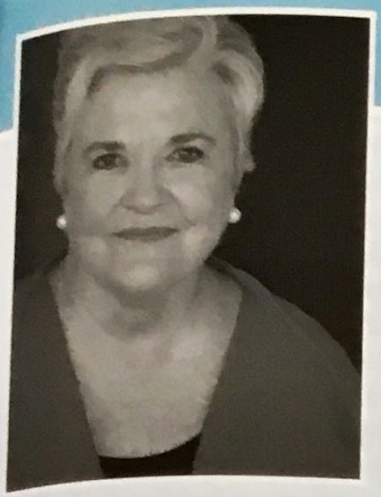

Patricia Benner

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Patricia Benner: Caring, Clinical Wisdom, and Ethics in Nursing Practice

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"The nurse-patient relationship is not a uniform, professionalized blueprint but rather a kaleidoscope of intimacy and distance in some of the most dramatic, poignant, and mundane moments of life."
(Benner, 1984a)

CREDENTIALS AND BACKGROUND OF THE PHILOSOPHER

Patricia Benner was born in Hampton, Virginia, and spent her childhood in California, where she received her early and professional education. She obtained a bachelor of arts degree in nursing from Pasadena College in 1964. In 1970 she earned a master's degree in nursing, with major emphasis in medical-surgical nursing, from the University of California, San Francisco (UCSF) School of Nursing. Her PhD in stress, coping, and health was conferred in 1982 at the University of California, Berkeley, and her dissertation was published in 1984 (Benner, 1984b). Benner has a range of clinical experience, including acute medical-surgical, critical care, and home health care.

Benner has a rich background in research and began this part of her career in 1970 as a postgraduate nurse researcher in the School of Nursing at UCSF. Upon completion of her doctorate in 1982, Benner became an associate professor in the Department of Physiological Nursing at UCSF and a tenured professor in 1989. In 2002 she moved to the Department of Social and Behavioral Sciences at UCSF as the first occupant of the Thelma Shobe Cook Endowed Chair in Ethics and Spirituality. She taught at the doctoral and master's levels and served on three to four dissertation committees per year. Benner retired from full-time teaching in 2008 as professor emerita from UCSF but continues with presentations, consultation, and visiting professorships as well as writing and research projects. She is currently Chief Development Officer for educatingnurses.com and works with Dr. Pat Hooper-Kyriakidis on an online clinical simulation program, NovEx (http://www.novicetoexpert.org) used in hospital orientation and professional development programs. The demand for this program has increased for clinical teaching in schools of nursing during the coronavirus disease 2019 (COVID-19) virus pandemic.

Benner published extensively and is the recipient of numerous honors and awards. She was inducted into the Royal Danish Nursing Society as an Honorary Member in 2012, and she received the Sigma Theta Tau International Book Author award, shared with her co-editors for *Interpretive Phenomenology in Health Care Research* (Chan et al., 2010). She was honored in 1984, 1989, 1996, 1999, and 2011 with *American Journal of Nursing* Book of the Year awards for *From Novice to Expert: Excellence and Power in Clinical Nursing Practice* (1984a), *The Primacy of Caring: Stress and Coping in Health and Illness* (1989, with Wrubel), *Expertise in Nursing Practice: Caring, Clinical Judgment, and Ethics* (1996, with Tanner & Chesla), *Clinical Wisdom and Interventions in Critical Care: A Thinking-in-Action Approach* (1999, with Hooper-Kyriakidis & Stannard), and the second edition of *Clinical Wisdom* (2011), respectively. *The Crisis of*

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Care: Affirming and Restoring Caring Practices in the Helping Professions (1994), edited by Susan S. Phillips and Patricia Benner, was selected for the CHOICE list of Outstanding Academic Books in 1995. Benner's books and several of her articles have been translated into 12 languages. Benner received the *American Journal of Nursing media* CD-ROM of the year award for *Clinical Wisdom and Interventions in Critical Care: A Thinking-in-Action Approach* (2001, with Hooper-Kyriakidis & Stannard), a forerunner for the NovEx clinical simulation learning program.

In 1985, Benner was inducted into the American Academy of Nursing. She received the National League for Nursing's Linda Richards Award for leadership in education in 1989 and both the National League for Nursing (NLN) Excellence in Leadership Award for Nursing Education and the NLN President's Award for Creativity and Innovation in Nursing Education in 2010. In 1990 she received the Excellence in Nursing Research and Excellence in Nursing Education Award from the California Organization of Nurse Executives. She also received the Alumnus of the Year Award from Point Loma Nazarene College (formerly Pasadena College) in 1993. In 1994, Benner became an Honorary Fellow in the Royal College of Nursing, United Kingdom. In 1995 she received the Helen Nahm Research Lecture Award from the faculty at UCSF for her contribution to nursing science and research. Benner received an award for outstanding contributions to the profession from the National Council of State Boards of Nursing in 2002, for developing an instrument, Taxonomy of Error, Root Cause and Practice (TERCAP), an electronic data collection tool used to capture the sources and nature of nursing errors (Benner et al., 2002).

In 2002, The Institute for Nursing Healthcare Leadership commemorated the impact of the landmark book *From Novice to Expert* (1984a) with an award acknowledging 20 years of collecting and extending clinical wisdom, experiential learning, and caring practices and a celebration at the conference "Charting the Course: The Power of Expert Nurses to Define the Future." Benner received the American Association of Critical Care Nurses Pioneering Spirit Award in May 2004 for her work on skill acquisition and articulating nursing knowledge in critical care. In 2007 she was selected for the UCSF School of Nursing's Centennial Wall of Fame and she received the American Organization of Nurse Executives (AONE) excellence in research award. In 2008, Benner was ranked as the fourth most influential nurse in the past 60 years by the readership of the journal *Nursing Standard* in the United Kingdom. She was a visiting professor at the University of Pennsylvania School of Nursing in 2009 and at Seattle University School of Nursing in 2013. Along with her husband and colleague, Richard Benner, Patricia Benner consulted around the world regarding clinical practice development models (CPDMs) (Benner, 1999). Benner was appointed Nursing Education Study Director for the Carnegie Foundation's Preparation for the Professions Program (PPP) in March 2004. The book published from this national study, *Educating Nurses: A Call for Radical Transformation*, was awarded the American *Journal of Nursing* Book of the Year Award for 2010 and the Prose Award for Scholarly Writing. In 2011 the American Academy of Nursing honored Patricia Benner as a Living Legend.

THEORETICAL SOURCES FOR THEORY DEVELOPMENT

Benner acknowledges that her thinking in nursing is influenced by Virginia Henderson. Benner studies clinical nursing practice in an attempt to discover and describe knowledge embedded in nursing practice. She maintains that knowledge accrues over time in a practice discipline and is developed through experiential learning, situational thinking, and reflection on practice in particular practice situations. She refers to this work as **articulation research** (influenced by Taylor, 1989, 1991, 1994; Geertz, 1973/1983) defined as "describing, illustrating, and giving language to taken-for-granted areas of practical wisdom, skilled know-how, and notions of good practice" (Benner et al., 2009, p. 5). A major philosophical distinction in Benner's work is the differentiation between practical and theoretical knowledge. Citing Kuhn (1970) and Polanyi (1958), philosophers of science, Benner (1984a) emphasizes the difference between "knowing how and when," a practical knowledge that may elude precise abstract formulations, and "knowing that and about," which lends itself to theoretical explanations. Clinical situations are always more variable and complicated than theoretical accounts; therefore, clinical practice is an area of inquiry and a source of knowledge development. By studying practice, nurses uncover knowledge. Nurses must develop the knowledge base in practice, and through investigation and observation, learn to record and develop the know-how of clinical expertise. Ideally, practice and theory dialogue create new possibilities and new understandings of skillful contextual nursing practice. Theory is derived from practice and practice can be extended and enriched by theory. Benner believes that nurses have been remiss in articulating and documenting their clinical learning, and "this lack of knowing of our practices and clinical observations denies nursing theory of the uniqueness and richness of knowledge embedded in expert clinical practice" (Benner, 1983, p. 36).

Hubert Dreyfus introduced Benner to phenomenology. Stuart Dreyfus, in operations research, and Hubert Dreyfus

in philosophy, both professors at the University of California at Berkeley, developed the Dreyfus Model of Skill Acquisition (Dreyfus & Dreyfus, 1980, 1986), which Benner applied in her work, *From Novice to Expert* (Benner, 1984a; Benner et al., 2009, 2011). She credits Jane Rubin's (1984) scholarship, teaching, and colleagueship as sources of inspiration and influence, especially in relation to the works of Heidegger (1962) and Kierkegaard (1962). Richard Lazarus (Lazarus, 1985; Lazarus & Folkman, 1984) mentored her in the field of stress and coping. Judith Wrubel was a participant and coauthor with Benner for years, collaborating on the ontology of caring and caring practices (Benner & Wrubel, 1989; Wrubel, 1985). Additional philosophical and ethical influences on Benner's work include Dreyfus and Taylor (2015), Dunne (1993), Løgstrup (1997), MacIntyre (1981), Martinsen (Alvsvåg, 2014), Merleau-Ponty (1962), and O'Neill (1996).

Benner (1984a) adapted the Dreyfus model to clinical nursing practice. The Dreyfus brothers developed the skill acquisition model by studying the performance of chess masters and airline pilots (Dreyfus & Dreyfus, 1980, 1986). Benner's model is situational and describes five levels of skill acquisition and development: (1) novice, (2) advanced beginner, (3) competent, (4) proficient, and (5) expert. The skill model posits that changes in four aspects of performance occur in movement through the levels of skill acquisition: (1) movement from a reliance on abstract principles and rules to the use of past, concrete experience; (2) shift from reliance on analytical, rule-based thinking to intuition; (3) change in the learner's perception of the situation from viewing it as a compilation of equally relevant bits to viewing it as an increasingly complex whole, in which certain parts stand out as more or less relevant; and (4) passage from a detached observer, standing outside the situation, to one of a position of involvement, fully engaged in the situation (Benner et al., 1992).

Because the model is situation-based and not trait-based, the level of performance is not an individual characteristic of an individual performer but a function of a given nurse's familiarity and skilled know-how with a particular situation in combination with her or his educational background. The performance level can be reliably determined only by consensual validation of expert judges evaluating direct observation of nursing practice, first-person-experience-near (Geertz, 1973/1977) narrative accounts of actual practice, and by assessment of clinical outcomes of the situation (Benner, 1984a; Benner et al., 2009). In research applying the Dreyfus model in relation to nursing, Benner noted that "experience-based skill acquisition is safer and quicker (more effective, efficient, and reliable) when it rests upon a sound educational base" (1984a, p. xix). Skill and skilled practice are defined as implementing skilled nursing interventions and clinical judgment through reasoning across time as changes occur in particular patient situations and/or changes develop in the clinician's understanding in actual clinical situations (Benner et al., 2011). It does not refer to context-free psychomotor skills or other discrete, explicit interventions without an understanding of the context of those nursing interventions.

In subsequent research undertaken to further explicate the Dreyfus model, Benner identified two interrelated aspects of practice that also distinguish the levels of practice from advanced beginner to expert (Benner et al., 1992, 1996, 2009). First, clinicians at different levels of practice live in different clinical worlds, recognizing and responding to different situated needs for action. Second, clinicians develop what Benner terms *agency,* or the sense of responsibility toward the patient, and evolve into fully participating members of the health care team. The skills acquired through nursing experience and the perceptual awareness that expert nurses develop as decision makers from the "gestalt of the situation" lead them to follow hunches as they search for evidence to confirm the subtle changes they observe in patients (1984a, p. xviii).

The concept that experience is defined as the outcome when preconceived notions are challenged, refined, or refuted in actual situations is based on the works of Heidegger (1962) and Gadamer (1970). As the nurse gains experience, clinical knowledge becomes a blend of practical and theoretical knowledge. Expertise develops as the clinician tests and modifies principle-based expectations in the actual situation. Benner refutes the dualistic Cartesian descriptions of mind-body person and espouses Heidegger's phenomenological description of person as a self-interpreting being who is defined by concerns, practices, and life experiences. Persons are always **situated**—that is, they are engaged meaningfully in the context of where they are. By virtue of being humans, we have embodied intelligence that we exercise through involvement in situations demanding our attention, concern, and action. When a familiar situation is encountered, the engaged intelligent agent experiences perceptual grasp, an embodied recognition of its meaning. For example, having previously witnessed someone developing a pulmonary embolus, a nurse notices qualitative nuances and has recognition ability for observing it before those nurses who have never seen it. Benner and Wrubel (1989) state, "Skilled activity, which is made possible by our embodied intelligence, has been long regarded as 'lower' than intellectual, reflective activity" but argue that intellectual, reflective capacities are dependent on **embodied knowing** (p. 43). Embodied knowing and the meaning of being are premises for the capacity to care; things matter and "cause us to be involved in and defined by our concerns" (p. 42).

While engaged in her doctoral studies at Berkeley, Benner was a research assistant to Richard S. Lazarus

(Lazarus, 1985; Lazarus & Folkman, 1984), who is known for his stress and coping theory. As part of Lazarus' larger study, Benner studied midcareer males' meaning of work and coping that was published as *Stress and Satisfaction on the Job: Work Meanings and Coping of Mid-Career Men* (1984b). Lazarus' theory of stress and coping is described as phenomenological, because the person is understood to constitute and be constituted by meanings. Stress is the disruption of meanings, and coping is what the person does about the disruption. Both doing something and refraining from doing something are ways of coping. Coping is bound by the meanings inherent in what the person interprets as stressful. Different possibilities arise from the way the person is in the situation. In applying this concept to clinical nursing practice, Benner theorized that nurses make a difference by being in a situation in a caring way. This engaged view of being involved in a lifeworld departs from Rene Descartes' (Trans, 2016) view of the private idiosyncratic individual with a private mind separated from the body and a separate objectified world.

Benner's approach to knowledge development that began with *From Novice to Expert* (1984a) initiated a growing, living tradition for learning from clinical nursing practice through collection and interpretation of exemplars based on first-person-experience-near narratives from immersion in clinical nursing practice (Benner, 1994; Benner & Benner, 1999; Benner et al., 1996, 1999, 2009, 2011). Benner and Benner (1999) stated the following:

> *"Effective delivery of patient/family care requires collective attentiveness and mutual support of good practice embedded in a moral community of practitioners seeking to create and sustain good practice … This vision of practice is taken from the Aristotelian tradition in ethics (Aristotle, 1985) and the more recent articulation of this tradition by Alasdair MacIntyre (1981), where practice is defined as a collective endeavor that has notions of good internal to the practice … However, such collective endeavors must be comprised of individual practitioners who have skilled know how, craft, science, and moral imagination, who continue to create and instantiate good practice."*
>
> ***(pp. 23–24)***

USE OF EMPIRICAL EVIDENCE

From 1978 to 1981, Benner was the author and project director of a federally funded grant, Achieving Methods of Intraprofessional Consensus, Assessment and Evaluation, known as the AMICAE project. This research led to the publication of *From Novice to Expert* (1984a). Benner directed the AMICAE project to develop evaluation methods for participating schools of nursing and hos in the San Francisco area. It was an interpretive, descri study that led to the use of Dreyfus' five levels of com tency to describe skill acquisition in clinical nursing pr tice. Benner (1984a) explains that the interpretive appr seeks a rich description of nursing practice from obse tion and narrative accounts of actual nursing practic provide text for interpretation (hermeneutics).

Nurses' descriptions of patient care situations in w they made a positive difference "present the uniquen nursing as a discipline and an art" (Benner, 1984a, p. xi More than 1200 nurse participants completed quest naires and interviews as part of the AMICAE pro Paired interviews with preceptors and preceptees w "aimed at discovering if there were distinguishable, cha teristic differences in the novice's and expert's descripti of the same clinical incident" (Benner, 1984a, p. Additional interviews and participant observations w conducted with 51 nurse-clinicians and other newly gra ated nurses and senior nursing students to "describe ch acteristics of nurse performance at different stages of s acquisition" (Benner, 1984a, p. 15). The purpose "of t inquiry has been to uncover meanings and knowled embedded in skilled practice. By bringing these meanin skills, and knowledge into public discourse, new know edge and understandings are constituted" (Benner, 198 p. 218).

Thirty-one competencies emerged from the analysis transcripts of interviews about nurses' detailed descr tions of patient care episodes that included their intentio and interpretations of events. From these competenci which were identified from actual practice situations, t following seven domains were derived inductively on t basis of similarity of function and intent (Benner, 1984

1. The helping role
2. The teaching-coaching function
3. The diagnostic and patient monitoring function
4. Effective management of rapidly changing situations
5. Administering and monitoring therapeutic interv tions and regimens
6. Monitoring and ensuring the quality of health ca practices
7. Organizational work role competencies

Each domain was developed using the related comp tencies from actual practice situation descriptions. Benn presented the domains and competencies of nursing pra tice as an open-ended interpretive framework for enhanc ing the understanding of the knowledge embedded i nursing practice. As a result of the socially embedde relational, and dialogical nature of clinical knowledg domains and competencies should be adapted for use i each institution through the study of clinical practice

each specific locale (Benner & Benner, 1999). Such adaptations have been implemented in many institutions for nursing staff in hospitals around the world (Alberti, 1991; Balasco & Black, 1988; Brykczynski, 1998; Dolan, 1984; Gaston, 1989; Gordon, 1986; Hamric et al., 1993; Lock & Gordon, 1989; Nuccio et al., 1996; Silver, 1986a, 1986b). The domains and competencies have also been useful for ongoing articulation of the knowledge embedded in advanced practice nursing (Brykczynski, 1999; Fenton, 1985; Fenton & Brykczynski, 1993; Lindeke et al., 1997; Martin, 1996).

Benner and Wrubel (1989) further explained and developed the background to the ongoing study of the knowledge embedded in nursing practice in *The Primacy of Caring: Stress and Coping in Health and Illness*. This text provides a reformulation of the Lazarus and Folkman (1984) cognitive model of stress and coping and instead emphasizes a noncognitive, often tacit or implicit background understanding of specific situations. Benner and Wrubel note that the primacy of caring is three-pronged "as the producer of both stress and coping in the lived experience of health and illness, as the enabling condition of nursing practice (indeed any practice), and the ways that nursing practice based in such caring can positively affect the outcome of an illness" (1989, p. 7). A few key tenets of *The Primacy of Caring* are:

1. Human beings more readily sense what matters to them, thus concerns shape the person's lifeworld, what actions they take, and prompt what they notice and respond to, and in what manner.
2. Meanings, intelligence, and notions of the good are embodied in habits and action, skilled know-how, and perception. This is why "knowing that and about" must be paired with situated understanding of "how, when, and why" in particular situations.
3. Embodied, intelligent agency in situations instead of being only or primarily thought about explicitly are in addition, lived (inhabited, dwelt in) and often are not accessible or available strictly through clear, explicit or "pure" detached intentionality or formal concepts.

Benner extended the research reported in *From Novice to Expert* (1984a) and in *Expertise in Nursing Practice: Caring, Clinical Judgment, and Ethics* (Benner et al., 1996, 2009). This book presents a 6-year study of 130 hospital nurses, primarily critical care nurses, examining the acquisition of clinical expertise and the nature of clinical knowledge, clinical inquiry, clinical judgment, and expert ethical comportment. The key aims of this research were as follows:

- Delineate the practical knowledge embedded in expert practice.
- Describe the nature of skill acquisition in critical care nursing practice.
- Identify institutional impediments and resources for the development of expertise in nursing practice.
- Begin to identify educational strategies that encourage the development of expertise.

In the introduction to *Expertise in Nursing Practice*, the authors stated, "In the study we found that examining the nature of the nurse's agency, by which we mean the sense and possibilities for acting in particular clinical situations, gave new insights about how perception and action are both shaped by a practice community" (Benner et al., 2009, p. xix). This study resulted in a clearer understanding of the distinctions between engagement with a problem or situation and the requisite nursing skills of interpersonal involvement. They found that these nursing skills are learned over time experientially. The skill of involvement was considered central in gaining nursing expertise. Understanding of the interlinkage of clinical and ethical decision-making (i.e., how an individual's notions of good and poor outcomes and visions of excellence shape clinical judgments and actions) was enhanced by this research. This study represented phase one of the articulation project designed to describe the nature of critical care nursing practice.

Phase two took place from 1996 to 1997 and included 76 nurses (32 of them advanced practice nurses) from six different hospitals. This work is presented in *Clinical Wisdom and Interventions in Acute and Critical Care: A Thinking-in-Action Approach*, which was published in 1999 and then updated and enlarged in 2011 by Benner, Hooper-Kyriakidis, and Stannard. The following nine domains of critical care nursing practice were identified as broad themes in this work:

1. Diagnosing and managing life-sustaining physiological functions in acute and unstable patients
2. Using the skilled know-how of managing a crisis
3. Providing comfort measures for the acute critically ill
4. Caring for patients' families
5. Preventing hazards in a technological environment
6. Facing death: end-of-life care and decision-making
7. Communicating and negotiating multiple perspectives
8. Monitoring quality and managing breakdown
9. Using the skilled know-how of clinical leadership and the coaching and mentoring of others

These nine domains of critical care nursing practice were used as broad themes to interpret the data and incorporate descriptions of the following nine aspects of clinical judgment and skillful comportment:

1. Developing a sense of salience
2. Situated learning and integration of knowledge acquisition and knowledge use
3. Engaged reasoning-in-transition
4. Skilled know-how
5. Response-based practice
6. Agency

7. Perceptual acuity and interpersonal engagement with patients
8. Integrating clinical and ethical reasoning
9. Developing clinical imagination

Identification of clinical grasp and clinical forethought (two pervasive habits of thought linked with action in nursing practice in phase two of this articulation project) enriched the understanding of clinical judgment (Benner et al., 2011). Clinical grasp is clinical inquiry in action that includes problem identification and clinical judgment across time about the particular transitions of particular patients and families. It has four aspects: "making qualitative distinctions, engaging in detective work, [re]nizing changing clinical relevance, and developing [cli]knowledge in specific patient populations" (Benner [et] 2011, p. 30).

Although clinical forethought plays a role in [cli]grasp, it also plays an essential role in structuring the [pr]tical logic of clinicians and deserves its own descrip[tion]. Clinical forethought refers to at least four habits of thou[ght] and action: "future think, clinical forethought about [spe]cific diagnoses and injuries, anticipation of risks, [co]and vulnerabilities for particular patients, and seeing [the] unexpected" (Benner et al., 2011, p. 71).

MAJOR CONCEPTS & DEFINITIONS

Novice

In the **novice** stage of skill acquisition in the Dreyfus model, the person has no background experience of the situation in which he or she is involved. Context-free rules and objective attributes must be given to guide performance. There is difficulty discerning between relevant and irrelevant aspects of a situation. Generally, this level applies to students of nursing, but Benner has suggested that nurses at higher levels of skill in one area of practice could be classified at the novice level if placed in an area or situation completely foreign to them, such as moving from general medical-surgical adult care to neonatal intensive care (Benner, 1984a).

Advanced Beginner

The **advanced beginner** stage in the Dreyfus model develops when the person can demonstrate marginally acceptable performance, having coped with enough real situations to note, or to have pointed out by a mentor, the recurring meaningful components of the situation. The advanced beginner has enough experience to grasp aspects of the situation (Benner, 1984a). Unlike attributes and features, aspects cannot be objectified completely, because they depend on experience-based contextual recognition.

Nurses functioning at this level are guided by rules and are oriented by task completion. They have difficulty grasping the current patient situation in terms of the larger perspective. Clinical situations are viewed by nurses in the advanced beginner stage as a test of their abilities and the demands of the situation placed on them rather than in terms of patient needs and responses (Benner et al., 1992). Benner places most newly graduated nurses at this level.

Competent

Through learning from actual practice situations and by following the actions of others, the advanced beginner moves to the **competent** level (Benner et al., 1992). Consistency, predictability, and time management are important in competent performance. A sense of mastery is acquired through planning and predictability (Benner et al., 1992). The level of efficiency is increased, but "the focus is on time management and the nurse's organization of the task world rather than on timing in relation to the patient's needs" (Benner et al., 1992, p. 20). The competent nurse may display hyper-responsibility for the patient, often more than is realistic, and may exhibit an ever-present and critical view of self (Benner et al., 1992).

The competent stage is most pivotal in clinical learning because the learner begins to recognize patterns and determine which elements of the situation warrant attention and which can be ignored. The competent nurse devises new rules and reasoning procedures for a plan, while applying learned rules for action on the basis of relevant facts of that situation. To become proficient, the competent performer allows the situation to guide responses (Dreyfus & Dreyfus, 1996). Studies point to the importance of active teaching and learning in the competent stage for nurses making the transition from competence to proficiency (Benner, 2005; Benner et al., 2010, 2011). The competent stage of learning is crucial in the formation of the everyday ethical comportment of the nurse (Benner, 2005).

Proficient

At the **proficient** stage of the Dreyfus model, the performer perceives the situation as a whole (the total picture) rather than in terms of aspects, and the performance is guided by maxims. The proficient level is a qualitative leap beyond the competent. Now the performer recognizes the most salient aspects and has an intuitive grasp of the situation based on background understanding (Benner, 1984a).

MAJOR CONCEPTS & DEFINITIONS—cont'd

Nurses at this level demonstrate a new ability to see changing relevance in a situation, including recognition and implementation of skilled responses to the situation as it evolves. They no longer rely on preset goals for organization and demonstrate increased confidence in their knowledge and abilities (Benner et al., 1992). At the proficient stage, there is much more involvement with the patient and family. The proficient stage is a transition into expertise (Benner et al., 2009).

Expert

The fifth stage of the Dreyfus model is achieved when "the expert performer no longer relies on analytical principle (i.e., rule, guideline, maxim) to connect an understanding of the situation to an appropriate action" (Benner, 1984a, p. 31). Benner described the **expert** nurse as having an intuitive grasp of the situation and as being able to identify the region of the problem without losing time considering a range of alternative diagnoses and solutions. There is a qualitative change as the expert performer "knows the patient," meaning knowing typical patterns of responses and knowing the patient as a person. Key aspects of expert practice include the following (Benner et al., 2009):

- Demonstrating a clinical grasp and resource-based practice
- Possessing embodied know-how
- Seeing the big picture
- Seeing the unexpected

The expert nurse has the ability to recognize patterns on the basis of deep experiential background. For the expert nurse, meeting the patient's actual concerns and needs is of utmost importance, even if it means planning and negotiating for a change in the plan of care. There is almost a transparent view of the self (Benner et al., 1992).

Aspects of a Situation

The **aspects** are the recurring meaningful situational components recognized and understood in context because the nurse has previous experience (Benner, 1984a).

Attributes of a Situation

The **attributes** are measurable properties of a situation that can be explained without previous experience in the situation (Benner, 1984a).

Competency

Competency is "an interpretively defined area of skilled performance identified and described by its intent, functions, and meanings" (Benner, 1984a, p. 292). This term is unrelated to the competent stage of the Dreyfus model.

Domain

The **domain** is an area of practice having a number of competencies with similar intents, functions, and meanings (Benner, 1984a).

Exemplar

An **exemplar** is a first-person-experience-near narrative of a clinical situation that conveys common taken for granted meanings of nursing practice recognizable by other nurses (Benner, 1984a).

Experience

Experience is not a mere passage of time, but an active process of refining and changing preconceived theories, notions, and ideas when confronted with actual situations; it implies there is a dialogue between what is found in practice and what is expected (Benner & Wrubel, 1982).

Maxim

Maxim is an apt phrase that points out how to perform in a situation, such as the instruction to neonatal nurses to "Follow the body's lead." A maxim provides a description of skilled performance that requires a certain level of experience to recognize the implications of the instructions (Benner, 1984a).

Paradigm Case

A **paradigm case** is a clinical experience that stands out and alters the way the nurse will perceive and understand future clinical situations (Benner, 1984a). Paradigm cases create new clinical understanding and open new clinical perspectives and alternatives.

Salience

Salience describes a perceptual stance or embodied knowledge whereby aspects of a situation stand out as more or less important (Benner, 1984a).

Ethical Comportment

Ethical comportment is good conduct born out of an individualized relationship with the patient. It involves engagement in a particular situation and entails a sense of membership in the relevant professional group. It is socially embedded, lived, and embodied in practices, ways of being, and responses to a clinical situation that promote the well-being of the patient (Day & Benner, 2002). "Clinical and ethical judgments are inseparable and must be guided by being with and understanding the human concerns and possibilities in concrete situations" (Benner, 2000, p. 305).

Continued

MAJOR CONCEPTS & DEFINITIONS—cont'd

Hermeneutics

Hermeneutics means "interpretive." The term derives from biblical and judicial exegesis. As used in research, hermeneutics refers to describing and studying "meaningful human phenomena in a careful and detailed manner as free as possible from prior theoretical assumptions, based instead on practical understanding" (Packer, 1985, pp. 1081–1082).

Formation

"Transformation and **formation** ... address the development of senses, esthetics, perceptual acuities, relational skills, knowledge and dispositions that take place as student nurses form professional identity" (Day et al., 2009, p. 87). It goes beyond content knowledge and role ... ment to development of moral character, self-understa... ing, and identity as a nurse.

Situated Coaching

Situated coaching was identified as the signature pe... gogy in nursing from the *Educating Nurses* study (Be... et al., 2010). It occurs in particular clinical situations in wh... the teacher describes his or her understanding of the s... ation for students, including what is perceived as most re... evant and salient (Benner, 2015). Situated coaching enable... students to learn to make qualitative distinctions and re... ognize trends and changes in the patient's responses (Da... & Benner, 2014).

MAJOR ASSUMPTIONS

Benner incorporates the following assumptions (as delineated in Brykczynski's 1985 dissertation) in her ongoing articulation research:

- There are no interpretation-free data. This abandons the assumption from natural science that there is an independent reality whose meaning can be represented fully by atemporal, abstract terms, or concepts (Taylor, 1982).
- There are no nonreactive data. This abandons the false belief from natural science that one can neutrally observe brute data (Taylor, 1982).
- Meanings are embedded in skills, practices, intentions, expectations, and outcomes. They are taken for granted and often are not recognized as knowledge. According to Polanyi (1958), a context possesses existential meaning, and this distinguishes it from "denotative or, more generally, representative meaning" (p. 58). He claims that transposing a significant whole in terms of its constituent parts deprives it of any purpose or meaning.
- People who share a common cultural and language history have a background of common meanings that allow for understanding and interpretation. Heidegger (1962) refers to this as *primordial understanding*, after the writings of Dilthey (1976) in the late 1800s and early 1900s, asserting that cultural organization and meanings precede and influence individual understanding.
- The meanings embedded in skills, practices, intentions, expectations, and outcomes cannot be made completely explicit; however, they can be interpreted by someone who shares a similar language and cultural background and can be validated consensually by participants and relevant practitioners. Humans are self-interpreting beings (Heidegger, 1962). Hermeneutics is the interpretation of cultural contexts and meaningful human action.
- Humans are integrated, holistic beings. The mind-bo... split is abandoned. Embodied intelligence enables skill... activity that is transformed through experience and ma... tery (Dreyfus & Dreyfus, 1980, 1986). Benner stated, "T... model assumes that all practical situations are far mo... complex than can be described by formal models, theor... and textbook descriptions" (1984a, p. 178). The hierarch... cal elevation of intellectual, reflective activity above em... bodied skilled activity ignores the point that skilled actio... is a way of knowing and that the skilled body may be e... sential for the more highly esteemed levels of human int... ligence (Dreyfus, 1979).

Benner and her collaborators explicated the themes o... *nursing, person, health,* and *situation* in their publication...

Nursing

Nursing is described as a caring relationship, an "enablin... condition of connection and concern" (Benner & Wrube... 1989, p. 4). "Caring is primary because caring sets up th... possibility of giving help and receiving help" (Benner ... Wrubel, 1989, p. 4). "Nursing is viewed as a caring practi... whose science is guided by the moral art and ethics of ca... and responsibility" (Benner & Wrubel, 1989, p. xi). Benne... and Wrubel (1989) understand nursing practice as the ca... and study of the lived experience of health, illness, and di... ease and the relationships among these three elements.

Person

Benner and Wrubel (1989) use Heidegger's phenomen... logical description of person, which they describe as ... person is a self-interpreting being, that is, the person do... not come into the world predefined but gets defined in t... course of living a life. A person also has an effortless a... nonreflective understanding of the self in the world" (p. 4...

Finally, the person is embodied. Benner and Wrubel (1989) conceptualized the following four major aspects of understanding that the person must deal with:

1. The role of the situation
2. The role of the embodied intelligent agent
3. The role of personal concerns
4. The role of temporality

Together, these aspects of the person make up the person in the world. This view of the person is based on the works of Heidegger (1962), Merleau-Ponty (1962), and Dreyfus (1979, 1991). Their goal is to overcome Cartesian dualism, the view that the mind and body are distinct, separate entities (Descartes, 2016). Benner and Wrubel (1989) define *embodiment* as the capacity of the body to respond to meaningful situations. They point out that nurses seek to understand the role of embodiment in particular situations of health, illness, and recovery.

Health

On the basis of the work of Heidegger (1962) and Merleau-Ponty (1962), Benner and Wrubel focus "on the lived experience of being healthy and being ill" (1989, p. 7). **Health** is defined as what can be assessed, whereas **well-being** is the human experience of health or wholeness. Well-being and being ill are understood as distinct ways of being in the world. Health is described as not just the absence of disease and illness. Also, on the basis of the work of Kleinman and colleagues (1978), a person may have a disease and not experience illness, because illness is the human experience of loss or dysfunction, whereas disease is what can be assessed at the physical level (Benner & Wrubel, 1989).

Situation

Benner and Wrubel (1989) use the term **situation** rather than **environment**, because situation conveys a social environment with social definition and meaningfulness. They use the phenomenological terms **being situated** and **situated meaning**, which are defined by the person's engaged interaction, interpretation, and understanding of the situation. "Personal interpretation of the situation is bounded by the way the individual is in it" (Benner & Wrubel, 1989, p. 4). This means that each person's past, present, and future, which include her or his own personal meanings, values, and perspectives, influence the current situation.

THEORETICAL ASSERTIONS

Benner (1984a) stated that there is always more to any situation than theory predicts or describes. The skilled practice of nursing exceeds the bounds of formal theory. Concrete experience facilitates learning about the exceptions and nuances of meaning in a situation. The knowledge embedded in practice can lead to discovering and interpreting theory, precedes and extends theory, and synthesizes and adapts theory in caring nursing practice. Benner has taken a hermeneutical approach to uncover the knowledge in clinical nursing practice. Dunlop (1986) stated, "As she does this, she is also uncovering the nursing-caring with which it is deeply intertwined" (p. 668). Dunlop also noted that Benner's approach "does not provide us with any universal truths about caring in general or about nursing-caring in particular—indeed it does not make any such pretension" (p. 668).

As such, the competencies within each domain are in no way intended as an exhaustive list. Instead, the situation-based interpretive approach to describing nursing practice seeks to overcome some of the problems of reductionism and the problem of global and overly general descriptions based on nursing process categories (Benner, 1984a). In a further description of this approach, Benner (1992) examined the role of narrative accounts for understanding the notion of good or ethical caring in expert clinical nursing practice. "The narrative memory of the actual concrete event is taken up in embodied know-how and comportment, complete with emotional responses to situations. The narrative memory can evoke perceptual or sensory memories that enhance pattern recognition" (p. 16). Some of the relationship statements included in Benner's work follow:

- "Discovering assumptions, expectations, and sets can uncover an unexamined area of practical knowledge that can then be systematically studied and extended or refuted" (Benner, 1984a, p. 8).
- Clinical knowledge is embedded in perceptions rather than precepts.
- "Perceptual awareness is central to good nursing judgment and [for the expert] begins with vague hunches and global assessments that initially bypass critical analysis; conceptual clarity follows more often than it precedes" (Benner, 1984a, p. xviii).
- Formal rules are limited and discretionary judgment is needed in actual clinical situations.
- Clinical knowledge develops over time, and each clinician develops a personal repertoire of practice knowledge that can be shared in dialogue with other clinicians.
- "Expertise develops when the clinician tests and refines propositions, hypotheses, and principle-based expectations [and learns directly from immersion] in actual practice situations" (Benner, 1984a, p. 3).

LOGICAL FORM

Through qualitative descriptive research, Benner used the Dreyfus model of skill acquisition to better understand skill acquisition in clinical nursing practice. By following

the model's logical sequence, Benner was able to identify the performance characteristics and teaching-learning needs inherent at each skill level. In reporting her research, Benner used exemplars taken directly from interviews and observation of clinical nurses at different skill levels to help the reader form a clear picture of practice. Guidelines for describing exemplars or clinical narratives, first termed "critical incidents," were presented in *From Novice to Expert* (1984a) and are developed further in *Clinical Wisdom and Interventions in Acute and Critical Care* (Benner et al., 2011). The approach for describing clinical narratives is consistent throughout the body of Benner's work whether the narratives are used in research, practice, or education. The goal of Benner's research is to bring meanings and knowledge embedded in skilled practice into public discourse. Benner (1984a) claims that new knowledge and understanding are constituted by articulating meanings, skills, and knowledge that previously were taken for granted and embedded in clinical practice.

ACCEPTANCE BY THE NURSING COMMUNITY

Practice

From Novice to Expert (1984a) includes several examples of the application of Benner's work in practice settings as follows: Dolan (1984) describes its usefulness for preceptor development, orientation programs, and career development; Huntsman and colleagues (1984) detail their implementation of a clinical ladder to recognize and retain experienced staff nurses; Ullery (1984) presents its usefulness for conducting annual excellence symposia where nurses present their clinical narratives to recognize and further develop clinical knowledge; and Fenton (1984) reported the use of Benner's approach in an ethnographic study of the performance of clinical nurse-specialists (CNSs).

Balasco and Black (1988) and Silver (1986a, 1986b) used Benner's work as a basis for differentiating clinical knowledge development and career progression in nursing. Neverveld (1990) used Benner's rationale and format in the development of basic and advanced preceptor workshops. Farrell and Bramadat (1990) used Benner's paradigm case analysis in a collaborative educational project between a university school of nursing and a tertiary care teaching hospital to better understand the development of clinical reasoning skills in actual practice situations. Crissman and Jelsma (1990) applied Benner's findings to develop a cross-training program to address staffing imbalances. They delineated specific cross-training performance objectives for novice nurses and provided support for experiential judgment needed to function in unfamiliar settings by designating a preceptor in the clinical area. The aim was for the novice to perform more like an ad beginner with an experienced nurse available as a re

Benner's approach continues to be used in the d ment of clinical promotion ladders, new graduate tion programs, and clinical knowledge develo seminars (Benner & Benner, 1999; Benner et al Coyle, 2011; Hargreaves et al., 2010). Mauleon an leagues (2005) conducted an interpretive phenomen cal analysis of problematic situations experienced by anesthetists in anesthesia care of elderly patients that cated a need for ethical forums for dealing with distress arising from their experiences. Uhrenfeldt's study of how first-line nurse leaders care for their staff was based on Benner and Wrubel's (1989) framework. Cathcart (2010) articulated the experien acquired knowledge, skill, and ethics embedded in manager practice after Benner's approach.

Benner has been cited extensively in nursing litera regarding nursing practice concerns and the role of c in such practice. She continues to advance understan of the knowledge embedded in clinical situations thro her publications (Benner, 1985a, 1985b, 1987; Benner Tanner, 1987; Benner et al., 1996, 1999, 2009, 2 Benner edited a *Dialogue with Excellence* clinical exem series in the *American Journal of Nursing* during the 19 and 1990s. From 2001 through 2008, Benner edited an ics column: *Current Controversies in Critical Care* in *American Journal of Critical Care*. Benner's work with National Council of State Boards of Nursing constitute major contribution to error recognition and safety of nu ing practice (Benner et al., 2002). This research exam practice breakdowns from a systems perspective with goal of transforming the culture of blame in the health c system to reduce health care errors (Benner et al., 2010

Education

Benner (1982) critiqued the earlier behaviorist approach competency-based testing as too abstract, element decontextualized, and limited for application to evaluati of professional nursing practice. Benner endorses m recent efforts to incorporate broader, integrative, contex dependent competencies into professional education recommended in the Institute of Medicine *Future Nursing* report (2011) and applied by Smith and Dolli (1999) and Cronnenwett and colleagues (2009). The outcome-based approaches are student-centered a focused on what learners should know, understand, dem onstrate, and be able to adapt to clinical practice beyo formal education (Pijl-Zieber et al., 2014).

Benner's original domains of nursing practice were inco porated into educational research with advanced practi nurses. Fenton (1984, 1985) applied the domains of clini

actice as a basis for studying skilled performance Her analysis validated all seven of the original n the CNSs studied. She identified additional illed performance for CNSs, including the con- e. Brykczynski's (1985, 1999) study used the pproach presented in *From Novice to Expert* to e question: "Where is the nurse in nurse practi- hat study produced an adaptation of Benner's mains and competencies for nurse practitioners s adaptation of the domains and competencies actice formed the framework for the National on of Nurse Practitioner Faculties (NONPF, 1990) n guidelines. Fenton and Brykczynski (1993) later the findings from their studies of CNSs and NPs r commonalities and distinctions between these practice nurses that were relevant for graduate n planning.

ling to Barnum (1990), it was not Benner's devel- f the seven domains of nursing practice that has greatest impact on nursing education, but the ion of the utility of the Dreyfus model in describ- ng and thinking in our discipline" (p. 170). As a rsing educators realized that learning needs at the es of clinical knowledge development are differ- those required at later stages. These differences e acknowledged and valued to develop nursing programs appropriate for the background expe- the students.

pertise in Nursing Practice, Benner and colleagues nphasized the importance of learning the skills of ent and caring through practical experience, the on of knowledge with practice, and the use of nar- undergraduate education. This work supports the t it is better to place a new graduate with a com- rse preceptor who can explain nursing practice in t the beginner comprehends, rather than with the whose intuitive knowledge may elude beginners not have the experienced know-how to grasp the . This work led to the development of internship ntation programs for newly graduated nurses and al development programs for more experienced

inical Wisdom and Interventions in Critical Care, and colleagues (1999) urged greater attention to tial learning and presented the work as a guide to . They designed a highly interactive CD-ROM to any the book (Benner et al., 2001). The second edi- *Clinical Wisdom and Interventions in Critical Care* et al., 2011) includes a chapter on the educational ions and recommended teaching strategies from onal study of nursing education *Educating Nurses: or Radical Transformation* (Benner et al., 2010). The two major types of integrative teaching strategies presented are coaching-situated-learning and a thinking-in-action approach of integrating classroom with clinical teaching.

The national nursing education study noted above was designed to identify and describe "signature pedagogies" that maximize the nurse's ability to cope with the challenges of nursing that have developed during the 30 years since the last national study of nursing education (Schwartz, 2005). The book *Educating Nurses: A Call for Radical Transformation* (Benner et al., 2010) reports details of this national study and concludes that nursing education is in need of a major transformation. An education gap has developed from the difficulty of addressing competing demands and keeping pace with the increasing complexity of practice driven by research and new technologies. The authors recommend that nurse educators make four major shifts in their focus: (1) from covering abstract knowledge to emphasizing teaching for particular situations, (2) from separations between clinical and classroom teaching to integration of these components, (3) from critical thinking to clinical reasoning, and (4) from emphasizing socialization and role-taking to professional identity formation. These findings and recommendations have been presented at national and international conferences and to faculty at many schools of nursing.

McNiesh and colleagues (2011) studied how students in an accelerated master's entry program experientially learned the practice of nursing. They found that independent care of a patient was pivotal in the development of students' identity and agency as nurses. Crider and McNiesh (2011) incorporated a three-pronged apprenticeship approach (Benner et al., 2010) that integrates intellectual, practical, and ethical aspects of the professional role in teaching students in psychiatric nursing to develop practical reasoning skills.

Research

Benner (1983) was the first to introduce interpretive phenomenology as a qualitative research approach for study in the human sciences of situated, embodied intelligence, skilled know-how, historical content, and meanings of events. Intricate nuanced descriptions of situational contexts (experience-near narratives; Geertz, 1973/1977) are the essence of this research approach, which dictates data be collected through situation-based dialogue and observation of actual practice. The situational context guides interpretation of meanings so there can be agreement among interpreters. This is a holistic approach that emphasizes identification and description of meanings embedded in clinical practice. The holistic approach is maintained throughout the research process as the situational context of narratives are interpreted through dialogue among researchers and clinicians.

nursing practice as a basis for studying skilled performance of CNSs. Her analysis validated all seven of the original domains in the CNSs studied. She identified additional areas of skilled performance for CNSs, including the consulting role. Brykczynski's (1985, 1999) study used the research approach presented in *From Novice to Expert* to address the question: "Where is the nurse in nurse practitioner?" That study produced an adaptation of Benner's original domains and competencies for nurse practitioners (NPs). This adaptation of the domains and competencies for NP practice formed the framework for the National Organization of Nurse Practitioner Faculties (NONPF, 1990) curriculum guidelines. Fenton and Brykczynski (1993) later compared the findings from their studies of CNSs and NPs to uncover commonalities and distinctions between these advanced practice nurses that were relevant for graduate curriculum planning.

According to Barnum (1990), it was not Benner's development of the seven domains of nursing practice that has had the greatest impact on nursing education, but the "appreciation of the utility of the Dreyfus model in describing learning and thinking in our discipline" (p. 170). As a result, nursing educators realized that learning needs at the early stages of clinical knowledge development are different from those required at later stages. These differences need to be acknowledged and valued to develop nursing education programs appropriate for the background experience of the students.

In *Expertise in Nursing Practice,* Benner and colleagues (2009) emphasized the importance of learning the skills of involvement and caring through practical experience, the articulation of knowledge with practice, and the use of narratives in undergraduate education. This work supports the thesis that it is better to place a new graduate with a competent nurse preceptor who can explain nursing practice in ways that the beginner comprehends, rather than with the expert, whose intuitive knowledge may elude beginners who do not have the experienced know-how to grasp the situation. This work led to the development of internship and orientation programs for newly graduated nurses and to clinical development programs for more experienced nurses.

In *Clinical Wisdom and Interventions in Critical Care,* Benner and colleagues (1999) urged greater attention to experiential learning and presented the work as a guide to teaching. They designed a highly interactive CD-ROM to accompany the book (Benner et al., 2001). The second edition of *Clinical Wisdom and Interventions in Critical Care* (Benner et al., 2011) includes a chapter on the educational implications and recommended teaching strategies from the national study of nursing education *Educating Nurses: A Call for Radical Transformation* (Benner et al., 2010). The two major types of integrative teaching strategies presented are coaching-situated-learning and a thinking-in-action approach of integrating classroom with clinical teaching.

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Benner's numerous studies and projects with research colleagues and graduate students have created a community of interpretive phenomenological scholars. Benner (1994) edited and contributed to *Interpretive Phenomenology: Embodiment, Caring, and Ethics in Health and Illness*, a collection of essays and studies selected from that community of researchers that she has inspired and taught during her career. The book offers a philosophical introduction to interpretive phenomenology as a qualitative research method, a guide to understanding the strategies and processes of this approach, and a selection of studies that conveys its resemblances and variations. Interpretive phenomenology cannot be explained as a set of procedures and techniques. Instead, "each interpreter enters the interpretive circle by examining preunderstandings and confronting otherness, silence, similarities, and commonalities from his or her own particular historical, cultural, and personal stance" (Benner, 1994, p. xviii).

A second volume of interpretive phenomenological readings and studies edited by Chan and colleagues (2010) arose from a *Festschrift* (retirement celebration for a scholar) honoring the impact and significance of the research tradition Benner established. That second volume presents the interpretive phenomenology philosophy and research approach that continues to evolve. The first section explores theoretical and philosophical discourses and issues within the interpretive phenomenological tradition, whereas the second section is a collection of studies that exemplifies the similarities and variations in the approaches across studies.

Benner and colleagues (De Jong et al., 2010) conducted a large-scale collaborative study with The TriService Military Nursing Research group to investigate knowledge development and experiential learning from nursing practice during the Iraq and Afghanistan Wars. It describes how nurses learned to improve clinical practice and care delivery during mass casualty events. That research was followed by a study describing the evolution of case management for service members wounded in Iraq and Afghanistan (Kelly et al., 2017). The new types of injuries, in-field treatment, immediate transport to multiple care centers, and new technologies required expansion of case management practice to include family support, reentry, and life coaching for extremely altered life circumstances. An additional study aim was to capture the experience of injury, transport, acute and rehabilitative care of the wounded warriors themselves (Benner et al., 2018).

FURTHER DEVELOPMENT

The separation of academic course work from clinical learning developed over time as nursing education moved from hospital schools to colleges and universities with the eventual result that nursing faculty and students can be regarded as "guests in the house" (Glass, 1975). The increasing complexity of technology and clinical practice coupled with the separation between education and practice sets the stage for new graduate nurses to a major transition upon graduation. Implementation findings from Benner and colleagues' extensive work articulating the knowledge developed in practice and describing ways to teach nursing that grate theory and decontextualized content with context-dependent know-how requires extensive transformation of nursing education.

The hidden curriculum described by Day and Benner (2014, p. 140) as "the implicit and unconscious development of practice-based learning in context and the privileging of theory-based" abstract learning must be recognized and augmented with integrated approaches that re-contextualize teaching and learning in nursing practice. There are many examples of how to teach nursing using integrated approaches that emphasize knowledge acquisition and knowledge use in practice, such as team-based and problem-based learning, simulation, narrative pedagogy, and unfolding case studies. Nursing faculty require ongoing continuing education and coaching to develop the skills and knowledge needed to incorporate these approaches into their teaching.

Benner initiated an educational newsletter to disseminate *Educating Nurses: A Call for Radical Transformation* (2010) study recommendations and create an ongoing dialogue among nurse educators. Benner (2012) discussed the progress in implementing study recommendations, reporting that several states have implemented suggested changes in nursing education and many hospitals and health science campuses have instituted nurse residency programs. Two websites were created to facilitate dissemination, implementation, and ongoing development of the study recommendations are listed in the Web Media references at the end of this chapter.

CRITIQUE

Clarity

The clarity of Benner's novice to expert model has led to its use among nurses around the world. An identification of the idea of clinical wisdom and varying levels of clinical expertise development progressed very quickly. The research approach differentiated Benner's work from other theoretical approaches at the time. Altmann (2007) addressed the question of whether the work was a philosophy or theory. Benner's work not only contributed to appreciative understanding of clinical practice but also revealed nuances of knowledge embedded in practice. Benner's perspective is phenomenological, not cognitive. She stated, "Cli

judgment and caring practices require attendance to the particular patient across time, taking into account changes and what has been learned. In this vision of clinical judgment, skilled know-how and action are linked" (Benner, 1999, p. 316). There has been ongoing debate over cognitive interpretations of Benner's concepts of expertise and intuition (Benner, 1996b; Cash, 1995; Darbyshire, 1994; English, 1993; Gobet & Chassy, 2008; Paley, 1996). Scholarly debate around these concepts has contributed to clarification of the nature of the research approach (Brykczynski & Benner, 2010).

Simplicity

Benner developed interpretive descriptive accounts of clinical nursing practice. The model is relatively simple with regard to the five stages of skill acquisition, and it provides a comparative guide for identifying levels of nursing practice from individual nurse descriptions and observations and interpretations validated by consensus. A degree of complexity is encountered in the subconcepts for differentiation among the levels of competency and the need to identify meanings and intentions. This interpretive approach is designed to overcome the constraints of the rational-technical approach to the study and description of nursing practice. Although a decontextualized (object) description of the novice level of performance is possible, such a description of expert performance would be difficult, if not impossible, and is of limited usefulness because of the limits of objectification. In other words, the philosophical problem of infinite regress would be encountered in attempts to specify all the aspects of expert practice. Rather, a holistic understanding of the particular situation is required for expert performance.

Generality

The novice-to-expert skill acquisition model has universal characteristics; that is, it is not restricted by age, illness, health, or location of nursing practice. However, the characteristics of theoretical universality imply properties of operationalization for prediction that are not a part of this perspective. Indeed, this phenomenological perspective critiques the limits of universality in studies of human practices. The interpretive model of nursing practice has the potential for universal application as a framework, but the descriptions are limited by dependence on the actual clinical nursing situations from which they must be derived. Its use depends on an understanding of the five levels of competency and the ability to identify the characteristic intentions and meanings, perceptual acuity, sense of salience, skilled know-how, interventions, ethical comportment, and relational and communications skills inherent at each level of practice.

Generalization is approached through an understanding of common meanings, skills, practices, and embodied capacities. Preferred strategies for generalization in clinical practice are based on the skilled knowledge, intent, content, and notion of good in clinical knowledge depicted by exemplars that illustrate the role of the situation. The generalizations possible with the interpretive approach are depicted through exemplars that demonstrate relational and contextually relevant intents and aspects of clinical knowledge. Benner (1984a) believes that the scope and complexity of nursing practice are too extensive for nurses to rely on idealized, decontextualized views of practice or experiments.

To capture the contextual and relational aspects of practice, Benner uses first person, experience-near narrative accounts of actual clinical situations and maintains that this approach enables the reader to recognize similar intents and meanings, although the objective circumstances may be quite different. An example of generalizability or transferability as used here follows: Upon reading or hearing a narrative about a nurse connecting with a family whose child is dying, other nurses can relate the knowledge and meanings conveyed to the experiences they may have had with families of patients of any age who were dying.

Accessibility

Clinical nurses around the world enthusiastically received *From Novice to Expert* (1984a). They found understanding of their practice in terms of what they did in specific patient situations validated and enhanced by this work, which taught them to listen to their voices as nurses. Subsequent research suggests that the framework is applicable and useful for continued development of knowledge embedded in nursing practice. This approach to knowledge development honors the primacy of caring and the central ethic of care and responsibility embedded in expert nursing practice (Benner, 1999). The qualitative interpretive approach describes expert nursing practice with narrative exemplars. Benner's work is considered hypothesis generating rather than hypothesis testing. Benner provides a methodology for uncovering and entering into the situated meaning of expert nursing care.

Importance

The landmark research reported in *From Novice to Expert* has influenced major changes in nursing practice, research, teaching, and administration. The thesis of the work was revolutionary in that it advocated developing knowledge from clinical nursing practice. This was a complete change from the time-honored approach of applying theory to practice. This represented what Kuhn (1970) referred to as a *paradigm shift*. It is an example of **articulation research**

wherein knowledge develops through dialogue (Benner, 1999) that provides a way of recognizing aspects of nursing that are relational, contextual, basic, and pervasive. *From Novice to Expert* gave voice and visibility to nursing's embedded caring practices that are often taken for granted, unrecognized, and unrewarded yet are essential to maintaining dignity, humanity, and safety in the cost-driven high-tech world of hospital nursing practice.

Benner claims that nurses need to overcome the limits of subject-object descriptions. Her call is to "increase public storytelling" to validate nursing as an ethical caring practice and "to extend, alter, and preserve ethical distinctions and concerns" (Benner, 1992, pp. 19
Benner (1996a) stated, "We have overlooked practit
stories that demonstrate that compassion can be wise
in the long run, less costly than 'defensive' advers
commodified technocures" (pp. 35–36). Benner's wo
useful in that it frames nursing practice in the conte
what a nurse actually is and does. The significanc
Benner's research findings lies in her conclusion tha
nurse's clinical knowledge is relevant to the exten
which its manifestation in nursing skills makes a dif
ence in patient care and patient outcomes" (Benne
Wrubel, 1982, p. 11).

SUMMARY

Benner maintains that caring practices are imbued with knowledge and skill about everyday human needs, and that to be experienced as caring, these practices must be attuned to the particular person who is being cared for and to the particular situation as it unfolds. Benner's philosophy of nursing practice is a dynamic, emerging holistic perspective that holds philosophy, practice, research, and theory as interdependent, interrelated, and hermeneutic. Her hope, voiced in the preface of *From Novice to Expert* (1984a), that domains and competencies would not be reified by syst
builders seems to have been largely realized, because th
who have sought to apply these concepts have honored t
contextual background on which they are based. Benne
work exemplifies the interrelationship of philosophy, pra
tice, research, theory, and education, and the resources s
and her colleagues have developed for teacher trainin
curriculum development, and online student learning int
grate practical and theoretical knowledge.

CASE STUDY

This case study is a narrative exemplar shared by a Clinical Nurse Specialist from the peer-identified nurse expert project that illustrates Benner's approach to knowledge development in clinical nursing practice (Brykczynski, 1993–1995, 1998). The nurse who described this situation had approximately 8 years of experience in critical care. She shared that her experience with this patient was significant to her practice because it taught her how to integrate care of a family in crisis along with care of a critically ill patient.

"Mrs. Walsh, a woman in her 70s, was in critical condition after repeat coronary artery bypass graft (CABG) surgery. Her family lived nearby when Mrs. Walsh had her first CABG surgery. They had moved out of town but returned to our institution, where the first surgery had been performed successfully. Mrs. Walsh remained critically ill and unstable for several weeks before her death. Her family was very anxious because of Mrs. Walsh's unstable and deteriorating condition, and a family member was always with her 24 hours a day for the first few weeks.

The nurse became involved with this family while Mrs. Walsh was still in surgery, because family members were very anxious that the procedure was taking longer than it had the first time and made repeated calls to the critical care unit to ask about the patient. The nurse met with the family and offered to go into the operating room to talk with the cardiac surgeon to better inform the family of their mother's status.

One of the helpful things the nurse did to assist this family was to establish a consistent group of nurses to work with Mrs. Walsh, so that family members could establish trust and feel more confident about the care their mother was receiving. This eventually enabled family members to leave the hospital for intervals to get some rest. The nurse related that this was a family whose members were affluent, educated, and well informed, and that they came in prepared with lists of questions. A consistent group of nurses who were familiar with Mrs. Walsh's particular situation helped both family members and nurses to be more satisfied and less anxious. The family developed a close relationship with the three nurses who consistently cared for Mrs. Walsh and shared with them details about Mrs. Walsh and her life.

The nurse related that there was a tradition in this par
ticular critical care unit not to involve family members in
care. She broke that tradition when she responded to
the son's and the daughter's helpless feelings by teach-
ing them some simple things that they could do for their

CASE STUDY– cont'd

mother. They learned to give some basic care, such as bathing her. The nurse acknowledged that involving family members in direct patient care with a critically ill patient is complex and requires knowledge and sensitivity. She believes that a developmental process is involved when nurses learn to work with families.

She noted that after a nurse has lots of experience and feels very comfortable with highly technical skills, it becomes okay for family members to be in the room when care is provided. She pointed out that direct observation by anxious family members can be disconcerting to those who are insecure with their skills when family members ask things like, "Why are you doing this? Nurse 'So and So' does it differently." She commented that nurses learn to be flexible and to reset priorities. They come to understand that some things can wait that do not need to be done right away to give the family some time with the patient. One of the things that the nurse did to coordinate care was to meet with the family to see what times worked best for them; then she posted family time on the patient's activity schedule outside her cubicle to communicate the plan to others involved in Mrs. Walsh's care.

When Mrs. Walsh died, the son and daughter wanted to participate in preparing her body. This had never been done in this unit, but after checking to see that there was no policy forbidding it, the nurse invited them to participate. They turned down the lights, closed the doors, and put music on; the nurse, the patient's daughter, and the patient's son all cried together while they prepared Mrs. Walsh to be taken to the morgue. The nurse took care of all intravenous lines and tubes while the children bathed her. The nurse provided evidence of how finely tuned her skill of involvement was with this family when she explained that she felt uncomfortable at first because she thought that the son and daughter should be sharing this time alone with their mother. Then she realized that they really wanted her to be there with them. This situation taught her that families of critically ill patients need care as well. The nurse explained that this was a paradigm case that motivated her to move into a CNS role, with expansion of her sphere of influence from her patients during her shift to other shifts, other patients and their families, and other disciplines" (Brykczynski, 1998, pp. 351–359).

Domain: The Helping Role of the Nurse

This narrative exemplifies the meaning and intent of several competencies in this domain, in particular creating a climate for healing and providing emotional and informational support to patients' families (Benner, 1984a). Incorporating the family as participants in the care of a critically ill patient requires a high level of skill that cannot be developed until the nurse feels competent and confident in technical critical care skills. This nurse had many years of experience in this unit, and she felt that providing care for their mother was so important to these children that she broke tradition in her unit and taught them how to do some basic comfort and hygiene measures. The nurse related that the other nurses in this critical care unit held the belief that active family involvement in care was intrusive and totally out of line. A belief such as this is based on concerns for patient safety and efficiency of care, yet it cuts the family off from being fully involved in the caring relationship. This nurse demonstrated moral courage, commitment to care, and advocacy in going against the tradition in her unit of excluding family members from direct care. She had 8 years of experience in this unit, and her peers respected her, so she was able to change practice by starting with this one patient-family situation and involving the other two nurses who were working with them.

Chesla's (1996) research points to a gap between theory and practice with respect to including families in patient care. Eckle (1996) studied family presence with children in emergency situations and concluded that in times of crisis, the needs of families must be addressed to provide effective and compassionate care. The skilled practice of including the family in care emerged as significantly meaningful in the narrative text from the peer-identified nurse expert study. This was defined as an additional competency in the domain called the *helping role of the nurse* and was named *maximizing the family's role in care* (Brykczynski, 1998). The intent of this competency is to assess each situation as it arises and develops over time, so that family involvement in care can adequately address specific patient-family needs, and so they are not excluded from involvement nor do they have participation thrust upon them.

This narrative illustrates how Benner's approach is dynamic and specific for each institution. The belief that being attuned to family involvement in care is in part a developmental process is supported by Nuccio and colleagues' (1996) description of this aspect of care at their institution. They observed that novice nurses begin by recognizing their feelings associated with family-centered care, whereas expert nurses develop creative approaches to include patients and families in care. The intricate process of finely tuning the nurse's collaboration with families in critical care is delineated further by Levy (2004) in her interpretive phenomenological study that articulates the practices of nurses with critically burned children and their families.