2 The Nature of Knowledge in Health and Social Care

Learning Outcomes

On completion of this chapter the reader should be able to:

- identify the sources of knowledge available to the health and social care professions
- appreciate the importance of research and evidence-based knowledge for health and social care practice.

Key Terms

- sources of knowledge
- traditions
- trial and error
- authority
- scientific knowledge
- tacit knowledge
- rituals
- intuition
- common sense
- reflective practice

Introduction

Within this text we consider the development of knowledge and practice, and the significance of research and evidence-based information to the nature of knowledge. It is the intention of this chapter to consider how health and social care knowledge has developed, and to highlight the need for the health and social care professions to develop information as part of professional growth.
In an attempt to understand the nature of health and social care knowledge, the complexity of health and social care information is discussed and the multidimensional aspects of the profession’s theory base are considered. The chapter will consider the importance of evidence-based practice, as identified in Chapter 1, specifically exploring the development of knowledge through tradition, ritualistic practice, intuition, tacit knowledge, common sense, authority, trial and error, and from a scientific base. Such discussions will reveal the many dimensions of health and social care theory, and, whilst not denigrating the development of any particular source of knowledge, will demonstrate the need for health and social care practice to question its knowledge base and accept those sources that provide a credible evidence base for practice. Thus, the practitioner might access a variety of forms of best evidence on which to base practice.

Traditions and rituals

‘We do it this way because we believe this is the best way.’ ‘We do it the way the team leader likes it.’ ‘Dr X likes his patients to be treated in this particular way.’ These statements reflect the use of tradition in the health and social care professions, the development of practice based on beliefs or myths which are accepted by the profession as a base for practice. Traditions can become customs, applied without critical thought, in a ritualistic way. Walsh and Ford (1989, 1994) have devoted two texts to the discussion of ritual practices in nursing, which are full of examples of care being given without thought for individual need. These texts give a picture of the way in which traditions and rituals can impinge on all aspects of the patient’s day and demonstrate the use of outdated practice by many nursing staff. It should be noted, however, that these texts are over a decade old and the absence of any new writing perhaps suggests a change in the ways in which traditional and ritualistic knowledge is being used to support health and social care practice.

Certain routine practices, which might be seen as ritualistic, are not necessarily undesirable. The performance of the handing over of client information from one staff member to another might be part of the care routine, but can also act as a
vehicle for social exchange and enhances social cohesion and team working.

Whilst some ritualistic practices might be beneficial, it is vital that outdated and unsafe practices are identified to allow health and social care practitioners to feel confident in the delivery of safe practice. These practitioners cannot afford to perpetuate traditional and ritualistic practice if it is at the expense of developments that are beneficial to the patient and the profession. Professionals are accountable for their practice and must be able to identify that the best possible care is being made available so that practice can be justified as the most appropriate.

**Intuition and tacit knowledge**

The use of intuition and tacit knowledge is apparent in health and social care practice, but they cannot easily be explained. For example, the physiotherapist who knows what the patient's needs are without detailed assessment, the nurse who knows when a patient's life is at an end but cannot explain why this is known, uses intuitive and tacit knowledge. Intuition is perhaps having acute sensitivity, a sixth sense (Burnard, 1989), built on knowledge and experience, which is applied to decision-making and problem-solving. Tacit knowledge is developed through the experience accumulated from practice over a period of time. It is the development of 'expert opinion' that is a synthesis of formal knowledge and clinical expertise. It is suggested that much of this knowledge is passed on to future generations of practitioners through modelling of actions, tasks and attitudes (Gunilla, Drew, Dahlberg and Lutzen, 2002).

The lack of objectivity and ability to identify a rationale behind intuitive and tacit decisions has affected the recognition of this source of knowledge, preventing it being viewed as a valid phenomenon for scientific investigation. Yet, it is argued that there are many situations where the application of intuitive and tacit knowledge is essential. These include the management of ethical dilemmas and situations where there is inadequate information with which to interpret potential behavioural response (Rew and Sparrow, 1987). Debates surrounding the use of tacit and intuitive knowledge in nursing practice are growing (Welsh and Lyons, 2001; Gunilla et al., 2002; Whitehead, 2005).
The experienced health and social care professional brings additional sensitivity into practice. This use of intuition and tacit knowledge enables the delivery of the best possible care. Within nursing, Benner (1984) sees the experienced nurse as the expert clinician that uses intuition and tacit knowledge as part of delivering holistic (total) care to the patient. Benner (1984) suggests ‘know how’ knowledge, which highlights the difference between the beginner or novice and the expert practitioner, should be valued more highly. The development of ‘knowledge that’ into ‘knowledge how’ as part of acquiring intuition allows the expert practitioner to view the complete situation and therefore apply holistic care, using past experience and knowledge. The value of intuition to holistic care is discussed by Agan (1987) who links intuitive knowledge to the development of personal knowledge through reflective practice.

Problem-solving through reflective practice was popularised by Argyris and Schon (1974), with the more recent work of Schon (1987) suggesting the development of two types of reflective skill. Reflection-in-action, where the practitioner is appraising care and making changes at the time, is compared with reflection-on-action, which follows the event and uses an analysis of preceeding practice to shape the future.

The work of Schon (1987) has been influential in health and social care practice and education. Though the work has been criticised (Greenwood, 1993), the value given to reflective practice in building personal knowledge, and ultimately in developing intuition and tacit knowledge, confirms the place of such knowledge in supporting health and social care practice.

**Common sense**

To use the words common sense is to suggest that something is widely accepted or generally known, as well as being logically reasoned and thought through. Sensible people would usually apply common sense. Knowledge based on common sense is therefore gained through accepted understanding, developed through individual experience that is not associated with any formal education or training.

Its value as a source of health and social care knowledge on which to base care can be limited, as can be seen through the examination of a common sense approach to certain clinical
practices. Common sense might lead to covering a warm but shivering child with extra blankets. Learned knowledge of the need to reduce a child’s temperature and therefore the shivering will result in the removal of any extra blankets and clothing. People often refer to childcare generally as common sense. The ability of parents to ‘bring up’ children will be evaluated through the amount of common sense the parents are thought to have. ‘Mr and Mrs Smith will be “good” parents because they have a lot of common sense.’ While it may be true that Mr and Mrs Smith will be ‘good’ parents, there is nothing that is at all common about the approach to parenthood. This can be seen in the plethora of texts available for parents that offer differing advice on all aspects of childcare.

As common sense is derived from individual experience, it is naturally limited, can be biased, and is drawn from individual reasoning rather than from external sources. The rationale for practice is consequently unsupported and may lead to the delivery of care that is not the best available, or the most appropriate.

Challenging practice based on common sense can be fraught with problems, as for the individual the practice is reasonable and understandable, and to them it makes common sense. Questioning common sense is, however, necessary to ensure care is of a high standard, and to prevent the perpetuation of practices that are restricted by individual experience and bias.

Common sense can provide a useful approach to care delivery, but health and social care professionals, as accountable practitioners, must critically examine and evaluate practice, choosing a knowledge base which supports professional and quality care.

**Trial and error**

Most of us use trial and error in solving problems on a day-to-day basis. When presented with a problem we will try one way of resolving it, and if this fails, different approaches will be taken until a solution is found. The solution is then remembered and used if the same or a similar problem occurs again.

Trial and error will only provide a solution to one specific problem and is therefore limited in its use. It is, however, an important source of knowledge, as others may recommend
solutions for use when faced with similar problems. For example, much advice is offered to people with common colds, such as to take high doses of vitamin C, and stay in the warm. The implications of passing on knowledge gained through trial and error learning may be to contribute to traditional knowledge or in fact to authoritative knowledge that is considered later. Knowledge based on trial and error, which may ultimately be developed into traditional or authoritative knowledge, can provide a valid basis for care.

**Authority**

Knowledge originating from people in positions of authority, who are often perceived as experts, can be accepted as a reasonable basis for practice. There are many individuals who impart authoritative knowledge: specialist practitioners, senior managers, lecturers, medical staff, therapists. In fact all personnel in the health and social care environments have the potential to be seen as an authority. This may develop from the person’s position, which is likely to be one of power, or the person’s perceived knowledge and experience, or the very personality and self-portrayal of the individual.

As a source of knowledge, the expert may have much to offer that will benefit students, staff and ultimately patients. There is, however, a concern that the expert will not be challenged, that the position of authority is above reproach and that the knowledge of the expert can be used without questioning the source. It is possible for the expert to offer a vehicle for the perpetuation of traditional and ritualistic practice, of practices which support the expert’s preferences and idiosyncrasies, rather than practice which is in fact sound and based on fact. There are many examples of such practice. The teaching of cardio-pulmonary resuscitation has varied according to the individual demonstrating basic life support skills, and continues to vary despite the development of Resuscitation Council UK Guidelines (2005) that are based on the current evidence base. It is therefore important for the recipient of authoritative knowledge to establish the original source of the information and determine a basis for practice that is justifiable.

It should also be remembered that experts impart knowledge through publication. The content of any journal article or text
should not be accepted as true just because it is published, but it should be questioned and critically appraised. All health and social care professionals need critical reading skills to determine the strengths and weaknesses of published work, and should be encouraged to adopt a questioning approach (see Chapter 11).

Policies and procedures are also used to guide practice. Many procedures used in the past gave step-by-step instructions for the practitioner to follow. More recently, the procedural approach has been succeeded by sound principles. These are less prescriptive and offer guidelines for safe practice. It is, however, important that the knowledge behind clinical principles is established. Rationales should be offered, which include referenced facts and high-quality evidence.

**Scientific knowledge**

**Scientific knowledge** is seen as informing health and social care practice through solving problems in a logical, systematic and rigorous way. The scientific approach to generating knowledge is seen as organised, following a series of logical steps (Polit and Beck, 2006). Chapter 1 gave some of the many definitions of research, which share commonality in suggesting a systematic approach to testing and generating knowledge. This suggests that the research process, described in Chapter 3, is used to provide a logical and systematic structure to problem-solving.

The need for scientific knowledge is acknowledged in the opening chapter, as is the need for education and training to enable health and social care practitioners to develop research awareness skills. Such skills are necessary to critically analyse and appraise research, thus allowing the identification of strengths and weaknesses in the research process (See Chapter 11).

The need for the health and social care professions to develop a scientific knowledge base for practice is also established, with research being viewed as a professional necessity. It is vital that the accountable practitioner can confidently deliver care based on reliable research evidence. There are benefits for the patient and professions in developing research-based health and social care practice.

The development of scientific knowledge in health and social care has its difficulties and limitations. Just as health and
social care professionals need to be critical in their appraisal of other sources of knowledge, so they need to be critical of research. The strengths and weaknesses of scientific knowledge must be identified through critical appraisal, as is highlighted in Chapter 11.

One independent organisation supporting practitioners in the development of evidence-based treatment is the National Institute for Health and Clinical Excellence (NICE). NICE is responsible for providing national guidelines in the promotion of good health and the prevention and treatment of ill health. NICE provides guidance in three areas for the National Health Service in England and Wales: public health, health technologies (medicines and treatments) and clinical practice (see http://www.nice.org.uk).

All research is fallible, all will have both strengths and limitations that should be considered in evaluating any of the recommendations made for practice.

The very nature of health and social care practice causes research difficulties, including ethical problems and measurement issues. Certain research may not gain ethical approval. For example, delaying pressure area risk assessment for more than six hours following admission to hospital ignores current best practice recommendations (NICE, 2003) and could endanger participants. Such research would be seen as negligent and unethical.

Though there are many measurement tools available to the researcher (see Chapter 8), the collection of quality information, as part of a qualitative approach, poses difficulties. The measurement of, for example, opinions, feelings, thoughts, viewpoint, behaviour, can challenge research.

Additional difficulties lie in health and social care itself. The impetus for research can be uncertain, the education and research skills of the professions are still developing, and the application of research knowledge to practice is not always uniform.

Health and social care professionals need to acquire research knowledge and skills, to shape the future of professional research. These skills are now developed to a basic level within all pre-registration courses, which often require the completion of a research critique, research project or dissertation. Most post-registration courses include research awareness skills and there are specialised research courses at master's level, with increasing opportunities for doctoral level studies. Career
pathways are also developing for those professionals who choose to make a career in research and practice or education.

Scientific knowledge may not always be the most appropriate source of information on which to base practice, but the use of scientific enquiry can establish the basis for care. It should be remembered that all types of knowledge discussed in this chapter can provide a basis for health and social care practice and the type of knowledge base employed may change with time and context as there is no single permanent truth.

**Key Points**

- Health and social care professionals need to be aware of the concept of evidence-based practice.
- The development of health and social care theory has been multidimensional, with knowledge being generated from many sources.
- Research must support measurement and the testing of knowledge in a systematic way.
- The professions are still developing research skills and expertise.

**Further Reading**


