Theory from practice for practice: is this a reality?

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INTRODUCTION

Dickoff & James (1968) assert that theory comes from practice for practice, however, in reality does theory building come from practice or should it remain with academics? In order to consider this contentious issue, the reasons why theory is needed for nursing will be analysed. These reasons will need to be considered in the context of their relationship to the nature of nursing knowledge and the development of theory in nursing. During these discussions the underpinning philosophy of science and its relationship to nursing can also be analysed. In the light of this, theory which comes from practice for practice can then be defined and its development by practitioners or academics debated.

THE NATURE OF NURSING KNOWLEDGE AND THE PHILOSOPHY OF SCIENCE

Carper (1978) identifies four patterns of knowledge. Firstly, empirics, which is linked to the science of nursing, secondly, aesthetics, which is linked to the art of nursing, thirdly, personal knowledge, and finally moral knowledge, which has its links within ethical decision making (Carper 1978). Within nursing all these domains of knowledge are used (Carper 1978), but it will be seen that some have more credence and value within nursing than others. In order to appreciate this difference in value, the roots of nursing knowledge must be examined. Cull-Wilby & Pepin (1987) review this history of nursing knowledge or epistemology, and through their discussion provide nurses with a clear insight into the recent ‘surge in its development’ (Cull-Wilby & Pepin 1987). Peplau (1987) and Meleis (1991) begin a historical review with the contribution that Florence Nightingale made to nursing knowledge. Florence Nightingale advocated that nursing had its own knowledge base, but did nothing to stem the rapid development of a knowledge base for nursing that bore its roots amongst what Carper (1978) coins the logical empiricists.

Logical empiricism is woven in terms such as measurement, tests, scientific hypotheses and control, nurse researchers using this philosophy attempt to define the truth, using a reductionist approach (Cull-Wilby & Pepin 1987). Popper (1989) and McCaughey (1992) criticize this reductionist approach, which attempts to manipulate the complex nature of the world into theory. Visintainer (1986) likens theories to maps and eloquently explains the problems associated with this approach, maps invented in the laboratory may need adjustment when applying them into the complex world of nursing practice.
New nursing pathway

Nursing has been drawn to towards this paradigm in an attempt 'to appear scientific' (Robinson 1993) and this is nursing's inheritance today (Gray & Pratt 1991). In today's health care arena nurses are developing their practice along the 'new nursing' pathway, encompassing a holistic approach to caring (Salvage 1990). New nursing is in conflict with the reductionist approach. Consequently, nursing is re-exploring its boundaries (Wright 1991) and moving away from the traditions of medical science, which are based within empiricism, to a 'professionalizing ideology for nursing', which fits with this holistic and individualistic view (Bond 1993).

Parallel with this development is the call for nursing to expand its own knowledge base rather than rely on borrowed theories from other disciplines, which can be problematic when they are applied to nursing (Chenitz 1984).

As a result of the drive towards holism, the move to expand nursing knowledge, and the dissatisfaction of many nurses with this approach, there was a move towards historicism or organicism (Fawcett 1984, Reed & Procter 1993). Historicism can be likened to Carper's (1978) pattern of knowledge, aesthetics, which has been described as the art of nursing, in contrast to empiricism, which is defined as the science of nursing. Within this paradigm, theory is developed during a process of understanding behaviour and considering the effects of this behaviour (Salvage 1990). Research approaches based in historicism are descriptive and phenomenological, compared to those of empiricism, which are experimental (Draper 1990).

Bond (1993) feels that there is currently more support for historicism within nursing. Moreover, the recently published report of the Taskforce on the Strategy for Research in Nursing, Midwifery and Health Visiting (Department of Health 1993) states that research training should be focused towards as qualitative as well as quantitative methods. Nursing in this scenario could have a future in both paradigms.

Alternative method

An alternative method for knowledge development in nursing (Cull-Wilby & Pepin 1987) is critical theory, which emerged after concern was expressed about the shortcomings of both the positivist and interpretative approaches to social science (Carr & Kemmis 1990). What was missing from these approaches was the direct link to practice, which critical theory encompasses, and knowledge gained in this way is the 'outcome of human activity' (Carr & Kemmis 1990). As such, this provides knowledge which has meaning for practice. Silva & Rothbart (1984) discuss these trends within the contrasting philosophies of science and conclude that nursing theory is currently 'experiencing shifts in its evolution'.

Another shift is the move towards what Reed & Procter (1993) label as 'radical academia', in which academics embrace practice experiences attempting to raise the profile of this practice knowledge. The popularity of Benner's (1984) work is an example of this. This is similar to what Schon (1987) calls technical rationality, which is the development of theories by theorists and researchers which is then applied to practice. However, one of the drawbacks of technical rationality and radical academia is that they are not developed by practitioners who are embedded in the practice situation and who therefore have a deeper awareness of the practice experiences. But are they prepared to undertake this role?

WHAT IS THE PURPOSE OF THEORY?

A theory is 'a statement that purports to account for or characterize some phenomena' (Stevens 1984). Botha (1989) suggests that theories 'provide ways of thinking about and looking at the world around us'. Moody (1990) sees theory as 'the systematic abstraction of reality that serves a goal or purpose'. Thus Botha (1989) and Moody (1990) agree that theory should be a true reflection of the world around, but is this achievable?

What is the goal or purpose that Moody (1990) suggests theory should have? Draper (1990) asserts that the generation of theory has several functions, to define nursing broadly, to aid curriculum design, to enhance professional nursing practice, and to form the basis for a language through which nurses can communicate. Walker & Avant (1988) optimistically state that theories advance nursing practice, and indeed the central belief which underpins theory building is that it exists to improve nursing practice by providing a rationale for nurses' actions (Marriner 1986). Manley (1991) sums up all these functions by stating that theory is one method for generating knowledge, providing maps to guide the way (Visintainer 1986).

So why do nurses want to develop these maps or theories? To enhance patient care is the natural retort. Ingram (1991) suggests, but then he sceptically suggests that it is also to satisfy nursing's desire to achieve academic satisfaction.

This comment can be understood given the history of the development of nursing knowledge, which shows that nursing was drawn to logical empiricism out of the need to be academically credible. With these conflicts in mind, the scope of theory development needs to be considered.

The scope of nursing theory

Dickoff & James (1968) propose that there are four levels of theory classified according to their scope and depth.
Firstly meta theory, which focuses on broad issues particularly related to theory in nursing. Recent examples of this are Botha (1989) and Shaw (1993).

Secondly grand theories, which give some 'broad perspective to the goals and structure of nursing practice' (Walker & Avant 1988). They include conceptual models such as Orem's (1971). Ellis (1968) argues that grand theories, as they are broad in scope, will lead to a greater significance for nursing. However, to return to Visintainer’s (1986) analogy of theories as maps, maps can leave out information that individuals in different contexts may find relevant. How can grand theories, with their abstractness and generality, lead to understanding within every context of nursing?

Thirdly there are middle range theories, which are limited in scope and variables. Concept analysis is often suggested as a method to develop middle range theories (Walker & Avant 1988).

Finally, there is practice theory, which will be compared with the other levels of theory.

**Practice theory**

Practice theory has been defined by Jacox (1974) as a theory that says given this nursing goal (producing some desired change or effect in the patient's condition) these are the actions the nurse must take to meet the goal (produce the change).

These are theories which come from clinical practice, their purpose is to explain a specific nursing practice (Meleis 1991). Practice theory is also what Dickoff et al (1968) define as a situation-producing theory. The purpose of this situation-producing theory is to 'guide action to the production of reality' (Dickoff & James 1968). In order to guide action, practice theory therefore must have a goal, directive for action and a survey list (Dickoff & James 1968). In this way practice theory is constructed to focus on a specific nursing problem, the examples Ramprogus (1992) uses are pain and sleeplessness. Others could be urinary tract infection or wound healing.

Dickoff & James (1968) and Jacox (1974) are widely regarded as the proponents of practice theory, the basis of their argument focusing on nursing practice being seen as the ideal situation for practice theory development. Ashworth & Longmate (1993) suggest that theorizing from practice involves analysing specific issues that come from practice and formulating theory from them with the aim of understanding them better. Practice theory is indeed theory which comes from practice for practice (Dickoff & James 1968).

There is, however, some contentious debate about the use of this term practice theory within theory development. Walker (1971) explains that practice theory can be seen as a set of principles or directives for practice, and sees practice as having a role in testing theories but not generating them. These principles that Walker (1971) discusses are not part of nursing theory and are nursing practices (Walker & Avant 1988). What is missing from nursing practices are the goal and the survey list, and it is these elements that distinguish practice theory from nursing practices.

However, perhaps these comments reflect nursing's historical nervousness of considering the practice of nursing as appropriate for theory development and are bound up with its past leaning towards empiricism. Beckstrand (1978) sums this scepticism up by stating that there is no need for practice theory, as nursing meets its needs for knowledge from scientific knowledge and logic (cited by Meleis 1991). Given the history of nursing knowledge, already debated, this viewpoint can be understood.

**Supporters of practice theory**

So why is practice theory needed in nursing? Supporters of practice theory argue that it allows for an in-depth analysis of a particular nursing practice and this narrow subject matter increases its utility (Jacox 1974). Relevance for nursing is increased, as opposed to grand theories which have been labelled as having little direct relevance for nursing practice.

Despite this, Ellis (1968) sees grand theories as leading to greater significance for nursing because of their breadth. Stevens (1984) continues the arguments against middle range theories, stating that if theories are developed to 'create boundaries for nursing and shared viewpoints amongst nurses in diverse activities or settings', then grand theories are the only type needed. However, this would result in theories that are 'so all inclusive and so abstract that in trying to explain everything they explain nothing' (Miller 1985), attempting to answer all the questions of life itself. Kitson (1985) Jacox (1974) concludes that nursing cannot achieve its own grand theory. Clarke (1986) agrees, stating that mid-range theories may appeal more to practitioners as they can be easily applied and understood.

Practice theory has only recently been used by nurses to theorize (Pearson 1992). It has, however, been heralded as a means to ensure the survival of nursing, since it integrates theory into nursing practice (Craig 1980).

It has been seen that the main advantage of practice theory is that it is based in the real world in which the problem is identified, whereas grand theories view nursing in the ideal world. This separation of the ideal and real in nursing theory has been suggested as one of the causes of the theory–practice gap (Miller 1985).

**THE THEORY–PRACTICE GAP**

One reason for the theory–practice gap is that in the 'ideal' world of nursing theory, nursing practice is discussed as being performed as it 'ought to be' (Ramprogus 1992). Stevens (1984) states that this 'ideal' view of nursing
theory has little relevance in health care today, and will only serve to fuel the battle between theory and practice (Miller 1985). Nursing will continue to be in conflict between its life as a 'practice profession and its life as an academic discipline' (Visintainer 1986). If academics and practitioners cannot reduce this divide and communicate their ideas, then the future of nursing is at risk.

Nursing theory and practice in this situation are viewed as two separate nursing activities, with theorists, seen as those who write and teach about the ideal, separate from those who implement care in reality (Lindsay 1990). Even more depressing is the view that theory is anything that is taught in the classroom and practice is what is done on the wards (McCaugherty 1991). Other authors believe that 'theory cannot capture all that is present in practical knowledge' (McCaugherty 1992). Perhaps practice theory would be the nearest nursing could get to capturing this knowledge embedded in practice.

Apart from the separation between the ideal and reality in nursing theory development, what else causes this theory–practice gap?

**Language**

Miller (1985) discussed the separation between nursing theory and nursing practice, and suggests that one of the causative factors is the language of theory, which is divergent from the language of practice. Adams (1991) eloquently calls this the 'language of the priesthood'. If practitioners were to develop practice theory, then this would not become an issue since the language used would be understandable to all.

Practice theory would also enable practitioners to value their personal and practical knowledge and make this knowledge available to others (Pearson 1992), as the practice theorist has no illusions about what nursing actually is. If, as Dickoff & James (1968) suggest, practice theory is the future for nursing's development of theory, then could it also help to reduce the so-called theory–practice gap by developing theories based in reality and which focus on problems encountered by practitioners?

But if practice theory is seen to be one way of reducing the theory–practice gap, then who should develop it? Should the developers be the practitioners or academics? If, as it has been argued, practitioners are in the ideal situation to develop practice theory, since they are closer to the practice situation, what are the possible barriers to them developing practice theory? Indeed, could academics become closer to clinical practice to enable them also to develop practice theory?

**PRACTITIONERS OR ACADEMICS DEVELOPING PRACTICE THEORY?**

In the past theory was thought to be 'best guided by members of its own discipline in academic settings', mirroring the focus on historicism and the move towards achieving professionalism (Moody 1990). Practitioners wanting to undertake this role within theory development are therefore fighting against the history of nursing theory development, which has come mainly from nursing theorists and academics and which is 'tinged with the mantle of elitism' (Bond 1993). This inheritance has meant that practitioners do not see themselves as theorists (Ramprogus 1992), they only implement theories which they have not been involved in developing (Rolfe 1993).

For practitioners to see themselves as having this wealth of knowledge embedded in practice, they need an awareness of practice theory itself and the research methods used to develop this. Practice theory needs to be sold to practitioners, who need to see the possible benefits of it for their clients and nursing.

However, this selling concept conflicts with the values inherent in a nursing culture, as marketing is often seen as unethical (Norkett 1985, Sheaff 1991). Also, there may be concerns that the promotion of practice theory is to develop nursing's academic standing further, as discussed, rather than improve nursing care. This can also be viewed as unethical. If practitioners could see themselves as theorists, would they then have the skills to develop practice theory? Indeed, can practitioners fully function within nursing today?

Pearson (1992) considers why this situation has developed, stating that he is battling, as many nurses are, against a nursing past which has the emphasis on doing and concrete thinking, without attempting to be scholarly. Even if practitioners have recognized that they have this ability, they may not have been able to articulate this knowledge in an acceptable academic style (Reed & Procter 1993).

The revolution in nurse education is aiming to produce 'knowledgeable doers' (UKCC 1986). Will these knowledgeable doers see things differently and have the skills and knowledge necessary to develop practice theory? McCaugherty (1992) is optimistic and sees the knowledgeable doer as being able to integrate theory and practice in a balanced way, having the skills to be able to do this. Benner (1984) agrees that expert nurses have the ability to develop knowledge and have a 'wealth of untapped knowledge'. Stevens (1984) agrees that any nurse who is defined as being 'fully functioning' has the ability to theorize from experiences in practice.

**Graduate nurses**

Certainly graduate nurses, who are academically prepared to undertake the development of theory, are staying in
practice rather than moving into education or management (Smith 1993) and are therefore in the ideal environment to undertake this type of theory development. Given the obvious advantages of developing practice theory, how can practitioners who have been ‘sold’ the idea be facilitated to develop this?

Reflection has been suggested as one method that can be used by practitioners to develop their tacit knowledge (Schön 1987, Powell 1989, Ashworth & Longmate 1993). Polyani (1958) defines this as knowledge coming from practice, in contrast with explicit knowledge that comes from words or symbols. Kolb’s (1984) learning cycle links the process of thinking and doing to achieve tacit knowledge through this process of reflection. This reflection is seen as a way to bring the lowlands of practice towards the high ground of research (Schön 1987), thus reducing the theory–practice gap.

Gray & Forsstrom (1991) describe how they used the process of reflection in an attempt to tap this knowledge and generate practice theory. They conclude that they have not yet met their aim, but demonstrate clearly the richness of data that can be obtained from practice.

This example of practice theory development is written by educationalists. But, are practitioners ready and able to take on this function of developing practice theory through reflection? Schön (1987) states that one of the identifying features of the experienced practitioner is that they are able to reflect-in-action. However, in Powell’s (1989) study the opportunities for learning from practice were not always recognized by the nurses. Perhaps this is due to the original argument, that practitioners do not see themselves as theorists and do not see the value of the data that they are exposed to in practice itself (Ramprogus 1992).

**Facilitating reflection**

However, to undertake reflection time and a safe environment are needed (Saylor 1990). It must be asked if the environment within healthcare today is safe enough to facilitate this process. Farmer (1991) cautions that Benner’s (1984) work needs to be carefully implemented and hints that in the present political climate the use of this approach to theory building must be carefully considered. Again perhaps this is a reflection on nursing’s inheritance built on empiricism. However, if risks are not taken then nursing theory and knowledge will not develop further.

Jarvis (1992) agrees that the structures are not in place yet to enable reflection to take place; consequently the theory–practice gap has not yet been closed. Jarvis (1992) particularly emphasizes that time must be spent training nurses to undertake reflection. Johns & Butcher (1993) and Johns (1993) clearly demonstrate the time needed to supervise a practitioner who is using reflection. As well as time it takes ‘patience and diligence’ to reflect, and it can be a painful experience (Bolt 1991). Meleis (1991) and Farmer (1991) conclude that there must be the resources to develop practice theory, including time and support.

An alternative strategy for the development of practice theory is to bring practitioners and educationalists/theorists together within the practice setting. Bringing researchers and practitioners together will reduce the inaccessibility of theories to practice (Phillips 1989).

One method of bringing researchers and clinicians closer together in the practice setting is within an action research methodology (Gray & Pratt 1991) which is grounded in critical social theory (Carr & Kemmis 1990). This methodology also takes time (Webb 1989), but joining together using such a collaborative approach could close the separation which Clarke (1986) identifies between theoretical and practical nurses, and could enhance the development of practice theory.

**WHO SHOULD DEVELOP PRACTICE THEORY?**

Practice theory has been shown to have benefits for nursing practice and the development of nursing knowledge. Its development is in its infancy and the body of knowledge that is developed through practice theory has been likened to a delicate plant (Reed & Procter 1993). Using Reed & Procter’s (1993) analogy, the plant’s roots are firmly embedded in practice and this should make it stronger to withstand the winds and demands of the changing health care arena.

Whether practitioners are ready and able to take on the role of developing practice theory has been considered. It has been seen that practitioners do not often recognize the potential for theory development in practice, and indeed do not view themselves as theorists. Again perhaps this is the legacy of the past, with nursing’s emphasis on empiricism and ‘doing’ rather than undertaking scholarly activity.

**Action research**

If practice theory can be sold to practitioners, resources such as time and support are needed for reflection to develop practice theory. Action research is also discussed as a mechanism for bringing researchers and practitioners closer together to develop practice theory. It has been seen that practitioners have access to a wealth of knowledge that can be developed into practice theory through the process of reflection. However, until they are sold its benefits and have had the opportunity to develop appropriate skills, nursing must also be sure that the ‘methodologically rigorous baby is not thrown out with the positivist bathwater’ (Bond 1993) and theory development should be encouraged along the continuum (Stevens 1984).
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