

The theory-practice gap in nursing: from research-based practice to practitioner-based research

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The aim of nursing research is generally agreed to be the generation of knowledge, and whilst this is a relevant aim in theory-based disciplines such as sociology, the primary concern of nursing is with practice. Using examples drawn mainly from the field of mental health, it will be argued in this paper that the application of generalizable, research-based knowledge to individual, unique, person-centred practice, the so-called 'research-based practice' advocated by the Department of Health, is one of the main causes of the theory-practice gap. It will be further suggested that nursing requires a paradigm of *clinical* research which focuses on the individual therapeutic encounter in order to complement the existing sociological paradigm of theoretical research which is best suited to the generation of generalizable knowledge and theory. The paper will conclude by suggesting that such a clinically based research paradigm must not only focus on the individual nurse-patient relationship, but that it must be carried out by the nurse herself. Clinical research, if it is to make a difference to practice, must therefore be practitioner-based research.

Keywords: theory-practice gap, professional judgement, research-based practice, clinical research, practitioner-based research, single-case research, randomized controlled trial

RESEARCH-BASED NURSING PRACTICE

Research in nursing is usually seen as a single, amorphous entity, or else it is divided according to the quantitative/qualitative split, and no distinction is usually made between clinical research and theoretical research. It will be argued in this paper that the failure by researchers to distinguish between clinical research, that is, research which relates directly to clinical practice; and theoretical research, that is, research to generate and test the theories and models underpinning practice, has been a major cause of the theory-practice gap in nursing. In order to develop that argument, this paper will begin by considering the stated aims and purpose of nursing research.

Table 1 contains a sample of definitions from the literature, and similar definitions can be found in almost any research text. There is one word that is common to all of these definitions: the aim of research is, by general consensus, to generate *knowledge*. The probable reason for this fairly unanimous agreement is that nursing has borrowed its research paradigm and methodologies almost entirely from the social sciences, and in particular, from sociology. Thus, most nursing research employs such methods and methodologies as surveys, interviews, phenomenology, ethnography and grounded theory, all established social research strategies. The main exception is the randomized controlled trial, which has come, as we shall see later, from agriculture by way of psychology and medicine. And,

Table 1 Some definitions of nursing research

[Research is] a planned, systematic search for information, for the purpose of increasing the total body of man's (sic) <i>knowledge</i> . (Lancaster 1975 p. 42)
[Research is] an attempt to identify facts, and the relationship between and among facts, by systematic, scientific enquiry in order to increase available <i>knowledge</i> . (Hunt 1982 p. 24)
The major reasons for doing research in nursing are providing the profession with a body of scientific <i>knowledge</i> and identifying and developing nursing theories. (Treece & Treece 1986 p. 18)
The primary goal of nursing research is to develop a scientific <i>knowledge</i> base for nursing practice. (Burns & Grove 1987 p. 4)
[Research is] an attempt to increase available <i>knowledge</i> by the discovery of new facts or relationships through systematic enquiry. (Clark & Hockey 1989 p. 4)
[Research is] rigorous and systematic enquiry... designed to lead to generalisable contributions to <i>knowledge</i> . (Department of Health 1993 p. 6)
[Research is] a systematic approach and a rigorous method with the purpose of generating new <i>knowledge</i> . (International Council of Nurses 1996 p. 3)
(Author's emphases)

of course, sociology is primarily a theoretical discipline whose aim is to generate social theory. Thus:

Social theory is not something which can be separated from the process of social research. Theory informs our thinking which, in turn, assists us in making research decisions and sense of the world around us. Our experiences of doing research and its findings, in its turn, influences our theorizing; there is a constant relationship that exists between social research and social theory.

(May 1993 p. 20)

Furthermore:

Social scientific knowledge is primarily propositional or referential, rather than practical, and this should immediately provide some clues as to why it seems unable, except very indirectly, to help us decide how to live.

(Sayer 1992 p. 15)

Unlike sociology, however, nursing is essentially a practice-based discipline, and the knowledge generated by clinical research must somehow be translated into nursing practice if it is to help us decide, if not how to live, then at least how to nurse.

The Department of Health, England (DoH) has addressed this problem of the relationship between research and practice in its *Strategy for Nursing*, stating that 'all clinical practice should be founded on up-to-date information and research findings' (DoH 1989). That is not to say that the Department of Health is encouraging nurses to *do* research. On the contrary:

Research, done properly, is a highly professional and specialized activity and not suited to every practitioner; but every practitioner needs to be involved in using the results of research.

(DoH 1995 p. 2)

Specialist and elitist activity

Research is therefore seen by the DoH as a specialist, even elitist, activity carried out by a select group comprised mainly of academics. These researchers then pass down their findings to practitioners to implement in what has been referred to as research-based or evidence-based practice.

Research-based practice is held up as an exemplar for the nursing profession, and suggests a hierarchical relationship not only between theoreticians and practitioners, but between theory and practice, such that research generates knowledge, which builds, supports or tests theory, and which in turn determines practice. Thus:

It is the theories of the pure scientists that dictate the actions of those in practice, the applied scientists. Though the relationship between theory and practice appears to exist, it seems somewhat unidirectional in nature.

(Prymachuk 1996 p. 680)

Similarly, the International Council of Nurses (1996) suggested that research be disseminated down to practitioners by journal publications, by the mass media, and through conference presentations, and that research findings 'can be introduced in a fairly straightforward way as a recommended procedure following staff education and agreement to the proposed change', or by the development of new clinical practice guidelines.

Schön (1983) has referred to this unidirectional, hierarchical relationship as technical rationality, 'the Positivist epistemology of practice', and claimed that it has resulted in a 'crisis in confidence in professional knowledge' and a growing mistrust by practitioners that academic knowledge can offer anything of relevance to practice situations. In nursing, this 'crisis in confidence' has become known as the theory–practice gap.

RESEARCH AND THE THEORY–PRACTICE GAP

Why should there be a gap between theory and practice in nursing, when the paradigm of technical rationality is so effective in other disciplines? In the hard sciences, for example, the theory-practice gap is almost unheard of: in civil engineering, if a bridge is designed to withstand a certain load in theory, it will almost certainly withstand that load in practice. A gap between theory and practice of the magnitude experienced in nursing would be intolerable and would place lives at risk. Why, then, do we seem resigned to it in nursing, where lives are equally at risk?

One answer is that in nursing, technical rationality, the implementation of scientific research findings by practitioners, usually depends not on the classic hard science model of laboratory experimentation employed by engineers, but on large-scale generalizable studies of the kind advocated by the DoH when it states that:

Many members of the nursing professions undertake small scale projects on issues which interest them... However, it must not be seen as a substitute for the generalizable and cumulative research which we would place at the heart of a strategy for advancing research in nursing.

(DoH 1993 p. 6)

The generalizable knowledge required by the DoH therefore derives mainly from the statistical model of research advocated by many social scientists, psychologists and medical researchers rather than from the single-subject approach of experimental research. This model argues that findings obtained from a carefully chosen (usually random) sample can be generalized to the population from which that sample was selected to construct or test a general theory, which can then be applied back to individuals from within that population. This statistical method therefore involves two logical processes: firstly, induction, from the specific cases of the sample to the general theory; and secondly, deduction, from the general back to the individual when we apply the theory to our particular practice setting.

Problems

There are a number of problems with this model of research, including the long-standing and seemingly intransigent problem of induction, and the enormous practical difficulties of selecting a truly random sample, particularly from very heterogeneous populations. However, this paper will focus not on methodological problems, but rather on the more fundamental issue of the suitability of the model itself for clinical research. It will argue that whereas statistical research is adequate for generating theory, we run into difficulties when we come to apply

that theory to practice settings with individual patients. Furthermore, the difficulty is not a technical one which could be resolved by refining the methodology or by improving the dissemination of research findings, but a logical one. In other words, no matter how much the statistical model of research is refined, it will *never* provide findings of use in individual and unique clinical situations.

Let us take an example to illustrate the problem. (The examples employed in this paper reflect my own clinical background in mental health. However, the arguments which the examples illustrate are equally applicable to all branches of nursing, and indeed, to all the 'helping professions'.) A researcher wishes to test the effectiveness of a new model of counselling for depressed people, and like a good scientist, she decides on a randomized controlled trial, the so-called 'gold standard' for nursing research. She therefore recruits two hundred people suffering with depression, and randomly assigns them to either a control group which receives the standard counselling method, or an experimental group which receives the new method. And sure enough, after six weeks, the experimental group shows a statistically significant improvement over the control group, as measured by the researcher's chosen depression inventory, to the extent that she can confidently say that the new method is more effective than the old in the treatment of depression.

However, let us consider what the findings from this randomized controlled trial are actually telling us. When a social or medical researcher discovers that method X is a better treatment for depression than method Y, she rarely finds that *all* the patients in the experimental group did better than *all* the patients in the control group, but that, *on average*, the experimental group did better. There will inevitably be some patients in the experimental group who did worse than some patients in the control group, and possibly some whose condition deteriorated over the course of the treatment. Nevertheless, the Department of Health (1993) would expect nurses to base their practice on the findings from such a study, and the nurse who has 20 depressed patients on her caseload and a very busy schedule will use method X and expect that, on average, her patients will respond better than they would have done to method Y.

However, nursing has, we are told, moved on from the days of task-centred practice where one nurse did the 'toilet round', and yet another did the 'dressings round'. Nursing, we are told by the DoH (1989), should be patient-centred, interpersonal, primary, or holistic, depending on your preferred terminology. As Radwin (1995 p. 368) points out:

highly individualised care is considered an indicator of quality nursing care, and treating each individual as a unique person is a cherished value in nursing.

Mental health nursing

Nurses should not be expected to carry out the same task with all the patients on the ward, but should have their own small group for whom they are the primary carer. Nursing, then, has moved from a task-centred approach to one which is 'carried out within relationships; it is, in essence, a special form of relating'. (Kirby 1995)

This is particularly true of mental health nursing, where there has been a strenuous challenge to the task-centred medical model since the work of Peplau in the 1950s. In contrast to the medical model view which focuses on what 'patients are assumed to have in common' (Gournay 1995), the patient-centred view has, for several decades, seen the individual therapeutic relationship as the defining characteristic of the profession, and as what distinguishes nursing from medicine (see Altschul 1972, for an overview of the early literature). Thus:

It is the responses of nurses to patients, within nurse-patient relationships, which provide the stimuli for constructive changes that psychiatric patients need to make in their thinking and in their behaviour.

(Peplau 1994 p. 5)

More recently, general nursing has begun to recognize the therapeutic importance of the nurse-patient relationship and its focus on the individual, and it is significant to note that the *Project 2000* curriculum Common Foundation Programme was based partly on the earlier 1982 Registered Mental Nurse syllabus.

In mental health nursing, then, and more recently in general nursing, there has been a shift from a task-centred approach to a focus on the individual patient, on 'how all people differ from one another, and how these differences represent the distinguishing characteristics of the person' (Barker & Reynolds 1996).

And this is where we run into problems with the findings from generalizable, statistically based research: positivist social research findings tell us about how well the majority of patients do, but not about any particular individual. Just as an opinion poll will tell us about how the population as a whole intends to vote at the next election, but not about how Mr Smith will vote, so a randomized controlled trial, or indeed any form of macro, statistically generalizable nursing research, will tell us how patients on average will respond to treatment, but not how a particular patient that a particular nurse is caring for will respond.

As McCaugherty (1991 p. 1057) points out, 'rather like the average British family, who have 2.2 children and live in the middle of the Bristol Channel, the average patient is not often met'. Thus, in order to know how patient P will respond to treatment X in situation S, we need to know patient P, and we also need to know how other

patients similar to patient P have responded in situations similar to situation S in the past.

PROFESSIONAL JUDGEMENT

Thus, in addition to scientific knowledge about the general effects of treatment X on the average patient, we also require *personal* knowledge about patient P and *experiential* knowledge about situation S. In other words, we need to draw on our personal relationship with this particular patient and on our experiences of similar situations in the past to decide whether we should accept or reject the generalizable, research-based findings about treatment X for our particular and unique patient.

This synthesis of personal, experiential and scientific knowledge that an experienced practitioner draws on when making clinical decisions has been referred to as professional judgement (Clarke *et al.* 1996), and is similar to what Benner (1984) called expertise. When forming professional judgements, the nurse relies first and foremost on her store of personal and experiential knowledge, and Benner claimed that she only falls back on scientific knowledge obtained from research when she finds herself in a novel situation.

The superiority of professional judgement over research-based findings when making decisions about individuals is well-recognized in other practice-based disciplines. For example, in the profession of teaching, Lawrence Stenhouse has stated to practitioners that:

What I am trying to do is to encourage the feeling that all the statistics can be thrown out if they don't accord with reality as you know it, and when you look at statistical results, somehow the thing to do is to end up not talking about standard deviations but talking about experience.

(Stenhouse 1985 p. 41)

Also, in psychotherapy:

Even after 15 years, few of my research findings affect my practice. Psychological science *per se* doesn't guide me one bit... My clinical experience is the only thing that has helped my practice to date.

(Matarazzo, cited in Bergin & Strupp 1972 p. 104)

Carl Rogers (1968) made a similar point when he noted that other people's research had made little impact on his clinical practice, and suggested that 'the only hope of doing *significant* research is to be immersed in clinical work'. Stenhouse (1981) later echoed these sentiments with his advice to practitioners that 'using research means doing research'.

These subjective opinions are supported by a number of scientific studies summarized by Cohen (1976), which indicated that 40% of mental health professionals thought that no research existed that was relevant to their practice, and the remainder believed that less than 20% of research

papers had any application at all to professional settings. It is not that these practitioners were unaware of the relevant research, but simply that they did not believe it to be appropriate to their everyday clinical work.

Conflicts between research and practice

We are now, perhaps, getting close to the source of the theory-practice gap. It is, arguably, the gap between what scientific research says should happen in the *majority* of cases, and what professional judgement says will happen in any *particular* case: it is the conflict between macro, statistical, research-based knowledge and micro, personal, experiential knowledge. Furthermore, if we accept this formulation of the theory-practice gap, then any attempt to close it by the usually advocated strategies of better dissemination and greater utilization of research findings, will actually make the gap wider by suppressing professional judgement and encouraging practitioners to utilize approaches which are not suited to their individual patients.

Even the DoH (1994) has now recognized the problem of attempting to apply the findings from statistical, generalizable studies to individual practice situations. For example, scientific research has provided us with a number of demographic factors which are associated with the risk of suicide. We know that there is a statistical correlation between suicide and young men, between suicide and the elderly, and between suicide and unemployment. We should, then, be able to make predictions based on this scientific knowledge and identify those people at high risk of attempting to kill themselves. However, in practice it is virtually impossible to predict suicide risk on an individual basis. Thus:

All these factors are well-known statistical correlates of suicide and must not be ignored. They do, however, present problems in the day-to-day clinical situation. Many individuals will possess these characteristics yet not commit suicide, and suicide can occur in people of very different characteristics.

(DoH 1994 p. 19)

The Department of Health (1994 p. 19) continues:

Suicide risk in any individual can only be assessed effectively by full clinical evaluation consisting of a thorough review of the history and present illness, assessment of mental state and then a diagnostic formulation.

In other words, professional judgement should and must over-ride judgements made purely on scientific knowledge. And if we *do* attempt to make our assessments of suicide risk according to the research findings, we run into the problem of 'false positives'. Pallis *et al.* (1984) have pointed out that if we target all those people in high risk groups, then for each positive identification of a suicidal patient, we will have another 104 people who fall into the

high-risk category but who do not intend to kill themselves. When it comes to making clinical decisions about individual cases, research based on statistical generalizations is of little use.

Stenhouse (1979) added an ethical dimension to the debate, and although he was writing about the teaching profession, his insights are just as relevant to nursing. He used the comparison between farming and gardening to demonstrate his argument, pointing out that the randomized controlled trial favoured by the technical rationality model originated in agriculture, where it was developed by the statistician R.A. Fisher to evaluate the effects of different growing conditions on identical fields of crops. By comparing the crop yield between the 'control' and the 'experimental' fields, it is possible to make research-based decisions on the relative merits, say, of two different pesticides. Therefore:

A measure of gross yield is an appropriate basis on which to select a crop treatment in large-scale farming, where a standardized procedure in which some plants do not thrive is more acceptable than a diagnostic cultivation of each plant individually.

(Stenhouse 1979 p. 74)

In other words, farmers accept that in any standardized procedure there will be some casualties; some plants will not respond to any particular treatment and others will die. The aim, however, is to maximize the yield, to find the treatment which produces the best crop regardless of casualties.

Unacceptable consequences

In nursing, however, this is totally unacceptable; in my view, we cannot nurse patients according to the ethical principle of the greatest good for the greatest number. We cannot base our working practice on research findings which provide the best *overall* care at the expense of a minority of patients who do worse than they would with an alternative form of treatment. Unlike the farmer, for whom it is impractical to treat each ear of wheat as an individual, we *must* vary the treatment given to each of our patients. The nurse, then, is more like a gardener who treats different plants differently, tailoring the treatment to each individual, and who 'must diagnose before he prescribes and then vary the prescription. The agricultural model assumes the same prescription for all' (Stenhouse 1979, p. 73).

And it is not enough to claim that research can differentiate between patient groups and prescribe, say, one model of counselling for middle-aged depressed women and another for young schizophrenic men. Every individual is unique and there are simply too many variables to account for each group. There is some justification, even, for claiming that each individual patient is a treatment group of one. Our best hope of diagnosing the appropriate treatment

for each patient, then, is by employing our professional judgement rather than generalizable research findings.

PRACTITIONER-BASED RESEARCH

It has been argued that there are a number of practical and ethical difficulties concerning the application of statistical research findings to individual patients. These problems make the traditional social scientific research paradigm a rather suspect basis for clinical decision-making with individual patients, and despite the Government's call for all practice to be research-based, it is likely, as Benner suggested, that many experienced nurses quietly listen to their professional judgement rather than to researchers. They might well say that they practice according to what the latest research tells them, but they actually practice according to what Schön referred to as their theories-in-use rather than their espoused theories.

However, if practitioners are ever to come out of the closet and preach what they practice, then their professional judgement needs to be put on a more solid footing, and must overcome what has been referred to as the dilemma of ritual vs. research (Hicks 1996), where practice that is not based overtly on research findings is assumed to be based on intuition, assumption and tradition, and is therefore unsound.

In today's intellectual climate of research-based practice, the only way that professional judgement can compete with the technical rationality paradigm is through practitioner-based research. As Stenhouse pointed out:

If after comparing the measurement results [of scientific research] with your own experience you find yourself uncertain of judgement, then basically there's no alternative to doing your own research [in your own practice setting].

(Stenhouse 1985 p. 41)

It is being argued therefore that we must distinguish between theoretical research, which is concerned with generating and testing generalizable theories, and for which the established social science and medical research paradigms are appropriate; and clinical research, which is concerned with improving the care and treatment of our individual patients, and which requires research methods and methodologies which inform us about the individual rather than about group norms. The only way to generate knowledge about our individual patients is to do research on and with individuals.

Furthermore, research to generate the knowledge on which to base individual clinical decisions is best undertaken by the nurse herself, since that knowledge is only relevant to the unique clinical situation of which the nurse is a part. It is being suggested therefore that clinical research, research into best practice in individual cases, involves only the practitioner who requires the knowledge

on which to base her practice, and the patient who is to benefit from it.

Single case research

Single case research is well established in sociology, where it is usually subsumed under the method of ethnography, and in psychology (much of Freud's work was based on individual cases (Freud 1977, 1979), and Piaget used a sample of two or three for much of his ground breaking work into child development (Piaget 1976, 1977)), and is often the method of choice in practice-based disciplines such as teaching and psychotherapy. Furthermore, methodologies range from the positivist and usually quantitative single-case experimental design (Barlow & Hersen 1984) through the interpretive and usually qualitative case-study approach (Yin 1994), to the participant observation studies of the Chicago School of sociologists (e.g. Whyte 1955). It is a particularly useful approach in outcome studies, and as psychiatrists Bergin & Strupp noted:

As a general paradigm of enquiry, the individual experimental case study... appears to be the primary strategy which will move us forward in our understanding of the mechanisms of change at this point.

(Bergin & Strupp 1970 p. 21)

Even the arch scientist and 'ratologist' B.F. Skinner suggested that 'instead of studying a thousand rats for one hour each, or a hundred rats for 10 hours each, the investigator is likely to study one rat for a thousand hours' (Skinner 1966 p. 240). However, single-case practitioner-based research does not necessarily mean working with individual patients. The single case can equally be a clinical area or an entire hospital. The point is that we are interested in learning as much as we can about the case we are studying, rather than attempting to generalize from a sample to a wider population. Furthermore, many practising nurses are already involved in such study, albeit on an informal and unrecognized level, but it rarely makes the transition into print from ward handovers or clinical notes.

Intellectual rigour and generalizability

One possible reason why single-case practitioner-based research is not more widely employed in nursing is its perceived lack of intellectual rigour. This problem stems largely from the adoption of the randomized controlled trial (RCT) as the 'gold standard' for nursing, and hence the application of the values and criteria of RCTs to all nursing research. This paper has already addressed the issue of external validity or generalizability, and has argued that the statistical generalizability offered by the RCT is not appropriate to many clinical situations faced by the practising nurse. That is not to say, however, that

single-case research does not aim to be generalizable, but rather that it is concerned with other types of generalizability.

Firstly, single case research can provide for naturalistic generalizations (Stake 1980), otherwise referred to as fittingness (Sandelowski 1986, Koch 1994) or transferability (Guba & Lincoln 1989), where findings can be generalized from one case to another, provided that the subjects and settings are suitably similar. Unlike with statistical generalizations, the responsibility of the researcher is not to ensure external validity through careful selection of the sample (an impossibility with a sample of one!), but to describe the context and setting in which the research took place in enough detail for a reader to make a judgement about whether the findings apply to her practice setting and her patient(s).

Secondly, single case research can be employed to make analytic generalizations (Yin 1994) from one or more individual cases to a theoretical proposition. Several cases are often employed to add weight to a theory, to broaden it, or to set limits on its applicability, but these cases are used replicatively rather than statistically. To take a simple example from the hard sciences: in order to generate a theoretical proposition about the boiling point of water, we need only boil a single test-tube of water. We do not repeat the experiment one hundred times and take the average, and any subsequent experiments will be used either to strengthen our faith in our findings through replication, or to extend our theory through experimenting, say, at different altitudes or with different degrees of water purity.

Other issues of rigour, such as internal validity and reliability, will depend on the type of single case research being carried out. For example, the single case experimental design (Barlow & Hersen 1984) conforms closely to the statistical model, and addresses issues of internal validity and reliability in the same way as most other positivist methodologies. At the other extreme, ethnographers and action researchers have argued that the same rules simply do not apply. For example, Hammersley & Atkinson (1983) claim that in ethnography and grounded theory, data and theory are developed reflexively and in parallel. It makes no sense therefore to apply the criterion of construct validity (whether the study measures the constructs it was designed to measure), or of content validity (whether it measures every aspect of the constructs) since the constructs are not specified in advance but grow inductively out of the data.

Kemmis (1980), on the other hand, rejects the whole notion of validity and prefers to talk about authority, which appeals to the tacit knowledge of the reader in recognizing the reasonableness and authenticity of the study, a view echoed by Adelman *et al.* (1976, p.142), who wrote of validity being obtained by the reader's 'shock of recognition'.

Even more extreme views are advocated by Elliott (1991)

and by Usher & Bryant (1989). Elliott saw the primary aim of practitioner-based research as the improvement of practice, and argued that the validity of the knowledge and theories it produces depend entirely on their 'usefulness in helping people to act more intelligently and skilfully'. If the application of a theory leads to better practice, then the research which produced that theory, and the theory itself, can be said to be valid. This, of course, begs the question of how we decide on what constitutes better practice. Elliott argued that the researcher should employ her own professional judgement in order to decide, and hence that single-case researchers must also be experienced practitioners (an argument advocated in this paper), whereas McNiff *et al.* (1996) suggested validation by peers, managers, patients, the academic community and the general public as well as self-validation. This could be achieved not only through presentations and publications, but by informal sharing and through specially established validation groups.

Finally, and most radically, Usher & Bryant (1989) saw the purpose of practitioner-based research in general, and action research in particular, as the generation of 'insider knowledge', making it difficult to validate its truth claim to outsiders. In fact, they went further to question whether action research can, or even should, attempt to justify itself to outsiders at all. Thus, at one extreme, certain types of practitioner-based research employ the same criteria and the same methods of establishing rigour as the positivist statistical paradigm, whereas at the other extreme, it is claimed that issues of reliability and validity are largely irrelevant, or that practitioner-based research should be justified by appeals to practice or to practitioners rather than to academics and intellectual criteria.

CONCLUSION

The essence of nursing is the therapeutic relationship between the nurse and the patient, and the recommendation by the DoH (1989) that all clinical practice should be based on research findings must be given a wider interpretation if we are to begin to close the theory-practice gap. The large-scale, statistically generalizable studies which both the gate-keepers to the nursing profession (that is, research funding committees, journal review panels, and so on) and the DoH (1993) favour might well be adequate for the construction and testing of theory, but it has been argued in this paper that such an approach to research can tell us nothing about the individualized nursing care which is central to effective practice.

Each clinical encounter between nurse and patient is unique, and the only way that we can begin to explore those encounters and generate knowledge and theory from them is if the nurse and the patient are themselves the focus of the research process. And the most effective and perhaps the only way that such a focus is possible is through single-

case practitioner-based research carried out by nurses themselves. Using research means doing research.

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