

NURSING PRACTICE: WHAT ABOUT NOT KNOWING?

by

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Abstract

The certainty of nurses' claims of knowing forms the background for this paper. The purpose of this literature review is to explore how not knowing is conceptualized within literature and nursing practice with a focus on the implications for nurses' ongoing learning. An exploration of some dominant discourses sheds light on how 'not knowing' is resisted and silenced within health care. In naming the tensions around a dichotomous view of 'knowing' and 'not knowing' we nurture an openness that encourages questioning: not for the purpose of arriving at an answer but rather to explore possibilities. The relationship between knower and knowledge emerges as an important concept. I suggest that the concept of not knowing, as a way of knowing, has received insufficient attention and merits further research.

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Dedication

I would like to thank my husband Garry and our children Brooke and Courtney for their support. They demonstrated patience and humor as I brought my book bag on every family outing. I thank them for being such wonderful teachers.

Nursing Practice: What About Not Knowing?

Introduction

Throughout my nursing career I have struggled with the tension around a dichotomous view of 'knowing' and 'not knowing'. As a clinical nurse educator, I am interested in the concept of 'not knowing' and the influence on learning and nursing practice. This critical literature review aims to explore nurses' experience of 'not knowing'. The concept of 'not knowing' is variously understood within literature and practice. Within the paper we will explore the various conceptualizations of 'not knowing' and the relationship between knower and knowledge. An exploration of some dominant discourses will shed light on the context of 'not knowing' in nursing. I understand discourse as "socially and culturally produced patterns of language, which constitute power by constructing objects in a particular way" (Francis, 2000, p. 21). Discourses are words, symbols, speech, and concepts that are taken up and used by people, contributing to a social reality. Personal narratives will be used to demonstrate and link concepts with practice. I spend some time exploring not knowing in academia and end in identifying some suggestions for further research. The goal of the paper is to nourish the openness of not knowing. In other words, I set forth to suggest that in nursing we do not always 'know', identifying that we need not be so certain about our claims of knowing. Further, I suggest that the concept of not knowing, as a way of knowing, has received insufficient attention and merits further research.

Two years ago I launched on a journey to achieve a master's degree in nursing. I thought I would emerge 'knowing' what I needed to know to practice as an advanced practice nurse. As I complete this last requirement for the degree, I realize that I emerge

with more questions than when I began. It seems reasonable to state that I have arrived at a location where I am comfortable in disrupting the notion of absolute truth. That is to say that I have come to believe in the existence of multiple truths, valuing all knowledge claims as socially constructed and therefore contextual and fluid. I believe that, on completing a master's degree program, I am better positioned to practice at an advanced level. I understand an advanced practice nurse as a creative leader who can begin to reveal the multiplicity of influences on nursing practice and can advocate for nursing and health care. My view is influenced by the Canadian Nurses Association (2008) which identifies that, "advanced nursing practice plays a key role in meeting the health needs of Canadians, by building nursing knowledge, advancing the nursing profession and contributing to a sustainable and effective health-care system" (p. 2). Here the multiple complexities which influence nursing practice can begin to be imagined, thereby contributing to an understanding of the multiplicity of questions that exist. Through my journey of deconstructing 'not knowing', I have come to value uncertainty and the process of ongoing purposeful questioning. In other words, I suggest that the process of engaging with the experience of not knowing enriches my nursing practice. I desire to share my exploration with others and hopefully stimulate some contemplation concerning not knowing.

In our Western culture, it is not uncommon to hear one refer to a "fear of the unknown". Some fears are commonly spoken about, such as a fear of darkness or fear of change. It seems that in our attempts to make sense of our world, situations that present the unknown may cause discomfort or fear. On the other hand engaging in the unknown is a daily activity, as life appears filled with unpredictability and unknowns. I suggest that many qualities that contribute to a meaningful life, such as humour and a good story, would

perish in an entirely predictable world.

As this paper will reveal, we must not ignore the social and political influences on claims of knowing and the resulting consequences. In the current discourse of world economic constraint, the concept of not knowing may be resisted. How is not knowing conceptualized under the umbrella of government policy and professional practice? Do we practice in a place where not knowing is silenced? What is 'not knowing'? It is my hope that I can begin to unpack the experience of not knowing, creating an openness to imagine the possibilities.

Example from Practice

The following narrative is from my practice. The purpose of sharing this story is to begin to develop the relationship between myself, the author and you, the reader by using a scenario from practice in which I hope we will share some mutual identification. The story is shaped by my perceptions and demonstrates what I have privileged to be an example of the denial of 'not knowing' in practice.

I recently attended an all day workshop with the morning session being facilitated by a knowledgeable and reputable physician. I found her to be skilled at using language and personal narratives to convey information so that it was generally understandable and related to clinical practice. She welcomed 'in the moment' questions during her presentation and created opportunities for learners to engage in facilitated group discussion about the new information. For the last fifteen minutes the facilitator created space for questions. Promptly, three experienced nurses described scenarios from their practices that they felt demonstrated how their current practice was already consistent with the presenter's key messages. However, it was evident to me that they had each uniquely made

sense of the information so that, in contrast to challenging their understandings, the new information supported their pre-existing ways of being in practice. I observed that their expressed interpretations were inconsistent with the concepts that the facilitator was introducing. In other words, they seemed to have received the information but ‘missed the meaning’. They appeared confident in their claims of having already integrated the concepts into their practice. I became intrigued with how these experienced nurses were experiencing the opportunity to learn.

Looking to the literature, I began to explore how adult learners identify their learning needs. If the responsibility for identifying a learning need and learning is located with the adult learner (Young & Maxwell, 2007) then: what if the identification of a learning need/opportunity is missed or neglected? What if the nurse considers her/his knowledge as ‘truth’, thus failing to identify any limitations or variations in their knowledge? What if you don’t know what you don’t know? Paul and Heaslip (1995) state, “If we do not recognize unknown as unknowns, if we are unable to recognize how much we do not know in relation to what we do know, then we are courting malpractice and endangering the health and well-being of our patients” (p. 42). Paul and Heaslip aptly point out a significant risk in denying what we do not know. In clinical practice, a person’s experience of health is at risk.

Risking the possibility of arriving at a premature conclusion (Munhall, 1993), I worked to open my ways of knowing towards a deeper understanding of not knowing. I arrived at an understanding that there are multiple ontological and epistemological views within the literature, of which one can reference to develop one’s own understanding. The exploration guided me to identify various possible interfaces between knower and

knowledge as well as differences in ways of knowing and ways of not knowing.

Throughout the paper, I pose a variety of questions, the answers to which may not be readily available but recognize that there is value in asking the questions. That is to say that an underlying benefit of the paper is to open space to appreciate the value of questions, without necessarily achieving answers.

Influenced by the words of Heath (1998) who states, a nurse risks “closure based on confidence in one’s own interpretations” (p. 1056), I knew that I had to pursue the topic of not knowing in nursing. What consequence does a nurses’ closure on knowing have on the patient/population that they care for? How are nurses motivated to learn? How might our relationship with knowing look different?

Further, I was motivated to pursue this paper by a particular poem by R. D. Laing. In the poem Laing translates into words the uncomfortable position of the experience of not knowing. Laing’s discomfort with not knowing is so intense that the desire to pretend to ‘know’ emerges. I suggest that it is possible that Laing is experiencing a fear of embarrassment in admitting not knowing, or a fear of being held in judgement by others who are assumed to be in a position of knowing. Laing states “You may know what I don't know, but not That I don't know it. And I can't tell you. So you will have To tell me everything”. These particular words within the poem resonate with me because there seems to be an assumption that knowing or knowledge is an independently existing truth that one can own and transfer from one person to another. Laing’s desire, or internalized pressure, to know seems to be powerfully embedded, nudging me to explore this resistance to ‘not knowing’.

No doubt, with each person who enters into a relationship with their claims of

knowing, a new interpretation will emerge. As my own interpretation of my relationship with knowledge and knowing has evolved during the course of writing this paper, I have been mindful that I do not simply trade one assumption, or ideology with another. For the purpose of this paper, I understand an ideology as an idea, belief, or attitude that exists as common sense within individual societal groups (Purvis & Hunt, 1993). Ideologies advance value-laden claims that perpetuate the favouring of some while disadvantaging others (Purvis & Hunt). For example, it might be easy to trade the ideology that older people own a lot of wisdom with the ideology that people who have achieved high academic achievements 'know' more than those who have not achieved recognition from academic institutions. As you read this paper, you might be mindful of what ideologies you are working within. Your interpretations will be translated through your own context and understanding. I suggest that developing your inquisitive sense of 'not knowing' might create space to imagine multiple possibilities.

Grounding the Paper

Project Approach

The literature search included the use of the Cumulative Index to Nursing and Allied Health Literature (CINAHL), Medical Literature on-Line (Medline), Education Resources Information Centre (ERIC), and Google databases, using the keyword search terms; nursing knowledge, not knowing, and knowing. Reference lists of articles were used to locate literature of interest and/or literature not indexed in the academic reference databases. Books that I have come to discover throughout my Master of Nursing program, which nourish my sense of curiosity, were also used. No identified ethical concerns were identified within the work of this project.

Theoretical Underpinnings

As a woman and a clinical nurse educator, I sought a theoretical position that would acknowledge the influence of my socio-political world that values patriarchal structures of knowledge. I engage in this paper through the central tenets of feminism and the interpretive paradigm, namely constructivism. Both feminism and constructivism attend to the social influences on the creation of knowledge and the experience of knowing.

As nursing is a primarily female gendered profession, feminism speaks to the woman's experience of nursing. Risking sustaining the dichotomous categorizations of male/female (Belenky & Stanton, 2000), old/youthful, gay and lesbian/heterosexual, rich/poor, non-white/white, or able-bodied/disabled, I look to the feminist commitment to confront oppression based on gender. Belenky and Stanton claim that the gendered relations of inequality are embedded in Western culture and "we must cultivate tools for dealing with the inequalities that exist and the new ones that are bound to rise" (p. 75). Our patriarchal health care system positions men in dominant positions, where they hold social and political advantage over women (Newman, 1997). More specifically, Lumby (1997) posits that medicine "reproduces the belief that women should be socially and medically controlled, silenced and made obedient for the sake of their own well being" (p. 115-116). I suggest this attitude transcends into how nurses are perceived in practice, where dominant discourses determines "whose voice(s) are heard and whose are silenced" (Lumby, p. 130).

Constructivism, viewed as a theoretical position, is well situated to explore knowing within the web of complex social interactions of health care. The central tenet of constructivism is the understanding that knowledge is socially constructed as opposed to found or discovered (Young & Maxwell, 2007; Carr, 2005). Each person seeks to find

meaning within their experiences and knowledge is constructed from their understandings (Boghossian, 2006; Appleton & King, 2002). Vygotsky, a Russian psychologist, posits that individual development occurs through social interactions with others (Young & Maxwell). In this way, each person constructs their own reality within their social context, thereby contributing to the existence of multiple realities. Here, knowledge is always understood as partial and questionable, personal and dynamic. Boghossian points out that in constructivism each person's subjective viewpoint, or created knowledge, is equally valid with no one person having "an epistemically privileged viewpoint" (p. 714). However, if truth is understood as an individual construct, then it could be said that individuals are given epistemological privilege as experts of their own lives.

It is recognized that in constructivist inquiry, the "researcher's own beliefs and values will influence the area to be investigated" (Appleton & King, p. 645). This is to say that what I have chosen to include and how I have interpreted the various pieces of literature and stories is influenced by my values and beliefs. As you will see, throughout the paper I will invite you into my interpretations through stories.

Knowledge and Knowing in Nursing

This section will take us through an exploration of the various contexts that influence nurses' commitment and pressures to 'know'. With the goal of nudging ourselves to expand our view of knowledge, we will review some various ways of knowing in nursing. It is here that we will begin to reveal the various conceptualizations of not knowing.

Expectations on Nurses to Know

Historically, nurses have prided themselves on owning the knowledge to deliver

health care to clients. Further, society expects experienced nurses to have ‘the knowledge’ to be competent practitioners (Gordon, 2006). The socially constructed ideology that nurses ‘know’ shapes nurses’ perceptions of what their practice should be and how they should be in their practice. In addition, government and professional practice organizations have an increasing role in how nurses practice. How does regulatory involvement in nursing impact the well being of clients and the larger societal context of health care?

Nurses are perceived as advocates for client’s health and health care, and are trusted worldwide to have the competencies to do so (Gordon, 2006). The Canadian Nurses Association Code of Ethics (2008) identifies that nurses, as members of a self-regulatory profession, are responsible to practice within professional standards, laws, and regulations and to practice within their own competencies. In addition, the International Council of Nurses (ICN) Code of Ethics (2006) states, “the nurse carries personal responsibility and accountability for nursing practice, and for maintaining competence by continual learning” (p. 2). Continuing professional development can be understood as, “the process by which health professionals keep updated to meet the needs of patients, the health service, and their own professional development. It includes the continuous acquisition of new knowledge, skills, and attitudes to enable competent practice” (Peck, McCall, McLaren, & Rotem, 2000, p. 432). What influence does regulation, through professional practice and policy, have on nurses’ ways of knowing and practicing? How is competent practice conceptualized and how is not knowing understood in the discourse of competent practice? Although these questions are beyond the scope of this paper, as we will come to discover, if we do not begin to ask the questions we risk believing that we know the answers.

The pressures from regulatory bodies and society on nurses to own ‘knowing’ is

evident. If knowing is understood as, “the state of being aware or informed of any thing” (Barber, 2006, p. 543), then not knowing could be understood as a lack of awareness.

Looking to the work of Benner, Nelson (2006) states, the expert nurse is “someone whose outstanding clinical assessment skills, contextual knowledge, and experience come together so that he or she arrives at an intuitive grasp of the whole situation” (p. 71). In this location, the bias includes an awareness that is so immediate that conscious reasoning is not required. Further, Benner and colleagues’ research demonstrated that nurses who expressed confusion or powerlessness in practice were dismissed as inexperienced (Nelson). The ideology that confidence is an indicator of competent practice is sustained. Could it then be said that nurses who claim to ‘know’ are privileged as expert over those who demonstrate confusion or powerlessness? It is worth noting that the perception of confusion or powerlessness is individual and interpretations will be unique to each individual, although common qualities will be determined by social and cultural norms. In other words, could nurses be internalizing social norms that they ‘know’ thereby perpetuating that any claims of not knowing are inexperienced practice?

Ways of Knowing in Nursing

Nursing draws on multiple forms of knowledge (Bonis, 2009; Carr, 2005). Various conceptualizations of knowledge and knowing exist within nursing. While empirical knowledge is the basis of the science of the discipline of nursing, there has been a gradual shift within nursing’s view of knowledge. In contrast to the dichotomies of science, a subjective interest in health has led to the embracing of the human experience (Bonis). Bonis’s concept analysis on knowing in nursing revealed that knowing; is a type of knowledge that lies in personal experience and personal knowledge, is shaped by personal

perspectives, is dynamic and changing, and evolves as one interacts with the world (Bonis). In this position, subjective knowledge is understood as valid knowledge.

In 1978, Carper's seminal work conceptualized the various ways of knowing in nursing, identifying four ways of knowing for nursing: empirics, aesthetics, ethics, and personal (MacDonald, 2008; Averill & Clements, 2007; Paley, et al., 2007). The purpose of this brief review of Carper's work is to provide an overview of the various types of knowledge that have been conceptualized in nursing. Having an understanding of the various ways of knowing in nursing contributes to an awareness of the complexity of nursing knowledge (Heath, 1998). What is at risk is supporting a view that knowledge can be deposited into individual categories rather than understood as interconnected and fluid. Another risk is that one limits their understanding of ways of knowing to the work of Carper.

Carper asserts that empirical knowledge represents the scientific basis of the profession (Averill & Clements, 2007). Empiricism claims that knowledge is derived from the five senses and reality is understood as existing independently of human beings. Aesthetic knowledge is the art of nursing. Here, rather than the quantitative qualities of empirical knowledge, the knowledge from the artful lived experiences of the person is recognized. Ethical knowledge is concerned with what constitutes the "good" within society. Finally, personal knowledge "is concerned with knowing, understanding, and actualizing self, as well as recognizing the same ongoing process in others" (Averill & Clements, p. 394). While many authors and researchers ground their study on the works of Carper, White claims to have identified a gap in Carper's work, adding the pattern of socio-political knowing (Averill & Clements). Socio-political knowledge acknowledges

the contextual considerations including “political, cultural, historical, economic, geographic, social, and other key factors” (Averill & Clements, p. 394). Further, Munhall called for the pattern of ‘unknowing’ be recognized as a way of knowing (Munhall, 1993). Heath (1998) suggests that Munhall’s pattern of unknowing is related to all patterns of knowing.

In suggesting that unknowing is not simple, Munhall (1993) posits that we must interact with unknowingness as a “de-centering process from one’s own organizing principles of the world” (p. 125). Munhall claims that in holding our biases, prejudices, preconceptions, stereotypes, and assumptions in abeyance we create the condition of openness. This openness occurs in a place of “atheoretical stance” (Munhall, p. 126). As conceptualized by Munhall, unknowing is understood as the ability to position oneself in openness, thereby creating space to understand another’s perspective. Munhall’s endorsement of the pattern of unknowing rests on the assertion that nurses need “to learn how to “unknow”- to be authentically present for the patient” (p. 125). Munhall’s work supports statements such as “I don’t know” or more specifically, “I don’t know how this experience is for you”. However, can one hold their situated context in abeyance to be fully aware of a patient’s subjective reality? That is to say, is it possible to identify and step out of our inherent complex context and point of view to achieve a state of unknowingness?

Averill and Clements (2007) concur with the tenets of Munhall (1993) that in unknowing one purposefully releases their preconceptions, stereotypes, biases, and assumptions. Averill and Clements look to the work of Heath and Kikuchi to view unknowing as an “idea of openness, of qualitative reciprocity to what might be learned, and of acceptance that not all the important questions have been asked and that many answers

to both scientific and philosophical questions remain elusive” (p. 395). This view of unknowing cultivates an open-mindedness through the exploration of multiple possibilities. Questioning is valued and it is understood that neither insight nor conclusion is ever complete. In this view there is a certain comfort in the idea that an answer is not always possible. This understanding of unknowing supports the tenet that no person holds the absolute answer because variables and context are always fluid. No two situations are the same and the possibility of new learning is lived in every moment. Here, an example statement includes, “The best evidence available informs us, however, we will never entirely understand the experience of the client”.

Whereas, Hankinson (cited in Blom, 2009, p. 169) states,

Positive un-knowing stands for an acceptance of uncertainty, arriving from a lack of knowledge. By accepting our lack of knowledge we can be in a position to know more than we are aware of. Un-knowing can imply a process of greater and greater openness, with a resulting transcendence of ordinary knowing.

In this view of un-knowing, is the idea of accepting an uncertainty due to a lack of knowledge. This understanding of un-knowing looks very different depending on what one considers as knowledge. From an empirical lens, a lack of knowledge could be a missing genetic code. From an ethical lens, the lack of knowledge could be understood as not knowing the impact of a woman’s shelter on the various populations within a community.

The concept of not knowing is not unique to nursing. I suggest that there are opportunities to learn from many disciplines. Here I look to the discipline of social work. In exploration within social work, Blom (2009) claims that “knowing presumes a predictable world” (p. 160). In response to this notion, Blom suggests that the approach of

'un-knowing' be used to compliment traditional ways of knowing. Simply put, Blom describes knowing as having the knowledge and un-knowing as not having the knowledge. Un-knowing is remaining open to the unpredictable and unknowns that are involved in the contextual relational experiences that are a part of social work practice (Blom). That is to say that Blom claims that social workers cannot fully understand the context of a person's situation within the world. Further, Blom suggests that, in contrast to a predictable world, a certain level of risk is inherent in decisions within the complexities of social work. I suggest nursing shares similar relational work with others and thus levels of risk surrounding claims of certainty. Later in the paper we will look at how 'not knowing' may be conceptualized in medicine.

Each of the preceding perspectives carries a slightly different conceptualization of not knowing. However, uncertainty and openness emerge as central concepts.

Influences on Nursing Knowledge

Potential Barriers to Not Knowing

Nelson (2006) suggests that as opposed to a focus on objective claims of knowledge, 'knowing' is possible through an embodied presence. Here a part of knowing is the "inherent meaning and value, or truth, underlying every human situation that is independent of our knowledge of it" (Nelson, p. 75). Nelson suggests that expert nurses have the confidence in their knowledge, their values, and their context to act ethically based on their intuitive knowing; even if their actions are in contrast to the objective claims of science. Paul and Heaslip (1995) concur, identifying that intuitive knowledge has value in nursing practice. They suggest that intuition is a part of everyday life, comparing intuitiveness to the swift swing of an experienced tennis player, where split second

decisions replace a lengthy process of conscious reasoning. If intuitive knowing is inherent, then what becomes of the conscious process of unknowing?

Paul and Heaslip (1995) heed warning that it is in the location of prejudice knowledge that danger lurks. Paul and Heaslip understand prejudice as judging in advance of the evidence. “Our minds are naturally inclined to leap ahead of and beyond what we really know, to conclusions that do not match up with and sometimes that are flagrantly inconsistent with, our genuine intuitive and non-intuitive knowledge” (Paul & Heaslip, p. 43). It might be said that in recognizing one’s prejudice, one might begin to appreciate the process of unknowing or acknowledgement of not knowing.

What influences our desire, or habits, to leap into assumptions and conclusions? Could there exist such pressures on nurses in practice to ‘know’ that they leap to conclusions without conscious reasoning? What is at work within the dichotomies of not knowing and intuitive ways of knowing?

Discourses Influencing Not Knowing

Language, discourses, and socio-political locatedness are recognized as influencing knowledge claims (Lawler, 1997). In this next section, we will explore how ‘knowing’ and ‘not knowing’ is shaped by some dominant discourses. The historical oppression of nurses and the traditional patriarchal organizational structures of health care position nurses low in the health care hierarchy (Daiski, 2004; Roberts, 2000). Zander and Zander (2002) suggest that the comparing and contrasting world in which we live contributes to the hierarchies by positioning some groups, people, knowledges, places, and ideas as more powerful or somehow more desirable.

Oppression of Woman in Nursing.

How might the historical oppression of woman in nursing influence nurses' claims to 'know'? Nursing, a predominantly female profession has historically taken a subservient and unassertive role to the male dominated medicine (Moland, 2006). Roberts (2000) asserts that in Western health care the "values of medicine and the medical model have been internalized as most appropriate" (p. 76). Power structures remain unquestioned with physicians positioned to lead the dominant medical model and the dominant discourse sustaining the trivialization of the knowledge that nurses brings (Clarke, 2006; Ceci & McIntyre, 2001). Nelson and Gordon (2006) state "we are concerned that discussions of nursing care tend to sentimentalize and decomplexify the skill and knowledge involved in nurses' interpersonal or relational work with patients" (p. 3). Ideologies are sustained such as the physician knows the disease and the nurse knows the client, with the value being placed on the claims of knowing within the respected domain of objective science. In addition, Gordon and Nelson (2006) point out that sentimental framing of nursing, such as the visual symbolism of an angel to represent nursing, is contrary to the view of nursing as a knowledge based profession. One could question what knowledge Gordon and Nelson are prioritizing as valuable?

However, nurses often describe their work "in terms of self-sacrifice and altruism rather than in practical terms of competence, expertise, and financial stability" (Moland, 2006, p. 54). Moland (2006) suggests this indicates that nurses self identify with their chosen profession. In light of Ceci's (2000) claim that any challenges to our beliefs can be interpreted, or experienced as a challenge to oneself as a person, the possibility exists that nurses personalize the submissive script. With such high investment of oneself in nursing practice (Moland), how might not knowing be silenced? What socio-political influences

might contribute to, and what benefits are there in sustaining perceptions of self-sacrificing? That is to say, the subservient, oppressed, sentimental positioning of nursing sustains the dominant patriarchal discourse of health care.

Newman (1997) points out that, “patriarchy requires, creates and sustains a particular kind of masculinity, which supports the absolute functionalist process of ordering our society through a clearly defined and socially supported profile of accepting male behaviour” (p. 137). Masculinity is often associated with images of power and control. In this location it is necessary for all persons, including men, to function within the predetermined social rules of masculinity (Newman). While this may advantage some men, those who deviate from the rules of masculinity risk subordination and oppression (Newman). That is to say that nurses who are male gendered are also at risk within the patriarchal structure.

In this context nurses have internalized the characteristics of an oppressed group including internal group conflict through passive aggressiveness, horizontal violence, and self-hatred (Roberts, 2000). In workplaces where nurses feel devalued and powerless, nurses respond by exerting power over patients and each other (Mason, 2006). If knowledge is power, then how does a nurse (as an oppressed member of the system) feel safe to engage with not knowing? I am left to ponder, are marginalized populations more vulnerable to the judgments concerning not knowing?

Scientific Discourse.

In nursing's pursuit to be situated in the respected domain of science, nursing attempts to emulate medicine's valuing of scientific objectification (Cutcliffe & McKenna, 2002; McDonald & McIntyre, 2001). McDonald and McIntyre (2001) posit that the

“scientification” of nursing privileges the objectification of human experiences. Scientific discourse “relies heavily on a form of objectivity which invites distance and detachment rather than engagement with the subjective” (Lawler, 1997, p. 35). Lumby (1997) suggests that working within a scientific framework can reduce the health care professionals’ sense of vulnerability. So why might practice within a scientific discourse decrease one’s sense of vulnerability?

Empirical or technical data is valued in a paradigm that views scientific knowledge as powerful (Sandelowski, 1999; Lawler, 1997). In empirical paradigms, knowledge is perceived as an externally existing truth (Cutcliffe & McKenna, 2002; Lawler, 1997), thereby sustaining the dualistic thinking of knowing and not knowing. Researchers test hypothesis through testing, arriving at a level of certainty that their findings represent the truth (Cutcliffe & McKenna). In positivist scientific discourse, this truth forms the foundation of evidence. The idealistic concept of certainty supports a linear view of valid knowledge as scientifically legitimate. Lawler claims that biomedical sciences and scientific discourse sustain “positivist, reductive, predictive and probabilistic” (p. 32) ways of knowing. Here, the ideologies that ‘knowing’ is the result of scientific research and that research is necessary for quality medical care are sustained.

It is generally accepted that nursing is based on evidence (Springer, Corbett & Davis, 2006; Cutcliffe & McKenna, 2002). Lawler (1997) suggests that the nursing process is constructed within a positivist tradition that fails to recognize “non-cognitive-intellectual ways of knowing” (p. 46). In this location a technical, outcomes based model of care is valued (Clarke, 2006). The view of humans as holders of individual and unique bodies of knowledge is ignored. In other words, other ways of

knowing (and unknowing) are silenced. In turn, in a positivist scientific paradigm nurses risk coming to believe that they 'know' what is necessary for client care.

So what is at work in the background of the dominant scientific discourse? The use of sophisticated language creates barriers (Keesling-Styles, 2003) that contribute to power inequities through the privileging of health care professional (knowing the language) and the marginalizing of others (not knowing the language). Further, the dominant patriarchal language of health care sustains the power inequities. Persons behave in socially ordered ways that perpetuate the patriarchal structures of health care and society. For example, the labeling of a client as "non-compliant" suggests a system of hierarchy, placing professionals in a position of knowing. That is to say, in health care professionals' claims of objective knowledge, the authority and accountability for health is located with the professional. The traditional emphasis of the health care professional/client relationship is that of conformity. In other words, within a professional's claim to own the knowledge for health exists the risk that other ways of knowing are discounted.

In addition, I suggest that organizational leaders who base resource allocation and policy development decisions purely on quantitative data enter their decisions with limited views of the human experience of health. To believe this, I bring a bias that research is primarily economically driven, which is addressed next.

Economic Discourse.

Health care is dominated by an economic discourse (Lawler, 1997). Within economic discourse, the focus is on measurements of productivity, cost effectiveness, and efficiency (Lawler). Clarke (2006) adds that in a world consumed with economic discourse, objectivity and data aimed at outcomes measurement are valued. Nursing work

is often invisible in the measurement world of economic discourse (Clarke). For example, a focus on the specific task (such as after death body care) misses the emotional work of nursing (such as the relational work with the family /friends of the deceased). A focus on the task may have prompted the replacing of registered nurses with non-regulated staff and/or families (Nelson & Gordon, 2006). Nelson and Gordon identify that “over the past decade or more economic changes in health care have overwhelmed nurses’ ability to compensate for declining resources” (p. 4). If there is limited time to do what needs to be done, then how might we create space to nurture the openness of unknowing? We must begin to ask the question: how can things be done differently?

Averill and Clements (2007) state that “dialectic thrives in an atmosphere that acknowledges differing perspectives but operates in openness and confidence that each may be given voice and a chance to be truly heard or read without penalty” (p. 395). The multiple ways of knowing in nursing could be perceived as a time consuming and iterative process of coming to know, which might be translated by funding agencies into- lacks efficiency. In addition, nurses are challenged to speak the language of business that is necessary to defend their position within an economic discourse.

We have revealed the existence of multiple power inequities concerning nursing practice. There are many barriers to nurturing the openness of not knowing. It is far easier just to practice in the status quo. How does a nurse enter into the paradigm of not knowing from an oppressive position within a patriarchal health care system that is positioned in a time of historical economic constraints?

Emerging Possibilities

As we have come to discover, Averill and Clements (2007) assert that it is in the

space of not knowing that authoritative knowledge is challenged. Ceci (2000) posits that hierarchical relations of power exist in our world and we can increase our understanding of authority by deconstructing our ways of knowing. Whereas, Munhall (1993) suggests that rather than discounting any one view as wrong, we look to reveal the intersection of how each person is in relationship with knowing. So how might we create space for not knowing?

Creating Space for Not Knowing

The trends indicate that unknowing is understood as a possibility. Similarly, Zander and Zander (2002) identify that “the frames our minds create define- and confine- what we perceive to be possible” (p. 14). They suggest that by opening your mind to the possibilities, you can shift your way of thinking to imagine the possibilities. Zander and Zander suggest beginning with the question, “What assumptions am I making, That I’m not aware I’m making, That gives me what I see?” (p. 15).

In challenging assumptions of what is understood as knowledge, we can arrive at a different place of understanding. In other words, what we think we know is always fluid. This is to suggest that at any moment in time, there exist multiple possibilities of meaning, and therefore the existence of multiple unknowns. Ceci and McIntyre (2001) suggest that dominant conceptualizations can be challenged by “developing a capacity to think differently, to expand our sense of the possibilities at play in any situation” (p. 123). In opening space to consider the epistemological positioning, ways of looking at the world can be transformed. This is to say that in contrast to living dominant discourse, new possibilities emerge.

Relationship with Knowledge

Ceci (2000) posits that our interpretations are shaped by our pre-existing theoretical commitments, biases, beliefs and assumptions. Ceci argues that the time has come to shift the focus from the kinds of knowledge within nursing to the relationship that we have with knowledge.

Understanding all knowledge as situated and people as situated as knower creates space to explore what influences and shapes our relationship with knowledge and thus our understandings (Ceci, 2000). Ceci states “what the world is, is what it is taken to be, and it is in this way that I would say there is no reality available to us that exists independently of the mind” (p. 62). In other words, in understanding how the world is available to us we begin to understand how we are within the world. It could be suggested that stakeholder position and investment influences the determination of what is valid knowledge. The question concerning how we do ‘not know’ is dependent on who is asking the question and in what context. In this lens, one can reconsider the value of the ongoing struggle to determine what knowledge is valid for nursing (Ceci). It could then be said that one’s un-knowing is influenced by one’s position as a knower. Through questioning one can work towards recognizing the boundaries of one’s knowing and can further challenge the interpretation of those boundaries to see a new beginning, a new level of understanding.

However, in this paradigm of possibilities lives unpredictability. As we have come to understand in exploring the barriers, the space of not knowing can be uncomfortable (Blom, 2009). This space of not knowing can be somewhat messy. Resisting a relationship with not knowing perpetuates the hierarchical binaries of, amongst many, certainty/uncertainty, known/unknown, and scientific/emotional. This is to suggest that polarities, truths, claims of knowing, etc. are all up for deconstruction.

In beginning to challenge my own assumptions concerning my relationship with knowledge and the meaning making experience, I begin to reveal the complexities and multiplicities of views. For example, Kurtz challenges our ongoing desire to make sense, identifying that “the compulsion to make sense is a resistance to unknowing” (cited in Munhall, 1993, p. 128). What does it mean to make sense, or make meaning intended on making new knowledge? I suggest the ideology that one can organize information so that it makes sense is powerfully embedded in our Western culture. If making sense is an intersect of various ways of knowing in context, how is context interpreted? For example, if a physician can explain a treatment plan so that it makes sense to the person with disease, how is the information provided biased and what are the implications of the bias? However, if one is not able to make sense then what might be the purpose of questioning?

Not Knowing in Practice

In this next section we will begin to unpack some clinical situations to see how not knowing might be lived in practice. We will start with an exploration of a palliative care case. Here we will briefly look at how not knowing is conceptualized in medicine. Then we will look to how the ideology that nurses know their clients might look different through the lens of not knowing. Finally we will look at how an expert nurse might ‘not know’.

Has Everything Been Done?

To further our conceptualizations of not knowing, let us explore an example from clinical practice. A person has been diagnosed with kidney cancer and has received the most up to date medical treatments that include chemotherapy and radiation. Two years post treatment the cancer has been identified on a follow up scan. After an assessment the primary oncologist breaks the news that everything that can be done has been done and the

person is registered with the palliative care program. There are many discourses operating here. Registration into the palliative program is determined by diagnosis and prognosis, which is concluded by the physician, who claims to have the expert knowledge. The socially constructed privileged position of medicine has a powerful influence on this person's life. Although the palliative care program will cover many of the financial costs associated with the care of the palliative phase of the disease, the categorizing of the person with the disease further contributes to a limited view of the person.

What the oncologist understands in the comment that 'everything has been done' is tied up in a particular point of view of the world, espousing the values and beliefs of the oncologist. A review of literature within medicine revealed the words "unexplained complaint" to describe an unknown. van Bokhoven, et al. (2009) describe an unexplained complaint as "those complaints for which a primary care physician, after clarifying the reason for the encounter, taking the patient's history, and performing a physical examination, is unable to establish a diagnosis" (p. 112). Similarly, Smith (2007), a family physician, views not knowing as an uncertainty, such as various possible diagnosis (or alternatives) of which a physician must choose the correct option. Smith describes not knowing as a burden for physicians. These descriptions of not knowing imply that an answer exists as an independent truth and the responsibility for identifying the truth (or diagnosis) is located with the physician. In this space, not knowing could be viewed as the physician not owning enough biomedical knowledge to conclude a diagnosis.

Alternatively, the palliative care scenario demonstrates a 'not knowing' attributed to the scientific community having not reached consensus, or hard evidence that supports the physician's practice to cure disease. In other words, medicine does not have an answer,

where 'answer' is understood as interchangeable with 'cure'.

Exploring the palliative care case through not knowing opens space to realize that many important questions may not have been asked. In living 'not knowing', one can explore the questions and presumptions around clients' views, what medicine can offer, what other needs/opportunities exist, and what is the context of the experience? Questions surface such as what knowledge is valued and what are the existing realities for the persons involved? What contextual factors are living here that influences the decisions (such as economic constraints or government drug regulations)? Ideologies such as; the client has choice, medicine contributes to good health, and a person holds responsibility for their health can be revealed and deconstructed.

In contrast to the uncritical acceptance of "the oncologist knows best" is the concept of not knowing where assumptions of knowing are deconstructed, keeping us creative and asking about the possibilities. The notion of not knowing can be explored to reach an understanding that although medicine does not have a cure, many possibilities continue to exist. The experience of the person with cancer can be unpacked, revealing the narrow view and the limited understanding of medicalization. Valued knowledge is understood as originating from persons who live within the world.

Fowler and Lee (2007) suggest that professionals need to attend to the intersection of the different "forms of knowledge and ways of knowing and coming to know" (p. 191). They claim that the differences, tensions, and struggles between professional knowledge and experiential knowledge need to be exposed. In privileging one kind of knowledge, such as empirical knowledge, one misses the opportunity to challenge the status quo and taken-for-granted ideas (Fowler & Lee). In other words, being open to the concept of not

knowing creates space for new knowledge.

Can Nurses Know Clients?

MacDonald's (2008) literature review of fourteen qualitative studies, found that knowing the patient is central to nursing. In my practice, nurses identify that in order to provide nursing care, they should know the client as a person. MacDonald's research supports that knowing the client facilitates the nurse to understand the meaning of health/illness to the client, identify the individual needs of the client, make more clinically relevant decisions about care, and contributes to a caring relationship. However, Munhall (1993) heeds warning when nurses claim to know the client. Rhetoric such as "I know how you are feeling" or "We have a good rapport" should prompt the nurse to proceed with full unknowingness rather than practice in the confidence of knowing (Munhall). Through the lens of practice dominated by knowing, a nurse risks "closure based on confidence in one's own interpretations" (Heath, 1998, p. 1056). In other words, the nurse draws conclusions about the client based on their own interpretation of the world, with all its preconceived sets of assumptions and biases. Munhall states "shared assumptions of reality, or conjunction, may: close further exploration, achieve the status of objective reality (when it might not be so), represent a shared defensive solution, represent a shared illusion or delusion, close off testing other alternatives, eliminate exploring origin of perception" (p. 127). Munhall stresses that in an attempt to reveal the inner individual perceptions of the client, it is urgent that we challenge perceptions of shared knowing. This is to say that in unknowing, the nurse lets go of preconceived notions that she/he knows what is best for the client. An acceptance that as nurses, we will never really know the client creates space for the client to be viewed as a 'knower' (Munhall). With the client as the 'knower' there are

shifts in power and relationships. The person experiencing the health care becomes the driver of their pursuit of health, however the person conceptualizes health.

On a personal level, I recently lost my mom to cancer. Upon her death some of the nurses at the hospice shared that they knew what I was feeling because they too had lost their parent. These nurses were operating under assumptions of shared knowing (Munhall, 1993). I suggest that the nurses' claims of knowing the experience of the death of a parent contributed to a confidence and a state of closure (Munhall). In contrast, if the nurse operated in an unknowing or not knowing way of knowing, then a space of openness could have been created.

I was particularly struck by Fowler and Lee's (2007) research on knowledge transfer. Fowler and Lee challenged the notion that knowledge can be transferred from one person to another. Using a case study, they shared the story of a public health nurse's (a lactation consultant) personal journey of initiating her own breast-feeding experience. They concluded that for knowledge to remain meaningful, rich, and relevant, it cannot be simply given to another, but must have a context and personal meaning. Fowler and Lee's research attends to the personal bias and prejudice of one nurse as she realized that her practice based on scientific evidence was more about research than the client's experience of knowing her baby. Fowler and Lee's research revealed the nurse's assumptions of shared knowing. They demonstrated that facilitated reflection could open space to expose nurses "confessions of not knowing" (p. 188). Their research points out the complexities of claims of knowing, highlighting the struggles between evidence based knowledge and knowing through experience.

How Might an Expert Nurse Not Know?

Remembering back to the opening scenario where the experienced nurses were confident in their ways of practice, there was no acknowledgement of limitations of pre-existing knowledge, resulting in no evidence of struggle to challenge their ways of practicing. What if the nurse misses the opportunity to deconstruct their ways of thinking, thereby missing the chance to make meaning of new knowledge? Heath (1998) posits that “while knowledge increases as expertise grows, a denial of unknowing and satisfaction with one’s own level of performance may be the most potent block to the development of expert practice” (p. 1057). In this location, as nurses gain confidence in their knowing, there is an increased potential for practice that is dominated by routine and coping. It could be said that certain ways of thinking become metanarratives and the practice becomes normalized (Mitchell, 1996). According to Mezirow unquestioned assumptions, or ways of being, can limit a person’s openness to change and personal/professional growth (Williams, 2001). That is to say “experience alone does not necessarily translate into learning” (Bruce, 2007, p. 422). On the other hand, Heath suggests that an experienced nurse, whose practice has become familiar, has the potential to focus and optimize new learning opportunities. We will build this understanding through exploring a case from practice.

Example from Practice

I recall observing an experienced nurse share her knowledge with a new nurse graduate. The experienced nurse found it difficult to articulate what she knew and how she came to ‘know’ what she knew. She used the phrase ‘not know’ to describe her inability to articulate what she ‘knew’. Although the new graduate appeared open to a broader meaning of ‘not knowing’, the experienced nurse claimed to own the knowledge, but rather

could not find a means to articulate her knowledge so that she would effectively communicate the knowledge. Dominant discourses may have influenced how the experienced nurse frames her 'knowing'. Such as the dominant discourse of biomedicine may have influenced the nurse to define and describe her knowledge empirically, discounting other ways of knowing, such as intuition or theory. Or the experienced nurse may "lack the means to express this type of knowledge" (Carr, 2005, p. 334). Carr suggests that there is a tendency to focus on and share the product of nursing as opposed to the process of nursing. A focus on product demonstrates a valuing of tasks versus the thinking. A view of thinking as work opens space for valuing the process of nursing (as opposed to the nursing process). Carper's work is one framework that could be used to honour and share different ways of knowing. I suggest that if one chooses to use Carper's work as a framework to share knowledge, one might consider including not knowing as a way of knowing.

Unknowing reveals an openness to negotiate the various understandings. The power inequity between the experienced nurse and the new graduate nurse was possibly evidenced by the experienced nurse's claims of 'knowing'. In the lens of unknowing, the nurses might have created space for each to listen to the other. In this space of openness lives the belief that there is no universal truth available to us (Fowler & Lee, 2007; Ceci, 2000). However, in contrast to claims of knowing, could the experienced nurse claim to 'not know' as a means of divorcing oneself from a responsibility or accountability?

Munhall (1993) warns that the process of learning from others can be problematic. Learning from others creates the potential for assumptions, biases, and taken for granted practice to go unchallenged, thereby limiting our interpretations and perceptions.

Determination of the utility of the knowledge may be biased, influenced by multiple discourses.

Nursing Curriculum

Nurses launch their careers as nursing students. Academia has a profound influence on the development of the nurses of the future. Young and Maxwell (2007) suggest that traditionally nursing educators have been viewed as the holders of knowledge and nursing students understood as passive learners. In my initial nursing training, some twenty-five years ago, it was simple- the purpose of questions was to locate an answer. Competition was underlying most situations, with the mark of judgment placed at a socially and politically constructed defined level of expert. If one stated, “I do not know” then they were viewed as lacking knowledge. Within a content-driven curriculum (based on the seminal work of Carper), faculty and peers frowned upon any form of not knowing. Nurses, faculty, and nursing students were expected to have an answer and if an answer was not readily available, then various coping strategies would be used, such as making it up. In other words, you were defined as ‘not a good nurse’ if you did not know the answer. I suggest this one reason that I am so moved by Laing’s poetry at the start of this paper. The expectation to use rote memory to own a range of knowledge, mostly within a quantitative scientific paradigm, supports a reductionist view of knowledge. When the concept of not knowing is limited to scientific paradigms, the solution seems to rest on identifying the knowledge deficit and moving towards locating the absolute truth. However, we must question if answers are always meaningful or generalizable.

The pace at which new information influences health care and nursing practice is staggering. The half-life of knowledge for nursing practice is short lived (Young &

Maxwell, 2007), thereby suggesting that we might not be so certain about what we believe is 'known'. I suggest not knowing contributes to lifelong thinking skills that support a learner's ability to construct knowledge.

Constructivism and Learning

Drawing on the work of philosopher Dewey, constructivism supports the tenet that teaching/learning is a contextually bound relational experience (Brown & Hartrick Doane, 2007). Teachers intentionally and thoughtfully facilitate learners to construct knowledge through a process of challenging existing ways of thinking and facilitating 'meaning making' of new understandings (Young & Maxwell, 2007; Diekelmann, 2001; Bevis & Watson, 2000). This approach to education is often described as student centered teaching. I see parallels to the ideology of client-centered care operating here, where nurses try to intentionally 'know' and understand the client's perspective. However, as mentioned earlier in the paper, similar risks may exist where there are assumptions that the teacher 'knows' the student.

Constructivism supports the tenet that the motivation for learning is pragmatic with the learner being the mediator of the learning process (Young, 2007). This is to say that learning is most likely to occur when the new knowledge is directly related to the learners' own lives. Starting from the position that the purpose of learning is to influence the way in which we live in the world, I hypothesize that if one does not intentionally question their way of being, the opportunity for learning is narrowed, minimized, or lost. In this view, creating cultures that embrace an openness and inquisitiveness supports an environment where people are facilitated to empower themselves to make sense of new information.

For example recently, in a clinical practice setting, I observed a small group of

intentional learners work through a facilitated learning activity. Here, working in small groups, learners were required to integrate some new information with their current understanding of a concept and then present their conclusions to the larger group. The learners identified that they experienced an uncomfortable time when they did 'not know', but it was in that discomfort of not knowing that they found the greatest learning experience. In practice, supporting 'not knowing' can create space for nurses to discover and learn in everyday practice.

As we have come to understand, the process of not knowing can be uncomfortable. Many nurses, such as myself, were trained in nursing within conventional 'sage on the stage' environments. Further, as we have explored, the contextual influences on nursing practice pressures nurses to claim ownership of knowing. In other words, there are many reasons why the concept of not knowing may be resisted within health care and nursing.

Space for Research

In the space of 'not knowing' the concept of always asking the questions is valued. The possibility for creative and innovative practice is in contrast to the traditional authoritative and often predictable ways of learning and being in practice. I posit that the concept of not knowing or unknowing, as a way of knowing, has received insufficient attention. There is space in nursing research for more attention to the view that as nurses we need not be so certain about what we believe is 'known'. Research aimed at understanding the experience of not knowing is called for.

Conclusion

This literature review validates the need for further examination of not knowing in practice. In this paper, we have begun to understand that we do not always 'know'. Further,

I have suggested that any claims of knowing support reductionist epistemological and ontological views.

In not knowing, one may intentionally escape the confines of what is known and what is comfortable. In this space there is less focus on the linear dichotomies of knowing and not knowing. Space is created for fluidity between what is known and understood, and the unknown. Knowledge is understood as partial, and a sense of curiosity and discovery is cultivated. In other words, we can choose to nourish the openness of the unknown and the unknowing can be the driver to exploration.

This paper has created space for many questions concerning the certainty in nursing practice. I posit that the concept of not knowing or unknowing, as a way of knowing, has received insufficient attention. Research aimed at understanding not knowing in nursing is called for. I conclude this paper with the question: How is it that experienced nurses engage with (or articulate) not knowing in practice? From this question I would hope to gain an understanding of how nurses come to arrive with a new way of knowing, including how they work within the unknowns in practice? It is my hope that the project recommendations for further research can be actualized in practice.

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