Particularizing the General
Sustaining Theoretical Integrity in the
Context of an Evidence-Based
Practice Agenda

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Proliferation of demands for accountability and health care quality places nurses under constant pressure to ensure professional practice is evidence-based. The corresponding emphasis on knowledge that pertains to general populations challenges nursing’s traditional focus on the uniqueness of each individual patient. Considering how nurses engage with professional systematic thinking processes, we reflect on ways competing agendas in the evidence-based practice environment compromise the professional vision aspired to by an earlier era of nursing model and framework builders. Exploring the scientific thinking underpinning practice evidence, we contemplate implications for applying general knowledge to particular practice, reconsidering options for conceptualizing nursing praxis.

IN AN ERA of evolving accountabilities in health care service delivery systems, health practice acts aligned with an “evidence basis” tend to attract public support and system investment. In response to this evidence-based practice imperative, nurses increasingly strive to frame their knowledge claims as deriving from some form of evidence. At the same time, we recognize nursing’s history of problematizing the evidence ideology for privileging a subset of empirical products while discounting other forms of knowledge that have been derived using equally rigorous approaches and may be of pressing relevance to the practice of the profession. Reviewing both serious and casual uses of the idea of evidence in nursing scholarly literature, we detect significant problems with conceptual inconsistencies regarding the meaning of evidence and how the notion of evidence relates to nursing. Concurrently, we observe that as the evidence-based practice imperative increasingly directs the gaze of the practitioner toward populations and systems of care, the discourse around patients as unique and distinct individuals seems to be losing ground as the epistemological foundation for a uniquely “nursing” angle of vision.

Despite persistent barriers to the uptake of research in nursing practice, and ongoing questions about the role that evidentiary claims generated on the basis of the study of populations and systems ought to play in guiding the decisions and directions of individual practitioners within particular practice instances, many practice settings advance a mandate aimed toward ensuring that practices are demonstrably evidence based. In response, nurses increasingly reference the notion of evidence with both fluidity and
interpretive license. In keeping with nursing's complexity and epistemological diversity, as well as the methodological creativity of scholarly traditions, various claims have been proposed as to what should properly constitute a functional definition of evidence for the purpose of professional practice. In some instances, these definitions reflect a diplomatic generosity for the broad scope of nursing scholarship in that they include not only formal measurement but also qualitative exploration, ethical theorizing, sociopolitical understanding, clinical craft knowledge, and pattern recognition in practice. Some have expanded that envelope as far as including even "patient preference" as a form "evidence." Although such definitions may seem reasonable by virtue of being inclusive of the diverse ways of knowing within the discipline, we suggest that they entirely misrepresent common understandings of the evidence concept outside of nursing's disciplinary context. Furthermore, they contribute to normalizing inherently illogical and problematic ways of substantiating nursing knowledge claims.

In this discussion, we seek to untangle and critically examine the complexities associated with nursing's theoretical discourse around the notion of evidence, to make explicit what we consider the predictable problems associated with departure from the shared meanings of the notion of evidence in the larger health care and public discourse. Although we appreciate the seeming benefit of this conceptual slippage in a discipline whose knowledge tradition straddles the social and the basic sciences and whose practice mandate requires members to take up "right action," we also recognize the need for a coherent scholarship to guide nurses in wrestling with the idea of evidence and ensure that their claims about it support rather than disadvantage their intellectual and strategic aims. In an earlier examination of conceptualizations of evidence within the nursing literature, we examined possible solutions within graduate nursing education. Here, we reflect on the important contributions that nursing theorizing and philosophizing might play in moving us beyond this somewhat tangled collection of ideas and toward an enhanced clarity of disciplinary thought.

**STRUCTURES AND PROCESSES OF NURSING'S DISCIPLINARY THOUGHT**

As an applied practice science, nursing's thinking and decision-making traditions have for the most part been grounded within a human health and illness problem-solving orientation, drawing on a wide range of basic, applied, and social science knowledge sources and conceptual structures and enacting them within an individualized relational context. Within this overall framework of understanding what the discipline entails, nursing has demonstrated an enthusiasm for grappling with the theoretical and conceptual structure of their discipline beyond that which is seen in the literature of the other health and social service disciplines. A critical review of the theoretical attention that nurses have paid to the problem of conceptualizing nursing yields a level of insight into the challenges associated with the problem of making sense of how nurses think when they do it well.

For several generations of scholarship, nursing scholarship focused on working out theoretical models and conceptual frameworks that could serve as systematic guides to the clinical reasoning entailed in excellent nursing practice. These disciplinary frameworks represented theoretically driven conceptual maps of the various phenomena of central concern to the practice of the profession. They were understood for the most part as intellectual drivers of the systematic decision-making processes by which nurses apply knowledge to their practice, including the sequential reasoning known as the *nursing process*. The idea they were striving to capture conceptually was the manner in which nurses systematically deal with multiple inputs within a dynamic and complex context and generate reasoned and defensible actions toward a valued outcome for the...
clients they serve. At the most fundamental level, those clients were conceptualized as individual persons or patients; as these models evolved and advanced, some also came to include families, groups, communities, and even societies. However, the nature of the individual *patient* (sometimes termed *client*), and theorizing in relation to how to understand and act in relation to that individual within his or her unique context, remained a foundational core constituent of nursing conceptual theorizing.

Because these models and frameworks were designed to address the complex problem of applying knowledge in general to what were unique and particular instances, articulating the precise role of science within the theoretical reasoning process confronted the discipline with a difficult challenge. Nursing science was but one component within the overall project of working out the discipline’s complex relationship to both subjectively and objectively derived knowledge pertaining to matters of health and illness. Because the profession’s curiosity has characteristically been drawn to the very complexity of human health experience, its science has reflected a range of domains, sometimes articulated as the *biopsychosocial*, but covering the full spectrum from cell to soul. This exceptional diversity in the experiential phenomena of concern to the profession has led nurse scientists to take up a wide range of investigative methodologies, capitalizing on both qualitative and quantitative traditions to develop practice knowledge.

Nursing’s profound commitment to holism and the idea of the whole person has had a powerful influence on the intellectual trajectory of the discipline and on the evolving relationship between its theory and science. Both the theory and the science serve the discipline’s ultimate agenda of guiding the judicious application of knowledge gleaned in relation to the general toward addressing specific and uniquely contextualized instances of the particular. Regardless of whether nursing practice is enacted at the individual, family, group, or societal level, or whether the special focus of immediate attention is a distinct body part or system, the profession seems to have consistently held an orientation to the holistically understood individual in his or her particular context as a core value. Furthermore, it has also expressed its relationship to the unique expressions of human health experience manifest in each individual patient as fundamental to its distinctive disciplinary angle of vision on collective human health phenomena. Thus, the knowledge base within which nursing has sought to accomplish nursing practice in all of its various dimensions involves a dialectic within which practice informs theory and theory informs practice in a continuous iterative manner. This *praxis* imperative forces a degree of disciplinary comfort with many different *ways of knowing.* In this manner, we see nursing’s profound commitment to a knowledge development context that merges insights obtained through science with those gleaned from other forms of reason, pattern recognition, and experiential learning.

**PROBLEMS IN UNDERSTANDING EVIDENCE**

In that it involved different ways of knowing and an emphasis on the particular, this disciplinary theoretical tradition may have inadvertently complicated matters as nursing began to interpret and enact its work within an increasingly evidence-based practice agenda. The unique *angle of vision* with which the discipline approaches health care and service delivery positions it to champion the *particular* (in the sense of recognizing the uniqueness of particular situations), while the evidence-based practice agenda leans toward favoring the *general* (emphasizing similarities across different situations and promoting standardization of care). We see this disjuncture as a product of the complex philosophical positioning within which the agenda is mounted, and recognize the challenge it has posed for a coherent nursing response. To help make sense of this complexity, we seek
to unravel 2 related problems: distinguishing the various knowledge sources upon which nursing draws, and reconsidering the fluidity with which the notion of evidence is defined within the discipline.

Ways of knowing versus evidence

Since Carper first published seminal work on patterns of knowing in 1978, nurses have taken up this heuristic as a conviction that nursing’s scholarship must extend beyond those questions for which empirical science has answers. The discipline’s scholarship therefore targets a range of ways of knowing complementary to empiricism. Skill depicts a competent performance based on experience by method of practice. Aesthetic knowing implies a reflective response to a nursing situation from which a sense of meaning emerges. Intuition implies a form of knowing based upon intimate familiarity with the patient care context and extending beyond the constraints of rational thought. Personal knowing for nursing implies a familiarity with the physical, emotional, psychological, and social responses of self and others as a basis for being therapeutically present. Subsequent work augmented these initial patterns to include sociopolitical knowing and later emancipatory knowing, as foundations for the critical reflection upon potential sources of inequity and injustice required by nurses working within social and political institutional contexts to enact their fundamental mandate on behalf of society. Collectively, these patterns of knowing represent diverse epistemological sources that, under various circumstances, serve to inform the praxis of nursing. However, despite the inherent value of each of these various ways of knowing in informing modern nursing practice across all settings and contexts, it would be inappropriate to consider all knowledge arising from them as evidence.

Evidence and true beliefs

In the health sciences in general, conventional understandings of evidence are based on the epistemological premises of propositional knowledge where evidential knowledge is defined in terms of justified true beliefs. Scientific and philosophical approaches are used as the foundation for justifying, or substantiating, beliefs with the purpose of developing a body of knowledge that is “evidential” in nature. A belief essentially refers to a proposition that can be articulated and the justification of it refers to a systematic process by which we argue or substantiate the warrants for its truth value. However, justification is not seen as universally conclusive; there exist differences of opinion about the degree to which particular beliefs are justified. The notion of “true” has an ontological implication in that reality exists in a form that is independent of human consciousness. Within the evidence-based practice discourse convention, the notion of evidence is inherently grounded in the epistemological premises of propositional knowledge such as would be needed to inform practice in a justifiably reliable and consistent manner.

Scientific approaches consist of systematic methods that combine logic with descriptions of directly and/or indirectly observable phenomena. As Kikuchi explained it, “science inquires into the phenomenal aspects of reality.” Although propositional knowledge is foundational to safe and competent nursing practice, nursing practice is inevitably influenced by additional nonevidential forms of knowledge. For example, philosophical approaches pertain to questions about metaphysical aspects of reality. Thus, disciplinary questions extending beyond the phenomenally oriented scope of science into such considerations as the nature of reality (ontology), the way we come to understand or acquire knowledge (epistemology), or the ethical or moral basis of practice are therefore more appropriately addressed using philosophical approaches that rely on reason, logic, argumentation, and common sense.

Knowledge forms such as personal, spiritual, or esthetic knowing and intuition represent knowledge of a fundamentally different nature than knowledge that conforms to the idea of true beliefs in that they represent...
subjectivities that are not, in their original form, directly shareable beyond the immediate context of personal experience. In that it is grounded in sources such as personal experience, intuition, or revelation, subjectively derived knowledge cannot be objective and generalizable in terms of the patterns of phenomena to which a particular evidentiary claim applies. Thus, although it may have a role to play in the praxis process, it is not in and of itself a shared form of knowledge that can be confirmed and argued as an evidential basis for nursing practice.

Evidence and ideology

Beyond these ways of knowing nursing practice is also inevitably influenced by ideology, or beliefs about reality that have not been justified on scientific or philosophical grounds. Ideology exists in 3 forms: (1) beliefs that have yet to be examined using scientific or philosophical approaches, (2) beliefs that, despite examination, have not yet been subjected to scientific or philosophical conclusions (for whatever reason), and (3) beliefs for which science or philosophy has not yet provided a conclusive answer. Beliefs tend to be deemed ideological when they are considered to be true by persons within a particular social context by virtue of their being widely shared or have become part of a larger belief system. In the practice of a profession many such beliefs are held to be true with a great deal of certainty despite the absence of scientific or philosophical justification. We might consider, for example, the belief that human nature is innately good. This constitutes an ideological position in that science cannot be used to determine the meta-physical properties of “good,” and philosophy is limited in justifying the universality of such a claim being true. Nevertheless, nurses typically hold some variant of this ideological stance as foundational to their enactment of professional practice.

Evidence and knowledge for practice

From this discussion of various ways of knowing, we can distil an appreciation for the multiplicity of ways in which knowledge informs nursing practice. Scientific and philosophical approaches generate knowledge that can be considered evidential in nature (ie, reliable and verifiable) in that it is based on established premises of empirical verification and philosophical argumentation, thereby informing nursing practice in a manner that is both general and systematic. Although subjective knowledge and ideologies inevitably influence particular nursing practices, they constitute knowledge of a different form from the evidential knowledge one would rely upon to provide direction to nursing practice in the more general sense. To illustrate, nurses would agree that protocols to inform nursing practice cannot derive solely from any individual practitioner’s experiential knowledge. However, they also recognize that the application of an agreed-upon protocol to any unique situation demands nursing judgment that is quite properly grounded in the context of the individual nurse’s experiential knowledge. Taken one step further, we note that safe and competent nursing practice is actually contingent on the ability of that nurse to recognize the particular instances in which the evidence-based protocol may not appropriately apply.

To further delineate the difference between evidential knowledge and other forms of knowledge, we consider the skill of administering an injection. With minimal training, most adults could follow the correct administration procedure, which is derived from principles based on evidential knowledge involving scientific justification (such as using sterile technique) and philosophical justification (such as those associated with respect or privacy). However, the professional nursing skill we associate with injection administration will have been developed through inner processes associated not only with knowledge but also with practice and experience, enacted using ways of knowing that are esthetic and personal in nature. As long as the principles are followed correctly, there is no scientific or philosophical basis for justifying these inner processes. As a result, nurses might have quite different
perceptions and experiences pertaining to the performance a particular injection. While one nurse may perceive a particular injection administration as adeptly performed, another nurse observing the act could have a different appreciation for the level of skill demonstrated. Even assuming adherence to all scientific and philosophical principles pertaining to injection administration, the performing nurse and the observing nurse might differ in the frame of reference upon which their experiential understanding is based because their perceptions and experiences are inherently subjective. Although evidence provides the foundational knowledge base for ensuring that all essential principles are systematically adhered to, the skillful enactment of a set of principles involves other ways of knowing, such as personal and esthetic knowing, that are not readily subjected to scientific or philosophical scrutiny.

Our intent in drawing upon this example is to illuminate the complexity associated with how nursing thinks about its practice knowledge and the kinds of legitimacy claims it uses as a basis for its clinical reasoning and practice actions. The trajectory toward practice expertise involves an increasingly fine-tuned capacity to know when and how to use (or in some instances depart from) evidence-based practice protocols, implying a prudent interpretation of population-derived knowledge the context of the highly individualized moments within which nursing care takes place. Thus, while it would be unacceptable for nurses to ignore relevant evidentiary claims in their clinical reasoning about individual cases, the practice domain is the unique, holistic, and complex client within a particular temporal, spatial, and relational context. Because of this, that which is evidentiary inevitably represents only a fraction of advanced expert nursing knowledge.

**Shifting conceptualizations of evidence**

A second set of problems arises from the inconsistent conceptualizations of evidence that have taken hold within the common discourse of nursing and found their way into some of the disciplinary literature.

**Definitional distortions**

Consistent with the original evidence-based medicine work by Sackett and colleagues, models of evidence-based practice for nursing depend on the integration of non-scientific knowledge forms, such as clinical expertise, patient preferences, and values, with that which is considered scientific evidence. Within the medical and health care contexts, this notion of scientific evidence explicitly references knowledge sources derived within an established hierarchy of reliability that confers a particular level of credibility for informing clinical reasoning. In this context, the systematic review of randomized controlled trials (RCTs) becomes the general gold standard for what constitutes best evidence, thereby privileging the kinds of questions for which agreed-upon instrumentation and measurement are readily available.

In the world of jurisprudence, information representing a wide spectrum of truth or falsity is properly taken into consideration in the process of weighing the “preponderance of evidence” and reaching the best possible conclusion. In medicine and health care discourse, however, we see a quite different approach in which the commonly understood definition of evidence explicitly distinguishes that for which a certain level of scientific proof exists against the inherent unreliability of everything else, including clinical knowledge and wisdom. Thus, while the law understands evidence as something that could potentially be misleading, medicine seems to have construed it as a form of truth that ought to trump all other competing claims. While it may be acknowledged that the enactment of evidence-based medicine inherently reflects application of inscrutable scientific facts to individual context, the emphasis within the movement is always and inevitably upon the forms of factual information that withstand a highly rigorous systematic review, the spirit of which has been described as...
“purity and exclusion.” Inevitably, then, evidence meeting such a standard pertains to knowledge that applies to the general and represents only part of the knowledge nurses need to inform practice in particular situations.

Further complications arise from idiosyncratic twists on this conventional definition of evidence that creep into the nursing discourse. In instances where a conventional scientific basis is either absent from or irrelevant to a particular clinical reasoning context, some authors have used creative terminological labels for nonscientific knowledge such as clinical evidence. This syntactical ploy suggests an attempt to reinscribe nonevidentiary knowledge as if it were a form of evidence in an attempt to justify its appropriateness as a basis for clinical action. Although such terminological distortions are not unique to nursing, this particular form of illogic seems to have encroached more deeply into mainstream nursing thought than has been the case in other health disciplines, possibly due to the discipline’s strong commitment to legitimizing idea of multiple ways of knowing as a basis for practice. In the context of the raging agenda of evidence-based practice, this conceptual maneuver seems reminiscent of Lewis Carroll’s Humpty Dumpty who argued that “When I use a word . . . it means just what I choose it to mean.”

Conceptualizing “best” evidence for practice

Notwithstanding the definitional distortions that creep into the literature, empirical findings are understood for the most part as sources of “best” evidence, superseding other forms of knowledge that differ in kind (such as physiologic principles or patient values) and that are not amenable to hierarchical ranking. Recognizing that much of what must be carried out in the name of medicine and health care is unsuited to RCTs by virtue of rationality, practicability, or ethics, we are left with something of a paradox. As Grypdonck expressed it, evidence-based health care has become an ideology that violates its own ideology in that it is not amenable to the basic test it sets out for other knowledge claims. The evidence-based imperative assumes the relevance of establishing confirmatory proof that one option works better than others, rather than helping sort through the range of reasonable options from which a skilled clinician might appropriately draw. In this way, it becomes a standardizing agenda, rather than one that supports individualization. The forms of science favored by the evidence-based practice imperative attend primarily to subjects and far less to representativeness of stimulus, thereby privileging the kinds of interventions and treatments for which confusing contextual contaminants (such as time, or subjective awareness) are controllable. And this, as the implementation science literature reminds us, is almost never the case in the complex business of delivering holistic nursing care to diverse individuals in the context of their unique relational and sociocultural worlds.

We concede that hierarchies of evidence may be beneficial in evaluating knowledge pertaining to predictable and causal relationships between well-defined phenomena (such as the efficacy of standardized interventions). However, the justification for the argument that evidence trumps all other knowledge forms in practice application is contingent upon the extent to which the form of evidence (as defined by the research design) is congruent with the nature of the knowledge needed to inform that particular aspect of practice. Different forms of evidence support conclusions associated with ways of knowing that answer distinct types of questions to inform nursing practice. For example, claims about efficacy or effectiveness require different forms of evidence than claims about the feasibility, appropriateness or meaning of a particular intervention for patients within differing backgrounds and contexts of care. While RCTs provide appropriate evidence pertaining to causal relationships (such as the general effectiveness of
specific interventions based on well-defined treatment outcomes), other forms of evidence are needed to understand the nature of phenomena and the various contexts in which particular phenomena take place (such as the secondary effects or meanings of such interventions within the larger personal or social context). To illustrate, although RCTs may provide compelling evidence about the general efficacy of particular pain management strategies, other forms of evidence are required if one wants to understand the experience of pain within the various contexts in which it might occur. Therefore, nurses may well draw on reliable RCT-based evidence to inform pain management strategies when the causal mechanisms and predictable outcomes are well-understood across situations in which the pain management strategy can be applied. However, their effectiveness in detecting pain and supporting its desirable outcomes may also require a familiarity with the many ways in which pain can be experienced and expressed. The latter will be more appropriately informed by knowledge approaches that are more descriptive and inductive in nature.

Interpreting the role of inference and judgment

Beyond identification of the kind of evidence that is compatible with the nature of the question arising from their practice, nurses must also consider the degree of certainty required before evidence is applicable. This implicit judgment as to applicability of an evidential claim represents a judgment as to the certainty with which it holds true based on a set of predefined premises that delineate the scope and context to which it applies. Statistical inference is foundational to deductive knowledge development where probability theory is used to objectively examine the truth (or falsity, from a Popperian perspective) of propositional claims. However, the assumptions inherent in probability theory rest on the ability to measure and isolate or control all relevant phenomena. Inevitably, the complexity of factors associated with human health and illness experience typically preclude our ability to consistently consider all potentially relevant phenomena. Because of this, evidential knowledge based on statistical inference must be interpreted with a degree of tentativeness in terms of its application to particular situations. Thus, because the nature of these probabilistic relationships between phenomena is such that the contributory mechanisms are rarely or never fully understood, nurses must make a judgment as to the extent to which a particular situation is sufficiently congruent with the probabilistic patterns of relationships that substantiate the evidential claim to warrant confident application of that claim in any particular instance.

Because processes for developing evidential knowledge rely on inferential mechanisms by which particularities have to a large extent been averaged out or controlled for, this conundrum of applying general evidence to particular situations has long been debated. Obviously, particularities are inconsequential or even irrelevant to strictly deterministic generalizable causal relationships. However, the nature of knowledge pertaining to human health and illness experience is such that deterministic claims to generalizability of causal relationships, irrespective of contextual variation, can rarely be made. For example, although probabilistically defined causal relationships pertaining to a theory of stress and coping may prove widely applicable across various contexts of nursing care, any nurse can conceive of innumerable cases, such as in particular forms of cognitive impairment, in which the theoretical notions underlying general stress and coping theory may be inapplicable. Without an in-depth familiarity of context, nurses risk unknowingly applying evidence to situations that are quite different from the patterns of phenomena to which that specific evidential claim applies. In this way, if the idiosyncratic particularities of situational context are inadequately considered, uncritical adoption of practices that are construed as deriving from best evidence
could produce adverse outcomes. An example might include such practices as offering detailed standardized information to the newly diagnosed cancer patient who is still in the phase of being paralyzed by information overload.

Although the application of evidence to practice rests more heavily on judgment than on any mechanistic process, it is also the case that some evidential claims require less judgment than do others when it comes to individual application. Advanced life support protocols are a useful case in point, as they have wide application as a justifiable approach in response to cardiac arrest across most circumstances where resuscitation is considered a desirable outcome. Because the premises for using these protocols are clearly delineated and understood, there is little need for extensive judgmental processes to determine whether an advanced life support protocol applies to a particular situation in nursing practice. However, bringing forward our prior example of pain management guidelines illustrates a different scenario. By its very nature, pain is uniquely experienced, interpreted, and managed; individuals hold varying thresholds within which it is tolerable and understandable, as well as value systems within which it confers meaning. Although we may have obtained certain forms of knowledge about pain patterns across populations within tightly controlled contexts, such knowledge will rarely be sufficient for providing the right answer to meet the needs of this particular patient on this particular occasion. In this context, nurses draw on evidence-based knowledge to predict the best options available within the context of the patient’s experience, but they also recognize that pain management requires other forms of knowledge as the basis for sensitive ongoing assessment, careful titration of intervention, and vigilant monitoring for unique responses. Thus, both evidence and its application represent highly complex conceptual dimensions underlying an applied practice profession such as nursing.

**TOWARD THEORETICAL INTEGRITY IN EVIDENCE DISCOURSE**

Skillfully navigating among competing empirical claims is a core competency inherent in the fundamental disciplinary knowledge base of all professional health care providers. The value of having an evidentiary base upon which to challenge persistent problematic beliefs or ideologies in health care delivery is undeniable. Numerous instances have been reported in the literature whereby widely accepted interventions or protocols have been modified or replaced on the basis of careful empirical testing and rigorous analysis for obvious patient betterment. However, in focusing our attention on matters associated with the quality of evidence and with the processes of evidence uptake, we have not always considered the evidence problem within the larger context of disciplinary theoretical integrity. For us, this broader intellectual context of disciplinary thinking makes the evidence question even more interesting.

**The role of critical reflection**

An essential competency for a professional entering into an inevitably ideologically driven health care context is the capacity to critically interpret the implications of the evidence-based agenda. In nursing, arguing that clinical reasoning is based on a sound interpretation of what we know is entirely insufficient because skilled practice must also necessarily include a thoughtful critical reflection of what we don’t know and why we don’t know it. As Kitson explains, “We need to recognize our theoretical and methodological blind spots and move from taking comfort in the certainties derived from simplistic reductionistic approaches to acknowledging the assumptions, biases, and weaknesses that characterize most of our scientific investigations.” For example, we must guard against the tendency within an evidence-based practice agenda to focus our
attention on efficacy or effectiveness rather than on understanding the processes, conceptual relationships, and philosophical premises underlying our evidential claims. Timmermans and Berg note as follows:

Proponents of evidence-based medicine are wary of reasoning from basic principles or experience; they distrust claims based on expertise or pathophysiological models. They prefer to remain agnostic as to the reason why something should or should not work—rather, they objectively measure whether or not it works in real-life settings.27(p3)

In considering what does and does not exist within the available evidentiary knowledge to inform strong practice claims, we are not merely harvesting an available set of scientific discoveries but also reflecting on the social, ideological, and even economic interests explaining which programs of research have and have not materialized.44 Thus, that for which there is "good evidence" is therefore not necessarily "best practice." It may in fact represent a convention within which the preponderance of available scientific products is taken to represent the most defensible decision.

Beyond possessing a strong capacity to critically reflect on the underlying reasons for the presence or absence of an evidence base in any particular context, nurses must also be able to distinguish knowledge claims that are framed in the form of evidence from other kinds of nursing knowledge that inherently rely on ways of knowing that may be both subjective and ideological in nature.45 Different aspects of the complex set of knowledge and skill we know as nursing practice are necessarily informed by distinctly different forms of knowledge. Some forms of knowledge come with a degree of certainty and generalizability, while other forms of knowledge pertain more explicitly to the individual case without having generalizable implications. It is therefore essential that we expand our collective disciplinary conversation so as to ensure that we maintain a strong grasp on the nature of knowledge needed in relation to particular aspects of nursing practice.46

Another imperative is to avoid misinterpreting the prevailing notion of evidence frameworks as implying that nursing practice will be best informed by the forms of evidence that reside at the top of the hierarchy. Rather, it is a basic scientific premise that different forms of evidence serve different purposes in relation to knowledge development. Clearly the diversity of problems encountered in nursing practice necessitates a diversity of epistemological approaches to developing knowledge. And to align the most appropriate epistemological approaches to the type of knowledge needed to guide nursing practices, we will also need theoretical understandings that help nurses differentiate knowledge pertaining to the various meanings of phenomena from evidence claims pertaining to efficacy of predefined interventions.

The role of philosophizing and theorizing

To help navigate this complex evidence terrain, the profession would benefit from an expanded cadre of nurse scholars equipped with not only a reasonable sophistication in systematic retrieval and critical appraisal of formal evidentiary claims but also an appreciation for the philosophical and theoretical nature of knowledge within a socially mandated practice discipline. The practice world requires thinkers and leaders who can guide nurses in recognizing their responsibility not only in building evidence-based protocols and practice guidelines but also in working out the defensible bases upon which variations and individualized applications of these entities can be justified. There is a vital importance in continually grounding nursing scientific knowledge within the framework of the disciplinary theoretical tradition. The nursing models and frameworks that have been all too often disregarded as if they were inconvenient remnants of an immature disciplinary science can instead serve as a strong philosophical foundation for expanding our understanding of the complexity, and context within which
nursing enacts is a particular role within the health care spectrum.\textsuperscript{3}

Although many of the original framework developers may have believed the contribution of their conceptual models to be conventionally theoretical, we now understand them as more philosophical in nature, reflecting ideas about problem solving, reasoning, individualizing, and weighing options that remain contemporary and fresh in the world of practice knowledge application. We recognize this body of nursing theoretical knowledge as offering a set of powerful conceptual organizing structures that made the values underlying professional nursing explicit through articulation of the intellectual challenges inherent in applying general knowledge to particular contexts in accordance with nursing’s distinctive social mandate.\textsuperscript{4,7} Thus the emergence of an evidentiary basis for answering certain questions about good practice and the refinement of conceptual orientations toward understanding the unique individual context within which that good practice direction will be considered are compatible and interdependent intellectual components of an applied health discipline.

We also see these frameworks as playing an important role in helping the discipline deconstruct competing discourses around what ought to be considered evidence in relation to practice knowledge. Without a solid grounding in the philosophy of science as it pertains to nursing, it may be difficult for some nurses to appreciate the inherent illogic in expanding the definition of evidence so that it can include all relevant knowledge forms that may pertain to any particular clinical decision. However, the issue here is not what can be considered “worthy” knowledge applicable to good practice decisions, as our theorizing reinforces why a very wide spectrum of possible knowledge is needed. Instead, the important challenge is to reach a shared understanding of the conventions and processes through which we not only support the uptake of practices with established general benefit but also learn how to eliminate poor practices. By attempting to be overly generous in our delineations of what constitutes evidence to democratically include the multiplicity of ways of knowing from which nursing practice may be informed, we inherently complicate our capacity to strive toward the values for which the evidence-based agenda was created. Thus, we argue that what is needed is actually a narrowing and delimiting of our definitional position toward the more exclusive species of knowledge that ought properly to be referred to as “evidence.”

The knowledge informing nursing practice must attend to, but not necessarily privilege, that which can be known in the form of evidence. Nurses also need knowledge forms that guide them in understanding when and how to defend certain kinds of clinical practices for which a conventional evidence base may be currently unavailable or inherently unattainable. They also need theoretical structures that will help them recognize confusing or ambiguous aspects of empirical studies that might influence their applicability, and others that sharpen their critical analysis of a phenomenon such that they suspend application until the weight of the available evidence makes for a more persuasive interpretation.

Understood with the insights accessible through study of the philosophical basis for nursing science, the models and frameworks of our nursing theoretical tradition provide a marvelous record of the ways in which thought leaders within the discipline have worked out difficult challenges such as human diversity, social context, meaning, intersectionality, and complexity. From studying these sources, nurses develop the sophisticated forms of analysis they will require to articulate the reasoning underlying complex clinical decisions.

Within a health care climate in which certain compelling evidentiary claims take on ideological dimensions, nurses need theorizing that will help them advocate for the full range of knowledge variants required to achieve evidence-informed practice excellence. To remain credible and effectively positioned in the world of increasingly sophisticated
and compelling evidence claims, the discipline therefore requires an ongoing thoughtful and dynamic scholarship about matters of evidence and ideas in the applied practice context. The challenge is not simply one of discriminating strong from weak evidence, but rather discerning the nature and substance of evidentiary claims so that the potential meaning and implications of those claims within individual and particular contexts can be known.

As the profession attempts to advance its claims with respect to the extent to which its practice is evidence based, we believe it must resist oversimplifying the interpretation of what constitutes evidence or its uptake, or engaging in formulaic “best practice” approaches. Rather, if nursing aspires to clear thinking and a collective integrity in relation to its social mandate, its approach to the inevitable complexities of evidence-based practice must be informed by a scholarly dialogue that is theoretically grounded and strongly philosophical. By ensuring the capacity of nurses not only to comprehend the structure and function of an evidence claim and the problematic nature of the health care world into which all of our knowledge claims are being applied but also to inform that understanding through discernment of the theoretical and philosophical underpinnings from which nursing understandings of human health and illness phenomena have arisen, we can support a kind of disciplinary thinking that models the underlying values for which the evidence-based movement was advanced without falling prey to an uncritical acceptance of its dominant rhetoric.

CONCLUSIONS

Through this examination of the complexities surrounding the application of an evidence-based agenda within a particularized practice discipline, we have attempted to illuminate the challenge of preserving integrity of thought in accordance with the values encoded in our philosophical and theoretical traditions despite an ever-evolving contextual world of competing knowledge claims. From our perspective, nursing’s somewhat indelicate straddling of science and philosophy has resulted in a rather confusing portrayal of what constitutes a logical theoretical foundation. We see the embeddedness of these remnants of disciplinary positioning in our referencing of the philosophical frameworks we use to guide practice thinking as “nursing theory.” This kind of slippage creates confusion as to whether or not theoretical claims are meant in the scientific, or evidential, sense.

In the current academic context, many disciplines are having to confront the schisms in scholarly discourse that arise from an uncritical adherence to ideas. By virtue of our commitment to explicating and valuing diverse ways of knowing, it may also be that we have inadvertently privileged the uncontestability of subjectively derived knowledge as a viable basis for sound clinical decisions. The ideas that are shared within nursing are often experienced as deeply felt convictions. Furthermore, the way nurses relate to their profession typically extends well beyond the ingredients of a vocational option and into the domain of what would have been considered a calling in our historic past or a moral imperative today. Because of this, nursing disciplinary thinking may also be particularly prone to an unsophisticated conflation of probability and “truth.”

The urgency of public accountability for health care costs and resource allocation decisions contributes to an escalated demand for credible justification of practice on the basis of evidence. In a world in which nurses face increasingly complex clinical challenges at the same time as confronting this expanding set of administrative and public pressures, we argue that the discipline must adopt a clear and unambiguous distinction between what does and does not constitute evidence. To achieve this, we believe that mechanisms must be found to obtain agreement on the reasoned basis through which to delineate the fundamental nature of the various forms of knowledge upon which our clinical mandate relies. Such agreement would imply a mutual recognition of common purpose across our
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various theoretical and philosophical stances, making way for a commitment to clarity and consistency in the terminology with which we reference our epistemological underpinnings. Toward this end, we must move beyond our tradition of adherence to specific theoretical positions and instead develop a more fulsome theorizing and philosophizing capacity as a hallmark of disciplinary nursing.

Our disciplinary credibility in a context of increasingly vigilant accountability depends upon our collective skill at interpreting and explaining the sources of knowledge upon which we rely and the manner in which we translate those knowledge sources into action. Unless nursing is prepared to abandon its unique contribution to the particular, it will continue to need strength in disciplinary theorizing and philosophizing to steer its way through the landmines of an evidence-based practice agenda that inevitably privileges the general.

REFERENCES


