New Ways of Thinking about Nursing

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Collected Conference Papers, 2010-2019

By

Gary Rolfe

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To my dad

Terry Rolfe

1935 - 2018

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PREFACE

I can still clearly remember the first time that I was asked to present a paper to a large invited audience. The occasion was the Second Redwood Inaugural Lecture at South Bank University in May 1998, and my title was: *From Research-Based Practice to Practitioner-Based Research*. My presentation was chaired by an eminent professor from the medical faculty, and I recall vividly his remarks after I had finished: "Thank you, Dr Rolfe, for that extremely interesting presentation, although I have to say that I disagreed with almost every word of it." As you might imagine, his comment left me somewhat nonplussed. I had used my presentation to urge nurse practitioners, academics and researchers to resist the introduction into the profession of the self-proclaimed "new paradigm" of evidence-based medicine, and so I was unsure whether or not to be pleased that my ideas were being strongly criticised by a prominent member of the medical profession. When I came to submit the presentation for publication in a well-respected nursing journal, I discovered that certain members of the nursing profession were equally resistant. My paper was rejected by the editor of the journal for being overly negative towards evidence-based practice and for failing to present a balanced view. I replied to her that none of the papers I had read in favour of evidence-based practice had presented a balanced view either, but to no avail. My paper was eventually published in a much-revised form in a different journal with a more enlightened editorial policy, but the experience caused me to realise that the climate of academic nursing was changing.

Academic journals have traditionally been the primary medium through which members of the nursing profession have communicated and exchanged ideas with one another. Until fairly recently, most journals had letters pages to facilitate critique and debate, and also included "Issues for Debate", "Discussion" or "Commentary" sections. This began to change as the profession became increasingly "evidence-based" and the publication of empirical research papers was recognised by university lecturers as the quickest route to promotion. There are, of course, a few editors still willing to publish "issues" papers that attempt to elicit debate and discussion, but our journals are increasingly dominated by matter-of-fact research reports and evidence-based systematic reviews which close down rather than open up discussion. The primary function of academic nursing journals nowadays

is therefore to inform and instruct rather than to encourage debate, argument and critique. I have noticed a similar trend in the world of academic book publishing, where it is increasingly difficult to interest commissioning editors in anything other than text-books for students. Again, it appears that communication through essays, philosophical debate, polemical writing and other discursive academic formats is no longer encouraged.

There are, however, a few remaining outlets for papers which attempt to trigger debate or encourage original thought. Invitations to give keynote conference presentations are largely free of conditions or presuppositions. There is an expectation that the paper will address the broad themes of the conference, but beyond that, the presenter is afforded the rare privilege of being free to speak about whatever takes her or his fancy. The same freedoms largely apply to invited public lectures and academic seminars. I confess that, over the past 20 years, I have shamelessly taken advantage of these opportunities on a regular basis to disseminate thoughts and ideas that are becoming increasingly difficult to share through other academic media. My method, which I have hopefully refined over the years, has been the "spoken essay", and my format has mostly been the polemic, a one-sided and unashamedly biased (because it is impossible not to be biased) presentation that seeks both to persuade the listener of my views but also to stimulate her or him to react, argue and debate.

This is, by definition, a spoken medium rather than a written one. Conference presentations are transient; they are "delivered" to a small audience and then they are gone. Which brings me to this collection of papers. It is a great privilege to be able to publish some of these spoken essays in a written form where they will be preserved and hopefully be seen by a larger audience. My biggest challenge was to select 12 papers from more than one hundred invited keynote presentations, public lectures and seminars from the past twenty years. Of these, I had written transcripts for only about half, some of which had already been published in books and journals. I further narrowed my choice by considering only presentations that had been given during the past ten years, and after discarding papers that overlapped in content or subject-matter, I found that I did not need to make any further decisions. This selection is therefore somewhat arbitrary, but it nevertheless covers a lot of ground and is fairly representative of my interests, which in retrospect appear to have remained more or less constant over my entire writing career.

At the heart of this collection, the reader will detect a strong dissatisfaction with the recent technocratic turn in nursing, which has downplayed clinical experience and expertise in favour of an evidence-based approach to practice, which values and rewards career researchers above expert nurses,

and which regards student-satisfaction rather than education as the mission of the university. As I said earlier, my aim is not necessarily to convert the reader to my way of thinking (although I would see that as an added bonus) but rather, as the title of this collection suggests, to encourage new ways of thinking about nursing. And who knows, perhaps new ways of thinking might even lead to new ways of doing. That, at least, is my hope.

This book has been far longer in the making than most. The papers date back to 2010, but I have been rehearsing many of the ideas expressed in them for my entire academic career. I would therefore like to express my deep gratitude to my wife, Lyn Gardner, who has made a major if unseen contribution to this book through her honest and insightful reviews, critiques and suggestions which have undoubtedly improved the quality of almost everything I have ever written. I must also acknowledge my three children, Jack, Jude and Gabriel, who might or might not have noticed my regular withdrawals from family life behind a closed study door. And finally, my thanks to Cambridge Scholars Publishing for taking a chance by venturing where other publishers feared to tread.

CHAPTER 1

EVIDENCE-BASED PRACTICE: MYTH OR REALITY

Invited Lecture
Trinity College Dublin, Ireland

September 2010

The title I have been given for this lecture is *Evidence-based practice: myth or reality*. The short answer to this question is "reality". By definition, practice is always based on evidence of some kind or else it would not be practice, it would just be random behaviour. Even practice based on the principle of "we've always done it like this" is evidence-based practice of a kind. Of course, those nurses who make this statement have not *always* done it like this—what they do has evolved over time in response to a wide variety of different kinds of evidence, including evidence of what does and does not work for them. We can see already, then, that the word "evidence" does not have a single, universally agreed meaning. The long answer to the question of whether evidence-based practice (EBP) is myth or reality therefore depends on what is meant by each of the three words in the term "evidence-based practice".

I will begin with the first word in the phrase. When the Evidence-Based Medicine Working Group first proposed the idea of evidence-based medicine in 1992, "evidence" meant research findings, and EBP meant basing practice on research findings rather than on tradition or the authority of senior figures. The evidence-based practice movement quickly took hold and was later extended to nursing and healthcare. As Ingersoll (2000) pointed out in an editorial for the journal *Nursing Outlook*, "evidence-based practice is just another term for research usage". However, some nurse practitioners and academics objected that this view was dismissive of experience, expertise and theory and that it played down professional wisdom and artistry. A number of nurse academics therefore widened the concept of evidence to encompass a broad range of influences. For example, LeMay claimed that evidence could be:

- based on our own research;
- based on the research of others;
- based on professional experiences;
- based on general experiences;
- based on theory;
- gathered from patients and carers;
- passed on by role models and experts;
- based on policy directives.
  (LeMay 2000)

Basing practice on a variety of different types of evidence is all very well, so long as the evidence from the different sources is all saying more or less the same thing. Quite often, however, we find that evidence from research, experience, theory and patients is contradictory. The problem with lists of different types of evidence is that they do not usually come with instructions about how they should be combined or selected. In other words, they give us no real indication about what it means to say that practice should be *based* on evidence.

Here is a typical example. Evidence-based practice is:

> the conscientious, explicit and judicious use of current best evidence in making decisions about the care of the individual patient. It means integrating individual clinical expertise with the best available external clinical evidence from systematic research. (Sackett et al 1996)

Sackett's famous and much quoted definition talks about *best* evidence and about *integrating* the best evidence with *individual clinical expertise*. Whilst he defines "best evidence" as the findings of RCTs, no definition of clinical expertise is given and, more importantly, there is no indication of how to integrate the two, that is, how to *base* practice on evidence. Often, all we are told is that we must "integrate" the various types of evidence. If we read the literature carefully, it is possible to detect a number of different suggestions for how to combine the findings from more than one source of evidence, although these suggestions are rarely explicit. They include:

- ***An exclusive hierarchy***, which is the original and still dominant medical approach advocated by the Evidence-Based Medicine Working Group (1992). We simply work down the hierarchy from RCTs, quantitative studies, qualitative studies to experience until we find the "best evidence".

- ***An inclusive hierarchy***, in which different sources of evidence are given weightings according to their position in the hierarchy of evidence. For example, the findings from 5 surveys might be equivalent to 1 RCT, and 5 RCTs to 1 systematic review.

- ***A different hierarchy*** which has been specifically constructed for nursing. Depending on the proclivities of its creator, this might have qualitative research or even personal experience at the top.

- ***Different hierarchies for different questions***. For example, Evans (2003) suggested separate hierarchies for answering questions about effectiveness, appropriateness and feasibility, although all three had systematic reviews and RCTs at the top.

- ***Different hierarchies for different situations***. However, it could be argued that *every* nursing situation is different from all others, resulting in a different hierarchy for each nursing encounter, which amounts to there being no hierarchy at all.

Ultimately, however, there has been no agreement on what it means to base nursing practice on evidence, leading Rycroft-Malone et al (2004) to the conclusion that "how these sources are melded together in the real-time of clinical decision-making is still virtually unknown". This admission brings the problem into stark relief. If EBP is to be anything more than simply following general protocols and directives, then we need to think about how evidence is to be utilised and applied in "the real-time of clinical decision-making".

This shifts the focus onto what is meant when we talk about *practice*. We tend to use the term fairly indiscriminately and rarely consider how a practice differs from, for example, an occupation or a job. Unfortunately, when we do stop to think about practice, we usually make the unhelpful distinction between practice and theory, as in the phrase "it's all very well in theory, but will it work in practice?" This is a very misleading dichotomy since, as we have seen, all practice contains theory.

Donald Schön (1983) referred to the separation of thinking and doing as "technical rationality", where *technicians* simply perform actions handed down to them by theorists and *technologists*. Technical rationality suggests not only a separation of the theoretical technologist from the practical technician, but also of the technician from the object of her work. Technologists work mainly in universities and generate research-based knowledge which they use to produce plans and blueprints. These plans are

then passed to a technician who implements them as specified by the technologist in order to produce an object, for example a bridge. In general, then, the technologist provides the brains and the technician supplies the hands and there is a one-way flow of knowledge and action with no obvious channel for feedback—unless, of course, the bridge falls down.

Technologist

↓

Technician

↓

Object

However, when the product of the work is a living, breathing patient, we can see how readily a technical rational approach to nursing can lead to dehumanisation and objectification. Patients are people, and people are unpredictable; they are subjects rather than inanimate objects; patients do not simply *respond* to our nursing interventions, they *react*. Objects behave themselves by responding in predictable ways, whereas patients often do not.

If nursing was a technology which could accurately and consistently predict how patients would respond, then there would be no need to conduct double blind randomised controlled trials to test our medical and nursing interventions. Randomization is an acknowledgement that people are all different and that we cannot trust the findings from any particular individual. Double blinding, where neither the patient nor the practitioner knows whether they are receiving an active treatment or a placebo, is an acknowledgement that people are much more than physical and chemical machines and that they can respond to treatment even when they are not receiving any. Nursing practice is not a technological intervention. It is a constant interplay between nurse and patient, where the nurse is applying a range of different types of evidence to practice, but is also constantly obtaining new and updated evidence directly back from the patient.

Theorist

↓

Practitioner

↑ ↓

Subject

Of course, evidence from theorists and researchers is important, but it is likely to be overridden by the fresh evidence constantly emerging from the practice encounter. David Sackett comes close to making this point when he says that individual clinical expertise should always take precedence over external research evidence:

> External clinical evidence can inform, but can never replace, individual clinical expertise, and it is this expertise that decides whether the external evidence applies to the individual patient at all and, if so, how it should be integrated into a clinical decision. (Sackett 1996 et al)

Practice—proper professional practice—is far more than the obedient application of externally generated evidence, regardless of whether that evidence derives from so-called "gold standard" RCTs, from qualitative research, from received wisdom or even from our own previous clinical experiences. Whilst all of these can provide us with background information, each clinical encounter presents a unique and complex puzzle that, as professional, autonomous practitioners, we have to attempt to solve in partnership with everyone else present at the time, including the patient. Practice, then, can best be seen as a series of experiments, each of which adds to our evidence-base and helps us to work more effectively on the puzzle that is this particular clinical encounter. Practice is not only *based* on evidence, it *produces* evidence.

So, to return to the question. Evidence-based practice: myth or reality? I suspect that very few practitioners would admit to *not* basing their practice on evidence of some kind, but as we have seen, the problem is that EBP can mean almost anything we want it to mean, from practice based solely on RCTs to practice based on intuition. In addition to the lack of agreement on what EBP means, there are also a number of practical, logical and psychological constraints to its implementation.

Firstly, there are clearly practical implications to basing everything we do on evidence, particularly on evidence from research. We cannot possibly carry around in our heads the findings from every piece of research we have ever read. This makes it very difficult to respond to on-the-spot clinical situations in a traditional evidence-based way. EBP of the traditional kind works best for routine situations that we know and can plan for in advance. It is of little help in dealing with emerging or evolving situations that are the bread and butter of nursing practice. As I said earlier, technical rational EBP can be applied to illnesses or conditions or medicines, but not to people.

Secondly, there are psychological constraints to evidence-based practice. I have pointed out the difficulty in applying predetermined "best practice" to unpredictable patients, but we also need to recognise that practitioners are also unique and unpredictable. We are not machines and we do not always do as we are told. For example, there is research evidence to suggest that teaching with PowerPoint results in superficial and shallow learning, but have we stopped using it?

There is also a logical inconsistency at the very heart of technical rational evidence-based practice. The founding principle of EBP was to replace the authority of self-appointed experts with hard objective research findings. And yet we do EBP precisely because self-appointed experts tell us to. Thus:

> It has not escaped the notice of either critics or champions [of EBP] that there is not, nor is likely to be, any empirical evaluation of the effectiveness of evidence-based practice itself. The lack of any empirical justification for the approach has meant that advocates have relied upon intuitive claims. (Trinder & Reynolds 2000)

There is no research evidence to show that practice based on research findings is any more effective than, say, reflective practice or intuitive practice. We do it because it feels right, or seems obvious, or because someone else has told us it works, or because someone in authority has told us that we have to. That is not to say that EBP does not work. It is simply to point out that the very people who advocate it, those who believe that all practice should be based on solid research evidence, have no such evidence to support their own belief in EBP, and so by their own logic should not be doing it.

To conclude, then, I have made a number of perhaps contradictory suggestions:

- That all practice is, by definition, evidence-based.
- That the term "evidence-based practice" has many different meanings.
- That the most problematic but also the most important word in the term is the one that is most often overlooked—the word "based".
- That the most usually understood meaning of the term "evidence-based practice" is practice based primarily on the findings of research, although even with this technical rational definition there is still confusion surrounding what is meant by the word "based".
- That technical rationality leads to an inevitable focus on illness, disease and treatment rather than on patients.
- That we need to let go of this technical rational approach to practice and encourage autonomy and experimentation where the most important and relevant evidence is that which emerges from the practice encounter itself.

I will leave you all to come to your own conclusions about the implications of these suggestions and offer one final thought on the question of whether evidence-based practice is myth or reality. On the one hand, we have seen that EBP is all-pervasive in nursing and health care, and is thus clearly a reality. On the other hand, the nature of that reality is widely contested and there is no consensus on how it might be best understood. Given that myths are stories that we tell one another in an attempt to make sense of reality, EBP could also be said to be a myth.

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CHAPTER 2

PRACTICE DEVELOPMENT THROUGH RESEARCH

Keynote Paper
Portuguese Nurses Association Conference,
Lisbon, Portugal

November 2010

The theory-practice gap

I have spent the last 30 years working as a nurse in the United Kingdom (UK), firstly as an untrained nursing assistant, then as a qualified staff nurse, then as a university lecturer, and finally as a professor of nursing. During this time I have seen many changes in the UK in the relationship between those nurses who deliver care to patients and those who work primarily in colleges and universities, and whose job it is to support front-line nurses in various ways. When I first started out in nursing in 1980, nurse teachers in the UK were employed by the health service and worked alongside practising clinical nurses as equal colleagues. Nurse teachers regarded themselves first and foremost as nurses, and only secondarily as teachers. They had more or less the same aims, objectives and values as their clinically-based colleagues and saw their primary purpose as the improvement of patient care. They achieved this aim in a number of ways: through the education of qualified and unqualified staff in the classroom and clinical areas, at a strategic level through influencing practice at meetings and on committees, and to a lesser extent through research projects aimed at providing answers to specific nursing problems.

A number of factors and events have contributed to a change in this partnership between clinically-based nurses and nurse educators, particularly over the past 15 years. In particular, two events in the nineteen nineties, which occurred almost simultaneously, have resulted in a dangerous and perhaps irreparable split between the practice of nursing and the practice of

nurse education. Firstly, a new curriculum for nurse education was introduced. This new curriculum, called Project 2000, emphasised theory over practice by structuring the timetable so that students spent the first six months in the classroom learning theory before being allowed on placements in clinical areas. It also introduced a range of new theoretical subjects such as sociology, psychology and philosophy into the timetable which meant that, for the first time in the UK, nurses were being taught by lecturers who were not themselves registered nurses.

The second big change, which happened at roughly the same time, is that nurse education moved from the health service into the higher education sector. This move was both geographical and professional. Many schools of nursing, which had previously been situated in hospitals, moved physically into university premises. At the same time, nurse teachers found themselves re-employed as lecturers on university contracts. They were no longer employed by the health service, and their new employers had quite different expectations of them.

This morning, I want to explore what it means to me to work as a nurse academic in an institution that has little regard for nurses and nursing; an institution that values theory over practice, theorists over practitioners and researchers over teachers. I want to examine a number of conflicts between the aims of higher education and the aims of nursing, particularly in relation to research. And I want to offer some suggestions for how lecturers and professors of nursing might rethink their views about the purpose and practice of research for the benefit of patients and nurses.

The rise of research

It is no coincidence that the transition of nurse education from the hospital to the university was accompanied by an enormous growth in nursing research and nursing journals. Whereas the former schools of nursing regarded teaching as their primary activity, almost all universities, and certainly those in the UK and the USA, consider research to be their number one mission. The top universities in the world: Oxford, Cambridge, Harvard, Yale, M.I.T., are famous not for their teaching but for their world-leading research. The mission statement of my own university states firstly that:

> Swansea University will provide an environment of research excellence, with research being undertaken that is internationally recognised and that informs all other activities at the University.

And only secondly that:

> Swansea University will deliver an outstanding student experience, with teaching of the highest quality, that produces graduates equipped for distinguished personal and professional achievement.

Promotion in most universities, including my own, depends to a large extent on the number of research grants I win and the number of papers I publish in the top research journals. Promotion to higher grades such as professor, require me to have a PhD, which is first and foremost a training in research.

Too much research

This emphasis on academic research has resulted in a number of unfortunate consequences for nursing. Firstly, research has become an end in itself. That is to say, more and more nurse academics are applying for research grants and doing research projects not because the findings will improve practice in some way, but merely because they realise that, in order to please their employers and to gain promotion, they have to do research. Too often I have seen colleagues make decisions about what research projects to bid for based on the size of the grant and the prestige of the funding organization rather than on the relevance or usefulness of the project to nursing practice. And even in cases where these researchers assure me that their main reason for doing a project is to inform nursing practice, they still usually publish their findings in academic journals which are read only by other academics.

As a result of this pressure to "publish or perish" I believe that there are far too many research reports in far too many journals, and that most of them are unnecessary, unhelpful, and increasingly unread. This phenomenon is not recent, and it is not restricted to nursing. As long ago as 1963, the American bio-scientist Bernard Forscher wrote a letter to the journal Science in the form of a parable in which he compared researchers to brick makers and theorists to builders (Forscher 1963). His complaint was that too many people are busy making too many bricks and no one is bothering to build with them. In other words, we have too many research papers and no one is using them to build theory or develop practice.

Let's take a nursing example. During the 1950s there was one research paper published on the subject of the therapeutic effect on patients of listening to music. During the 1960s a further 17 papers were published, with another 45 during the 1970s and 86 during the 1980s. The numbers increased rapidly over the last two decades, and there are now nearly one thousand published research papers on the subject in the discipline of nursing alone. To use Forscher's analogy, that's a lot of bricks.

Decade	Number of published papers
1950-1959	1
1960-1969	17
1970-1979	45
1980-1989	86
1990-1999	288
2000-2009	534
TOTAL	971

Numbers of papers retrieved from PUBMED using the search terms "music" and "nurs"*

The first question to ask, then, is *do we really need one thousand research papers on the subject of using music as a form of nursing therapy?* The second question to ask is: *to what use have we put all this research?* or *what have we built with all of these bricks?* The answer to this question is not very impressive. A recent systematic review of the literature concluded that music can help to promote patient comfort and relaxation. However, it was also concluded that the effect is not well understood, and the author called for further research. So, after nearly one thousand research papers published over a 50-year period, we know that music can help to make patients feel better, although we don't as yet know why. Is it only me who finds this rather worrying? This is not an isolated example. Far too much of the research being conducted by nurse academics is being undertaken in response to the demands of the university to bring in research grants and increase publications rather than in response to the demands of nurses for work that will help them to improve their practice.

I am suggesting, then, that nurse educators like myself, that is, nurses who are employed by universities primarily to teach other nurses, are being pulled in two often opposite directions. On the one hand, we feel a professional and perhaps a moral requirement to make a contribution to the care of patients. This does not mean that nurse educationalists should be doing clinical work or working directly with patients. It means that we should be making our own educational and academic contribution to patient care through teaching and research. On the other hand, we have a contractual obligation to our employers to meet the mission statement of the university for "world class research", by which is meant research projects that are funded by eminent academic bodies and published in eminent academic journals.

I have suggested that this pressure to publish or perish has resulted in a flood of inappropriate and unnecessary research papers which are not read by practising nurses and which add little to the theory and practice of nursing. In short, the nursing research agenda is being driven by the needs of academics and by policy-makers rather than by the needs of nurses and their patients. My first point, then, is that there is too much research being done at the expense of other more important and more useful contributions nursing academics such as myself should be making to patient care.

The wrong kind of research

My second point is that not only are we doing far too much research, we are also doing research of the wrong kind. Let me explain what I mean. Many of the first generation of American nurse academics in the 1950s and 1960s had degrees in the social sciences and were trained in social research methodologies and methods. It is therefore perhaps unsurprising that nursing research adopted the social science research paradigm rather than, for example, the more experimental paradigm of psychology and medicine or the more humanistic paradigm of the arts and humanities. The argument has always been that nursing is a social activity and that the social science research paradigm is therefore the most appropriate way of generating nursing knowledge. However, I believe that there is a flaw in this argument. Whilst nursing is undoubtedly concerned with social activity and social interactions, these are on a different level from the concerns of the social sciences.

The aim of social science research is to generate knowledge about societies in general. Social scientists wish to know, for example, about general similarities and differences at the level of whole societies or of large groups within societies. Social scientists wish to understand about differences, for example, between men and women, between the young and the old, and between the rich and the poor. And the research methods developed by social scientists tend to reflect this concern with large groups or whole populations.

If we think about the design of quantitative social research studies, they usually begin by selecting a research sample that represents the target population. Any findings from our sample can then be generalised to the population as a whole. For example, if we find that 70% of our sample of patients responds therapeutically to music, then we can assume with some degree of certainty that 70% of all patients will also respond therapeutically. This information is very useful if, for example, we wish to introduce the intervention uniformly across an entire hospital. However, our ideas about

nursing have developed a great deal since the introduction of the social science research paradigm in the 1960s.

Ever since the 1970s, nursing has been moving away from a task-centred model where the nurse has been expected to perform the same task on every patient, towards a person-centred model which demands that we regard every patient as a unique individual and every nursing intervention as a unique therapeutic encounter. This shift is illustrated by the following definitions:

- "[Nursing is] a social activity, an interactive process between individuals, the nurse and the patient." (Chapman 1979)
- "Nursing consists of interactions between unique individuals, with unique experiences, and it always takes place in unique situations." (Sarvimaki 1988)
- "Nursing involves seeing the recipient as a holistic being, and using this view to meet his or her individual needs through meaningful interaction." (Pearson 1988)

As we can see from these definitions, nursing is a series of unique and different encounters which demand unique and different interventions. A social research study might tell us that 70% of all patients will respond therapeutically to music, but it will tell us nothing about how each individual patient will respond.

And we meet similar problems with qualitative social research. For example, a phenomenological study might appear to be exploring the "lived experiences" of individuals, but in practice these individual experiences are usually sorted into general themes and categories in order to make observations and recommendations that apply to larger groups and populations. The problem, put simply, is that social research provides us with knowledge and theories about patients in general, whereas the most useful knowledge required by nurses is about specific, unique individual patients. To return to my earlier analogy, not only are nurse researchers producing too many bricks, they are bricks of the wrong shape and size for building knowledge and theory for practice. Rather than taking a research paradigm designed to produce general and generalisable knowledge about large groups and populations as our gold standard, the profession of nursing might have done better to look at other practice-based disciplines such as education, social work and psychotherapy, which tended to start with a rather different concept of what constituted the most appropriate knowledge for practice.

Research has been separated from teaching and practice

My third objection to the current state of nursing research is that researchers have allowed themselves to become separated from teaching and from nursing practice. Prior to the move into higher education, nurse academics were first and foremost teachers and many of them were clinically-based. Some of these teachers were also researchers, but their research was informed and directed by their teaching and by their nursing practice. As the pressure to win research grants and publish research findings increased, the research component of the academic role has gradually become the most important and the most dominant. In some universities in the UK, research institutions are being created in which academic staff are no longer expected to teach or to engage with practising nurses in any meaningful way. In these institutes, people spend their time either writing funding bids or else conducting funded research. Often, they are under pressure to earn enough money from research grants to pay for their own salary. One nurse researcher I spoke to recently had been set a target of £200,000 per year with the consequence that he was prepared to do almost anything that the funders required of him. Thus, the focus of the projects that these researchers are involved with is usually determined by the funding body rather than by practising nurses or theorists. Often, these projects are so large that they require a team of researchers, each working on their own small part of the project, for example, the literature review or the data analysis, without ever getting an overview of the whole project. Someone once described these institutes as research factories, and I think that sums them up very well.

More and more, the academic activities of teaching and research are being carried out by two separate groups of people who rarely communicate with one another. Therefore, despite the rhetoric from universities about teaching and practice being informed by research, this is not happening as well and as often as it might. More seriously, however, research is not being informed by teaching and by nursing practice. As I argued earlier, the research agenda is not being influenced nearly enough by practising nurses and by those academics who are teaching them, resulting in a body of nursing research that is out of touch with the needs of patients and nurses.

Practice Development Units

What, then, is to be done? Re-uniting researchers with the needs of teachers and practitioners of nursing is the joint responsibility of all three groups. Researchers, teachers and nurses must work together on a shared agenda

and a shared strategy for achieving that agenda. There are many ways that this can be achieved, but I want to focus on one way in particular that researchers, teachers and nurses can form productive partnerships which meet all of their needs, but most importantly, the needs of the patients to which all three groups are accountable.

We have in the UK a growing network of Practice Development Units (PDUs). These are clearly defined clinical areas or teams of nurses—and sometimes practitioners from other professions—whose aim is to develop innovative and effective practice through partnerships with researchers and educationalists. PDUs aspire to be centres of excellence and pioneers in new methods and techniques of nursing care. PDUs conduct research and evaluation into their own work. They publish their work and present it at conferences. They lead the development and innovation of practice in their own organization by offering mentorship and supervision to colleagues. They run seminars and classes locally and nationally. And they work with colleagues from other wards and clinical teams to help them to become PDUs.

Practice Development Units require two things. They require a partnership between practising nurses, nurse researchers and nurse teachers with a full commitment from everyone to innovate and develop practice for the benefit of patients. And they require the imagination and intelligence to look at nursing practice, research and education from a new and different perspective. In other words, PDUs demand that we think again about what nursing might, and perhaps should, look like. Firstly, we need to move away from the idea of nursing practice as a technology; the idea that nursing is merely the application of the findings from research. This technological model of practice has recently become more prominent with the introduction of evidence-based practice into nursing. The technological model of practice reduces nursing to a mechanical process of doing that requires little or no thought. The scope of practice is narrowed down to what researchers have shown to be effective; that is to say, what is measurable. We can see the results of this narrow approach in the UK in the way that the Advanced Nurse Practitioner role has evolved.

Advanced practice in the UK is defined, measured and recognised in terms of the demonstration of competencies that can be ticked off as they are achieved. This technical, competency-based approach to practice development simply means becoming more competent at more and more skills, for example, prescribing medication or making diagnoses, rather than becoming truly advanced at some of the core nursing activities such as building therapeutic relationships with patients. The problem for the technical model of nursing is that the core nursing activities such as

relationship-building are not easily measurable and so cannot be turned into competencies. In order to develop practice, we need to move away from the technical idea of nursing as simply the application of research findings towards a concept of nursing as a form of experimenting in practice. This means making individual assessments of our patients, trying out new ideas and evaluating their effectiveness on an individual basis. It requires nurses to reflect on their practice and apply their learning back into practice. Practice therefore becomes a continuous reflexive cycle of doing and thinking.

As the name suggests, nurses in Practice Development Units do not simply apply the findings of researchers; they carry out carefully controlled experiments to develop their own individual practice in their own individual way with their own individual patients. Nurses in PDUs are responsible for the development of new practices as well as the implementation and testing of old ones. But to do this, they need to form partnerships with researchers. However, if researchers are to work in partnership with nurses on this experimental approach to practice, they in turn need to re-think their ideas about the function and purpose of research. The technical model suggests that the purpose of research is to generate universal, generalisable knowledge which practitioners take and apply to their practice. The reflexive model suggests that the most important knowledge for practice is generated by nurses themselves directly from their own practice. This can happen on an individual basis, where individual nurses reflect-in-action (to use Donald Schön's term) in order to shape and modify their practice as they are doing it. It can also happen away from the site of practice through verbal or written reflection, that is, through clinical supervision or by writing reflective journals. It can happen through more structured reflective methodologies such as auto-ethnography and autobiographical writing. And it can happen through action-oriented methodologies such as action research and co-operative inquiry.

Conclusion

In all of these examples, nurses and researchers have to rethink the purpose of research for a practice-based discipline in a number of fundamental ways. Firstly, they have to recognise that the "gold standard" of large-scale, decontextualized, generalisable research does not necessarily produce findings that are of much use to individual nurses working with unique, individual patients in unique situations and settings. What is required is a philosophy and a collection of methods and methodologies that will address each specific nursing issue as it arises; what I have referred to elsewhere as

a "science of the unique". Large-scale research projects provide us with general, background information. What is more important and useful is local projects for local problems. Secondly, and related to this point, we need to recognise that the most important research questions, along with the answers to those questions, arise out of practice itself. Rather than seeking to distance themselves and decontextualize their work, researchers need to immerse themselves in the practice that they are exploring. And thirdly, we need to recognise and accept reflexivity, the idea that our research can and should have an immediate effect on the nursing practice that we are researching, and that changes to practice will influence the shape and direction that our research will take during and as part of the research process itself. This suggests that research is not something that researchers do *to* or *on* nurses and patients, but something they do *with* them.

We must also recognise that these new ways of thinking about nursing practice and nursing research have implications for how we think about nurse education. We learn about, and come to understand, the world of nursing through experimenting, researching and reflecting on practice. Education, like research, is not something that is applied *to* practice, but something that arises *from* practice; something that is an intrinsic part of practice. It is impossible to practice in a thoughtful way as a nurse without learning, and the role of the educationalist is therefore to work with the practising nurse in order to facilitate that process of learning. Taken together, these ideas, philosophies and approaches to practice development constitute a new set of relationships between nurses, researchers and educationalists, and between each of these professional groups and the organisations for whom they work. If nurses, researchers and teachers continue along their separate paths, then ultimately it is patients who will suffer.

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