Patterns of knowing: Review, critique, and update

Carper's patterns of knowing in nursing have been consistently cited in the nursing literature since they appeared in 1978. The degree to which they represent nursing knowledge in the mid-1990s is explored, and a major modification is suggested—the addition of a fifth pattern, sociopolitical knowing. The article also suggests modifications to the model for nursing knowledge put forward by Jacobs-Kramer and Chinn to enable this model to be used more effectively as a framework for exploring processes of inquiry into nursing knowledge and practice. Key words: *empirics, esthetics, ethics, patterns of knowing, personal knowing, sociopolitical*

Jill White, RN, CM, MEd
Professor
Department of Nursing and Midwifery
Victoria University of Wellington
Wellington, New Zealand

IN 1978 Barbara Carper[1] published "Fundamental Patterns of Knowing in Nursing" in the first edition of *Advances in Nursing Science.* Based on her doctoral work, the article described her typology of patterns of knowing in nursing. These patterns she named empirics, esthetics, ethics, and personal knowing.

Carper's patterns of knowing have been much cited and commented on, albeit somewhat uncritically, in the writing of nurses over the ensuing years. As with much of nursing's written heritage, there is little connection between the number of citations and the extent of critical development that has taken place. An important exception to this, however, was the work of Jacobs-Kramer and Chinn[2] a decade after Carper's article first appeared. Jacobs-Kramer and Chinn extended Carper's framework by producing

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a model that elucidated their understanding of the creation and development, the expression and transmission, and the assessment of each of Carper's patterns of knowing. Their intention was for such an elucidation to facilitate the integration of these patterns of knowing in nursing into clinical practice.

The lack of recent dialogue about the patterns themselves or about the model may reflect the decreased interest in the use of models generally in nursing, part of a move from reductionist thinking. The continued citation of both Carper and Jacobs-Kramer and Chinn, however, suggests their work is still being used in teaching.

The "patterns" of Carper[1] and "model" of Jacobs-Kramer and Chinn[2] do provide convenient conceptual organizers for introducing students to different ways of knowing in nursing. The patterns and model can be used to facilitate exploration of nursing practice and to enhance understanding of the rich history of modern nursing writing. They enable the contributions of nurses from the past to be analyzed in terms of the dominant social, political, and philosophical contexts of

Table 1. Summary of essential elements: Model of nursing knowledge

Dimension	Empirics	Ethics	Personal	Esthetics
Creative	Describing Explaining Predicting	Valuing Clarifying Advocating	Encountering Focusing Realizing	Engaging Interpreting Envisioning
Expressive	Facts	Codes	Self: authentic and disclosed	Art-act
	Theories	Standards		
	Models	Normative-ethical theories		
	Descriptions to impart understanding	Descriptions of ethical decision making		
Assessment: critical question	What does this represent?	Is this right?	Do I know what I do?	What does this mean?
	How is this representative?	Is this just?	Do I do what I know?	
Process-context	Replication	Dialogue	Response and reflection	Criticism
Credibility index	Validity	Justness	Congruity	Consensual meaning

Source: Jacobs-Kramer M, Chinn P. Perspectives on knowing: a model of nursing knowledge. *Schol Inq Nurs Pract.* 1988;2(2):129–139.

their time and enable nurses to trace with understanding the cumulative and disparate knowledge development that contributes to the discipline of nursing.

Given that the patterns and the model are still being used in education, it is appropriate that they be reviewed and critiqued within the context of nursing knowledge development in the mid-1990s. This article offers such a review, critique, and update.

In her seminal article "Fundamental Patterns of Knowing in Nursing," Carper[1] identified the following patterns:

- empirics, or the science of nursing;
- ethics, or the moral component;
- the component of personal knowledge; and
- esthetics, or the art of nursing.

In this article the author explores each of these patterns in turn, looking first at what Carper had to say, then at the extension of this pattern within the Jacobs-Kramer and Chinn model, and finally at questions that arise with reference to the current literature and each particular pattern. Table 1 summarizes the essential elements of Jacobs-Kramer and Chinn's model of nursing knowledge.

EMPIRICS: THE SCIENCE OF NURSING

Carper described empirics as

> knowledge that is systematically organized into general laws and theories for the purpose of describing, explaining and predicting phenomena of special concern to the discipline of nursing. ... The first fundamental pattern of knowing in nursing is empirical, factual, descriptive, and ultimately aimed at developing abstract theoretical explanations. It is exemplary, discursively formulated, and publicly verifiable.[1(pp14–15)]

The key element here is that the "ultimate aim" of this knowing is "theory" development. Inherent in theory development is the ontological position that nature has a single or dominant reality commonly experienced and about which one can draw generalizable abstract explanations. This clearly encompasses the traditional view of scientific knowledge with its stance of objectivity and context-free replicability. This view was the dominant one in the nursing research and writing at the time of Carper's doctoral work. However, it is debatable at this time whether this pattern encompasses all research-based knowing, which Jacobs-Kramer and Chinn expressed as "facts, theories, models and descriptions that impart understanding."[2(p132)]

The realist ontological position, whose assumptions allow generalization, may also be seen as including grounded theory and ethnographic research, which generate generalizable abstractions. However, the relativist position of the interpretive paradigm as represented by phenomenology, for example, also seeks to provide "descriptions that impart understanding" but would not be consistent with Carper's definition of having an ultimate aim of developing abstract theoretical explanations that could be "systematically organized into general laws and theories."[1(p14)]

It is therefore suggested that the definition of the empirical pattern of knowing needs to be modified to accommodate the relativist ontological positions of knowledge development using methodologies such as phenomenology. If not modified, nursing needs to acknowledge the limitations of this definition in encompassing empirical knowing that seeks not to generalize, but rather through interpretation or description to put

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before the reader context-embedded stories whose purpose is to enrich understanding.

The inclusion of the word "understanding" by Jacobs-Kramer and Chinn[2] within the aim of the empirical pattern of knowing may be confusing; "understanding" is more commonly associated with the aim of research within the interpretive paradigm. The ontological position of the interpretive paradigm embraces the notion of multiple realities that cannot be generalized and puts this paradigm outside Carper's definition of this pattern of knowing. As discussed later, interpretive and critical research is encompassed more appropriately elsewhere.

Jacobs-Kramer and Chinn's model suggests that the pattern of empirics is expressed through "facts, theories, models and descriptions."[2(p132)] This expressive dimension may be extended to include the common mode of expression and transmission via books for academic theoretical instruction and professional journals for stimulation of professional debate.

Jacobs-Kramer and Chinn's[2] assessment dimension asks the critical questions, "What does this represent?" and "How is it representative?" The process of assessment is by replication, and the index of credibility they suggest is validity—that the knowledge can be demonstrated to be what it is thought to be. The assessment dimension is dealt with in their article in a brief paragraph that makes it somewhat difficult to fully grasp the intent of the critical questions; a critical question, one would assume, inquires about the relationships between the variables under study and the generalizability of the relationships.

In the case of grounded theory, a critical question would be the relationship to the core concepts of the other concepts and the nature of these relationships. The process of judging the trustworthiness of the results would require both sufficient detail to enable replication and application and the seeking out and offering up to professional debate of the findings. As Kuhn said, "There is no standard higher than assent of the relevant community."[3(p94)] The remaining process for ascertaining credibility is the "fit" of the new knowledge with the extant knowledge in the area at the time.

It is within this assessment dimension that the case for empirics, not including work using the interpretive or critical paradigm, gains credence. Here, clearly, the standards of credibility are not related to validity, replication, or relationships between variables or categories. If the empirical pattern were to be expanded to accommodate knowledge created through interpretive or critical work, an entirely new assessment would be required with different critical questions, processes, and credibility indices.[4] Possible modifications to the pattern of empirics within the model of nursing knowledge are proposed in Table 2.

ETHICS: THE MORAL COMPONENT

"The fundamental pattern of knowing identified here as the ethical component of nursing is focused on matters of obligation or what ought to be done."[1(p20)] In exploring this pattern Carper acknowledged the im-

portant place of knowledge of norms and ethical codes: "The examination of the standards, codes, and values by which we decide what is morally right should result in a greater awareness of what is involved in making moral choices and being responsible for the choices made."[1(p21)]

However, Carper goes on to caution that the complexity of the ethical issues in modern health care practice means that "moral choices to be made must be considered in terms of specific actions to be taken in specific concrete situations."[1(p21)] In extending this caution, Carper represents one of the earliest nursing writers to speak of the situational and relational importance of moral decision making, which has become fundamental to the ethic of care now so prevalent in the nursing literature.

There has been a plethora of publications in the area of moral knowing. Principal among these are the works of Benner,[5,6] Benner and Wrubel,[7] Bishop and Scudder,[8,9] Cooper,[10,11] and Watson.[12,13] Not directly within nursing but highly relevant are the works of Gilligan,[14,15] Noddings,[16] Pellegrino,[17,18] and Zaner.[19,20]

Much of this work has its origins in Gilligan's[14] critique of Kohlberg's[21] hierarchy of moral decision making. Gilligan chal-

Table 2. Empirics: Essential elements

Dimension	Original model[2]	Modifications
Creative	Describing Explaining Predicting	Describing Explaining Predicting
Expressive	Facts Theories Models	Facts Theories and models described in books and professional journals
	Descriptions to impart understanding	Descriptions that indicate relationships
Assessment: critical question	What does this represent?	What relationships were found?
	How is it representative?	Under what conditions do these relationships hold?
Process-context	Replication	Replication and application Professional debate Fit with extant knowledge
Credibility index	Validity Reliability	Validity Reliability

lenged Kohlberg's contention that believing in "the primacy and universality of individual rights" was the highest form of moral development and that this represented a morally superior position to Kohlberg's penultimate stage, which embodies a "very strong sense of being responsible to the world."[14(p444)] Gilligan suggested that the focus on individual justice is a predominantly male orientation, whereas women more commonly adopt the contextual, relational, care orientation that focuses on social and moral good.

Moss[22] provided an excellent exploration of the impact of Gilligan's work over the past 15 years, particularly in relation to nursing. Together with Moss, Bishop and Scudder,[9] Benner,[6] and Watson[12,13] suggested that the moral ideal of doing what is good (that is, adopting a caring orientation), rather than that which is just, will most fruitfully be revealed through the exploration of practice rather than simply through reference to "rule-books." This, they suggested, will happen through processes of reflection, discussion, and storytelling of life and nursing practice.[6,9] Bishop and Scudder made a particularly salient point for nurses within this discussion by questioning the notion that moral decision making is about "solving" dilemmas at all: "One way in which the moral sense differs from traditional nursing ethics is that it directs us to moral dilemmas which cannot be solved but must be lived with and, when possible, ameliorated."[9(p124)]

Zaner, with reference to physicians but equally applicable to nursing, suggested "Moral life is essentially communal at its root, and it is mutuality (in all its complex forms), not autonomy, that is foundational. Nowhere is this more plainly evident than in the contexts of clinical situations dealing with ill persons."[20(p292)] Zaner went on to say

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that "autonomy and rights" inhibit moral decision making within health care, which requires, foundationally, cooperation and collaboration.

Cooperation is also emphasized in the work of Gadow[23] on existential advocacy. She reinforced the importance of collaboratively making "the effort to help persons become clear about what they want to do, by helping them discern their values in the situation and on the basis of that self examination, to reach decisions which express their reaffirmed, perhaps recreated, complex of values."[23(p44)] Gadow put this effort forward as a moral ideal, not duty, norm, or prescription. It is a moral enterprise through situated engagement.

Jacobs-Kramer and Chinn[2] focused on justice in their assessment dimension of this pattern. An expansion of the assessment dimension is required to accommodate an ethic of care as well as an ethic of justice. Thus, potential modifications to the ethical pattern of knowing are listed in Table 3.

The discussion about ethics shows how intimately linked the patterns of moral and personal knowing are. Moral knowing requires fundamentally an authentic interpersonal involvement for its development.

PERSONAL KNOWING

The pattern of personal knowing is concerned with "the knowing, encountering

and actualizing of the concrete individual self. One does not know *about* self; one strives simply to *know* the self. This knowing is a standing in relation to another human being and confronting that human being as a person."[1(p18)] The pattern of personal knowing develops when the nurse approaches the patient not as an object or category of illness, but strives instead "to actualize an authentic personal relationship between two persons."[1(p19)] This pattern requires the nurse to allow the person who is the patient-client to "matter." It involves engagement as opposed to detachment.

Mayeroff, whom Carper[1] cited as a source for her notion of personal knowing, saw a special feature of caring for a person as being "able to understand [the person] and his world as if I were inside it."[24(p42)] For Mayeroff relationship is about reciprocity,

Table 3. Ethics: Essential elements

Dimension	Original model[2]	Modifications
Creative	Valuing Clarifying	Valuing the moral idea of caring
	Advocating	Critically appraising values Existential advocacy[23] Sensitizing to other value positions Fostering articulation of everyday notions of good[6]
Expressive	Codes, standards Normative theories Descriptions of decision making	Codes, standards Normative theories Observation Storytelling to explore embedded notions of good
Assessment: critical question	Is it right? Is it just?	Is it good? Is it just? Is it right? Does it embody caring?
Process-context	Dialogue	Dialogue Critical reflection Collaborative values elaboration
Credibility index	Justness	Justness Goodness Caring Congruence with personal values of patient

about helping the other "grow" and through this, growing oneself. However, Mayeroff's words harbor subtle paternalism: "I want it to grow in its own right...and I feel the other's growth as bound up with my own sense of well-being."[24(p8)] Such a position mitigates against genuine reciprocity.

Mayeroff's reciprocity was elaborated on and refined in the works of Watson[12] in describing her concept of "transcendental moment," by Taylor[25] in her exposition of the "ordinariness" of nursing, in Morse's[26] work on nurse-patient relationships, and in Moch[27] in her exploration of "personal knowing," and probably most well known within nursing is Benner's[5] seminal work *From Novice to Expert.* Benner's notion of involvement and engagement was further developed collaboratively with Tanner[28] on intuition and with Wrubel[7] on the primacy of caring.

The idea of "being-with," of presence, of letting the person matter and being open to help that person make meaning out of his or her experience, is an essential feature of nursing practice. Without this knowing of self that allows an openness to the knowing of another person, nursing is only technical assistance, not involved care. In Carper's words, "It is concerned with the kind of knowing that promotes wholeness and integrity in the personal encounter, the achievement of engagement rather than detachment, and it denies the manipulative, impersonal orientation."[1(p20)]

In the model of nursing knowledge described by Jacobs-Kramer and Chinn,[2] the pattern of personal knowing is seen as being created by "experiencing the self—encountering and focusing on self while realizing the realities and potentialities."[2(p135)] It also involves "experiencing, encountering and focusing."[2(p135)] These are not easy concepts to grasp. Carper herself said of this pattern that it "is the most problematic, the most difficult to master and to teach. At the same time, it is perhaps the pattern most essential to understanding the meaning of health in terms of individual well-being."[1(p18)]

The creation of personal knowing may be enhanced through the use of art, poetry, literature, and storytelling in an endeavor to more truly "understand [the person] and his world as if I were inside it."[24(p42)] An example of this is poetry about childbirth that helps the midwife "see" inside the patient's world; poems such as Sharon Doubiago's "South American Mi Hija" (in Chester[29]) show the intensity that can allow the soul to grow, whereas stories such as Anais Nin's "Birth" (in Chester[29]) illuminate the potential for the soul to shrivel if a woman is not supported by the right kind of caring. Poems such as "Sunshine Across Living Centre" in Krysl and Watson[30] help nurses "see" the humanity of nurse and patient in interaction. The expressive dimension is the self as authentic (privately known) and disclosed (revealed to others): "Personal knowledge is expressed as ourselves, through the self."[2(p135)]

The assessment of this pattern comes through the "focus on the self as privately known and expressed to others. Assessment of self is a process carried out by the self through a rich inner life."[2(p135)] The critical questions involve exploration for congruence between knowing what we do and doing what we know, between the authentic and disclosed self. The process through which this assessment is made is the reflection and response of others to us, which we reflect on in turn. Agan put it succinctly by suggesting that "credibility of this type of knowing is determined through *individual*

Table 4. Empirics: Personal knowing

Dimension	Original model[2]	Modifications
Creative	Encountering Focusing Realizing	Encountering, focusing, and realizing through practice and through art, literature, poetry, and storytelling
Expressive	Self: authentic and disclosed	Self: authentic and disclosed
Assessment: critical question	Do I know what I do? Do I do what I know?	Do I know what I do? Do I do what I know?
Process-context	Response and reflection	Reflection informed by the response of others and our reflection on our response to the life-world of other
Credibility index	Congruity	Congruity

reflection that is informed by the responses of others [italics added]."[31(p70)] The credibility index is therefore congruence with the authentic and disclosed self.

Although the volume of literature in this area has provided much clarification and extension of the notion of personal knowing, the "essential elements" identified by Jacobs-Kramer and Chinn[2] are still pertinent. An elaboration could include, within the creative dimension, some examples of the means by which "encountering, focusing and realizing" might be facilitated (eg, poetry, art, literature, and storytelling) and within the process-context dimension, reflection informed by the response of others (see Table 4).

ESTHETICS: THE ART OF NURSING

Carper suggested that the delay in explicating the esthetic pattern of knowing is associated with nursing's attempt to see itself as scientific and to "exorcise the image of the apprentice-type education system."[1(p16)] This delay has certainly been overcome, and there has been intense interest in this pattern recently. The pattern had its beginnings in the works of many early nursing writers. Wiedenbach[32] suggested that esthetic practice is making "visible through action" the nurse's perception of what the patient needs. Orem[33] spoke of the "creativity and style in design" of the provision of care. Orem also mentioned as necessary in artful practice the ability to "envision" models of helping with regard to the appropriate outcomes. Benner[5] was foremost in the development of the notion of perceiving the whole of a situation, without reference to rational processes, in her work on expert nursing practice. The concept of "intuitive" knowing developed by Benner and Tanner,[28] Rew,[34] and Agan[31] (and mentioned earlier as part of personal knowing) is an important component of perceiving and envisioning.

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The design of the art-act combines all patterns of knowing in its esthetic form—it is all of and more than the other patterns: "The design, if it is to be esthetic, must be controlled by the perception of balance, rhythm, proportion and unity of what is done in relation to the dynamic integration and articulation of the whole."[1(p18)]

Carper named "empathy" as an important mode in the esthetic pattern of knowing; however, there is currently debate in the nursing literature over the appropriateness of this concept for nursing. Morse, Bottorff, Anderson, O'Brien, and Solberg suggested that "empathy was uncritically adopted from psychology and is actually a poor fit for the clinical reality of nursing practice."[35(p273)] They recommended exploration of other communication strategies that have been devalued, such as sympathy, pity, consolation, compassion, and commiseration. To these Taylor[25] might add affiliation, fun, and friendship.

Whatever the definitional outcome, the basic requirement of effective and authentic interpersonal engagement remains. This is highlighted in the recent Australian work of Taylor[25] and in the innovative work of Lumby[36] in her development of a critical feminist methodology for exploring nursing.

According to Jacobs-Kramer and Chinn,

> Esthetic knowledge finds expression in the art-act of nursing. Like personal knowledge, the expression of esthetic knowledge is not in language. We can unfold our art and retrospectively recollect and write about its features, and we can record it using electronic media, but the knowledge form itself is not what we write or record. The knowledge form *is* the art-act [italics added].[2(p137)]

They then proceeded to raise an important issue, albeit indirectly, that experience is an important component of esthetic knowing:

> As practice contexts are encountered, processes within the creative dimension of esthetics are initiated. Through the process of engagement, interpreting, and envisioning, "past" knowledge is enfolded into esthetics, and clients are uniquely cared for. As caring processes continue, new knowledge merges.[2(pp137–138)]

In putting forward experience as a necessary condition to esthetic practice, it may be necessary to include this context-specific experience as part of the creative and generative dimension, suggested by Jacobs-Kramer and Chinn as including "engaging, interpreting and envisioning." The addition of experience, particularly context-specific experience, suggests that these acts are cumulative, aligning with Benner's[5] position that expertise is context specific and not a transferable skill.

In exploring the assessment dimension within Carper's model of knowledge, Jacobs-Kramer and Chinn followed her inclusion of notions of esthetic appreciation from other art forms. They suggested that the critical question is, "What does this mean?"

> Criticism requires empathy and an intent to fully appreciate what the actors meant to convey. As the art-act is criticized, credibility is discerned by reaching for consensus—a full and rich understanding of the art-act that brings together the perspectives of a community of co-askers who construct and confer meanings.[2(p137)]

Table 5 presents the essential elements for the esthetic pattern.

Table 5. Esthetics: Essential elements

Dimension	Original model[2]	Modifications
Creative	Engaging Interpreting Envisioning	Cumulative experience by engaging, interpreting, and envisioning and including the "artful enfoldment" of all other patterns
Expressive	Art-act	Art-act
Assessment: critical question	What does this mean?	What does this mean?
Process-context	Criticism	Exhibition and criticism Recognition as authentic to other nurses
Credibility index	Consensual meaning	Consensual meaning

The major point of Jacobs-Kramer and Chinn's model development appears to be the unfolding of a story that suggests that each pattern may be seen by "examination of the art-act that integrates all knowledge patterns as expressed in practice...[as it] provides a comprehensive, context-sensitive means for enfolding multiple knowledge patterns."[2(p138)] This, they suggested, leads nursing away from "a quest for structural truth and towards a search for dynamic meaning."[2(p138)]

The model and its exposition of essential elements provide critical questions that may structure our process of inquiry, processes by which the inquiry might take place, and credibility indices to which claims of rigor may be addressed. If it is to be useful in the process of our practice-based inquiry, the model must adequately account for all patterns of knowing and their appropriate processes of inquiry.

SOCIOPOLITICAL KNOWING: CONTEXT OF NURSING

The patterns and inquiry processes in Jacobs-Kramer and Chinn's[2] model appear adequate to the description of the nurse-patient relationship and the persons of the nurse and the patient. What appears to be missing is the context—the sociopolitical environment of the persons and their interaction. This represents a fifth pattern of knowing essential to an understanding of all the others.

The other patterns address the "who," the "how," and the "what" of nursing practice. The pattern of sociopolitical knowing addresses the "wherein." It lifts the gaze of the nurse from the introspective nurse-patient relationship and situates it within the broader context in which nursing and health care take place. It causes the nurse to question the taken-for-granted assumptions

about practice, the profession, and health policies.

Sociopolitical knowing may be conceptualized as including understandings on two levels: (1) the sociopolitical context of the persons (nurse and patient), and (2) the sociopolitical context of nursing as a practice profession, including both society's understanding of nursing and nursing's understanding of society and its politics.

The sociopolitical context of the persons of the nurse-patient relationship fundamentally concerns cultural identity, for it is in culture that "self" is intrinsically located. This cultural location influences each person's understanding of health and disease causation, language, identity, and connection to the land. Such understanding goes well beyond Carper's[1] or Mayeroff's[24] notion of personal knowing. It is related to deeply embedded historical issues of connection to and dislocation from land and heritage.

Chopoorian suggested that "nursing ideas lack an archaeology of the social, political, and economic worlds that influence both client states and nursing roles."[37(p41)] She claimed that unequal class structure, power relationships, and political and economic power produce sexism, racism, ageism, and classism, which in turn affect health and result in illness. Chopoorian continued, "Nursing practitioners continually confront the human responses to the underlying social dynamics of poverty, unemployment, undernutrition, isolation and alienation precipitated through the structures of society."[37(pp40–41)]

Violence, drug dependence, and diabetes are examples of responses to what are inherently political rather than simply personal problems, and nurses' efforts to deal with them require nurses to articulate what they see resulting from societies' structures. Stevens suggested that nurses must provide a "critique of domination within fundamental social, political and economic structures and the analysis of how domination affects the health of persons and communities."[38(p58)] This effect includes the

Table 6. Sociopolitical knowing: Essential elements

Dimension	Characteristics
Creative	Exposing and exploring alternate constructions of reality
Expressive	Transformation Critique
Assessment: critical question	Whose voice is heard? Whose voice is silenced?
Process-context	Critique and hearing all voices
Credibility index	Shared governance, enlightenment Movement toward equity

position and visibility of nursing in policy planning and decision making about health issues.

To have a voice in these decisions, nurses must both be articulate about what they know and do and be recognized by others as having something to contribute to debate. Nurses must have an understanding of the gatekeeping mechanisms within the political arena and their function. It is a paradox that when people are involved with nurses and nursing as patients or as concerned friends, the contribution of nurses is prized. Why then is it so quickly forgotten when these same people are influencing health care decisions? Diers and Fagin[39] suggested that the reason is visible in the metaphors the public associates with nursing, which include nurturance, dependence, and intimacy. These images are often reminders of personal pain and vulnerability, the natural reaction to which is suppression. To resurface an understanding of nursing is to resurface the context and all that is associated with it. Nurses must find a way of helping people remember, when they are well and politically able, what they knew of nursing when in crisis. Nurses must find the intersections between the health-related interests of the public and nursing and must become involved and active participants in these interests.

A sociopolitical understanding in which to frame all other patterns of knowing is an essential part of nursing's future in an increasingly economically driven world. Nurses must explore and expose alternative constructions of health and health care, find means of enabling all concerned to have a voice in this care provision, and develop processes of shared goverance for the future. Table 6 illustrates how the sociopolitical dimension might be added to the model of knowing.

As Chinn said of nursing in the next century, "it is time to construct critical analyses of our present that are informed by the ethical and political ideals that we seek. It is time to begin to envision what our future nursing might be like and to create knowledge and skills that we need to begin to make it happen."[40(p56)] Understanding the context of nursing practice is fundamental to this endeavor. Appreciation and exploration of all the patterns of knowing in nursing and their interactions can contribute to the future articulation and development of nursing practice and nurses' place in determining the future of nursing practice and of health care.

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