

Framing learning through reflection within Carper's fundamental ways of knowing in nursing

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Carper's fundamental ways of knowing have been utilized as a framework for the practitioner to consider what he or she has learnt through reflection on experience. The purpose of this paper is to consider, through an interpretation of Carper's writings and through analysing one practitioner's experience shared in a supervision milieu, whether this use of Carper's work can be reasonably justified on a theoretical and practical level

INTRODUCTION

Reflective practice is attracting considerable interest within nursing education and practice. The essential purpose of reflective practice is to enable the practitioner to access, understand and learn through, his or her lived experiences and, as a consequence, to take congruent action towards developing increasing effectiveness within the context of what is understood as desirable practice.

To help the practitioner access the breadth and depth of reflection on experience, a model of structured reflection has been constructed (Table 1) through a constant process of analysing supervision dialogue within guided reflection relationships (Johns 1993a, 1994). Such a model can only be offered as an heuristic tool. By 'heuristic' I mean that the intention of the model is to provide a framework for this activity, whilst simultaneously enabling the practitioner to transcend the model to reflective in response to the unfolding situations that present within everyday practice. The essential nature of learning through experience is reflexivity. By this I refer to how the practitioner assimilates learning through reflection with existing personal knowledge, i.e. the embodied knowledge the practitioner has available to respond to clinical situations. As a consequence, the practitioner responds to new situations within

a changed perspective. This change can be visualized through comparing and analysing the practitioner's reflected experiences over time.

Within this process, contradictions between desirable work and actual practice are made visible and become a focus for action to resolve them. However taking appropriate action may be difficult because of specific social norms or barriers (Mezirow 1981) that are embodied within the practitioner and embedded within the fabric of the work environment. Indeed the practitioner may feel powerless to take necessary action. It is in this sense that the practitioner needs both challenge and support, to confront practice as exposed through reflection on experience.

Hence learning to become an effective practitioner is not simply a question of skill acquisition. It involves a process of personal deconstruction and reconstruction in dealing with these issues. Essentially, learning through reflection is a process of enlightenment, empowerment, and emancipation (Fay 1987). 'Enlightenment' is to understand 'who I am' in the context of defining and understanding my practice, 'empowerment' is to have the courage and commitment to take necessary action to change 'who I am', and 'emancipation' is to liberate myself from previous ways of being to become 'who I need to be', as necessary to achieve effective desirable practice.

Table 1 A model of structured reflection (10th version)

Write a description of the experience	
Cue questions	
Aesthetics	<p>What was I trying to achieve? Why did I respond as I did? What were the consequences of that for the patient? others? myself? How was this person feeling? (Or these persons?) How did I know this?</p>
Personal	<p>How did I feel in this situation? What internal factors were influencing me?</p>
Ethics	<p>How did my actions match with my beliefs? What factors made me act in incongruent ways?</p>
Empirics	<p>What knowledge did or should have informed me?</p>
Reflexivity	<p>How does this connect with previous experiences? Could I handle this better in similar situations? What would be the consequences of alternative actions for the patient? others? myself? How do I now feel about this experience? Can I support myself and others better as a consequence? Has this changed my ways of knowing?</p>

CARPER'S WAYS OF KNOWING

The work of Barbara Carper (1978) has been utilized to set learning through reflection in a context. The assumption is that knowing within all experience can be framed within the discrete yet interdependent ways of knowing explicated by Carper: the empirical, ethical, personal, and aesthetic ways of knowing. This offers a widely acclaimed and useful way to help people make sense of their practice worlds and to perceive the dimensions of their personal knowledge (Chinn & Kramer 1991, Vaughan 1992). Boykin & Schoenhofer (1991) note how 'Carper's four patterns of knowing provide pathways through which the fullness of the nursing situation can be known'.

Hence, the model of structured reflection (Table 1) offers a set of cue questions to tune the practitioner into each of Carper's four ways of knowing within a reflexive and temporal context.

The validity of using Carper's fundamental ways of knowing to frame learning through reflection becomes evident through analysis of Carper's beliefs. She notes that (Carper 1978)

if the goals of nursing are to be more than conformance to unexamined norms, if the ought is not to be determined simply on the basis of what is possible, then the obligation to care for another human being involves becoming a certain sort of person and not merely doing certain kinds of things. If the design of nursing care is to be more than habitual—the capacity to perceive and interpret the subjective experiences of others and to imaginatively project the effects of nursing actions on their lives becomes a necessary skill.

The model of structured reflection is a framework for challenging 'unexamined norms' and 'habitual' practice, for 'interpret[ing] the subjective experiences', for 'project[ing] the effects of nursing actions', and for 'becoming a certain sort of person' as espoused by Carper. The quotation above is laden with Carper's beliefs about the nature of nursing, it is steeped in humanistic values that exemplify the role of the nurse as working with the patient in unique and responsive ways. The outcomes of nursing action are clearly dependent on the sort of person the practitioner is and hence, reflection always aims to develop the self to be used more effectively within the person's practice.

If Carper's ways of knowing do represent the complexity of knowing within experience then it is obvious that they need to be clearly understood by practitioners.

Empirical knowing

Carper (1978) notes the 'urgency regarding the development of a body of empirical knowledge specific to nursing'. She refers to

empirical knowledge as synonymous with positivist science — as 'knowledge that is systematically organized into general laws and theories for the purpose of describing, explaining and predicting phenomena of special concern to the discipline of nursing'.

Since publication of the Briggs Report (Department of Health and Social Security 1972), there has been a widely accepted sense of urgency that nursing practice should be grounded in such empirical understanding. Although Carper is not referring to Briggs, she does note however how

one is almost led to believe that the only valid and reliable knowledge is that which is empirical, factual, objectively descriptive and generalizable.

The appropriateness of knowledge developed in relation to the natural sciences for the human science of nursing has attracted widespread debate, and is not a point at issue here. However, it is noted that for such knowledge to be used meaningfully by the reflective practitioner, within the context of a humanistic nursing philosophy, it must always be interpreted within the context of a specific clinical situation and, in the process of assimilation into the

practitioner's personal knowledge, it is transcended. In other words, empirics cannot stand before practice in order to dictate its outcomes (Van Manen 1990). A reflective science reduces the status of empirics to its proper place of informing aesthetics and reduces the (false) dichotomy of science and art to dialectical patterns within experience itself, for example the dialectic between the values of the self and the values of others. These dialectics emerge through reflection as the contradictions apparent between intended action and actual practice.

Aesthetics

This way of knowing directly contrasts with the type of knowing envisaged as empirical. An aesthetic action is concerned with the practitioner's response to a particular clinical situation. Whereas empirics encourages the practitioner to stereotype the situation according to some rule or law that predicts an outcome, aesthetic knowing involves a process of perceiving or grasping the nature of a clinical situation, interpreting this information in order to understand its meaning for those involved, whilst envisioning desired outcomes in order to respond with appropriate and skilled action, and subsequently reflecting on whether the outcomes were effectively achieved (Figure 1).

The practitioner never responds in exactly the same way as to a previously experienced similar situation, not least because of learning through previous similar experiences, even though this may not have been consciously reflected on.

Grasping and interpretation

Carper notes how

the art of nursing involves the active transformation of the patient's behaviour into a perception of what is significant within it — that is, what need is being expressed by the behaviour

Whilst Carper recognizes empathy as the core skill necessary for this 'interpretation' of the clinical situation, I believe a more accurate description of this core skill is intuition. The intuitive grasp of and response to a clinical situation by their very nature are not easily articulated or

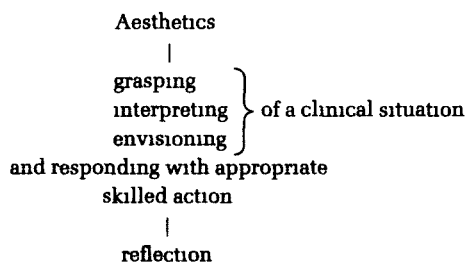


Figure 1 The nature of aesthetics

explained. Intuition is based on an understanding of the situation as perceived, never on a blind or wild guess (Benner 1984). Benner's work, using the Dreyfus model of skill acquisition, is important in recognizing how skilled practitioners transcend linear process models in perceiving situations and making decisions.

Envisioning and responding

Drawing on Orem (1980) Carper notes how

the art of nursing is creative in that it requires development of the ability to envision valid modes of helping in relation to results which are appropriate.

An appropriate and skilled response involves the ability to accurately envision the desired and practical outcomes of intervention. Indeed the 'goal' element within the nursing process recognizes the need for this clear focus. Whilst this may be achievable to some extent with particular technical aspects of caring, it becomes problematic with situations grounded in psychological areas of care requiring significant personal involvement of the practitioner and ethical deliberation (Seedhouse 1988). Envisioning may only truly be possible within the actual situation.

The process of responding within aesthetics is therefore based on an interpretation of the whole situation and an analysis of the interdependence of the parts within the latter. In some human caring situations this process may be more deliberative, for example responding to an area of redness on the sacrum of an unconscious patient. The envisioned outcome and appropriate response are probably fairly straightforward. Contrast this with the more emotional response of the nurse to a distressed and tearful woman who has been told she can no longer manage safely in her own home. In this situation the envisioned outcome and hence the appropriate response is likely to be less easy to gauge.

The aesthetic response is similar to Polanyi's (1962, Street 1992) concept of 'connoisseurship', in that he considers qualitative judgements to be based on a perceptual, intuitive grasp of the whole situation, which can never be reduced to sets of rules to be technically applied in the situation. This understanding supports Carper's claim that the practitioner's response to a clinical situation is made as a response to the whole situation as it is perceived and interpreted.

Mastery

Carper notes how

the design, if it is to be aesthetic, must be controlled by the perception of balance, rhythm, proportion of unity of what is done in relation to the dynamic integration and articulation of the whole.

It is the whole's quality of unity that gives it its holistic dimension. Whilst it can be observed and sensed, it is not

easy to articulate the nature of mastery Schön (1983) notes that

when we go about the spontaneous intuitive performance of the actions of everyday life, we show ourselves to be knowledgeable in a certain way. Often we cannot say what it is that we know. When we try to describe it we find ourselves at a loss, or we produce descriptions that are obviously inappropriate. Our knowing is ordinary, tacit, implicit within our patterns of action with which we are dealing. It seems right to say that our knowing is in our doing.

Although this mastery cannot be easily articulated, that does not detract from its observed reality, or deny the profound knowledge which must be embodied in the practitioner to achieve it. As one begins to reflect on these rhythms of action they emerge as visible and significant and can begin to take shape in language (Chinn & Kramer 1991).

The personal way of knowing

It is necessary to make the distinction between the personal way of knowing and personal knowledge. Personal knowledge is the total knowledge the practitioner uses to practise, whereas, Carper describes 'the personal' as being 'concerned with the knowing, encountering, and actualizing of the concrete, individual self'.

The aesthetic response is always influenced by the person of the practitioner and the degree to which, in the human encounter with the patient, the practitioner is prepared to be engaged. The empiric stance encourages the practitioner to be dispassionate or detached, objective, rational or 'clinical'. Yet this encouragement denies the fundamental notion of involvement that is always a requisite with human caring for another person. Hall (1964) notes how 'the nurse needs to learn who she is so that her own concerns will not interfere with the patient's exploration of his concerns'.

This can be interpreted as the 'knowing of self' within the context of the clinical situation in order to achieve an effective therapeutic response. The knowing of self involves three inter-related factors

- 1 the perception of the self's feelings and prejudices within the situation,
- 2 the management of the self's feelings and prejudices in order to respond appropriately,
- 3 managing anxiety and sustaining the self

I have described elsewhere how these factors impinge on the aesthetic response (Johns 1993b). This personal way of knowing is necessary to 'be connected' within the situation. This is particularly true in situations where feelings or prejudices may be negative towards others and block or limit the practitioner's therapeutic response.

This does not mean the practitioner can suspend or

bracket her or his feelings and prejudices. The point that somehow practitioners can be objective or rational within the situation is a fallacy of positivist thought. It is an absurd notion because who we are must necessarily influence the way we respond. To think otherwise is a form of self-delusion that involves some form of self-denial and ultimately self-alienation (Jourard 1971).

It is nursing legend that practitioners need to 'protect' themselves from the anxiety and stress of involving themselves in intimate relationships within caring ones. Of course, failure to become involved means the relationship is not a caring relationship in the sense of being concerned for someone and connecting with them. Benner & Wrubel (1989) have drawn attention to the fallacy that caring is the sickness that causes burnout, where in fact the real sickness is the lack of caring within systems that fail to develop and sustain caring practices.

McHaffie (1992), drawing on Lazarus & Folkman (1984), implies the value of reflection when noting that

in order to understand coping it is essential to be specific to describe concretely what people think and do to cope with harm or threats in their lives. It is not enough to ask what the individual would do in a specific situation, one must ask what the individual actually does, or thinks, or feels.

Clearly the practitioner has to learn to cope with caring in such ways that caring can be sustained. Failure to achieve this will tend to result in limited engagement or withdrawal from the patient in order to survive. The cue questions within the model of structured reflection (Table 1) begin to encourage the practitioner to pay attention to who he or she is and to the impact of his or her own feelings in the context of the presenting clinical situation.

The ethical way of knowing

I have interpreted this as knowing what is right or wrong and being committed to take action on this basis. Within all experience the ethical dimensions become manifest through reflection in ethical narratives (Benner 1991) and stories (Parker 1990, Johns 1993b). The significance of reflection in this dimension is captured by Benner (1991), who states that 'To examine what is worth being and preserving, one must study everyday expertise and narratives embedded in the practice of communities'.

It is only through reflection that this embedded expertise becomes apparent. To act ethically is a process of deliberation within the specific situation. It is not possible to merely adhere to or apply ethical principles. As with empirical knowledge, ethical principles serve only to inform the situation. There is always a tension between traditional ethical principles and situational ethics (Cooper 1991). In determining appropriate ethical action, the practitioner must always pay attention to conflicts of

values within her/himself and between her/himself and others

The ethical dimensions can be characterized by a series of conflicts in a way that offers empirical support to the significance of ethical knowing within all experience (Table 2). The potential consequences of these conflicts are a significant determinant of possible aesthetic response

Inter-relatedness

Carper (1978) described the above ways of knowing as discrete but inter-related. However, reflection on their use in practice indicates that the aesthetic way of knowing is the core way of knowing in practice, informed by the empirical, the personal and the ethical dimensions of practice (Figure 2). Carper's recognition and explication of the aesthetic, personal and ethical ways of knowing emerge, to put the value and dominance of empirical knowledge into perspective.

The aesthetic response should involve the practitioner in interpreting any relevant empirical knowledge to fit the situation, rather than fitting the situation to some such theory or research finding. Just because a theory is shown to be significant in some objective and universal way it can never be assumed that it will neatly represent the

Table 2 Classification of situational ethics based on levels of conflicting values within experience (developed from Johns 1993b)

First level	Situations of conflicting values within the nurse
Second level	Situations of conflicting values between the nurse and the patient which subsumes Situations of conflicting values within the patient Situations of conflicting values between the patient and 'family'
Third level	Situations of conflicting values between the nurse and other nurses/healthcare workers/organizational context of practice

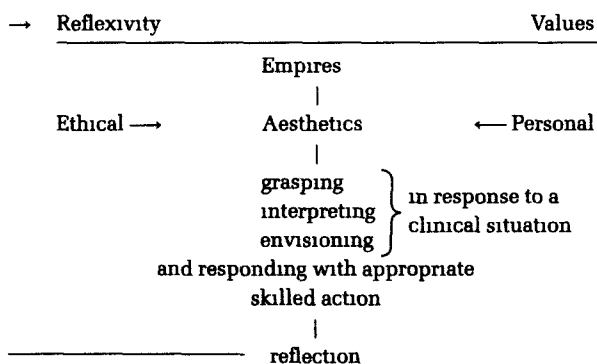


Figure 2 The inter-relatedness of Carper's ways of knowing

human encounter faced by the practitioner and the patient, as this would reduce both parties to objects to be manipulated in the achievement of ideal goals. This approach may be acceptable for the more technical aspects of nursing work, but it will inevitably fail when responding to the humanness that is widely acknowledged to be central within nursing (Morse *et al.* 1991).

FRAMING LEARNING THROUGH REFLECTION

The intention of reflection (on experience) is always to enable the practitioners to tell their stories of practice and to identify, confront and resolve the contradictions between what the practitioners aim to achieve and actual practice, with the intent to achieve more desirable and effective work (Johns 1993a). Practitioners tell their stories vividly because these experiences emerge as significant for them in some way. They pay attention to these experiences because they are invested with their concern.

Yet, in practical terms, practitioners with whom I have worked, in clinical supervision and on educational courses, have generally struggled to frame the development of their personal knowledge within Carper's ways of knowing. When these practitioners commence reflection, this personal knowledge is tenuous, uncertain, poorly articulated and understood, having been largely ignored as a significant source of knowing and learning and hence not easily amenable to reduction into apparently artificial and poorly understood categories of knowing. And yet, it is only through reduction that the practitioner is able to get access to the dimensions of knowing within experience, in order to make sense of them and learn through them. Therefore, to be valid for the individual practitioner, the ideas of Carper call for interpretation and understanding on a personal level and guidance to make the connections with personal knowledge.

Illustration

How the concepts of Carper's ways of knowing have been used to frame the process of understanding and learning through reflected experience, is illustrated in the following practitioner's experience shared within a group supervision milieu. The practitioner, Lee, works in an occupational health department within a large industrial company. Lee's words were recorded by written notes during the session.

Lee's story

Tom, a young man referred himself to the Occupational Health department. He was shaking he said he was 'feeling dreadful breaking down'.

I got him to rest on the bed and called the other nurse to help me
He said 'I've done drugs'

I asked 'What do you mean?'

He said 'I done drugs 10 minutes ago'

I confronted him 'Why at work?'

He said 'I've done them before but I have not felt like this I've lost my job haven't I?'

I thought to myself — 'Hang on I don't know what to do' The agency nurse with me was also flummoxed She said she had never seen anything like this

Then he began to hyperventilate he gave me a bag with 'substance' in it — asked me to get rid of it He became more agitated and I decided to call the ambulance He was pacing around the waiting room, saying he had to get back to work or else he would be in trouble, and then screaming that he was going to die

I then pressed the emergency button The security men came running — it took four of them to persuade him to sit down He was rocking in the chair — asking us just to talk to him which he needed — and it did help to calm him down

Pressing the button was a safety issue — a response to his and our panic!

When the ambulance came he was still agitated By this time an audience had gathered — including the company vice-president who had seen the ambulance arrive whilst attending a meeting next door

I helped Tom into the ambulance — he asked if I would let his wife know I was then questioned by the vice-president — I had to tell him the truth — he reacted — 'I'm not having you under that pressure' — I was subsequently contacted by personnel and asked to write a report

The man was sacked although the union have appealed against this The union representative came to see me — to check that I had not been threatened I assured him we had not been He also reassured me that it was the right decision to report drug-taking I'm not aware of drugs — I don't know what they were, perhaps I need to know

I threw the substance in the bin — I intended to keep quiet about it I was prepared to cover it up — although when the ambulance came I retrieved the drugs to give the ambulance man a sample

The key issue in this experience was maintaining confidentiality of the health informant When I decided to cover it up I confronted him — 'I'll forget it this time but if you ever do this again I will have no hesitation in reporting it!'

Having outlined this description of the experience, Lee used the model for structured reflection (Table 1)

She asked herself

How do I feel now? — I still feel quite bad about it — I don't think I could have done anything more or acted differently

It was helpful to go over with it with the agency nurse — the unions were also helpful and supportive — it is also helpful to share this within the group — I feel supported

At this stage the supervisor clarified Lee's concerns, and suggested that her anxiety was related to two issues

1 Feelings of guilt (What had happened to this man, you feel responsible for his losing his job)

2 You haven't resolved the dilemma of whether you should have reported him or not, i.e. worked out the ethical dilemma

Lee agreed with this interpretation

The supervisor then framed Lee's experience using Carper's ways of knowing

Empirics

It is important to note Lee's lack of knowledge of drug reactions She acknowledged that it would be useful to have this empirical knowledge because of the widespread use of drugs on the shop floor, even though this was the first situation of this nature she had experienced Knowledge of drugs and drug reactions as well as health promotion strategies would be clearly useful for her in pursuing a strategy of drug prevention given the knowledge that it is better to prevent people falling in the stream rather than always needing to pull them out (Butterfield 1990)

Neither she or the supervisor knew of any 'case study' reports of similar events in other industrial settings Two recent studies by Morse, concerning the use of empathy (Morse *et al* 1992) and levels of involvement in relationships with patients (Morse 1991) were useful in helping Lee to frame this experience, to challenge her sense of involvement with Tom, and to help her make sense of sympathy as a positive emotion

Ethical

Lee's experience enabled her to acknowledge how ethical principles cannot be easily applied because they take no account of the particular situation and the concerns of the actors within the situation The ethics of this situation can only be explicated as a process of deliberation, using what is described as situational ethics (Yarling & McMurray 1986, Packard & Ferrara 1987) It became evident to Lee in considering the situational variables, that there were no easy answers Lee was immersed in an ethical dilemma between, on the one hand reporting this man to the authorities for drug-taking, as this was company policy, and, on the other hand, a strong sense of responsibility towards Tom to maintain his rights of confidentiality

As it was, events overtook Lee and prompted her to call the security men because she was concerned for Tom's safety, to call the ambulance because of his drug reaction, and to tell the truth to the company vice-president She didn't know at this time that Tom's reaction to the substance he had taken was in fact the 'trip' and not an adverse reaction at all

Tom was sacked and Lee experienced considerable guilt about her actions, a guilt she had been living with for some days, prior to sharing the experience She felt responsible for the outcome for Tom

If Tom had not had the violent reaction, but had merely expressed his concern about his drug-taking, Lee felt she would not have reported him. It is pertinent to note that Lee felt sympathy with Tom because of his recent financial hardship. His wife now had a job and things had been looking brighter for them. It was obviously Tom's first drug-taking episode and drugs had been available on the shop floor.

These variables can be fed into a situational ethics map (Figure 3) enabling the possible variables to be considered in the context of ethical principles. This proved useful in helping Lee to make sense of and learn through the situation, to help her to rationalize her sense of guilt and to repair her shattered self-esteem.

It was noted that the company always took complaints more seriously when they needed to shed jobs. Hence Tom could be seen as victim of this strategy rather than the drug-taking. The company had been very tolerant to other men who presented with alcohol-related problems, although, of course, drug-taking is illegal which made a qualitative difference in policy.

One supervision technique is the use of 'ideological framing' to expose and critically analyse the contradictions between desirable intent and actual practice (Argyris &

Schön 1974), often experienced as conflict. Lee expressed her value that patients attending the clinic should be treated in a confidential manner. In the actual practice situation though, this was difficult. Therefore it is important to clarify the practical nature of confidentiality. Lee believed that it was crucial for workers to understand this concept if they were to feel confident and trusting in attending the department and in taking up the counselling opportunities which it offered.

Personal

Although Lee had met this man before she didn't know him well, and struggled to know him in this experience, as a basis for informing her response to the situation. Although disapproving of drug-taking she acknowledged Tom's humanness and saw the situation from his perspective. She 'naturally' became involved with his concerns and responded accordingly, whilst acknowledging her moral concern for his drug-taking.

Her anxiety about this situation was reflected in her 'critical mother' stance towards Tom, admonishing him, as she might have done a small child for his naughtiness, with the threat that if it happened again such leniency would be missing. Lee found that framing her involvement with Tom, and her subsequent interventions, within the theory of transactional analysis offered a rich background for understanding her dynamics. Moving into the 'critical mother script' (Stewart & Joines 1987) was a way for Lee to express her anxiety and to cope with the situation.

Lee speculated that it might have been more appropriate to stay in control of her anxieties and respond to Tom in an adult-adult mode to help him take responsibility. Yet he had clearly lost control because of his great fear.

Lee was unable to share this experience in meaningful ways with any colleagues at work. In fact she had to support her agency nurse colleague who felt very upset about this incident.

Aesthetics

This experience highlights the intuitive nature of grasping, interpreting, envisioning and responding. There was no careful consideration of appropriate interventions as events unfolded so dramatically. The major factors that influenced Lee's 'appropriate response' can be summarized as

- 1 empirical, i.e. there was no knowledge of drug reactions and appropriate treatment,
- 2 ethical, i.e. there was an immediate dilemma between whether to report drug-taking, according to company policy, versus respect for Tom's confidentiality, and knowing that Tom might have been sacked if reported but also knowing his socio-economic background, and
- 3 personal, i.e. Lee's own sense of panic and her limited knowledge of Tom as a person.

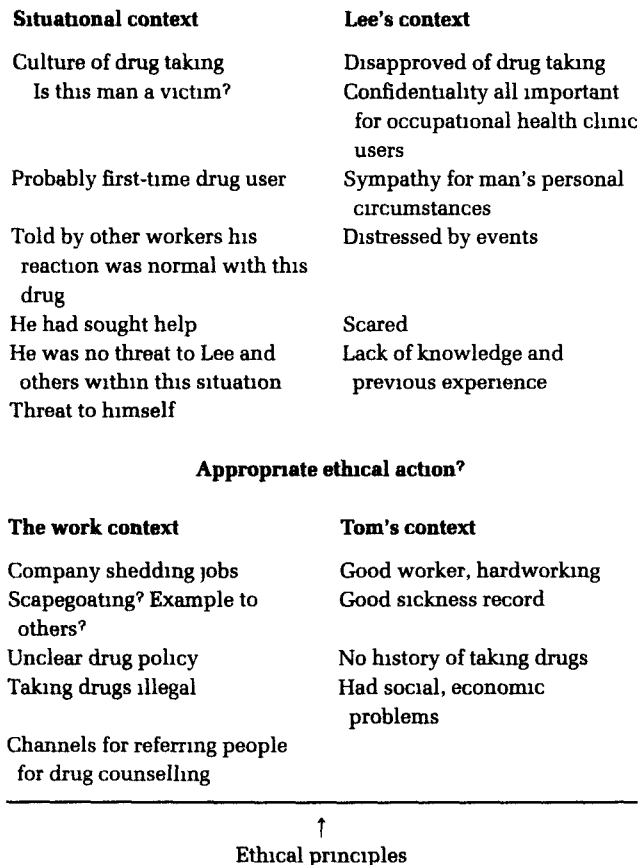


Figure 3 Situational ethics map of Lee's experience

In the group supervision, Lee was confronted with a number of questions

- 1 Can I go to the vice-president and advocate Tom's reinstatement, based on this ethical framework?
- 2 Do I see this as my role?
- 3 Would it help deal with my sense of guilt?

Lee felt she needed to discuss this issue with the vice-president. However, giving 'uncomfortable' valid feedback had emerged as a particularly difficult aspect of her practice, because of her greater need to avoid conflict within the workplace and her felt lack of assertiveness. Lee had recognized this in herself from previous experiences when she had related to an experience shared by another practitioner concerning failure to give feedback to her manager. This had left the practitioner feeling frustrated and angry at herself for her failure to achieve this, and towards her manager because of the experience.

It was Lee's sense of contradictions and conflict that would empower her to take action to resolve these dilemmas (Kieffer 1984). However, she might have failed to take action because it was too tough for her at that time. Learning may take many months to achieve given the barriers which act to limit the achievement of effective practice (Carr & Kemmis 1986). What was certain is that this experience would be 'picked-up' in Lee's next supervision session and explored further in the light of subsequent action and consequences.

CONCLUSION

Carper's great achievement is to draw attention to the ways of knowing that explicitly challenge the appropriateness of a human science based on empirical values, because of its inevitable dehumanizing effect on people and because practice is just not like that. Explicitly recognizing the value of aesthetics and the dimensions of personal and ethical ways of knowing enables nurses to see, value, embrace and know human caring in deeply personal ways.

It is therefore evident that the aesthetic way of knowing is the unifying way of knowing. It is also concluded that the constructed knowledge (Belenky *et al* 1986), gained through reflection, is the most significant form of disciplinary knowledge. This is because it is the knowledge used to practise.

Adherence to outmoded beliefs about the nature of disciplinary knowledge, as based on empirics, limits the growth of an appropriate epistemology for nursing knowledge, which is grounded in the practitioner's lived experience, and which can be demonstrated through frameworks such as Carper's ways of knowing. The latter framework is an heuristic device within the model of structured reflection, because it does not intend to force theoretical conformity, but merely offers a valid way to help the practitioner frame his or her learning through practice.

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