples of such difficulties.
Q8. Which of the following statements indicates the meaning of the term 'professional'?

(a) a career-minded person  
(b) a person with a smart appearance  
(c) a person with expertise who is paid  
(d) a person who has social status and earns a high salary  
(e) none of the above statements

Please tick the appropriate box (you may tick more than one).

If you have ticked box (e), please state what you mean by this term.

additionally I would add professional are providing a public service.

Q9. Is it appropriate to state that nurses are 'professional practitioners'?

Please tick the appropriate box.

☑ YES  ☐ NO

Please give reasons for your answer.

[Handwritten: Yes because they do fulfill the criteria for professionalism]
Q10. Should nurse practitioners use research-based knowledge in practice?

Please tick the appropriate box

☑ YES ☐ NO

Please state the reasons for your answer.

In order to provide best standard of care for their clients, it may be cost effective eventually.

Q11. Which of the following statements reflects the meaning of the term 'professional values'?

(a) adhering to the Code of Professional Conduct
(b) having a set of beliefs about nursing
(c) having a philosophy about practical procedures
(d) basing care on models of nursing and theories of care
(e) none of the above statements

Please tick the appropriate box

☑ (you may tick more than one)

If you have ticked box(e), please give your own meaning.
Q12. Do you think that 'professional values' might place constraints on your practice?

Please tick the appropriate box

☐ YES  ☑ NO

If you have answered 'YES', please give some examples of such constraints.

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE
MAIN QUESTIONNAIRE

Would you please answer the following questions:

Q1. Which of the following statements reflects the meaning of the term "knowledge"?

(a) a justified true belief
(b) a consensus of opinion
(c) What the establishment thinks
(d) the stage reached in our professional discourse
(e) none of the above statements

If you have ticked the box (e), please state your own meaning.

Q2. Which types of knowledge do you use in your nursing/educational/management practice?

Information that can be backed up by evidence which has not shown to be detrimental to my client's safety.

Q3. Of the types you have stated, which do you use

(a) most often? (Please state your reasons)

(a) because I don't believe in doing things without a reason and just for the sake of routine.
(b) least often? (Please state your reasons)

(b) Sometimes there isn't evidence to support why things are done. Many people have received an initial period of care and treatments have had it helpful.

Q4. Which of the following statements indicates what 'nursing knowledge' is?

(a) a set of beliefs about caring
(b) experience gained through practice
(c) a body of scientific knowledge
(d) a knowledge of caring behaviours
(e) none of the above students

If you have ticked box(e), please state what you think 'nursing knowledge' is.

Q5. Which of the following statements indicates the meaning of 'research-based knowledge'?

(a) useless rubbish
(b) knowledge gained through a systematic enquiry
(c) medical knowledge
(d) knowledge gained from reflecting on practice
(e) none of the above statements
If you have ticked the box (e), please state what you mean by 'research-based knowledge'.

Q6. To what extent do you think that research-based knowledge is used in practice?

On a scale of 1–10 about 4 is research based. It depends on the area you work in and who the managers are. On the other end of the scale, some people quite more 'use' as research based, but no research may use may have none.

Q7. Please state whether the application of research-based knowledge to your own area of practice might present you with any difficulties?

Please tick the appropriate box

☑ YES  ☐ NO

If have answered 'YES', please give some examples of such difficulties.

1. The use of pindone in babies consto less research proved to be no good but is still routinely handed out to nurse.
2. Infection of labours coming ruptures of membranes after 10 pushups when research suggests that an average 2nd stage can take 8 hours.
Q8. Which of the following statements indicates the meaning of the term ‘professional’?

(a) a career-minded person
(b) a person with a smart appearance
(c) a person with expertise who is paid
(d) a person who has social status and earns a high salary
(e) none of the above statements

Please tick the appropriate box (you may tick more than one).

If you have ticked box (e), please state what you mean by this term.

Just because I have ticked i... I don’t believe it should be like that. I believe that it is now it is.

Q9. Is it appropriate to state that nurses are ‘professional practitioners’?

Please tick the appropriate box

□ YES □ NO

Please give reasons for your answer.

At present I don’t believe it is although I see nurse as working in a professional manner.
Q10. Should nurse practitioners use research-based knowledge in practice?

Please tick the appropriate box

☐ YES ☐ NO

Please state the reasons for your answer.

I believe we should practice using evidence-based knowledge where possible so that charts can be treated as individuals and care is made away from stillness.

Q11. Which of the following statements reflects the meaning of the term 'professional values'?

(a) adhering to the Code of Professional Conduct
(b) having a set of beliefs about nursing
(c) having a philosophy about practical procedures
(d) basing care on models of nursing and theories of care
(e) none of the above statements

Please tick the appropriate box (you may tick more than one)

If you have ticked box(e), please give your own meaning.
Q12. Do you think that 'professional values' might place constraints on your practice?

Please tick the appropriate box

☐ YES  ☒ NO

If you have answered 'YES', please give some examples of such constraints.

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE
MAIN QUESTIONNAIRE

Would you please answer the following questions:

Q1. Which of the following statements reflects the meaning of the term “knowledge”?

(a) a justified true belief  □  Please tick the appropriate box
(b) a consensus of opinion  □  (you may tick more than one)
(c) What the establishment thinks  □
(d) the stage reached in our professional discourse  □
(e) none of the above statements  ✔

If you have ticked the box (e), please state your own meaning.

Facts, concepts, ideas (etc) which either arise theoretically and are applied to nursing (or life in general) or which are generated from practice (or life in general) and from which theory is generated [also the various patterns of knowing as a way of classifying knowledge]

Q2. Which types of knowledge do you use in your nursing/educational/management practice?

Probably all types one way or another.

Empirical knowledge – because so much of my work data
starts in the abstract and needs to be applied deductively.

Aesthetics – because my job is about relating to people and
working within the “pedagogic”. Personal knowledge – because
I believe that one’s inner self meets up with other people’s inner
selves is where creativity begins and ethics: because nursing
and education are essentially moral arts and values

Q3. Of the types you have stated, which do you use

(a) most often? (Please state your reasons)

Probably Empirical and personal knowledge (for the reasons stated in Q2)

But I wish I could add others that it a bit more often
(b) least often? (Please state your reasons)

Aesthetic knowledge - Because I just don't take as much time for people as I feel I'd like.

Q4. Which of the following statements indicates what 'nursing knowledge' is?

(a) a set of beliefs about caring
(b) experience gained through practice
(c) a body of scientific knowledge
(d) a knowledge of caring behaviours
(e) none of the above statements

Please tick the appropriate box (you may tick more than one)

If you have ticked box(e), please state what you think 'nursing knowledge' is.

SAME AS THE ABOVE QUESTIONS - I do not separate out nursing knowledge from knowledge generally because nursing knowledge is just all the above in nursing.

Q5. Which of the following statements indicates the meaning of 'research-based knowledge'?

(a) useless rubbish
(b) knowledge gained through a systematic enquiry
(c) medical knowledge
(d) knowledge gained from reflecting on practice
(e) none of the above statements

Please tick the appropriate box (you may tick more than one)
If you have ticked the box (e), please state what you mean by 'research-based knowledge'.

Q6. To what extent do you think that research-based knowledge is used in practice?

From my experience, not often.

Q7. Please state whether the application of research-based knowledge to your own area of practice might present you with any difficulties?

Please tick the appropriate box

☐ YES
☐ NO

If you have answered 'YES', please give some examples of such difficulties.

My practice is education - I am working towards using reflection on educational practice to general theory related to teaching and learning. Also - much of educational research is not easily applicable to teaching and learning in higher education.
Q8. Which of the following statements indicates the meaning of the term 'professional'?

(a) a career-minded person
(b) a person with a smart appearance
(c) a person with expertise who is paid
(d) a person who has social status and earns a high salary
(e) none of the above statements

Please tick the appropriate box (you may tick more than one).

If you have ticked box (e), please state what you mean by this term.

A professional is a person who makes informed decisions, can argue their decisions, and can articulate justification.

Q9. Is it appropriate to state that nurses are 'professional practitioners'?

Please tick the appropriate box.

☐ YES   ☑ NO

Please give reasons for your answer.

My experience tells me that few nurses can behave as described in Q8.
Q10. Should nurse practitioners use research-based knowledge in practice?

Please tick the appropriate box

☐ YES  ☐ NO

Please state the reasons for your answer.

☐ Only if and when the research has been critiqued and judgments made about suitability for use in their clinical area;

☐ Only when practice demands a rational, decision rather than an intuitive, empathic decision.

Q11. Which of the following statements reflects the meaning of the term 'professional values'?

(a) adhering to the Code of Professional Conduct
(b) having a set of beliefs about nursing
(c) having a philosophy about practical procedures
(d) basing care on models of nursing and theories of care
(e) none of the above statements

Please tick the appropriate box

☐ (you may tick more than one)

If you have ticked box(e), please give your own meaning.

I don't believe there is such a thing as professional values. I believe in moral responsibility as human beings. The same moral responsibility that governs our personal lives should govern our professional lives. Moral responsibility is not behaving how anyone else tells us is right to behave. Moral responsibility is applying our personal value system to our lives and our work, justifying this and articulating it.
Q12. Do you think that 'professional values' might place constraints on your practice?

Please tick the appropriate box

☑ YES    □ NO

If you have answered 'YES', please give some examples of such constraints.

It ignores personal responsibility for values and moral action. It "passes the buck" onto codes, the law, management policy etc and stops us from developing a sense of personal moral responsibility.

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE
APPENDIX 6
Pre-pilot Study (23.08.94)

**Group Discussion: Transcription**

John  What is knowledge?
Sue  What do you understand by the term ‘knowledge’?
John  Understand, I think
Sue  When I mention the word ‘knowledge’ does that conjure up immediately any other words for you?
John  Study
Regan  Gaining information and using it
Peter  Wisdom to some degree
John  No. It doesn’t conjure up wisdom for me
Peter  It doesn’t necessarily conjure up old matron, the wise owl but to some degree you are wise about something
Noreen  I think maybe the word wisdom suggests a good use of a body of knowledge rather than a body of knowledge itself
Sheila  A body of useful knowledge as well
John  What is useful - what is not useful?
Sheila  I mean useful knowledge in relation to research practice....knowledge that you can actually put out into practice. You have the theory to work with but you can actually use it to make your practice better....the practical side of it. It is a body of useful knowledge.
John  Knowledge is always useful. There is no such thing as not having useful knowledge, is there? Whatever you learn.... you might be able to use it
Regan  You can’t function without knowledge
Noreen  Maybe having full-depth knowledge of Harley Davidson fuel injection systems is going to help you have a strong rapport with patient in bed six who is a motorbike freak....I don’t think that any knowledge is useless in our work setting
Peter  Knowledge is factual
Noreen  If you didn’t have knowledge we’d be all up the creek without any paddle
Regan  You wouldn’t get anywhere, would you?
John  I think it’s about direct learning into certain areas - then in certain skills....because you can’t cram in everything that’s out there....but then that doesn’t restrict your learning other bits and pieces
Noreen  I think one of the big problems with it is when you learn something and you take it on as part of your.... ’the things you know’ and it becomes background to the research thing....is people are loathe to rethink....and that’s there....you know it....that’s it
Peter  You’ve done it....it’s worked
Noreen  You’ve done it....it’s worked....and you’re not going to take anybody else’s view or opinions or research on board because....
Peter  Unless other people start doing it....if you’re the one that’s read this article on how to bed bath
Regan  Or unless they have proved that it’s better than your way of doing it
Noreen: Yes, but even then, some people really baulk at the idea.
Peter: Yes. Unless you see it in practice, then it’s done...like you come on to a new ward and everybody does it...it’s a new way of doing it...then there’s no way you cannot do that.
Noreen: But it’s getting it into practice. I mean most people won’t take it on board. I mean it’s a well-known fact that the new mattresses we use in the hospital, those hideous pink beds are as equally as effective as “Spencos” but people are still running around like loons using spencos because spencos are soft and they must be better for your pressure areas. Nobody is willing to take on board that these mattresses are a waste of time.
John: Is that true?
Sheila: Yes
Doris: I didn’t know that
John: Who told you that, then?
Noreen: I’ve read about eight articles on it.
Sue: So what do you understand by the term ‘research-based practice’?
Peter: You do it because you’ve investigated it.
Noreen: That it’s proved to work.
Peter: Yes, rather than to do it because you like it or to do it because it’s always been done...because someone said oh, let’s do it like this.
Sue: How does knowledge relate to research-based practice?
John: You need to have an understanding of what you are about to research.
Peter: No, not necessarily.
John: So hang on...so what you are implying is that willy nilly you are going to tell me about research banned mattresses without really knowing what mattresses are?
Peter: No, no...that’s taking it too far. If someone turned up with a sore and I hadn’t the foggiest how that sore is being created then I am going in blind to some degree but I know that they have got a sore..... something has happened.....let’s research.
Regan: You have to have a basic understanding of what a sore is, though, because if you didn’t have an idea or a clue to what a sore is.... practice is irrelevant, isn’t it.
Peter: But research brings out ideas that haven’t been tried or formulated before.
John: But you need to have a base to work on. You can’t really delve into it blind.
Peter: Yes, that’s implied.....then you know what’s....you know what the results are.
Noreen: Well can’t you have some form of object in front of you of a sore and your objective is to discover what it does.
Peter: Ways of caring. That is knowledge of how the sore.... the A + P of the sore rather than knowledge.... or researching ways in which to stop that sore progressing.
Noreen: Yes, but that’s all research does. We have every disease process on the fact of this earth...started in a base where nobody know what it was and people had to find out and then find ways of curing it so you don’t.
need any basic knowledge of when bubonic plague happened....nobody knew what it was...Peter
Yes, you're right...Doris
Yes, but they knew what it did to people...John
But you need to have a basic knowledge of diseases.... the disease process. You need to have the knowledge of some understanding of the human body and how it functions normally. This is something abnormal...we've never come across this. We know how to treat this and that... but we don't know how to treat this but on the basis of how you've treated other diseases which you've done in the past, you try to develop a new system, a new method. You can't disregard everything that's been done in the past for the sake of research....for something new...you learn from other people and you learn from what has happened in the past but, you say, hang on, what we've done in the past doesn't seem to work on this particular case, let's find a new way...Peter
I don't say you disregard the knowledge...John
You use it....you utilise it....in order to utilise it you need to know something about that knowledge...Peter
That knowledge it very, very limited in its usefulness...John
Not necessarily - just because that knowledge....Peter
No, no...if you have this sore then just having knowledge about the sore won't help you directly find a cure....it's your research that is going to help you find out other things...John
It could do...Peter
So knowledge of the sore isn't necessarily going to...Regan
Yes, but then you've got knowledge of like...say...a cell you have knowledge from past illnesses whatever...how to....how they found out what it was...John
You need to have the tools....if you don't have the knowledge you don't have the tools...Peter
Well...how....Regan
Well, you know if you say the HIV virus, or something....they went through certain methods to find out how that....how it was or what the virus was....and what have you. So with a new infection or virus whatever they are going to go through the same sort of thing whether it be through a microscope or whatever but....John
No, if that scientist said, 'listen, I don't need to be a scientist. I don't need to be a virologist in order to investigate the HIV disease.' O.K let's just go and do....this is a new problem....we don't know anything about it and we can get other people that have no understanding of immunology....of A + P whatever....let's find out what we can do about it'...that would be pointless...um....it would....all the things which other people have done in the past would have been disregarded, wouldn't it? You need to know something about sores....for instance, this is a bed sore....now I don't know how this bed sore came along...let's see how we can treat it and how we can cure it. It's not a sore caused by a bullet, or, if this man hasn't been stabbed....that's the thing.
Pre-pilot Study (23.08.94)

Sue So what sort of commitment do you think nurses give to the notion of research-based knowledge? Do you think they are aware of the concept of research-based knowledge? Are they able to say what it is?

Peter I think theory are in name....if that’s alright....they are sort of ‘yes’...then you must be aware of research - to be committed to research-based knowledge, but very few practise it, if that makes sense

Regan Yes, but I don’t think you hear about it either....I mean this thing about the mattresses....

Doris I mean...how often do you see an article turn up on the ward?

Regan If you’re in a ward setting, say, and, you know, all this sort of research should be at hand, say on the notice board so that everyone can see it. It shouldn’t be, you know, just up to the individual.

Noreen It should be discussed at a ward meeting, you know. We’re changing our practice....this has been researched...we’d like to do this now...or...one of us....if we’ve seen a research article that was really important and you felt had something you could improve your practice with, then you should sort of be directing other people towards it.

Peter Well, no....not necessarily. It is the responsibility of the individual to find out....you can’t have someone...

Regan True, but I don’t think...

Noreen Yes, but I can’t read every nursing journal and every piece of nursing research that exists in the world

Peter Yes. I’m not implying that you should so. What I am saying...you should, say, read Nursing Standard or another one because these things come up every week. Everything changes so quickly.

Noreen Yes, well most of us do, but there’s still a lot that’s missed

Peter I know, but for one person to be responsible, say, for maintaining this board

Noreen No, I’m not saying that...I’m saying if you’ve seen something that was, you felt, valid to your practice area, then what is the harm of bringing it in and handing it round

Peter Oh no, not at all. Yes

Carol It’s up to them to practice it and teach others. Otherwise research is no point. Not everybody is going to read the same article

Regan And for just one person to practice this thing.... when the next nurse comes along to, say, dress this wound...it’s all going to go against each other, isn’t it, so on the whole, you know, in the ward situation, everyone has to know.

Peter Yes, I see what you mean....it’s a find balance there that, yes, it’s the responsibility of the individual to look themselves - you can’t just sit back and have one nurse, who is the research nurse, telling everybody else....that is just being purely lazy but then, yes, if you find a piece of knowledge that is relevant to your clinical area, then, tell everybody. But I think that people don’t apply it because a lot of them are frightened of kicking up a stink

Noreen How about the easy life!

Peter Yes, that’s what I mean....doctors they’ll just sit around.....
Pre-pilot Study (23.08.94)

Noreen I don't mean that....I mean sheer laziness....I mean the effort of getting this new piece of equipment out of the cupboard and using it....whereas they’re perfectly all right on the piece of equipment that’s been hooked up to them for days and why bother....that’s complete laziness....and I’ve done it.....

Peter But with someone who’s ordered this new piece of equipment...say, like in orthopaedics, they have this little plastic boot....that’s a real revolution...um...and people just don’t use it because....well....you don’t put plasters in baths....that sort of thing....um

Regan But it’s even like the slings....you know the blue slings that help you with the lifting....they’re at the other end of the ward and if you can’t be bothered to walk along the ward to get them

Noreen But that’s laziness.....because sometimes it is easier to stick your arm under somebody’s arm and bloody drag them up the bed, than it is to walk down the other end of the ward, get the slings....find eleven other people to help you lift this person and do it all properly.

John I wouldn’t say it’s laziness

Noreen Oh, I would....because I’ve done it and defy anybody to say they haven’t

Peter Yes,...that is where research

John I use slings all the time....but it’s not

Noreen O.K so may be that’s a bad example for you but I guarantee that for some people that is done

Peter That’s an example, though, of research....it’s in the ward....everybody know about it but because they think....well I find it easier to lift someone up the bed without it....therefore I’m not going to use it. It’s stubborness as well, yeah.

John I don’t know, it’s very individual

Sheila But that is where nursing usually falls flat because people go about doing their research and trying to put it into practice and other nurses just don’t bother with it

Peter Well, people get fed up with saying it’s another ‘ruddy research nurse’....let’s not bother.

Sheila But those are the ones who you find are scared of change....and they are not willing to accept the fact that there are new ways and better ways for the patient and for everybody else to do things.... and that is why nursing will always continue to fall flat.

Peter Well, is that because people see research nurses um....I don’t mean this personally Sue, as not a real nurse....you know.....out of the clinical area....they’re not the ones wiping bums so why should they tell us that this new wash cloth is better than another type

Regan I don’t know, but I think if someone can actually come up to you and prove to you that it’s better, I’d take it on board

Sheila I would as well

Regan If someone just put this thing in front of me and said ‘right do that...it’s a lot better’...then it wouldn’t mean anything
Pre-pilot Study (23.08.94)

Noreen It’s like coming back to that thing...if it was done in the ward meeting... but how often have you arrived on the ward and somebody’s said ‘well, we don’t do that anymore’?

Peter But do you think people are reluctant to put that into practice because they haven’t shown me...I haven’t got proof...sort of...almost like a leap of faith....you know you think....well because they hadn’t done this, then I’m not going to do it, rather than taking the research nurse

Regan Or the value of going into it

Peter Well, yes...but

Regan You know...well I don’t know it’s true value so why should I do it until I do

Peter Yes, but rather sort of believing the research nurse...the research nurse had done this and said ‘O.K., this is a better way of doing it...do it this way’ Would people be prepared to take them at face value?

Regan If, say, well my way’s better than your way....well that’s just being pig-headed, isn’t it...to me. I mean if someone actually proved to me saying look, this is the better way of doing it because of this, this and this, then I’m more likely to do it that if someone said ‘well my way is better than yours’.

Peter Do you think a lot of nurses say ‘Well prove it to me, then’?

Regan No

John The thing is, there are so many different reasons, different people don’t apply research-based practice...to practice for different reasons. There’s not one reason why I don’t do it. That could be because of time constraints, because there aren’t that many staff around....because that day I don’t feel good about it...or, I mean, there are lots of reasons

Peter Yes, sorry, but if someone came up to you and said...’um, I’ve done this research...this is the way you do it now’. Would you accept that or would you say ‘prove it to me’?.....Do nurses need proof to put things into practice?

John Well, there’s two reasons....if you feel confident...sometimes I have the knowledge, O.K., to turn around and say ‘listen, that doesn’t make sense to me because I’ve read this and this somewhere else, O.K.’ Now if that goes back to my knowledge, I do have a certain knowledge about the subject you are talking about, so it doesn’t make sense to me, so I ask you....I challenge you....hang on, but I read this and this elsewhere....prove to me that you’re right...but this and this and this reason....this is why we should be doing it. If I didn’t have any knowledge of, for instance, mattresses or bed sores, I could respond in two ways...I could be the arrogant, pig-headed person...hang on, I’ve been doing this for yonks, O.K and I know better, or, I don’t know anything about that....so it’s best just to duck and stay low and just follow what everyone else is doing

Sue Do you think that all nurses, John, think about the type of knowledge they are using when they are in nursing practice?

John No
Because from what you’ve said you obviously, from your own personal point of view, you do think of the type of knowledge you’re in command of or that you’re using when you do deliver nursing care.

Well, the thing is....if I know something about that certain area I feel more confident to ask and challenge. If I don’t, I would respond, I think most probably say either play the meek student nurse, O.K new research....blah, blah, blah...I’ll do it without challenging because I’ve no knowledge of that or at times I’ll think....hang on....No, I’m not going to do this. I haven’t done this myself but I can see other people doing that especially who are stuck in their old way or a bit old fashioned in their mentality.

But, say, if you’re a staff nurse and a research nurse or someone came up to you and said ‘Look...let’s do it this way’. If, say, you decided you wouldn’t do that, would you not do it because you saw it um....as the research nurse muscling in and an affront to you...

No. I wouldn’t be threatened by someone turning round and giving me new knowledge and enlightening me. I wouldn’t feel that.

I think if that does happen it’s the nurse’s own personal problem. If she’s taking other people’s, the way they react into account she’s not....you know, it’s her duty to talk about the research and take that into account and whether it works, the knowledge of it and then act upon it and not whether or how the person spoke to her about it. I know it does affect you, but she should still respond to the research.

Carol, can I just take you up on that point. Do you think that nurses actually accord any authority to different types of knowledge? Do you think they accord authority to research-based knowledge? In other words, do they actually place that (rx-based knowledge) on their list of priorities as a very important source of knowledge for use in their own practice?

Um...I don’t think it....it’s got to be a very general statement...but for a lot of people I’ve found...the knowledge if there but it doesn’t necessarily come up high in priority and a lot of times it comes back to situations. All of us have mentioned articles of research that have happened on the ward and we’ve said....actually it’s been proven and that doesn’t work....and you can say it time and time again but the staff just ignore it......and you know, a lot of the time, I think, they’ll go to put it forward and it doesn’t happen....so.....but I don’t think it comes necessarily as a priority.

So, from that last point we can actually assume that may be nurses work with different types of knowledge.

What do you mean different types of knowledge?

Well, let me just ask you, John. How have you come to know what you presently know in relation to your practice?

Different sources, really.

What are the different sources?

The school has been a source and also practical skills. I think the majority of ideas I do have I’ve learned on the ward from other staff.
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Peter	I'd say the School (of Nursing) has put a lot of theory behind nursing but a lot...but even more than that...I've also learnt a lot of directly-related theory on the ward itself. If, say, I'm on a medical ward I've gone over the functions of the kidney or whatever...or functions of the lung.

Regan	I think that's the place where you learn it because you associate it with what you see.

Peter	Yes, what we've learnt in School is a lot of how you care for this patient with COAD...that type of thing. I couldn't be a nurse if I was taught one hundred per cent in school. I'd have to go out...and you learn so much in the wards.

John	But, then, if I didn't have the knowledge the School gave me I wouldn't be able to function in the ward anyway.

Peter	Yes.

John	You need that and the School did give me that base.

Sue	Do you think the School has helped you to appreciate the difference between knowledge gained through experience and research-based knowledge?

John	To a certain extent 'yes'. I've come to appreciate research-based knowledge more in my clinical setting than from what I've gained from School...um...especially going back to my previous allocation...HIV allocation. The difference research-based practice can make on the lives of people...the quality of their lives is amazing...and that is the real turning point for me...personally...um...but I mean I would also say I haven't really seen any practice based on research or animosity towards it because of the...the way the ward was...either Sister or the Charge Nurse...because they didn't want any change...they wanted it to be done this way...they were dictators so to speak...this is my ward...this is the way you should be doing things...blah, blah, blah...

Regan	There's so much enthusiasm in HIV as well though, isn't there?

Peter	It's the whole atmosphere.

Regan	The patients are so much younger and willing to buy that sort of thing.

Carol	And it's a new research topic and a new unit...it's quite trendy....

Sheila	Do you think, like, it depends on the area of where you work that you find the staff or whoever you are working with....they actually put more emphasis on research and they actually encourage you to think....whereas, you know, take on HIV, for example, everything was built on research and everything, whereas on an orthopaedic ward most of the staff consider it getting everybody washed and dressed or getting them prepared for the theatre list.

Regan	It's priorities though, isn't it?

Sheila	Yes, but still...I mean...

Regan	I mean...compare Care of the Elderly...I mean....if you look at some of the staff...no offence to it.....they've been up on Care of the Elderly for say 10,20 years and you do tend to...

Peter	Stagnate.

Regan	Yes.
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Sheila: Yes

John: I think the leadership on the ward is more prone to implementing research-based practice. It would reflect on its staff and hence reflect on us as students on the ward and it has....

Peter: But, doesn't it also...yes, it comes from the top, but also those members within that group...it's going back to HIV...they're all young and keen, energetic, go-getting, no-nonsense nurses

John: But...the ward is like...the atmosphere is....hang on you've got an opinion....tell me what you think, but on other wards that I've worked on...I mean....not all of them but some of it's like...this is what I think...let's go out and do it. So I mean if that leader said 'Listen, I'm willing to listen to other people and what they have to say...things might have been different because......

Peter: What, on an old-type ward?

John: So to speak

Peter: Yes

Regan: I think the 'old school nurses are very much like that though, aren't they

John: You are the Staff Nurse....I listen to the Sister...or my Senior Staff Nurse....you listen to me....now if you've got an idea....you can keep it to yourself...you know, it’s very....I mean you don’t challenge them, do you....because we’re scared that if we turn around and say this, how’s it going to reflect upon our report....how’s it going to reflect upon us. They are going to make life difficult for us...or, hang on, we’ve got a cheeky student nurse on our ward.....thinks he knows or she knows more than I do. I’ve been in nursing for 10 years.

Carol: But when we have challenged it hasn’t....it’s had no effect

John: It hasn’t made the slightest difference

Peter: Yes

Sue: How do you think nurses perceive themselves as individuals? Do you think they actually see themselves as professionals?

Peter: No

Sheila: No

Regan: No

Peter: I’d say some of them do. Those that....

John: In general, I’d say ‘No’

Peter: The real career nurses think that....I’ve learnt this, I’m going to put this into practice and the ones who are really innovative....yes, do see themselves as professional and they will really strive to change things because of a report they’ve read, or something.

Noreen: O.K I’m a younger nurse.... I’m about to qualify in 5 months. I don’t see myself as a professional

Regan: It doesn’t mean everybody

Peter: No, no...that was a very general....individual statement

Noreen: I’ve got an awful lot of friends who feel the same way....newly qualified nurses who do not feel it

Sue: Why don’t you feel that?
Noreen: I think it’s just an overused word. I think we’re here to do a job. I think that someone’s gone and put a stupid bloody label on it and, you know, we’re just striving to be something we’re not. We are not...our training is not of the standard that you would expect from the traditional professionals, professions. It’s just not. We don’t keep ourselves updated. An awful lot of us don’t behave in professional ways at work...

Carol: Yes, but that’s very general.

Noreen: I said ‘an awful lot’, I didn’t say everybody.

Peter: But don’t you think though that...it’s changing. Forty years ago nursing was very much ‘stick in the mud’ and that sort of change to professionalism takes years and years. You look how long medicine’s been practising and they started off say, as surgeons and barbers...say 200 to 300 years ago...and now look at them...nursing can’t become professional overnight.

Noreen: I just think it’s a word...I think it’s a word that is a complete waste of time.

Peter: No, no.

Sheila: I mean there are still quite a bit of the ‘old school’ nurses around who are holding quite high posts....I mean we still...I mean with the introduction of primary nursing and team nursing and all this sort of thing...you still have young nurses who are team leaders but they are responsible for their patient they are looking after and I think they should be able to put into practice whatever research they can prove is worthwhile for the patient’s benefit, but because of the ‘old school’ nurses who are still carrying high posts...they can’t...because they are still running the ward as such.

Peter: Yes, be more of the nurse practitioner...you’re responsible rather than...

Sheila: Well, that’s the way we’re going to aim to be a profession.

Peter: Yes, rather than say having the Sister in charge...

John: I think the problem is...I see myself as a professional but I think the reason that most nurses don’t see themselves as professionals is that the society in generally doesn’t see them. The reason is...they think that a professional...there is a certain mystique attached to being a professional...and on top of that, O.K, you are a professional if you drive around in a BMW or you have a nice house, or you’ve got a good income...now because nurses don’t earn that type of money that other professionals receive, such as doctors, lawyers...I don’t know...whatever. We don’t have that. They don’t see us as professionals. ‘Oh, you’re a nurse’....I’ve heard that so many times....but that doesn’t make me feel any less.

Noreen: Sometimes I think that society outside of the profession...oh, gosh, I hate that word....outside of nursing sees us as more of a profession than we see ourselves.

John: No.

Noreen: Well, I do.

John: I’m not saying I’m right, I’m just saying I don’t see it that way.
Yes, but the public see lawyers and doctors as something above them. Nurses are on their level.

We’re not. We’re not on the same level.

Maybe that why we’re not perceived like that because we don’t look like, you know,.... we don’t earn the money as lawyers and doctors.

Money is always associated with being a professional...from the lay person’s point of view.

Doris...is that possibly because anybody can practice some sort of nursing. I don’t mean go on a ward and be a nurse, but you can nurse somebody and anyone can sort of do that whereas you can’t be a lawyer, a doctor....type of thing.

But don’t you think that patients or the general public talk to you...will talk to you...will ask you questions more than they’ll challenge doctors, lawyers, anyone else...because we’re an equal to them. We don’t have the same power....and I think, we don’t have the same power as doctors.

And I think the day we reach real top professional status...if it ever happens, is the day that people stop being able to talk to us and we become a complete waste of space.

Just because you’re a professional doesn’t mean you’re alienated.

No....because you become aloof and it happens.

Oh yes. A lot of people do, even now. There’s a lot of nurses who are completely aloof.

Noreen’s got a good point, though.

Yes, but there are still those doctors and lawyers who are very approachable.

It’s up to the individual really.

Yes, but the problem is that all the doctors I can know I can name the approachable...I can name the approachable like I’m fitting on the fingers of 5 hands....1 hand....5 fingers on one hand.

Yes. You’ll have that on board. You’ll have, say, a group of, say, 6 or 7 doctors....a few will be approachable....a few will not be.

But then you get approachable nurses and you get unapproachable ones.

I agree.

You see I think the mentality of being a professional should be changed. I mean being a professional doesn’t mean that you have to be arrogant....aloof, or, you know, away from the person. You can still be professional, knowledgeable and understanding and caring, if that’s the perfect word to use, but the problem is that we have to appreciate ourselves first, before other people can appreciate us. If you don’t respect yourself as a professional.... if you don’t respect what you are....because you know what you are....other people don’t out there...it has to start from us. The reasons that...well apart from money and all that, O.K....we’re not going to get that...I mean that doesn’t matter, but if we start respecting ourselves as professionals and abide by our Code of Conduct, or whatever it is, within...in and out of our work setting, then other people will start respecting us for what we
really should be respected for...not respecting us because we are doing things that other people normally wouldn’t do. We are cleaning people’s bottoms...we are caring for them...we are holding their hands...that’s the way they see us. The number of people that have talked to you say ‘I couldn’t do what a nurse does’. Why have they said that? It’s not because I have been through 3 or will have gone through 3 years and 3 months of training, it’s because the things they think I do, they couldn’t see themselves doing. So, it’s down to me to prove to them....there’s much more to nursing than cleaning a person’s bottom.

Peter
Yes, but going back to your point, though,...professional...they’re not seen as professional because they don’t drive a BMW, but it is also because the body of knowledge of nursing isn’t very large and...I’m sticking my neck out here. You can become a nurse in 3 years, I know....I’m going to get shot down here.... but it takes 5 years to become a doctor and I don’t know how many years to become a lawyer, so if we increase that body of knowledge or do it in more depth, will we be seen as more professional?

Doris
I reckon that degree nurses and diploma nurses will see themselves as more professional than we do.

John
But don’t you think they have a right to?

Regan
No

Sue
Why do they have a right to, John?

John
Well, going back on the point you just made, O.K., now...knowledge doesn’t mean that you get to be more arrogant, but let’s face it, a degree nurse does or will have more knowledge when they qualify. That doesn’t make them a better nurse, but they’re more knowledgeable. Now you can’t say ‘No’ to that, can you?

Elaine
I don’t necessarily agree with that, actually

Peter
What? Knowledge doesn’t necessarily....

Elaine
No, no. don’t necessarily agree with what they were saying about degree nurses.....that they’re more knowledgeable than us.

Noreen
Yes, but does knowledge make you a professional?

John
It’s the first step towards becoming professional. It’s one of the most important criteria in becoming a professional. I think that...let’s say...not on an individual basis, but on the whole, so to speak, a degree nurse does have a far greater body of knowledge than us.

Doris
Yes, I think they have more knowledge than us. They spend more time in school, knowing why things happen as they do but we know how to....more able to cope with what to do when confronted with a patient like this.

Peter
Yes. By saying they’ve got more knowledge, they’ve spent 4 years....it doesn’t necessarily demean, say, what Elaine was saying, or I think at least what you were trying to say, that because they’ve got more knowledge, they aren’t necessarily better nurses and therefore, we’re not demeaned, but we’ve got experience.

John
I didn’t imply that at all. What I am trying to say is that...no that’s a different discussion also - who is a better nurse? I don’t think you can
really create a person. You’re a better nurse because you do this or that, but the thing is...going back to our topic about knowledge and research, O.K., now if this person has a bigger body of knowledge, O.K they have a better understanding, O.K.,....if they have a better understanding, they can challenge people on different issues, different areas and they’ll be more accepting....they would accept research because, at least, they have some understanding of where it’s stemmed from, where it’s come from.

Peter  But you don’t necessarily need an in-depth knowledge to challenge something, do you?
John  Yes you do because if you don’t they are going to say...Listen, what do you know about this. I need to have some understanding of something
Peter  Oh, yes. But you wouldn’t necessarily need a degree nurse’s depth of knowledge to challenge a piece of research, though, would you.
John  No, not necessarily, but the person does have more knowledge and that was the first thing we discussed, wasn’t it....that if you have more knowledge you’re more accepted (receptive???) to research. The reason other people don’t try to implement research-based practice could be because they don’t have the knowledge.

Peter  But there again you could quite easily say, conversely, if you’ve got more knowledge then you’re less likely to accept research
John  No, no......
Sheila  No
Peter  Well, you could, say, have read some equally...um.....some piece of research which disproves it
Regan  Yes, I mean if you’ve read two articles, which one do you pick.
Noreen  It’s a complete wariness of research. I mean.....like every day someone manages to disprove something that everybody’s been practising for years that they all originally thought was research-based anyway. Everybody just sits back and thinks....well, we’ll give it a while....because they might change their minds next week

Peter  You mean, what we do now, sort of thing
Noreen  I mean like, what, 4 years ago we were allowed to....no it’s more than 4 years....we shouldn’t have eaten bread....it’s bad for you and no potatoes.....

Peter  Now the government’s saying 3 potatoes a day
Noreen  ....and drinking...the alcohol thing...you know...any alcohol in any form is completely bad for you...and now everybody is going on about this wonderful glass of red wine that everybody should take.

John  It’s basic knowledge. We take that on its merits and this research that’s proven this....in the future they could disprove it. It doesn’t mean that something that’s handed over to me is engraved in stone. I’m not going to say - this is it. I’m never ever going to turn round
Noreen  No, I’m not saying that people can’t think like that, but people sometimes don’t because there’s so much research coming our and so much conflicting, you know, I mean...2 research articles can come out in one week and have completely opposite point of view

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John And if you have that base of knowledge you can critically analyse that and say...listen, to me that doesn't make any sense - A makes sense, B doesn’t.

Noreen That’s great, that’s lovely. If that’s available to you and you want to do something, but a lot of people just think....

Regan You should be looking a research and critically analysing it because if you don’t then you’re just neglecting your patients, aren’t you.

Noreen But people are.

John Well, why are they? Is it because they don’t have the knowledge, they don’t have the guts or they don’t have the courage? What is it?

Noreen Well, maybe they just don’t, like, think it’s their place. I mean....

John And that’s why I think that if more nurses...

Noreen It comes down to self-awareness about understanding your...

John ...if there are more nurses that have a sounder and a larger knowledge base they’d be able to challenge and pick up the courage and say ‘hang on I don’t agree with that!’

Noreen I don’t agree. I think it may be if they had the confidence and knew they had the backing and a strong self-awareness and a knowledge that they had the ability to do these things because, you know, self-knowledge then, yes, maybe, rather than a strong knowledge-base based upon facts.

John A simple example...when we finished doing our essay when we’d revised everything, I felt so much better about myself because I knew more and because I knew more I felt I could be a better nurse. I could go out there and, you know, do things because I had all this bits and pieces, you know. It made me feel so good about myself.

Peter Particularly in orthopaedics, I’d revised everything and so I’d go up even to the Sister and, say, look I’ve read this - we do it this way or something.

John Well, let’s take that a step further. What about degree nurses then...they’re doing the same thing on a yearly basis, so if that makes you feel good about yourself, wouldn’t having a degree behind you make you feel better about yourself.

Peter Yes.

Regan Yes. But you’ve got to have an awful lot of confidence to go up to someone and say ‘look, it’s done this way because this, this and this.’ You take, say, me... I wouldn’t be able to go up to Sister and say ‘this is done like this because....

Peter Yes...well...I probably wouldn’t say ‘Sister, you do it this way...’ but I’d say...

Regan No, but you would be more likely to do it than me.

Peter Yes, well I’d say ‘look, I’ve just read this, do it this way’ or ‘I’ve just read this in Lippincott, so let’s do it this way.’...but the more you do it, the easier it gets.

Noreen Oh, you wouldn’t do it to Sister Li-in-oy...I think she’d probably slap you or something.
Peter: Well, it's also judging the personality... if you think you can get away with it by being slightly cocky but that just makes it less intimidating that other person...but it's a personality clash.

Regan: But it's still personalities, isn't it.

Peter: Oh yes. If you get on well with them, you feel more confident more relaxed to say 'well, can we do it this way...sort of thing...'

Regan: If you're a really stand-offish ward sister, you're less likely to accept change...or to encourage change.

Peter: Oh quite, yes.

John: So the fact that different personalities would reflect on research based practice is also true, too, from our own experience.

Peter: Yes.

John: Wouldn't that boil down to education, too. If you were taught in school...hang on...stop being timid...if you think something's wrong...challenge it. We've never really been taught that, have we.

Noreen: Well, we've sort of been that but at the end of the day we all back off when we think about these stuffy little ward reports that we are going to get at the end of the day. The ward report was the most hideous invention in the universe...because we all worry about it so much, none of us will open our mouths.

Carol: Occasionally, we do but...

Noreen: Although I have to say that on the occasions I have, I have actually had better ward reports.

Peter: But it's the way in which you do it...because we're encouraged say from...well, I felt we were encouraged from the word go...not to be susceptible...say the staff nurses say 'do this' and say 'why, well why do we do it?'

Noreen: I think we've been taught not to question authority from the beginning...that's how I feel...because we are taught not to question...oh God, without being violently personal...you never questioned Margaret...you just didn't...you couldn't...and that reflects...

Regan: We did, though.

Carol: They did teach in the beginning to question but as we've gone along in school we have questioned and they haven't responded.

Noreen: Responded...yes.

Peter: Yes, exactly.

Carol: But they did originally teach us to challenge.

Peter: Yes. That's so because a lot of the lecturers are 'old school' and they say 'you do it because I've done it'.

Doris: We're just getting too good at giving challenges.

Peter: Yes...on my Care of the Elderly ward though I did challenge because I felt well the school was there...they could back me up...they taught me to challenge...that's the only reason I did it because I've been taught to challenge.

John: I think Carol's got a good valid point. Initially we were taught to challenge but in practice when we did challenge...hang on...we get our hand slapped...so we're getting conflicting messages. From one hand you're being taught, OK...challenge...stand up...be brave...be honest...,
OK ...and the next minute, when you do stand up...sit down, you fool...you know...

**Completion of Side A**

**SIDE B**

Peter  But doesn’t it go back to the way you criticise. If you say to the Sister...grab her by the frillies and say...'no you don’t do it this way...I’ve been taught this way...I’ve just read an article...’, isn’t it.

Noreen  But, going back...and I’m going to say this if it kills me: going back to the bit about whether we were taught to criticise or not in school. I think we were taught to criticise with one hand for the simple reason because that’s the official line and that’s what we should be taught because it looks very pretty. But I think, on the other hand, they don’t mean it.

John  Absolutely...

Noreen  ...and if we do it...it’s sort of...

John  ...they get annoyed.

Regan  And it can make them look as if they’re in the wrong...especially...not especially in school but people who are actually teaching you...you say ‘well it’s actually better if you do it this way’. It looks as though you’re better than them.

Peter  Yes, if you say ‘well I’ve read this and you’re wrong’ then yes, it will make them feel like that. But if you say ‘well I’ve read this, what do you think of that?’ If you do it on a one-to-one...

John  Peter, prudence is understandable as being tactful...I mean, I’m not denying that of course you don’t go up to the person and say ‘listen, I don’t think this is right...you should be doing it this way’. There are ways of putting things and I think all of us have learnt to be diplomatic. The thing is...that you can’t deny it...I shouldn’t say that...but I really think that as a nurse, we’re taught one thing in theory, but in practice we learn to do totally the opposite...don’t challenge...don’t rock the boat...and don’t stick your head out, because if you do, you’ll get slapped.

Peter  Yes, but ‘rocking the boat’ is different.

Noreen  But, Peter, you’re very strong. You personally are a very strong person who has no problem with questioning authority...so, an awful lot of us do have problems with questioning authority.

Peter  Yes, but I think that people get mixed up with ‘rocking the boat’ and so...I could easily ‘rock the boat’ and be really obstreperous.

Noreen  And do regularly.

Peter  Well, yes. That’s when I’m not particularly tactful but, say, on a ward setting, you don’t necessarily need to rock the boat to challenge someone.

John  Well, of course not but we weren’t talking about the wards, we were talking about in school...and that reflects on practice in the wards.

Peter  I’d say the older lecturers do, but the ones just coming in...
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John  I don’t know...
Doris  I don’t think that’s true...
Peter  The ones that are just coming in are more willing to be questioned.
Doris  I think there are some lecturers who you can challenge and you can say ‘I don’t think this is right’ and all this and they’ll accept it with how it’s phrased.
Noreen  I don’t think that’s fair on some of the older lecturers.
Doris  I’m not saying the older lecturers.
John  But I think that this reflects on the way I question things on the ward. If I know that in my school, in my college or whatever, OK, they will understand, they will tolerate me being stupid, me being silly, me being pig-headed, OK, I’ll be brave enough to challenge people on the ward, too. Now, it’s a chain, isn’t it. But on the ward I know that hang on...if I challenge this person, however prudent I am, however tactful I am, they might have a go at me...What will happen next? They will call the school. Will the school back me up on this? From my previous experience, I have been taught, they won’t. Because when it’s their problem, they back down. Now this is not their problem...I’m on another person’s turf. That is exactly what is going through my mind so the best thing to do is to stay quiet and just don’t rock the boat and let things go by. And that is the way we’re taught...you see the same thing happening. Then I qualify with that mentality. The best thing to do...

Doris  Then nothing ever changes then, does it.
John  No, it doesn’t and that’s the problem. I disagree with that totally. If I don’t do it, then I’m going to break my hands and arms.
Peter  I don’t think we are taught to sit down and let it go.
Noreen  But lots of us do and this is a discussion of opinions.
Peter  I’m accepting all these criticisms, but I just disagree...I’m not demeaning your criticism...I think we are encouraged to do it...it just depends if you’re sort of switched on...you think yer, I’ll challenge that one rather than thinking ‘no, I can’t’.

John  Well, I’ll be repeating myself if I say so, but I mean that’s your opinion, but I disagree...the fact is...
Peter  You can go to some lecturers and not others. Well, why is that?
Noreen  Have you ever heard that you don’t have to turn up if you don’t want to routine...when you don’t, you’re absolutely up the creek.
John  Well, I mean... broadening this...it’s the same thing, isn’t it,...on a ward we said there are some wards that allow you to challenge them because of the leadership. It’s not a dictatorship, it’s a democrat. So listen, OK you’re a student, you’re a member of my team...let’s hear what you’ve got to say. I’ve been on those wards and there are other wards that...hang on...you’re the student, OK stand up...let the staff nurse sit down...The same thing happens in school. Now there could be other colleges...I don’t know...I can’t talk about other colleges, but my impression for my colleges is, OK: the leadership it’s like a dictatorship...it dictates to others and it filters through...it goes like this...there is one person at the top...this is the way it should be done
and the lecturers have to follow suit. And we're the foot soldiers, aren't we, down there.

Sue
So you're talking about professional values...actually dictating other people's behaviour and the way they should act.

John
This is the way you should act, this is the way you should sit, this is the way you should stand, this is the way you should perform...

Peter
And therefore you don't introduce your practice...I won't do it because...

Sheila
So what we are trying to say is that our attitudes and perceptions of research-based practice is moulded from school, then...from our training.

Noreen
Yes.

John
It has a lot to do with it...yes.

Doris
Yes...in 10 years time when all these...you know...then younger people are coming up through the ladder...hopefully, it will change because people who are working on the wards now who might be teachers later are learning to...are saying 'yes, you are a student, you are a valid member of this team. Challenge me...tell me what you think...' and then in school it will get taught to the new students, but it takes time.

John
That's the essence of higher education, isn't it...that you don't take things because Noreen told you to, OK. You challenge Noreen and say 'listen, what'. I wouldn't, but in general...

Peter
I wouldn't.

John
You challenge them. Now in order to challenge them you need to have some knowledge and that's higher education. You don't follow other people's things, you learn them.

Noreen
But at the end of the day, it's still taken by your personality and your personal opinions, your upbringing, your education...those people around you...the environment in which you work.

John
Noreen, that's a very important thing...I'm putting my foot into it, but let's look at...in nursing general...people come into nursing at the age of 18 to 19 OK...their personality is shaped while they're on the course...

Noreen
That's why I think the age entry to nursing should be changed.

John
It wouldn't be my place to say that, but it has a lot to do with it so I mean what they learn here is...will reflect on their future life, too. It's going to be very difficult for you to change all of a sudden the way you have been reared and taught so as you said...hopefully in the future when things do change...nursing education changes, research-based practice will change. If we have more knowledge, we are braver...if we are braver, we can commit ourselves to research and stick by it because we believe in it...and not be so big-headed and say 'listen, I could be wrong'.

Sheila
Professionally, one mustn't let personalites and attitudes get in your way.

Carol
But if we were taught initially...because we have had hardly any sessions...we had one the other day on assertion but if we were taught
from day one about being more confident and basically they built this up while we were in school we'd be more into it.

Doris I mean I think some tutors have tried to build up our confidence and others haven't nurtured it...they say 'you've got to accept it because I say it's right'...and you don't question it.

John Then on the same par, you can't expect tutors to rock the boat too much, too. They can say their bit, but they can't go further.

Carol Then the person at the top should be willing to accept them, too.

John Absolutely, I couldn't agree more.

Noreen I've never seen the person at the top.

John I have.

Sheila It's an Irish lady.

Carol I don't think I've missed out, though.

Sue Right, thank you very much for that discussion. It was certainly a lively one, so I do appreciate your co-operation in this particular pre-pilot study.

Thanks very much.
APPENDIX 7
SUE. Hello, thank you for coming along this afternoon and taking part in this
interview. I know you’re very busy so I’m actually very grateful to you
for coming along.
Last week I did explain to you what my research was all about and, in
fact, it’s looking at the relationship between knowledge and
research-based practice. So what I’d like to do is start the conversation
by asking you to tell me a little bit about your own work in this ward
area and how maybe the kinds of knowledge that you have and need to
have...how they actually fit into the work you do in the ward area?

Q.P. O.K...um. Well, I think I start by saying that I am in the Care of the
Elderly and have been for a very long time...um...many years now. My
first love in nursing was really surgery...and then I left surgery to come
into care of the elderly. At that time I didn’t really have a lot of
knowledge about looking after elderly patients. I came to stay in it for
one year and I never went back to surgery.

SUE. How long have you been in it, Sister?

Q.P. Um... about 20 years.

SUE. That’s a long time.

Q.P. Yes...it’s a long time...and I’m surprised at myself as well... that I
stayed that long. But when I started I didn’t have all that knowledge
about care of the elderly. I...but there was just one patient that changed
my mind completely for me to stay in it and um...I watched that patient
admitted with a stroke and I watched that patient leave the ward on the
arms of her husband...walked out of the ward...after having a
stroke...and I’ve stayed in the care of the elderly since then.

SUE. So that was a meaningful event for you.

Q.P. Yes...because I realised from then that you needed...in surgery it
was...you didn’t need any skills at all to do...to remove sutures...to do
observations and so. To look after...to do the work that we do here
you’ve got to be skilled in certain areas. Um...we...my job really is...I
see myself as a clinical manager and as overall ward manager. Um...I’m solely responsible for everything I should say in this ward...all staff, the patients, the clinical side of it...um...the overall managerial side of it, resources that we use, teaching...um...delegating, organising...all this I suppose comes under management.

SUE. So would you say that there is such a thing as management knowledge?

Q.P. You need to have that.

SUE. To be able to do all the different things you have just listed.

Q.P. Yes. You have to...I’m talking about life, say, in this field of nursing...in care of the elderly. You’ve got to have good knowledge of nursing older people. You...you...

SUE. Would you say that it takes longer to acquire that knowledge because they are older people?

Q.P. Yes.

SUE. And it takes more experience maybe.

Q.P. Yes...you need a lot of experience and understanding, you know, to look after these patients and I mean I myself think at times I think that perhaps enough research isn’t done or hasn’t been done in...what shall we say...not care of the elderly...gerontology.

SUE. So actually looking at older people.

Q.P. Yes...yes...because....... 

SUE. Looking at how they function and what their needs are.

Q.P. Yes...their needs and, you know, it’s not everybody, not everybody can work in this field because you need to really understand...you need skills, you need to understand. You will find, you’ll find house officers working in some of the other medical wards and they come to a ward like this and they think they can just walk into the ward and see a patient and say you’re well enough... you can go home today...they don’t think of the needs. They are going in the community...their
needs...what they are going to need and for the relatives as well. you
know. They don't think of that...they don't see beyond that, you know.
They just walk in...a patient came in... the patient was very ill and now
the patient is so much better - so you can go home. There's so much
more...because you got to think of what does this patient need now?
This patient is going into the community...she's going to need a
package set up for her to go back into the community. You've got to
look into all these things. You've got to have knowledge about all these
things. Who needs a social worker? If a patient needs a district nurse.
If the patient needs a special diet...um...all these things... a whole
package sometimes is essential and they don't see that. They don't
understand it, you know.

SUE. Are you saying, Sister, it's one of those areas where you can't know
about everything or learn about everything in a short space of time
that, in fact, it's one of those areas where you'd have to stay a for quite
a long time maybe to get that essential knowledge about older people
and how they function and what their needs are and to get that
essential experience?

Q.P. Yes.

SUE. Is that maybe what you're trying to say.

Q.P. Yes. You can't just go into this field of nursing and just with...go in
there thinking I can go and just wash and dress a patient and just make
sure they have something to eat and think that's it. It's not

SUE. Do you think some of the students think like that when they come to
your ward?

Q.P. Well ...yes. They...I think some of them are really shocked you know.
Afterwards, they found out how much is involved in caring for these
patients. Am I talking too much about Care of the Elderly or did you
want to talk...

SUE. No...I want you to talk about what you want to talk about.

Q.P. Yes...o.k.

SUE. Did you ever do the Care of the Elderly course?

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Q.P. I did. I did the Care of the Elderly course.

SUE. How did you find that?

Q.P. Um...well...it's no good if you're going onto a course and you go on a course and, then if you're not going to come away with something that you can go and practise and work on it...you know...and implement things from it, then it's no good just going there and sitting down and listening. Now, I get a lot of my...um...I suppose my experience from or ideas..... (Conversation interrupted by a telephone call)

SUE. Right, so you were talking about the course, Sister, and how when you do a course you should be able to bring something back from it and then put it into use...and practise in your own area.

Q.P. Yes.

SUE. Now would you say you have been able to do that in your own area?

Q.P. I like going on study days to do with my area of nursing. I like going to Ward Sisters Conferences and...because I hear different views, you know,...different people and I always get ideas from these study days and from conferences and I come back with it and try to work on that and, you know, to implement things, you know.

SUE. And update other people's knowledge of this area of nursing.

Q.P. Well, I find that you have to...you know...you have to keep up with...well, I tend to strive to keep my own knowledge base up to date date...by going on study days, conferences, seminars whatever...read...I get a lot of ideas sometimes from reading...um...Nursing Times...you know...because they're all... Sometimes, you know, there are articles in there of people who perhaps have more experience or they've done research in something to do with this field that I never thought of, you know...you'll read it up...and then to try that and see how it would work for me and my staff. I try to analyse and criticise my own performance...um...

SUE. When you are trying to put something new into practice, maybe something you've learned from attending a study day or conference, or maybe a research study that you've read about do you ever find that
some members of your staff are a little bit resistant to the idea of change and trying to put those new ideas into practice?

Q.P. Oh yes. You get that all the time.

SUE. Why do you think that is?

Q.P. Because, I suppose that everything, anything...some people are quite, quite happy with the situation as it is. Any sort of changes...that they're thinking...oh, we’re going to change from this routine and we’re going to do this now. Some of them are perhaps thinking it’s more work for them...it’s going to be tougher... some perhaps are just not that way inclined at all...they’re not..they don’t care about changes or they don’t see...you know, you’ve got to try to explain to them just for them to understand that with today’s climate and with all the different changes, you can’t just sit there and not do things. Every day...there must be...there’s always something...because if you were to compare when we were training and the way training is going on now, they think that we used to do...there’s a vast difference, you know. Years ago in looking after...when I started looking after patients in Care of the Elderly it was comparing it...it’s nothing at all to what it is now. This is really acute nursing and in those days it wasn’t anything like that, you know. All these involvements. Now you’ve got to...you’re doing CVP lines...setting up CVP lines on patients. You’ve got ...... a little while ago we weren't able to do GTN infusion on the ward- Digoxin infusion. Who would have thought of that years ago in Care of the Elderly, that these things would take place. They were sent to the wards, but not on Care of the Elderly, so nowadays you have got to accept changes and if you find you’ve got some difficult...I never...I never really say go for conference or study days and come back with ideas and say ‘Right this is what we are going to do’. No. I bring back leaflets and we have ward meetings and we sit and discuss and we decide let’s talk about it and, then give them the leaflets to read and then we have another meeting and ask everybody what do you think. Recently, I had a meeting with my staff nurses and we have decided that we should write...I put it to them, what do they think about the idea of us writing our own care plans to make things easier and they thought about it and they thought about it and everybody was for it because they realised it’s going to make life easier...having our own care plans...because of instead of sitting down and filling up all these different areas, we’ve got a care plan to go with the kind of patients we get on the ward. We’re doing care plans to do with stroke patients, incontinence, urinary incontinence, faecal incontinence, which, these
are the kinds of patients you get...um...haematemesis, hypothermia...all these. We’re doing our care plans on these...so, you know, which I think will make it so much easier and I am looking forward to it.

SUE.  So, it’s sort of standardising care plans, in a sense..

Q.P.  Only on this ward.

SUE.  It seems like a good idea.

Q.P.  Yes, so...

SUE.  So that’s an exciting new development then.

Q.P.  Well, yes, it is. I don’t just go along with my own ideas. I try to see everybody’s point of view, you know.

SUE.  And then decide whether or not it’s worth putting into practice.

Q.P.  Yes, I mean there’s no point in doing somthing that is going to be a waste of time for everybody, you know..um...I find for myself doing this kind of work...I think for me you have to do this and do it well. I mean you must accept that you will get some sort of criticism...not everybody will be happy with some of the things but I feel to myself most of the time that I have got to be totally committed to my work. I spend many hours here so as to get things right and for the benefit of the patients and relatives and staff. To run and manage I think it needs...as I say you’ve got to be committed...totally committed. Secondly, I believe very much in principles and regulations...exercise good and consistent...enforce consistent regulations and principles. I believe very much in principles. I believe that patients should have a say. You learn so much from talking to patients and you get a lot of experience from that to use in this ward area by talking to many patients you get their views and relatives, too, you know. You know their needs - you get to find out sometimes what they are thinking. I think they should be encouraged too - they should be treated with respect and they should get an explanation... if they want an explanation of their treatment and what you are doing to them I think they are entitled to that.

SUE.  It’s interesting what you’re saying, Sister, because, I think what you are saying is that it takes a long time to get the necessary knowledge and
experience of this type of nursing - care of the elderly. But that underpinning it is commitment and the idea of having some professional values, some principles. Is that what you are saying?

Q.P. Yes.

SUE. And that takes time, doesn’t it? That’s a struggle.

Q.P. If I was the clinical manager and I was interviewing someone for the post of a ward sister, ward manager for a Care of the Elderly ward, if they hadn’t the experience of working in it I wouldn’t be interested.

SUE. Because of the demands it makes on your knowledge base and understanding.

Q.P. It’s a lot of understanding and experience. You need experience. You can’t just take somebody and put in Care of the Elderly ward and say, you, know, look after that ward and expect them to. It wouldn’t be fair on the person, I don’t think. It wouldn’t be fair on patients, if you haven’t got that understanding and experience, you know. I suppose you could look right across the 4th Floor and you would think and I know that the first person they would seek...Ask Sister because she’s got more experience in the Care of the Elderly and I have and I know that I have got it more than any of these ward sisters because they haven’t been in it as long as I have, you know. There are times...sometimes that I would go into that ward...I have been in the ward already and doing a ward round and I went to...as I went into the middle of the ward and saw the patient I looked at that patient and I said to the nurse. “Who sat that patient out in the chair? I’m sure she is going to arrest today” and they looked at me and said “Why do you think she is going to arrest today?” I said “that lady does not look well enough to be sitting out in a chair because I am going to prove to you that she shouldn’t be sitting out in a chair, she should be in a bed and we need to get the doctor to see her”. Now that patient went for, in my absence, went down to the X-Ray department...the patient arrested down there and about 2 weeks ago I went into the ward and I stood up right at the nurses’ station and I looked straight ahead of me at this patient in Bed 4, just about 2 weeks ago and I said “oh what’s the matter with L, she doesn’t look well?” and they said to me “she wasn’t very well last night, Sister” and I said “Well have you called the doctor?” and they said “Well her breathing is not very good and she’s had oxygen, but that’s about all” and I didn’t stop,... I was beginning to get angry now and I went straight into the ward and took one look at
her and I knew that at any moment, if something’s not done immediately, this lady’s going to die...I’m not making it out as if I know it all but I get to know...maybe because it’s my experience of looking after these patients like this... watching their behaviour and everything and I just knew something is going to happen to this lady today. I bleeped the doctor immediately. I said “This patient of Dr X is very ill on the ward. This was about 8.30 and I think somebody ought to come to the ward now to see her”. The registrar came and from that moment on we had to work very very fast to save that lady and she’s told her husband, she’s told the nursing staff...everybody that “thank God for sending Sister for what she did today because she saved my life”. She knew she was...she felt that she was dying as well. She was in that state, you know.

SUE. So that’s a special kind of knowledge that you have, isn’t it?

Q.P. I don’t know.

SUE. You didn’t even have to take the observations. You knew.

Q.P. Yes I just looked at her. Her condition needed medical intervention...not just giving oxygen...you know...um....

SUE. Sister, Can I just take you back to a point you made quite early on during the interview and it was about research...and you felt that may be not enough research goes on in this particular area of nursing. Why do you think that may be?

Q.P. I don’t think...I don’t think many people...um...I think before many people were not all that interested in Care of the Elderly but I think because patients are living so much longer now and the type of patients that you get now in hospital, you know...and the demand of elderly patients for beds...I think they need to do...because they are living so much longer...more is being done, It’s not like years ago, you know, that an elderly person admitted in hospital with a fractured hip and pneumonia and you think twice...should we or shouldn’t we...leave her to go in peace. I mean the moment they come into hospital now it’s quite a lot of intervention here and it’s not...it’s not that anymore that you leave them and, say, give them antibiotics and that’s it. We don’t do any pin and plate to this fracture...we’ll leave them. No...I mean...we are...we’re...a patient who was transferred today...92 years old and her breathing was very, very bad and you just didn’t give her oxygen,
nebuliser and perhaps a Frusemide tablet...No...you go further than that now and although she's 92 she's a strong 92, so you don't just leave her there. You put in a Venflon and you're giving Frusemide IV and you're giving fluids and everything...so, so much more is going on and I just think...I think there are still young medical doctors and...um...who still haven't got it right...you know...about this type of nursing, this type of work really and I think much more...Nowadays, I don't think you should just even take...um...skills for granted and say that is enough. I think you need much more than that. Patients are going out in the community and so much more...I mean...they're going out in the community. You're bringing them back after being treated in hospital with DVT and they're on Heparin, Warfarin and you're bringing them back to monitor...you know...their INR and you...you...you've got to have knowledge I think...because you've got to know that you've got to communicate with G.P.s and let them know what's going on You can't just...these days you don't just send a patient...discharge patients perhaps with a month's supply of tablets. You need follow-ups. There are more investigations going on...they don't just come in and you don't just take X-Rays.

SUE. Thank you for giving me this interview.
SUE. Hello, Robert. Thanks ever so much for coming along this afternoon to take part in my interview. I think I did discuss with you a little earlier on what my research was actually looking at and, in fact, it’s looking at the relationship between knowledge and research-based practice. So what I’d like to do this afternoon is to start the conversation by asking you to tell me a little bit about the work that you do here as a manager and may be how you see knowledge fitting into all of that.

CSM. Yes, by all means. Right. I’m the In-patient Service Manager for the Medicine Directorate and have been in post for a year and a half, so my role has changed vastly to when I was first appointed. In a nutshell, a summary of my roles. There are various facets to the role of the In-patient Service Manager and I’ll talk really about my roles now as to what they were when I first took up post. Um...looking at my roles...as I said earlier...there’s lots of facets to it. I see one of the key roles as managing people and I’m a nurse by background, so hopefully, that helps me in managing people and looking at leadership and role modelling ...and ...um... really supporting the staff in what they’re doing on the wards as well as I work clinical shifts or started to work clinical shifts ...um... two days, three days every month, so, hopefully, I can impart to them the knowledge I have. I mean looking at the roles I take on board ... as I say ... it’s looking at managing non-pay and pay budgets, which really comes into my role in working with X and managing budgets and to that I hopefully have a fairly good knowledge of the non-pay and the pay. But I think what’s very dear to me is I don’t feel cuts should be made to the detriment of patient care and that leads me onto very much the quality. I’m involved a fair bit in quality initiatives, quality strategies and to that I feel you have to have very much a broad knowledge base of audits, quality initiatives ...um... and really reviewing what knowledge base that has before you take that on board. From the point of view of quality, we’ve moved forward in great strides with quality in the directorate as in setting a quality forum where we have devised terms of reference. So I feel you have to have knowledge around that particular area and all of us sort of went off and researched sort of quality and looking at what we needed to do to formulate the group ... and the group comprises ...um... E grades up
from each individual ward area and also Sisters and F grades. And into that we then look at ... initially I chaired it until ... gosh ... it was probably September time, then a sister has taken over the chair of that and into that we look at things like the Named Nurse concept, documentation which we audit every four months, the Named Nurse we used to audit every four months and really quality initiatives, policy-making, ...um... all the things that we do in the Directorate related to quality are the things that we look at. A big part of the quality forum which I see is a huge remit in my job. We look at the nursing targets and into that we’ve ...all the wards have set three areas that they want to audit over the next year which I follow through and support the staff in standard-setting and reviewing it and looking into all the things you have to re-structure, process and outcome, which you sometimes forget about. So that’s the quality aspect. Business management I’ve spoken about. I also ... a big part I manage is all the complaints, which can be a never-ending task and that’s something I think also comes in managing staff as well and what I then do when I receive complaints I then send that to all the ward staff who then follow that through. I don’t think there’s any research into that. I think it’s just very, very sort of looking at good quality of care for patients. Um... what else do I do ... there’s a vast amount. Certainly, a big part is the communication aspect, which was lacking a great deal and that I see as a very important part of any person’s role and from that we have monthly staff meetings. We, as well have ...um... we do a lot of education in relation to in-service training, which communication plays a big part of ...um... and, as well as sending out lots of memos which the staff get very fed up of receiving from me. Other aspects of my role is supporting the teaching charge nurse with education and that’s where I think a lot of research does come in where we explore our knowledge base and very much look at what we have to give to other staff because very much, I see this role as being very much, as I’ve said previously, a facilitator and very much a role model. I feel that if you haven’t got the skills, you are not able to give that to other members of staff.

So from the educational component we looked at the role in the health educational programme for all the staff. We have in-service training. We also have a discharge group where we look at discharge and good quality practice. We also in that group look at the targets of nursing and auditing as well and from an educational point of view Y was involved in the audits with the Named Nurse and documentation.

SUE. Who actually sets the targets in nursing, Robert?
CSM. The targets for nursing .... Very much we looked at the document that Miss X wrote with her nursing group and then the Sisters set their own targets. We’ve achieved all the targets for the last year 95/96 and we’ve now just set the 96/97 targets ...um... which are a mixture of ...um. Examples are ... Ward A are looking at primary nursing and the Sister has been involved quite heavily in research there and has put things through for approval, which is now going through. An example on Ward B ... they’re going to be looking at blood transfusion, endoscopy. Ward C are going to be looking at mixed sex wards, which very much comes into the Named Nurse .... not the Named Nurse, the Patient’s Charter. Ward D- very much the care of the elderly ward are looking at things like mixed sex wards as well, Alzheimer’s and looking at targets there and finally Ward E, customer satisfaction, discharge planning in primary nursing as well.

SUE. So research does have quite an important role to play.

CSM. Yes. It’s certainly ... it’s very high on the agenda in what we do in the medicine directorate. I think quality and research was not at the forefront of the nurses’ minds so a lot of work had to go in sort of with the support of T, initially, as to how we really could bring it to the forefront of the nurses’ minds because I think they very much saw, as with the Nursing Process and nursing documentation, something that wasn’t important, whereas I think now on each ward we now have a quality facilitator and they then bring to the ward the research that we do at the quality forum. And we’ve recently also put on a quality presentation for the hospital where we spoke about the current research issues that we were doing, certainly with the pressure sore strategy. We audit that every month and without repeating myself again, as with the nursing documentation, with the Named Nurse ... those are audited and any research is included in there every four months. So a fair bit of work is now done on research and, hopefully, with the support mechanism for the students as well with what’s available on the wards i.e. with educational programmes. I mean the emphasis is there now on research-based practice.

SUE. You mentioned students. Can I just ask you what you think about the present Project 2000 scheme of training?

CSM. Certainly, I am very reliant on what the Sisters feel about the training and certainly from the Sisters’ meeting at the moment, they feel that
the students aren’t with them for long enough periods. They’re there for - I think ... is it two days a week or so and they feel there’s no continuity there that the students come and they really enjoy what they do and then they’ve gone again until the following week, and sometimes students come and sometimes they don’t which I think is ... is a strange sort of set up. I don’t know whether that should or should not happen ... um ... because I’m not perhaps in the throes of it as ward Sisters are. I think the other issue is as well as, I mean, I feel very much, so I think with the students’ training the way it is now has to be that way of training. I think very much for us to become professionals and not just viewed as a vocation, I think they need the degree status behind them. I feel nurses should be more autonomous and I feel they should be viewed very differently now as they were in the past by the the doctors as very much the handmaidens for doctors. I think those days have gone and I think it’s very much now ... it puts us on a par with people who have degrees. Um ... it’s not just something where people are coming in and doing their three years’ training. I think it also gives them that ... that ... that stance and the credibility that the nurses deserve. I mean, in relation to other issues that the Sisters have brought up is very much ... um ... the short notice when the nurses are coming. I think perhaps they’d like more notice and I think it’s sometimes very difficult to get the nurses to work with the preceptors because of the ... just the couple of days they work.

SUE. O.K. I think you were talking a little about Project 2000 students and you said that you felt the training was the only type of training which would enable our profession to go forward. I was just wondering. Do you think the Project 2000 students as they are going along in their training have any real concept of what research is about?

CSM. I certainly feel that they do. I think what has to be looked at, I think it’s the happy medium between the theoretical component and the clinical skills, because certainly, from my day which is not very long when I qualified in ‘84, it was very much “hands on” care and I very much wanted more of a theoretical base for when I hit the wards or for when I qualified. I think a lot of the nurses now come to the wards and they are research-minded and very much into the mode of thinking theoretically. I feel sometimes they are very scared clinically. I think they’ve got all the theoretical components and I think certainly the nurses on the wards now are overcoming the fact that these nurses... these nurses ... they view them coming along
with all these special skills theoretically ... um... is now changing to perhaps to what it was two or three years ago when they saw the nurses coming along as being very theoretically-minded and didn't have a clue what to do clinically. But now I think it's ... I think it's getting better because of the nurses who are ... who do have the enthusiasm and motivation will get in there very quickly and want to learn and certainly it seems to be ... I don't know whether "criticism" is the correct word, but I think they want more clinical, they want to be involved from the word "go". So that's ... that's something that I feel perhaps needs to be looked at in the future ... . Whether it will be, I don't know.

SUE. It may well be actually ... because only the last seven months of their particular training is actually given over entirely to clinical practice and, in a sense, it would seem to be too short a period of time.

CSM. I would agree.

SUE. So maybe that will change, you know, in the fullness of time. But thinking back to your own training. What did you feel about that?

CSM. My own training. I trained at Guys, which seems many moons ago now and started in 1981... and it wasn't until the end of our training where the nursing process came in, so just before we did our exam we had a couple of hours session on how to do the nursing process and then was thrown in to do the three year exam and the multiple choice. Um... certainly, I fully enjoyed my training and when I went on to do the degree I perhaps realised how little I knew theoretically ... um... because I didn’t feel it was that theoretically based. It was a very much you making the beds and doing your assignments and a lot of pressure was on to do your assignments and I don't know ... because I thoroughly enjoyed my training apart from some of the ogres of Sisters, who you, know, hopefully have moved on or retired, but I enjoyed it thoroughly.

SUE. What sort of degree did you do after your training?

CSM. I did a degree. I ..... initially. After I qualified I went off and did an A and E course because my background was mainly Casualty and so I went to L--- and did an A and E course and I did the usual courses i.e. the 998, 934 and then I got my first senior nurse post from Hospital A for a nurse in A and E . I then went off and did a
degree part-time for two years. I did a BSc. (Honours) in Health Service Management. Um... it nearly killed me because I never actually thought academically I could cope with a degree and it was very tough and I did six hours every day for two years, which I would never do again. I suppose now because I haven’t studied for ... gosh... it must be about three or four years since I did my degree... I am applying to do MBAs and things at university, so I need to go on and do something because certainly careerwise I would very much like to be a Director of Nursing because I feel there is so much you can influence as a Director of Nursing because nursing is very dear to me.

SUE. Great. Wonderful. How soon are you sort of planning to start that?

CSM. Certainly, I was very fortunate because I got my first Charge nurse’s post when I was 24 and I am now 33 Um... so I climbed the ladder very quickly ...um... Certainly when I first got my first Charge nurse’s post, I hadn’t a clue, but I was with Sisters who then were in their late thirties/forties and when you’re in your twenties, that’s old. But I think when you reach thirty yourself you think... it’s not old, it’s not old and they were perhaps a very different breed to the Sisters as they are now ...um... which some of them, thank goodness, they are. And they certainly don’t treat students as ... which with the Project 2000 which I should have said earlier ... are not now treated as a pair of hands, you know, they’re treated as autonomous human beings who deserve to be respected as I deserve to be respected, so thank goodness that’s changed. But careerwise, certainly, I got my first senior nurse post when I was 26 and ...um... have sort of climbed the ladder since then, but, certainly I would like to have done my Masters and I am reaching for an Assistant Director of Nursing post now and then a Director of Nursing post in about five years time.

SUE. That’s wonderful. It’s nice to talk to someone who has such great enthusiasm.

CSM. Yes. I think what is important to me is actually going around the wards and being a role model and I would still want to do that as a Director of Nursing and I think you can really then influence nurses. You cannot trust the ward to have a voice. Um... I mean ... very much I look at X and see her as a role model. I don’t think I would be that “nursey” ...um... as much as I love nursing and that’s
not being detrimental to X because I still feel the business side needs to come into it as well and I perhaps haven’t got those ... as much skills as X whom I really have a great deal of admiration for. Um... but I’d like to think I’d make it one day.

SUE. I’m sure you will. Can I just ask you. What about nursing for the future? Where do you see nursing going for the 21st Century?

CSM. Um... I think it has to develop. I think it has to move forward. Certainly, I think when we’re looking at documents like the Strategy for Nursing and, certainly, some of the very good recommendations there and then the Vision for the Future with the way in which it’s some years ago now and how they see nursing moving forward, I think it only can move forward certainly with degree nurses. Um... and I’m sure they’ll start looking and I mean, certainly, some of the nurses I know who have done degrees are going on to do Masters fairly quickly and that’s why I feel I can’t be left behind. Certainly, I would never do a PhD because, academically, I couldn’t cope with it, so I don’t see me getting myself going that way. Um... but I don’t feel you can go back. I think it has to move forward. I think the only thing I would say is that as long as patient care is not compromised ... that we don’t forget that at the end of the day we can have as many qualifications as we want behind us, but I think as long as nurses aren’t there ... as long as the nurses are there and are giving the care and not forgetting that there’s a patient there and bringing all the theoretical components, I think nursing will be fine. But if that patient and what the patient needs gets forgotten I think we’ll go backward very quickly.

SUE. O.K. Well, that was a most interesting conversation.

CSM. Thank you.

SUE. Thank you very much indeed.

CSM. O.K. Thank you very much.
Interview with a Nurse Lecturer in Higher Education

SUE. Good morning, Tracy. Thanks ever so much for coming along this morning to take part in this interview of mine. I think I’ve explained to you what my work is looking at and basically it's looking at the relationship between knowledge and research-based practice. I was wondering whether we could begin the conversation this morning by asking you to say a little bit about the work you do here as a lecturer at this university and may be how you see knowledge fitting into your everyday working activities.

N.L. O.K. Well, I’ve worked here at this university for five years now...um... my... originally when I came to work here I was employed as a senior lecturer predominantly on the Bsc Nursing Course and my actual job title was...um... lecturer in Human Relations and the reason I say that is because my job is much wider than that now...um... and, as often happens, that wasn’t really what I found myself doing once I got there. So what I have done over the past five years and I’ll put this in context because it is changing for the better for me in some respects. What I did find myself doing when I first came here was teaching psychology and human relations to the nursing...pre-registration nursing courses, but also teaching psychology and social psychology and developmental psychology to a whole range of other professionally related courses, which wasn’t really where I wanted to be, but, organisationally there weren’t that many people around to teach psychology. So, over the five years through some process of appraisal and chipping away at the organization I’ve got myself into a position where I teach more of what I want to teach and more of where I feel my knowledge base lies because I have a first degree in psychology, a Master’s degree in organizational and occupational psychology and I’m currently doing a PhD from the psychology department at College Y which is in the field of organizational psychology, so I’ve been over...you know... making steps towards teaching applied psychology in relation to largely... in relation to sort of nursing, health and social care...um... and I’ve managed to drop some of the social developmental psychology but that’s all been part of the process. So, on the pre-registration courses, on the degree in nursing I will be teaching from September...um... and I’ll talk about the new unit as they have been developed from the
old units and I'm really quite pleased in the amount of psychology, how it's gone up from sort of a few odd sessions slotted in here and there ...um... to two whole units on the pre-registration course so that's quite a coup for me ...um... I'll be co-ordinating the unit, which is called “Learning to Learn”, which has got some psychology along with other issues in relation to professional working and learning, which is a Semester One unit and an introduction to psychology and then in the Branch I will be co-ordinating a unit that’s called ... let me think ... Psychosocial and Cultural Factors in Adult Nursing, which is very much sort of an applied path from social psychology within a wider socio-cultural framework. I also teach some research methods ...um... and I'll also be co-ordinating a unit, which is called “Management of Health and Social Care”, which because I have written the unit is now half management and half applied organizational psychology. So I've got some organizational psychology in there now. I also run a unit called “Organizational Psychology and the Provision of Health Care”, which is an M level unit in Year 2 of the Master's programme. So that's ... that's sort of ...um... in a nutshell what I do. I then do odd sort of workshops in terms of things like stress management for health visitors, district nurses ...um... radiographers, social workers ... that sort of thing, so I do sort of “one off” type or sort of series of work-related workshops on other courses, but I’ve managed to sort of narrow my teaching quite a lot.

SUE. Um... that’s interesting. Um... so you’ve obviously got quite an intensive knowledge base there from what you have been telling me about the different courses that you actually input into. How do you actually manage to keep up with your knowledge?

N.L. Right. It ... it's become easier as I have refined and sort of narrowed down the breath of my teaching so that, for example, a lot may well be in terms of sort of lesson preparation or lecture preparation and what have you ... will involve me sort of researching and ...um... sort of keeping up to date with current research in the field so that ... that helps enormously ...um... and also doing my own post-graduate work as well, which I'm looking at informal communication and gossip in organizations, but part of that will be looking at it in relation to nursing ...um... so, so ... it’s my sort of ... the content of what I’m teaching and the way that I research and plan for that and it’s also my own post-graduate research that I’m doing at the moment.
SUE. Right...um... How do you think students view the knowledge that
you try to deliver to them.

N.L. Um... depends on the level that they’re at...um... depends on their
previous background to knowledge and it also depends on their
expectations, so it depends upon a lot of things. Um..., for example,
the way that...say for example...um... an introduction to psychology
would be delivered to a first year student. That would be delivered
largely in a sort of lecture format and for some students—it would be
knowledge that they have never had before, particularly with some
things like psychology and the sort of images that go with
psychology...um... they don’t really know necessarily what to expect
or they have those clichés in terms of they don’t really want to say
anything in case I sort of start analysing their conversations. I spend
sometimes a bit at the beginning actually sort of putting my...why I
became interested in psychology, how psychology has helped me in
terms of understanding other peoples’ behaviour in a nursing and
now in a work setting...um... to try and make it...try and make it
real. And the balance to that particularly in terms of teaching on a
degree programme is also getting a sufficient depth of knowledge of
what psychology is as a social science...um... before you can think
about applying it to nursing, so it’s giving them the balance of the
depth of knowledge that I think that they need, but in a sort of real
world setting. But, equally, there are some students who may well
have done an “A” Level in psychology, for example, or indeed we’ve
got some students who have got their degree in psychology who are
actually doing the nursing degree at the moment so they will come
with very different knowledge and experience and expectations and
there is also a difference in terms of, for example, the students on the
Mental Health Branch who are always a much smaller number. We
have about ten students doing Mental Health Branch at the moment
out of a total intake of sixty, who are also being taught with the DHE
students, so like a tenth of a potential sort of student body at a
lecture, with the mental health students who want more, more, more,
more, they...they can see a much, you know, a very clear relevance
to them and they want more and they want in more depth, so I
suppose coming back to your question is...it varies tremendously
...um... in terms of what students want, expect and know previously.

SUE. Yes I mean obviously as they progress from the first year and become
second year students and then third year students they obviously
learn how to handle the material and knowledge that you give them
during your particular sessions. What would you say are the basic differences, for example, between a first year student and the way in which they approach knowledge and let’s say a third year student?

N.L. I think talking about it in relation to psychology, first year students need a lot more pointers in terms of how, for example, a knowledge of psychology will help the understanding of themselves and an understanding of what they observe and experience on their placements, for example. Um... but sometimes students do need quite a lot of help in pointing out, you know, making those connections certainly in the first year. They also need help with psychology, in particular, in making the connections and making a difference between, for example, psychology, social psychology and sociology, so sometimes those differences need to be made explicit sometimes...um... a sort of a... a sort of a pointer if you like for students in terms of what you may not have encountered yet but you may well in the future so you might want to look at some point and try and remember the sort of things we’ve done, so students at the beginning sometimes need a bit of direction. Um.. what I expect of students in the third year is... is a lot more, particularly up to the third year of a degree, is for students to have a grasp of what psychology is and how it’s different from sociology and have a sort of critical ability to look at where it’s relevant and applicable and where it’s not...um... and that they don’t need me to tell them that.

SUE. Right. So, it’s the development of a critical... a critical faculty that you see as being the main difference between first and third year.

N.L. Yes.

SUE. What do you think they think about this whole idea of research knowledge? Do you think that by the time they get to third years do you think that they will have made the connection between what they see in clinical practice and research knowledge?

N.L. Some of them will some of them won’t.

SUE. Why do you think that some of them don’t necessarily make that connection even at that late stage in the training.

NL. I think that maybe some of it might have something to do with the way students approach their studies and I have noticed the difference
between students, particularly a difference between what we would term mature students as opposed to students that come straight ... sort of straight from “A” level, BTEC, GNVQ, whatever, and, particularly students that have done and I’m talking now about students that are not predominantly, but students that are doing mainly the Learning Difficulties and Social Work Branch or the Mental Health Branch. If they’ve had exposure to that level of thought previously ...um... and they don’t necessarily have to have done a degree to do that, ... some of them have quite ... particularly in terms of the Learning Difficulties Branch student ...um... may have come from areas of practice in the field of working with people’s learning difficulties, where depending on again the sort of quality of that experience they may come with a more sort of open and enquiring and critical mind, whereas other students tend to be much more ...um... pragmatic in some respects in terms of ... in terms of what they want and what they need and tend to be quite ...um... I don’t want to say convergent thinkers because that’s ... that’s not necessarily what I’m trying to say but I think it’s the way in which students think about ... think about their practice, think about their work and think about it in the widest sense rather than in a ... and again it’s very easy to make these sort of stereotype differences in terms of saying students in the third year of the Adult Branch are going to be well I’ve been so busy. What do I need to know? Why do I need to know it? and that’s it rather than having ... having the space to be a bit more open and critical and reflective.

SUE. Right. To what extent do you think that people working in the clinical areas ...um... to what extent should they have some responsibility or try to help the students to make that connection between knowledge and research-based practice?

N.L. I think they’ve got a really key fundamental role to play and just to give you a very real life example. Um... because......of ...um... the way that the degree in nursing has progressed at this university over the last twenty odd years and because of the links that have been established with practitioners particularly at Hospital A and Hospital B, but elsewhere as well ...um... we as a course team have a ... I think a good ... a good relationship with practitioners and some initiatives that are going on at Hospital A at the moment are in relation to using research in practice and the phrase that’s used is “research in action” ...um... two ... so two ways in some respects. One is that, for example, some of the small-scale action research projects, but they’re not always action research projects, but some of the small-scale
projects that some practitioners have been doing at Hospital A and Hospital B under the umbrella term of research in action, research is something that’s there and should be part of everybody’s practice, everybody’s way of thinking through a micro up to a sort of macro level. They will come and talk to some of our students about very real world, very practical type small studies where practice has changed and developed as a result of that, somebody’s coming to talk about quite soon is one that was looking at ...um... I think sort of with regard to the use of documentation and records and that sort of thing.Um... and talking to sort of people like this who are involved in these ... these developments under the very broad term of sort of nursing practice developments ...um.. I think brings it to life for students because it’s not something that’s different or additional or, you know, on a shelf and all those sort of phrases people say about it. It’s something that’s in everybody’s ...um... it’s just part of their nursing practice and so it’s it’s using research in nursing. So I think they ... you know ... practitioners and attitudes towards research and using research are fundamentally involved.

SUE. So from what you are saying obviously there seems to be quite a good research initiative taking place in some hospitals.

N.L. In some ... in some parts, yes, yeah, yeah.

SUE. Do you actually have any clinical link yourself?

N.L. I do ...um... At the moment the way that we work is that I link largely with Hospital X students, at Hospital X when students are on whatever placement ...um... then I’ll visit them at Hospital X, but that’s something that I’d quite like to change ...um... and the reason for that is that my colleague and myself have become involved with an action research project at Hospital A. and Hospital B, which is looking at evaluating a staff training pack that’s around implementing “The Patient’s Charter”, for example and it’s around sort of quality initiatives and as a result of having an involvement in this ...um... ongoing action research project I’d quite like to have more of a visibility, if you like, back at Hospital A and Hospital B, where the research is going on which is something that I’m looking to change which isn’t to say that there’s not very much research going on at Hospital X, but there’s ... there feels that like there’s more of a direct focus at the moment.
'And perhaps a final question is this. How do you see the role of nurse education for the year 2000 and beyond?

Oh, we had a staff conference about this in Friday. Um.. good timing! I mean I think from the point of view of nursing and nurse education, it needs to be at the forefront, if you like, of ...um... developing practice and valuing and particularly in terms of nursing in ... in the sort of transit, because I think nursing and nurse education is still in the transit into higher education and although I've worked here for five years with the degree programme which has been running here, you know, for twenty odd years, now working with colleagues who have become incorporated into the faculty ...um.. in much larger ... in much larger numbers then there's a clear role as far as I can see it for ... for innovation and development with regard to ... with regard to nursing practice and practice has got to be very much to the forefront. One of the difficulties that we’ve had with the degree in nursing here ... I don’t know how it links with your experience ... is actually getting the university to sort of value and acknowledge practice so, for example, the times that are spent by us as nursing lecturers visiting students on placements, the university don’t count as academic contact time and it hasn’t ever really been as a sort of, I don’t think anyway, a key ... a key part of ... of the role so I think practice development ...um... has got to be one of the key things.

You sound very positive anyway for the year 2000 and beyond and that’s good. Right ... thank you very much for that conversation. That was really interesting.

That was fairly painless.

Thanks.
Interview Transcription - Student Nurse

Interview with Project 2000 third year student nurse

SUÉ. Hello, Paula. How are you?

S.N. Fine thank you. How are you?

SUE. Fine. Thanks ever so much for consenting to participate in this interview I really do appreciate it. I really do. I know that you know already that my own work is looking at the relationship between knowledge and research-based practice. So what I’d like to do this afternoon is to start the conversation by asking you to tell me a bit about life as a student nurse, your course and about the work you do here in this clinical area and maybe how knowledge fits into all of that.

S.N. O.K. Well, I’ll start off by telling you a bit and just interject and ask me if I’m rambling off the point.

SUE. O.K. Will do.

S.N. Well, I’ve been on this ward probably 2 months and, as you know, I’m a 3rd year student so we’re very much gearing up towards being a staff nurse now and I’ve being doing night shifts here and the usual early shift and late shift...er... and I find I’m slotting into working within different teams. They practise team nursing on this ward and...um... as far as the ward goes I am enjoying it here. I think there’s always room for improvement. I time the sort of questions that I ask to different staff. I mean I have questioned a few of the things I don’t necessarily agree with, but and that fits into knowledge... where it’s come from... how it’s practised... why it’s practised...um... I mean, for example, not many people on this ward are on intravenous infusions but the people that are... I’m constantly amazed... they say oh it’s running very late and I say but why, you know... when you have facilities like the pump to monitor. If a bag has got to go ii, in 12 hours... you know... why is it running 8 hours late... you know... that’s not good enough... you know... oh, it’s positional... oh, it’s because of the arm... oh, it
needs a flush and 3 hours later it will be flushed so I think that the little things like that are very important and a lot of things ... oh, it doesn’t matter you know, but, you know, if the patient is nil by mouth then I think it does matter a lot and the fact that the doctor has written it up for a bag to go in over 8 hours ... I think that things like that I ... just little things and I think that a lot of the time you do pick up on things and there’s other things you just take for granted because that’s the way we’ve done it, you know, and you can see that’s the way it’s done because it’s always been done like that but then I like to say well, you know, perhaps there is a better way or another way or what about this, but ...um.. well, you know, I think it’s about getting on with staff and not upsetting the apple cart too much and ... I think you take a lot into consideration as well as jumping on somebody’s back about that’s not being done properly. I mean I don’t know how you’d feel about that. As a student you are always just passing through and there are other things to consider, too.. getting a good report, you know, and ....

SUE. Oh, I think that the points that you have made are valid. What I was going to say was that as a student passing through I think that you do automatically want to ask questions and find out the answers to those questions, but this actual business of asking questions is quite important ... and I was just wondering how you approach that.

S.N. I think getting to know the staff is the first part ... it’s building up a rapport with the people you’re working with and using your judgment and how people respond to you and seeing how you get on with people but I’ve always found that staff anywhere I’ve been are often more than receptive to questions and I’m very much one to ask questions all the time because i’d rather ask them know than when I qualify in the summer and not know the things that I should have been asking about, so, and I think it’s the way you ask questions, you know, you can be very diplomatic about things that you might not necessarily agree with and you know, have the staff say ... no that’s a good point or we need new ideas, we need people to be asking things and I’ve noticed as well a lot of the staff have said that when you have got students that are asking a lot of questions it makes them question their own practice and a lot of them as well enjoy teaching ... they said it makes them think about what they are doing ...um... which can only be a good thing and I’ve found people very willing to teach and explain why and often I’ve asked a couple of different staff the same thing just to see whether,
you know, there is a consensus and... you know, some people have a different way of explaining things and are much better teachers than others. No, I ask lots of questions.

SUE. What about research knowledge. How does that feature in the work on this ward?

S.N. Um... I think it depends on individual staff to a certain extent, but I do think they're getting more geared up towards constantly looking at research and seeing how we can improve patient care I mean, for example, the... I don’t know if this would be sort of one research-based one exactly, but team nursing and the named nurse concept because of the Patient’s Charter. Now that’s only recently been introduced on this ward and, you know, they say well it’s not really working for this, that... and the other reasons and I think that there is a reluctance in introducing new research, but at the same time... I don’t know...I’ve noticed that the younger, the more recently qualified staff tend to be a bit more keen on reading research and implementing it but... I don’t think it’s a very dynamic area for research-based practice to be quite honest...um... I don’t know whether that’s because this is a Care of the Elderly... I hope it’s not because of that... I think maybe it’s because a lot of people have been here quite a long time and they’re more I’d say traditionally trained and that to do with knowledge... this is the way we’ve always done it kind of thing, but that comes down from the top... I’m not naming anybody, but I think that the person that’s in charge can very much...um... set about a dynamic structure for the ward and that doesn’t really happen here.

SUE. Can I go back to the point you mabe about newly qualified staff. You said that they’re probably more likely to want to get research into practice. Do they ever sit down with you and talk about it?

S.N. They haven’t done, No. We haven’t had... I’ve had one teaching session on this ward and that wasn’t research-based...um... no... nobody has actually on this ward spoken to us about any recent research...um... but then, you know, I think it’s as much down to us to be saying “Have you read this”, or... you know... as... I said before there are so many other factors that come into your training... struggling to just get by as it is...um... and I think it’s a shame. I think that... that there are... I it’s as much my fault... you know... I could or should be saying while I’m here “Have you read this or...
what about this or, you know, how could we improve on this and I've read such and such that we could ... so I think I ... I ... don't think I would point the finger at anyone ... I think it's everybody and nobody ...

SUE. Everybody's responsibility.

S.N. Yes, very much so ... but then I would be very interested if there was a research nurse that came round saying ...um... Have you thought about this perhaps? I'm always one to say "Yeah that's great ... why don't we do that ... and I think perhaps a lot of people need a bit more motivation and I think that if someone were there to motivate them it would have more incentive perhaps. I mean what do you think ... I mean I know there are these research nurses but...

SUE. There is a research nurse here in this hospital.

S.N. Right.

SUE. She actually has to serve all units and departments within this hospital ...um... you've probably heard of her ... her name is X.

S.N. No. I haven't actually.

SUE. No. I don't know how often she visits the departments but she is definitely around and available should you need her.

S.N. Is she enough ... just one nurse for the whole hospital?

SUE. Well, I think that's quite a debatable sort of question.

S.N. I think ... you know ... I hope that ...um... that the Care of the Elderly wards aren't left off the list ... you know ... perhaps medical units are served more by the research team or the research nurse ...um...

SUE. I think probably what the research nurse would like to see very much is that when practical procedures are devised and brought into play ... there are practical procedures, which are validated by the Nursing Practice Group, that those procedures to a marked extent are research based. I think that that, in a sense,
would seem to be the role of the research nurse ... to make sure that the main procedures that are carried out in the clinical areas are underpinned by elements of research. That's how I see it.

S.N.    Um... yes ... O.K.

SUE.    Paula, can I just move on to maybe ask you about the course you are doing. Tell me a little bit about that.

S.N.    I think so. I think when I started the course I didn’t really see the relevance of all the facets of our training ... the six subjects ... you know ... exactly what they are ... but research being one of the equal six components of the course ... and I think in the beginning I didn’t really see the importance of it enough but that’s because we weren’t on the wards and only since a lot of clinical practice now can I see where it all fits in. The lectures we had with you ... I can now see the relevance of them but I think that you need to be in the clinical setting to really understand the importance of it and ... and rearch is dynamic ... you know ... it’s constantly ... it ... you know ... it questions what we’re doing and I ... I don’t think there’s enough importance put on our practice ... you know. I don’t feel that I think because the way nursing is generally ... it is a practical based training.

SUE.    Would it have been better to give you the lectures in the clinical areas instead of the School of Nursing?

S.N.    No . I think we needed that knowledge to build on. I think we needed the theory input that we had ...um... I mean there’s always improvements isn’t there ... I mean I think as a subject it can be quite dry, can’t it.(ha ha ha ...) Oh I’m saying this to the wrong person ... I find it as just a subject, the theory of it quite dry but I think you need to be now in the clinical setting to see the relevance and importance of it...um...

SUE    But as you say, in the early days that relevance wasn’t particularly clear but as you’ve gone along in training obviously it has become a bit clearer to you and now you can see maybe the relationship between nursing and research.
S.N. ...Um... but I do think the ...part of the role of the nurse is to question her practice and to underpin all nursing practice with research-based knowledge and ...um... studies that have been done but I don’t really from my own experiences see that being done all the time. I still think as a subject it’s not linked enough to nursing but with our style of training I just think it’s been with us from the start so as nursing continues to develop I see it becoming more important ... um...

SUE. Why don’t you think it’s linked up with nursing? It’s an interesting point you’ve made there.

S.N. ...Um... I just don’t see research in people’s minds as being linked to nursing. I think ...um... I was reading something the other day about that people think that nursing research is just a follow-on from medical research ... that it’s sort of mimicking medical research in nurses’ quest to be considered as a profession ... and I think ...you know... probably a lot of people do think that. You know, we’re striving to be a profession therefore we sort of have to do research, you know, and I ... I don’t think it will ... I don’t know whether it’s taken seriously by a lot of people. I can’t imagine the general public would associate research with nursing. I think it would be more regarded as a separate subject than as a part of nurse training ... but I think we need to explain to patients that it is very much part of our training. The other day, for example, one of the patients was talking about his rheumatoid arthritis and was saying that ...um... it was because of his diet. Now I then and I still want to go on and find out ... I don’t know enough about rheumatoid arthritis but I wanted to go and read up on some background knowledge of the anatomy and physiology and I wanted to find some research for him to ... because I think he’s ... he’s a bit muddled along the way and I wanted to know more about it myself before ... and I thought the only way I could do it was by backing it up with research-based practice ... and some sort of study or ... and I thought ... well, I could do a literature search at the library at college and read ... try and read some of the most recent ...um... research about it and, you know, I think it’s one of the first times I actually thought that’s an example where I myself can find something out for a patient and introduce research, you know, that he probably hasn’t found out about before.
S.N. Well, he, you know, he was saying it's because he's been homeless and that he hasn't got any...he's never had any social....that he's been.....that his diet...his appalling diet for the last goodness knows how many years he's been homeless and I didn't want to say, 'Oh, rubbish, it's got nothing to do with that', but I thought, you know, I can't, I can't say anything until I know myself and I thought, well, that's something I can do. I can actually find out and say to him, well, you know, your theories are, you know, from your experience, you know, your beliefs are from what you've experienced that here is something to read that, so you know........

S.N. And it's, you know, there's constantly little things that are going on that you think....right I must find that out and I'll have to see if there's any research about this. I'm pro....I'm pro research but I don't think I do enough myself to...um...

S.N. I just think that there's always and there is always room for improvement. There's always a little bit more you can find out and the more you find out, the more you want to know as well really.

S.N. Um......well, that's something else, but it's talked about a lot ...

S.N. Can I just ask you what you think about reflection?

S.N. Um......well, that's something else, but it's talked about a lot ...um...but I don't think it's actually done. I think you can reflect a lot without actually thinking I am engaged in a reflection session, but as regards to staff on various wards I haven’t noticed it being done at all. There’s been a few incidents when people have said, 'Oh, do you feel all right about that? Do you want to talk about it?, which, in itself, is reflecting on something that’s happened, some critical incident, however minor or major it is, and I noticed in Accident and Emergency, they were quite good on, you know, do you need to talk about it....shall we just go through
what’s happened and ...and... I think we probably do it informally with...with our colleagues....you know, you have a real allegiance with people you train with, don’t you, and you do talk about things and I live with three of of my colleagues and, you know, we...not...anything too confidential, but, you know, we tell each other what’s happened because it helps us and it is reflecting...um...and I do think it’s important....I do think it’s important to look at what has happened and try and break down why you might have strong feelings about some things and then try and look at it as ..um..a separate incident and see how next time you could improve on some things or what were the good things, what were the bad things and how you can...how that incident might help you in the future and I think nursing ....um...you do experience so many different things and you need to learn something from those experiences, You need to take something away....something perhaps awful that’s happened that will help you for the future.

SUE. You mentioned the word ‘experience’. What sort of value would you put on experience?

S.N. I think you’re constantly trying to ...um...be a better nurse in lots of different areas and I think that your experiences enable you to do that and you do gain certain knowledge every day from the tiniest little things...the things that you can’t even quantify....um...you gain valuable experience and I think if you reflect on those experiences you can accept that you have gained some knowledge from that...that can be used in another area...that you can share with other people ....and I think probably I don’t...I don’t actually write things down enough but...um...and I think I should really keep a more, not structured, but unstructured journal on critical incidents and different experiences that you’ve had because otherwise, they can just go...they can sort of just go, can’t they.

SUE. That’s right. Yes, I think you need to sort of write them down at the time.

S.N. Yes.
SUE. Share them may be with other people.

S.N. I think I personally use reflection more than writing something down. You know, I wouldn't be one to just keep quiet about something. I would speak up and I hope that I do.....I hope that I do gain something and remember it at the same time...um...it's hard to actually explain a lot of things, but I think, you know, only by sharing them you can...we can all learn something from them. We've had plenty of reflection sessions at college...um.... and ,you know, it is very interesting when other people share their's with you and you can all talk about them together and it's all kept within the confines of that room and, you know, confidential, so.....

SUE. So really it's a tool for learning.

S.N. Yes.

SUE. It's a tool for sort of going forward.

S.N. Definitely.

SUE. And helping you to develop yourself as a student nurse in training.

S.N. But I think you need to be made aware and...because I say it'd something we do anyway. I think students probably need to be aware that that is a tool for self development....um... you know, appraisals that you have, and becoming more self aware and using reflection and improving your practice...... a lot of it can be done without actually realising that you've actually done something that is valuable. I mean I'm.... I don't think when I started my training that I would have thought...gosh, that was a...um...a tool that I would use to improve my practice.....so.....no I do think we need to be made more aware that, you know, this is a tool for learning and something that needs to be developed.

SUE. Yes. Do you think it has any link with research?
Reflection and research?

S.N. Um......What do you mean? Using reflection?

SUE. May be as a starting point for research......for investigation.

S.N. Sorry, I don’t really understand....I don’t really know what you mean.

SUE. Well, let’s say you’ve reflected on a particular situation that tends to occur in your area quite a lot of the time.... let’s say that as a result of reflecting upon it you’ve decided you’re not happy with what you’re doing in your clinical practice and may be the next stage is..well, o.k. I’d like to change that....how can I do it? So, you may start to look at all the work that has been done on that so far....perhaps, do a literature search around that particular area of practice and may be get some ideas of which you could say....well, o.k. I wonder if we could just try it this way. Experiment with it.

S.N. Um.... A small example of that would probably be...um.. we were using the little tempadots to record the temperatures and they are supposedly a quicker and accurate measure of a temperature and we found......we’ve found....we’ve just sort of conducted like a very very small study in a little bay of six patients of the tempadot under the axilla, the tempadot under the tongue and a mercury thermometer under the axilla and we found we were getting different recordings and we thought, well.....these are supposed to be the new accurate measure of somebody’s temperature and we’re not....we’re getting different readings of somebody’s temperature and it does make you, you know......that incident....I thought, well.....something isn’t right here, you know, and I think...you know.....perhaps there hasn’t been enough research into these new little paper or plastic.....um....temperature gauges and I think in that instance you do reflect.... you think....well, perhaps we could do something about it. You know, something isn’t right. We’ve done little mini, mini, mini studies, but
nothing has....I don’t think.....I think they’ve stopped using them here on this ward but I think it does make you question.....you reflect on the practical side of things and, you know, that.....that could trigger you into thinking, well, perhaps we could do something about it....see if anybody else has found anything about this and you could do that by doing a literature search....and then conducting your own research into it.

SUE. That’s an interesting example that you’ve given. Thank you for that. And perhaps a final question because I know you’re busy. What are you going to be doing at the end of your course when you’ve qualified?

S.N. I haven’t really decided yet. I’m waiting to see what the next ward holds in store for me. It’s an oncology ward and I haven’t had any cancer care experience and I’m quite looking forward to seeing the difference, if there is a difference, in actual patient care but I .....I would like to work somewhere that’s more dynamic than here and I see that perhaps in an area...um...may be not a Nursing Development Unit straight away but I think I need a lot more stimulation and I need to be working with other people that I consider are dynamic that are keyed up on things like research that want to ....that want to constantly move on....that don’t want to have some static practice that is perhaps more traditional....you know....that want to question things because, you know, I think it’s great that patients are complaining now. I think complaints need to be looked into..... I don’t think that, you know, we bow and scrape to the doctors and accept everything they say without questioning it. You know, I want to....I....I just think the most important thing is that this....you know.....holistic, individualised patient care, you know, those favourite words that are around but.....I want to work somewhere that I feel carries out that nursing care...... and I couldn’t......I don’t think I could do that here.

SUE. O.K. Thank you very much for a very nice conversation.
S.N. It’s quite all right.

SUE. It’s very kind of you to give up your time.

S.N. No. That’s fine.
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