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Knowledge Development and Evidence-based Practice

Insights and Opportunities From a Postcolonial Feminist Perspective for Transformative Nursing Practice

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Although not without its critics, evidence-based practice is widely espoused as supporting professional nursing practice. Engaging with the evidence-based practice discourse from a vantage point offered by the critical perspectives of postcolonial feminism, the incomplete epistemologies and limitations of the standardization characteristic of the evidences-based movement are analyzed. Critical analysis of evidence is suggested, such that it recognizes the evidence generated from multiple paradigms of inquiry, along with contextual interpretation and application of this evidence. We examine how broader interpretations of evidence might contribute to nursing knowledge development and translation for transformative professional nursing practice, and ultimately to address persistent health disparities within the complex context of healthcare delivery. **Key words:** *evidence-based practice*, *knowledge development*, *knowledge translation*, *nursing knowledge*, *postcolonial feminism*

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NURSING knowledge development is largely understood as generating the evidence required for professional nursing practice. Evidence-based practice (EBP) is currently the primary approach to knowledge uptake for professional practice, and is believed to support efficiency and ensure that practice decisions result in the provision of effective treatment.[1,2] Best practices based on sound research-based evidence are undisputedly needed given the complexity of today's healthcare environments, with their reliance on rapidly evolving technology, corporate priorities with a focus on efficiencies, and diverse sociopolitical milieus characteristic of the broader society.[3] However, there have been wide-ranging critiques of EBP, from concern with the definition and breadth of evidence, to how this approach erodes the autonomy of nursing practice.[4–8]

In this article, we engage with the EBP discourse from another vantage point—that offered by critical perspectives such as postcolonial feminism (PCF)—with the aim of

examining how this interpretation of evidence might contribute to knowledge development and translation for transformative nursing practice, and ultimately to address persistent health disparities within the complex context of healthcare delivery. This effort is not to replace the current discourse on evidence, but rather to add another dimension or analytic perspective. Our interest is both epistemological and pragmatic, as we question: "What is evidence?" "How might evidence be conceptualized within different paradigms of inquiry?" "Can different conceptualizations of evidence complement one another?" Driving these questions is a pragmatic concern that traditional notions of evidence, based in Western science, may not sufficiently address the types of deep-rooted factors underlying health disparities, such as poverty and material life circumstances, nor fully account for the complexities of people's everyday lives that ultimately shape health and illness to a significant extent. For example, we have put forward the argument[9,10] that it is not "culture" in some narrow sense that organizes the ways in which people manage an illness, but rather the complex mediating circumstances of their lives. Certain interpretations and use of EBP tend to turn our attention away from these social factors to focus on individualistic models of health with biomedical solutions,[11] in effect bypassing complex problems. Indeed, such complexities may well require that evidence derived from multiple sources, through various modes of inquiry, be considered to support clinical practice.

We begin our engagement with EBP discourses by providing an overview of EBP, and the critiques leveled against it. We then employ the theoretical perspective of PCF as a point of engagement with the EBP movement. Finally, drawing on our programs of research, we apply these insights to a discussion of the reciprocal processes of knowledge development and knowledge translation that serve as a foundation for the transformative knowledge necessary to support professional nursing practice, with the contention that multiple forms of intersecting and complementary evidence are required to address current complexities in health and healthcare.

PRÉCIS OF CRITICAL QUESTIONS ABOUT EVIDENCE-BASED PRACTICE

The evolution of the EBP movement within healthcare has taken place over the last 3 decades. Reflecting its roots in evidence-based medicine, as envisioned by Sackett,[12,*] nursing's equivalent of EBP has been defined as "the integration of best research evidence with clinical expertise and patient values to facilitate clinical decision-making."[13(p4)] Underlying this beginning was the belief that epidemiological and statistical research findings could be useful for influencing the effectiveness of clinical practice.[5,6] The reflection of this origin is present in EBP tools today; for instance, best practice guidelines usually display a set of criteria—strongly favoring evidence from random clinical trials (RCTs) over other studies[14,15]—regarding validity of research findings.

In tandem with the evolution of EBP, we have witnessed a rise in concern about economics and the costs of healthcare. This concern has resulted in the goal of providing

*Sackett defined *evidence-based medicine* as "the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research. By individual clinical expertise, we mean the proficiency and judgment that individual clinicians acquire through clinical experience and clinical practice. Increased expertise is reflected in many ways, but especially in more effective and efficient diagnosis and in the more thoughtful identification and compassionate use of individual patients' predicaments, rights, and preferences in making clinical decisions about their care. By best available external clinical evidence, we mean clinically relevant research, often from the basic sciences of medicine, but especially from patient-centered clinical research into the accuracy and precision of diagnostic tests (including the clinical examination), the power of prognostic markers, and the efficacy and safety of therapeutic, rehabilitative, and preventive regimens."[12(p71)]

efficient care, in that decisions about healthcare practice often require a cost-benefit analysis component, yet how we define "benefit" is not always clear. Healthcare management's adoption of EBP processes has been used to support resource allocation decisions.[2,7] Economic restrictions have resulted in shifts toward decentralization of governance and the subsequent requirement for management tools related to clinical practice decisions.[4] Therefore, while ensuring that professional practice is based on the latest scientific evidence, the evolution and adoption of the EBP movement has also supported economic restrictions and decentralization of governance, which rests on the values of *effectiveness*, *efficiency*, and *standardization* of care. As we argue later in the article, we are not quarreling with these notions, *but rather in their interpretation and use*, particularly when these concepts are used as recipes, without attentiveness to context. Although we would all support the notion of efficient care, the complexity of this concept is often overlooked. For care to be efficient, it has to be effective, and for care to be effective, it means that it has to be appropriate to the context.

Nursing, along with other healthcare professionals, has been faced with integrating this approach to EBP into care delivery. The push toward adopting EBP within nursing has met with critical questions; here, we highlight three interrelated positions within the academic dialogue that are particularly germane to our engagement, later in this article, with EBP.

The first position, articulating an epistemological concern, focuses on the limited view of nursing knowledge characteristic of EBP. It is argued that EBP, with its reliance on RCTs and systematic reviews, provides limited guidance to critically consider evidence from the diversity of research methodologies found within nursing literature and other related disciplines relevant for nursing practice.[6,14] Furthermore, other sources of knowing such as personal experience or expert knowledge are de-emphasized in clinical decision making, yet nurses clearly rely on knowledge beyond that which can be empirically verifiable.[16] Included in these "ways of knowing" are Carper's[17] personal, aesthetic, and ethical knowledge. Representing these types of concerns, nurse scholars have argued that the very nature of nursing as relational practice does not lend itself to "highly rationalized frameworks of perception, let alone intervention."[7(p151)]

The second position raised in nursing literature relates to concerns about the translation of research findings into practice[5] and the relevance of research studies, especially RCTs, which control contextual factors that might be influencing the variable being studied. There is concern that applying context-stripped findings to a context-rich clinical setting makes the application irrelevant. For example, a clinical guideline for pain management may be of limited usefulness when the contexts in which pain occurs are not explored.[16] Underlying such a concern is the ongoing debate regarding the application of evidence to particular or individual circumstances, given the inferential mechanisms of evidential knowledge by which particularities (eg, individual variations) have been averaged out.[16] Research studies, such as random control studies, result in an ability to predict a specific behavior or treatment outcome at a population level. However, what they do not tend to provide is a complete explanation of a behavior or treatment outcome, in particular, an integration of individual variations or contextual factors.

The final position raises concern in relation to nurses' professional practice. Given the complexity of nurses' work environment, nurses need to acquire information or evidence from sources, such as philosophic or aesthetic knowledge, other than research findings to support professional practice.[18] The concern stated here is that EBP tools do not acknowledge or address the reality of nurses' work environment, and so will have, at best, limited utility. Barnes,[4] for example, raises the possibility that this limited utility could well result in the erosion of nurses' autonomy and authority within their current scope of practice. The concern then is that if the practice expectations defined within

an evidence-based tool become the norm for practice, these tools will begin to reshape nurses' work. Notably, other scholars[19] tell us that EBP has been embraced within the health professions as a means to improve professional status by making visible their "scientific" knowledge base. These critical issues highlight the complexity of bringing together a narrow view of evidence, such as that traditionally advocated for by EBP, with the realities of nursing practice. While we offer our own critical analysis of EBP later in this article, our response to this concern regarding the erosion of professional practice puts forward a somewhat different interpretation; another way of looking at this is that these tools, in and of themselves, do not address the complexity of patients' lives. We would argue that it not EBP, per se, that risks eroding nurses' autonomy. Rather, autonomy is eroded if nurses use evidence as recipes, without drawing on their professional knowledge and clinical judgment to interpret evidence, and make decisions about *best evidence* in context—this is the core of professional practice.

In summary, although healthcare systems and the profession of nursing have adopted EBP, there are philosophical and practical concerns regarding how EBP is used to guide professional nursing practice. Proponents of EBP refute these concerns as ill-founded misconceptions, and argue that when correctly operationalized, EBP integrates the best research evidence (derived by various research methods) with clinical expertise and patient values to facilitate decision making, implying a thoughtful and critical use of knowledge.[13] Given the complexity of practice and the persistent presence of health disparities, we contend that although the EBP perspective has considerable merit, different ways of looking at evidence are nonetheless needed, not to jettison the work that has been done, but rather to broaden the scope of how evidence is constructed. Furthermore, we would stress that a key issue relates to how nurses interpret and use evidence. The problem arises when evidence is seen as driving clinical decision making, rather than as a tool to be used by the professional nurse as he or she assesses, and makes decisions about best practices within a given context. PCF, we suggest, offers one framework that might help to further our understandings of evidence and EBP. We suggest that rather than replacing evidence generated from a scientific perspective, PCF complements EBP by enriching contextual understandings, and underscoring professional responsibility and accountability to use this knowledge to work toward equitable healthcare for all people. As such, it provides another angle on doing science that reframes our ways of constructing what counts as evidence.

A POSTCOLONIAL FEMINIST READING OF EVIDENCE-BASED PRACTICE

Postcolonial theory, joining other critical social theories that have at their core the analysis of relations of power, represents a broad based and rapidly expanding domain of scholarship. Said to have originated in the 1960s and 1970s, led by the influential work of anticolonial scholars such as Frantz Fanon[20] and Edward Said's *Orientalism*,[21] postcolonial theory deals with the relations and aftermath of the colonial period and ongoing neocolonialism characterized by oppressive tactics, economic and cultural hegemonies, and totalizing global expansions. Postcolonial feminist theory and black feminist theory, particularly that of scholars such as Patricia Hill Collins,[22] bell hooks,[23] Toni Morrison,[24] and Rose Brewer,[25] direct attention to multiple intersecting oppressions, inclusive of gender, class, and *race* oppression to reveal the multiple dimensions of oppression within societies, and the unequal effects of racism on certain groups of people (eg, women and children). Feminist theory also contributes sustained critique of issues of identity, voice and difference, and the politics of representation; and the articulation of clear methodological direction for both research and practice.

A growing body of nursing scholarship informed by postcolonial feminist theories

provides rich analyses of the historical, economic, cultural, and social dynamics at play within healthcare (see, for instance, references 9, 10, 26–34) and demonstrate the salience of these perspectives for nursing scholarship. These works not only attempt to examine the complex intersections between different social relations that have a profound impact on the experiencing of health and illness but also hold up to scrutiny taken-for-granted assumptions about different ethnocultural communities. Indeed, like Ahmad,[35] these scholars challenge notions of culture as static and determining, and draw attention, instead, to the context in which cultural meanings are constructed, to issues of racialization, systemic racism, and other forms of oppression. Perhaps, most important, no one form of oppression is privileged, but there is the continuous search to understand how intersections operate in everyday life, and in everyday social encounters. This growing postcolonial feminist scholarship builds on earlier integration of critical theories such as feminist and antiracist theories into nursing, as exemplified by Allen et al,[36] Barbee,[37] Campbell and Bunting,[38] and Webb,[39] and shares the agenda of other nurse scholars committed to pursing social justice through critical analyses of how the social construct of race is employed.[40–44]

Postcolonial feminist theory, with its cogent critique of oppressive structures that tend toward standardization, representation of majority view, and erasing of experiences of racialization, classism, sexism, ageism, and homophobia, expands EBP's scientific discourses to be inclusive of various social relations, and in doing so transforms our notions of science. As both academics and practitioners, we have grappled with the application of postcolonial feminist perspectives to practice, and, in particular, to current management discourses and practices. Recognizing the entrenchment or perhaps the inevitability of these discourses and mechanisms, we seek to examine critically current EBP discourses, and offer alternative interpretations that might equip healthcare workers for professional practice and assist in the creation of practice environments that nurture such practice. In doing so, we are working toward opening up spaces for an enriched dialogue regarding evidence as it is generated and applied in practice, with the understanding that EBP itself is not a single entity but rather can be taken up in various ways to support professional practice.

In our effort to reappraise EBP, we join together the deconstructive and constructive imperatives of postcolonial feminist theorizing. PCF approaches are disruptive and resistive in their primary intent, seeking to uncover theoretical, moral, and political inadequacies through lenses of race, class, gender, age, sexual orientation, and other forms of oppression. Simultaneously, the PCF project opens up new sites for the legitimation of currently delegitimated knowledge,[45] and offers new possibilities for professional practice within current practice environments that have become increasingly restrictive. Salient to our discussion here are those features of PCF that hold up for scrutiny of epistemological claims that derive from and maintain the hegemonic center (in this case, the Western center). Equally valuable in the tenets of postcolonial feminist theorizing is the attention to power relations along a shifting and intersecting variety of axes, including race, religion, gender, and class. Our critique focuses on 3 themes made visible through the PCF lens: the problem of incomplete epistemologies; the shortcomings of uncritical standardization; and the everyday realities of race, class, gender, age, and sexual orientation as they operate within contexts of EBP. Together these themes point to the need for a shift toward a more inclusive, reciprocal approach to knowledge development and uptake.

Incomplete epistemologies as the basis for evidence-based practice

A PCF reading reveals how the knowledge upon which EBP is based can, unwittingly, be racialized, gendered, ageist, classist, and

homophobic. Notably, a PCF lens does not mean one sets out to criticize science itself, rather we raise questions about *how* science is practiced by those who conduct and fund research to perpetuate racialized, classed, and gendered approaches to study design. Furthermore, we are not arguing against empirical knowledge as foundational to professional practice, but do caution against segregating science from the humanities and social sciences in our knowledge generation and application.

Randomized clinical trials (RCTs) serve as the criterion standard of evidence for EBP.[14,15] However, for various reasons such as the complication of seeking interpretive services and the ethical implications of conducting research with people who might be vulnerable for a variety of reasons, researchers have traditionally conducted RCTs with the most accessible dominant majority populations. Yet, the findings of these studies have routinely been generalized as though they represent a universal experience.[11] Similarly, many of the research instruments, interview questions, and tools used today have been developed by and for the majority population and therefore may not capture the experiences of those marginalized within mainstream society.[11,46] Furthermore, the types of research questions that gain funding have traditionally been reflective of the interests of the dominant majority (eg, cardiovascular disease in white men) rather than the needs of groups that have been marginalized. According to a study by the Global Forum for Health Research, health research continues to reflect the priorities of the rich, with 90% of research funding investigating the diseases of 10% of the world's population.[47] Moreover, current values in the scientific community see the favoring of efficient research approaches that require homogeneous study populations, consequently excluding those who find themselves on the margins.[11,46]

The inclusion in our research of social groups that have been marginalized is an important step in developing knowledge to support nursing practice. However, inclusion alone is not sufficient—the nature of our questions, the research methods we use, and the theoretical lenses informing research carry considerable importance in the types of knowledge that result. Meleis and Im[46] observe that while nursing scholarship has moved to study diverse ethnocultural populations, a culturalist and relativist approach has resulted in knowledge that remains essentialist and incomplete through the application of dichotomous thinking that constructs difference as irrevocable and acontextual. They explain,

> By dividing into dichotomies, we may be maintaining categories that have historically defined each culture and each gender. Dichotomies such as male/female, immigrant/nonimmigrant, and African American/Euro-American have helped us to value interstice patterns and responses, but the dichotomies may be preventing us from recognizing the socio-political forces that inhibit us from changing the status quo.[46(p96)]

To counter these historically embedded incomplete epistemologies, a shift in research agendas is needed, such that researchers not only study cultural knowledge but also situate such knowledge against the historically bound and contextually situated processes and effects of marginalization.

A growing body of evidence from across the globe demonstrates that social inequities in health are widespread, both within and between countries. Whitehead et al[48] note that overall gains in a nation's health frequently mask significant and worsening health outcomes for some population groups (often along lines of gender, geographic region, ethnicity, or socioeconomic characteristics). Many of the causes of inequities in health are social in origin, reflecting income and education disparities, differential exposure to health hazards, and systematic variations in life opportunities for healthy lifestyle or reasonable access to essential goods and services. As Whitehead et al[48(p313)] explain, "Individual lifestyles are embedded in social and community networks, and in living and working conditions, which in turn are related to the wider cultural and socioeconomic model."

How is this convincing body of evidence regarding the crucial influence of social determinants of health taken up in the realm of health policy and healthcare services, including at the point of care? Is this type of evidence amenable to the heavily relied upon tools of EBP? Kemm is cautious in the application of the EBP model to public health policy:

> Taking communities rather than individuals as the unit of intervention and the importance of context means that frequently randomized controlled trials are not appropriate for study of *public health* interventions. Further, the notion of a "best solution" ignores the complexity of the decision making process. *Evidence* "enlightens" policy makers shaping how policy problems are framed rather than providing the answer to any particular problem.[49(p319)]

From a PCF perspective, then, the mediating circumstances of what are often referred to as the "social determinants of health" need to be integrated into our nursing knowledge. This inclusion is particularly urgent in the area of culture and health. Given the rise in diversity and the implications this diversity carries for healthcare delivery, considerable nursing scholarship energy has been invested in describing various cultural beliefs and practices, with the hope of improving healthcare services, and, in turn, health outcomes, for ethnocultural communities. Yet, this focus on the individual as a member of a circumscribed cultural group often overlooks the evidence offered by population-based studies pointing to the root causes of health disparities. Put another way, our knowledge development and concomitant knowledge uptake need to extend beyond "culture" per se as a static determinant of health, to account for the complex intersectionalities with the social, historical, economic, and political forces, in determining health and health outcomes. The individual experience must be linked to the social context.

How this accounting of social determinants of health is accomplished is fraught with its own set of challenges. Deriving from a Western empiricist paradigm reliant on operationalization and measurement of discrete variables, health and social sciences have for some time used race as a variable of study, citing the possibility of identifying, tracking, and eliminating health disparities as reason to do so. Yet, race as a biological category has been contested, and, by and large, discounted as a biologically based and meaningful category. In its place, race has been recast as fluid and socially constructed, varying across time and place as a function of historical circumstance.[50] This latter line of argument resonates with the postcolonial feminist conception of race that acknowledges the salience of the term, not in a reified or essentialized fashion, but as a signifier of social relations. While the collection of health statistics by ethnicity continues, and increases in some contexts,[51] the concurrent trend to identifying more specific indicators for health disparities studies stands to offer improved explanatory capacity regarding the mechanisms behind health disparities. Estroff and Henderson explain,

> When factors such as individual lifestyle and behaviours, cultural beliefs, physiologic measures, geographical location, insurance coverage, education, and income are included in studies, the remaining health differences may be attributed to the effects of racial bias or discrimination.[50(p19)]

Underlying such racial bias/discrimination is the context of broader historic and contemporary social and economic inequality. A PCF reading of EBP thus, necessarily, warns against this type of operationalization of variables such as race (and its metonym, ethnicity).[42] Where race is adopted uncritically as an indicator or a variable, the "evidence" derived may contribute to policy and practice that focuses once again solely on the individual, suggesting in effect that cultural difference accounts for variations in the experience of health and illness. In the process, the scientific use of these social categories inadvertently reinscribes the predominant social approach to racializing groups of people by color or ethnic affiliation.[52] Instead, the nature of evidence needed is that which makes visible the *social* pathways that lead to health disparities.

Future research enterprise, thus, must seek a new level of rigor in conceptualization, expanding research to incorporate the role of power in knowledge development through theoretical frameworks that carry the capacity to uncover injustice and marginalization.[46]

The limitations of standardization in the applications of evidence-based practice

At the level of the pragmatic, a PCF lens also draws our attention to some potential shortcomings stemming from EBP's move toward standardization of patient care, in effect extending the general critique of acontextual application of research findings. By strictly or uncritically adhering to the tools that bring EBP into practice (clinical pathways, best practice guidelines), rich contextual issues that influence patients' experiences as they move through the healthcare system may be stripped away (eg, important factors that may influence a patient's ability to successfully recover from an acute episode may be overlooked). Thus, while tools such as care maps provide a beginning point for guiding practice, their usefulness is dependent to a large degree upon the nurse's professional judgment based on knowledge of science and the social context of people's lives.

One of the challenges of these tools is the tension between supporting standardization of practice and the corporate agenda versus supporting critical thinking regarding practice decisions.[4,8,19,53] Standardization can support and strengthen a profession's claim to legitimacy as indicated earlier, but it also lays the groundwork for external controls, the imposition of which, suggest Timmerman and Berg,[19] are the very antithesis of professional autonomy and power. Approaching this issue from another vantage point, a PCF lens prompts consideration of the embeddedness of EBP in current organizational discourses, and envisions ways to resist the associated *colonizing* possibilities. Organizational theory has been acknowledged, indeed promoted, as being distinctly Western, with its bent toward expansionism, managerialism, and rationalism.[54] In efforts to foster the development of organizational theory as legitimate "science," proponents have drawn on Enlightenment assumptions of universalism to establish management practices that would apply in all contexts, not unlike "natural law." Building on gender analyses that have unveiled the masculinist propensities of organizational theory, and the falsity of representing organizations as gender and race neutral,[55] a PCF lens offers unique analytic leverage in making visible the influence of *empire* on contemporary ways of knowing and being in the arena of organizational practices. PCF scholars have gone as far as to typify today's organizational practices as "colonial regimes."[56] The deconstructive imperative of postcolonial critique, thus, provides an angle of analysis from the margins as to how managerial concepts such as EBP tend to be taken up as neutral uncontested categories in organizational theory. To hold such concepts up for scrutiny becomes an important contribution, particularly as we ask "who is privileged or advantaged by management practices such as EBP?"

A PCF lens raises questions about when such standardization serves as a force for social justice (eg, in ensuring that all receive equitable care based on empirical knowledge for best practice), and when standardization becomes a force for inequities as its homogenizing bent writes out group histories and individual identities. On the one hand, several authors have argued on behalf of EBP as a mechanism to ensure equitable healthcare for all by the merit of an objective application of "best practices" to all clients, regardless of group affiliation and a healthcare provider's potential propensity to discrimination.[57] On the other hand, the contingencies and particularities, all imbued with relations of power, exposed by postcolonial feminist and other critical theories stand in contrast to the standardization of EBP.[53] To treat all as equals risks the real chance of inequitable treatment where the unique qualities and life circumstances of certain people continue to be overlooked. A postcolonial feminist analysis of

EBP, then, while not debunking the notion of EPB, would advocate critical reflection on the concept of "evidence" and the context of people's lives in which such evidence would be used. From a PCF perspective, we bring into focus multiple forms of evidence from different paradigms of inquiry.

To counter the epistemic violence that results from generic applications of incomplete knowledge, a shift is needed as to how evidence itself is established, the types of evidence valued within the clinical setting, and subsequently how evidence is applied. Our concern then lies with a culture of standardized clinical decisions based on a larger healthcare environment of managerialism—particularly where EBP becomes a routinized recipe approach to decision making without attentiveness to context, or a management-imposed method of clinical decision making that diminishes nurses' clinical decision-making processes. In this way, the PCF lens picks up cogent critiques of EBP and extends the analyses more specifically to consider *for whom* the standardization might not "fit."

The obfuscation of everyday realities such as racism, sexism, and classism

The two proceeding concerns regarding incomplete knowledge development and uncritically applied standardization work in tandem to obscure a world of racialized, gendered, ageist, and classed relations within healthcare. To illustrate, our research has uncovered how a politics of belonging is created as the dynamics of racialization and gender oppressions are negotiated in today's healthcare settings,[10] and how the mechanisms of health reform have disproportionately disadvantaged those in minority positions.[9,58] Commonplace racialized assumptions drawn upon within healthcare (eg, that families from certain ethnocultural groups will care for their elderly) result in overlooking the needs of individuals made vulnerable by the mediating circumstances of their lives, and who often do not speak the languages of healthcare (English; medicalized discourse).[9] Societal discourses—typically taken-for-granted—regarding culture, aboriginality, and egalitarianism as professional mandate similarly shape nurses' encounters with First Nations patients to the detriment of respectful care.[59] Women have been the "workhorses" of healthcare as nurses, care aides, frontline managers, rehabilitative specialists, nutritionists, kitchen staff, and cleaners, yet remain underrepresented in current management decisions and structures. White women, in particular, are in ambivalent positions, as they themselves have lost voice in the corporate discourses of today's healthcare management, but have also been complicit in longstanding patterns of racializing practices.

Through a PCF analysis of the EBP movement, we question whether the priorities and practice environments created by EBP foster critical reflection that acknowledges such everyday realities of privilege and disadvantage, oppression and resistance, within healthcare. Clearly, if we want to create spaces for addressing these relations of power, we must carefully consider the types of practice environments created by the agendas of EBP. Likewise, as far as EBP assumes a "standardized patient" in a homogeneous or universalist sense to whom evidence can predictably be applied, a PCF framing alerts us to the possibility of erasure of individual differences and imposition of dominant mainstream ways. For example, where clinical practice guidelines are invaluable in the case management of HIV/AIDS, experiences of urban First Nations women living with HIV/AIDS speak to the profound shortcomings of existing healthcare services and programs in meeting their needs, given the intersecting realities of poverty, gender positioning, and racialization.[60] Without making visible the context of their everyday lives, healthcare services fall short of addressing their particular needs. Such situations require thoughtful practitioners who bring together evidence from a range of knowledge to apply in patient-oriented and context-specific ways. A PCF approach then draws attention to the pragmatics of the everyday and supports the inclusion of transformative knowledge in

order to support nursing practice in the current context of healthcare delivery.

TRANSFORMING PRACTICE THROUGH KNOWLEDGE DEVELOPMENT AND TRANSLATION: INSIGHTS AND OPPORTUNITIES FROM A POSTCOLONIAL FEMINIST PERSPECTIVE

In this final section, we consider in further detail the implications of the insights derived through a PCF reading of EBP for knowledge development and knowledge translation, both of which are foundational to transforming nursing practice. What are the lessons we might take from a PCF critique of the current EBP movement for application to knowledge translation efforts? Can the divergent epistemologies of EBP and PCF be brought together in a complementary alignment to expand our sources of evidence upon which to base practice? Some nurse scholars who critique EBP distance themselves from its applications. Given the widespread adoption of EBP, we look for ways to constructively engage with the evidence-based movement, with the assertion that PCF offers another angle by which to understand evidence, thereby enriching the possibilities for knowledge development and translation that open spaces for transformative practice. In this way, we hope to contribute to the EBP discourses in a manner that encourages critical engagement with the notion of evidence, pushing for an expanded understanding of the types of knowledge needed for clinical decision making.

Anderson explains that transformative knowledge is "under girded by critical consciousness on the part of healthcare providers, and . . . unmasks unequal relations of power and issues of domination and subordination, based on assumptions about 'race,' 'gender,' and class relations."[61(p205)] We take as a starting point that transformative knowledge for practice is dependent upon the interrelated processes of knowledge development and knowledge translation. In the arena of knowledge development, insights from a postcolonial feminist perspective have brought to light the common claims of representative research-derived generalizable knowledge that is, in reality, based on selective populations that often exclude marginalized populations. Great caution must thus be taken in applying this knowledge in a universalizing sense. In response, a PCF lens calls for the inclusion of subjugated knowledge in our knowledge development processes. In addition, the need for empirical evidence to provide a better understanding of the mechanisms of health disparities is also emphasized through a postcolonial feminist analysis of EBP, such that the broader intersecting forces impinging on life opportunities necessary for health—including access to education, housing, income, social networks, and healthcare resources—are identified and addressed. Expanded research agendas will be necessary to fill these gaps.

At its heart, the evidence-based movement draws on a view of science that holds to a hierarchy of evidence that profiles the purported objective, quantifiable outcomes of RCTs, and other measurement-based methods as superior to narrative-based "subjective" methods. Our PCF reading suggests the importance of recognizing the limitations of this trend, and seeking complementary sources of knowledge that bring to light both large-scale phenomena as well as the contingencies and particularities of situated knowledge. We call for what Lather articulates as "a more capacious scientificity of disciplined inquiry."[62(p28)] Such science does not "divest experience of its rich ambiguity because it stays close to the complexities and contradictions of existence."[62(p23)] Notably, an insistence on a broad range of inquiry methods is driven not by allegiance to any methods for the sake of method per se, but rather by recognition of the breadth and depth of knowledge required for transformative practice. That is, a PCF commitment might see research conducted via a range of methodologies, across a range of quantitative and qualitative methods, with the goal of generating

knowledge that supports practice in today's complex environments while illuminating the broader social forces (historical, economic, political) that shape how healthcare services are structured and delivered with ultimate implications for health outcomes. Importantly, the call for multiple sources of evidence accumulated in part (giving credence to practice-based and personal knowledge) through a range of disciplined scientific approaches takes a remarkably different stance to knowledge translation, seeing it as an *effort to foster understanding, reflection, and action*, instead of a narrow translation of research into practice.[62]

A postcolonial feminist framing makes clear that narrow applications of procedural knowledge without the incorporation of other ways of knowing and knowledge about the social context of health/illness for the individual healthcare recipient will continue to fall short of providing humanistic, effective, and efficient healthcare. As explained, the EBP movement has largely been taken up in practice through the tools of clinical pathways, best practice guidelines, and care maps. The orthodoxy of EBP suggests a linear approach to clinical decision making; however this is just one way of viewing the applications of professional knowledge. Although some aspects of clinical practice may well be predictable, the complexities of the clinical environment, along with the heterogeneity of people seeking healthcare services, point to the need for a thoughtful practitioner who draws on a variety of knowledge, with the clinical judgment to know *when* and *how* to integrate these knowledge. Moreover, as the feminist perspective cautions against viewing research participants as "objects of study," so too the warning can be taken not to construct the recipients of healthcare as "objects of evidence-based practice." Any efforts at transformative knowledge translation must grapple with this challenge of enhancing nursing practice for individualized, client-appropriate, contextualized care based on the latest knowledge and skill. To illustrate how PCF interpretation of EBP might support transformative nursing practice, we conclude with an example of a knowledge translation project.

Contextualizing our position: Reframing cultural safety

Providing the impetus for this article and its rereading of the EBP movement is a recently initiated knowledge translation pilot project, *Cultural Safety and Knowledge Uptake in Clinical Settings: A Model for Practice for Culturally Diverse Populations** (nominated principal investigator, J. Anderson funding Canadian Institutes of Health Research), that synthesizes knowledge from the programs of research of a team of investigators in the Culture, Gender, and Health Research Unit at the University of British Columbia (http://www.cghru.nursing.ubc.ca/) and, in a collaborative effort with clinicians, translates this knowledge into practice. Shared themes of these programs of research are culture, social justice, gender, and health, with substantive foci including inequities in access to health and healthcare services; vulnerabilities as structured by various socially constructed classifications (eg, racializing categories and stigmatizing labels) and by certain life transitions and circumstances (eg, poverty, aging, violence, migration, hospitalization, and transition to home); and strategies to reduce inequities and vulnerabilities through innovative approaches to knowledge translation that engage key stakeholders.

Specifically, our exemplar here draws on our experiences in developing and implementing a collaborative approach to knowledge translation (J. Baumbusch et al, unpublished data), grounded in the dialectic between research and practice, in which the

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integration of transformative knowledge—the reflexive knowledge that makes visible and critiques relations of power operating through social relations and structures, and envisions actions that shift these power relations—leads to transformations in practice. In clinical environments where the language of clinical pathways, best practice guidelines, and care maps predominate, we are exploring how to best incorporate knowledge from this established program of research that has drawn extensively on postcolonial and feminist theories.

The concept of cultural safety, originating in the Maori context of New Zealand, has served as a starting point for several of our projects.[9,63] Conceptualized by Irihapeti Ramsden and incorporated into New Zealand's Nursing Council guidelines in 1992, *cultural safety* is defined as

> The effective nursing of a person/family from another culture by a nurse who has undertaken a process of reflection on own cultural identity and recognizes the impact of the nurse's culture on own nursing practice. Unsafe cultural practice is any action which diminishes, demeans, or disempowers the cultural identity and wellbeing of an individual. (cited in Clarke[64(pv)])

Cultural safety underscores the importance of acknowledging the historical sociopolitical context that shapes people's health and healthcare encounters, and in this way aligns with a postcolonial feminist framework. Yet, even within this framing, the types of knowledge or evidence that may be invoked when the concept of cultural safety is employed are not unproblematic.

Our initial steps to translate this concept into practice highlight the complexities of both the concept itself and some of the challenges of knowledge translation from a postcolonial feminist stance. In our earlier empirical work, we set out to establish what cultural safety looks like in practice.[9,63] However, rather than coming up with a practice guideline (eg, a neat framework of values, attitudes and/or practices characteristic of cultural safety), we concluded that cultural safety can best be understood as an interpretive lens brought to the healthcare encounter by the provider, in which the provider reflects upon his or her own sociocultural positioning with accompanying values and assumptions, and seeks to understand what each patient brings to the healthcare encounter. Clearly, cultural safety then becomes not the *subject* of a clinical pathway but rather a *way* of approaching professional practice. Moreover, "culture" itself is problematized to reveal the widespread tendencies to generalize and/or stereotype on the basis of presumed group affiliations when the nature of culture is itself socially constructed. Indeed, our research has impressed upon us the limitations of the languaging of cultural safety, where the very use of the term "culture" may reinscribe the notion of discrete cultural groups with the all too common accompanying propensities toward stereotyping. To reflect the shifting and contextual nature of how subject identities are enacted and perceived, and the empirical observations that anyone, regardless of social status, ethnic affiliations, gender, and so forth, may face a convergence of events such that they are particularly vulnerable,[9] we have coined the phrase "situated vulnerability" that does not essentialize groups as "vulnerable populations." Rather, we examine the contexts and conditions under which people are made vulnerable. This is not to undermine the suffering of those who have been disadvantaged, but rather, to acknowledge that vulnerability is a social construct, created through the social conditions of people's lives, and not a fixed state of being, or "ethnic trait."

The promotion of reflective practice through the use of transformative knowledge is an important avenue, while less tangible than a clinical pathway, in supporting nurses to provide individualized, client-appropriate care that is attuned to these situated vulnerabilities. Nurses require tools to support not only their objective/technological dimensions of practice but also the relational, contextual, and historical dimensions to assist professional nursing practice. Therefore, while the mechanisms of EBP (ie, clinical

pathways, best practice guidelines, care maps) offer one route to clinical decision making applied to a relatively narrow range of clinical phenomena, we advocate for the incorporation of sociological, qualitative, and humanities-based knowledge into the frontline of nursing practice to foster the "critical consciousness"[61] necessary for reflexive thinking and transformative practice.

However, *how* to best translate this type of knowledge into clinical practice poses considerable challenge. We have found that translation of this type of transformative knowledge requires a much more intense relationship between research and practice where researchers embrace a more active role in the process of knowledge translation. In our current knowledge translation efforts, we are exploring more organic ways to facilitate the uptake of a wide range of knowledge, keeping in mind the goal of fostering "understanding, reflection, and action."[62(p23)] Although our initial work with managers and other administrative healthcare decision makers saw a preference for managerial discourses (particularly the language of "numbers") in the communication of research findings, we are now embarking on an exploration of the type of engagement required to facilitate the uptake of transformative knowledge for frontline nurses.

In this more active engagement, our team has been exploring how to translate research-based knowledge from the language of the academy into the language of practice, simultaneously engaging with different discourses in the clinic. We are delving into ways to prepare knowledge in such a way that is accessible to practitioners, resonates with their experiences of the realities of everyday practice, creates a space of openness to the uptake of transformative knowledge, and, ultimately, to transformations in practice. For example, we have taken as starting point practice tools that have been developed for discharge planning (ie, discharge planning guidelines) and used case examples to exemplify how individuals experiencing a vulnerable period in their lives—hospitalization—may not fit within the narrow constructs of the tool. Rather than viewing these individuals as outliers, we then engage practitioners in the process of critical reflection on how this individual's care could have been approached differently, and how guidelines around discharge planning could be written in a way that lead nurses to take up transformative knowledge and translate it into practice within the complex and demanding environments in which they work. Our experiences to date with translation of transformative knowledge has underscored for us the new terrain that this effort represents, particularly as we bring knowledge derived from critical inquiry to the mainstreamed enterprise of knowledge translation and EBP.

CONCLUSION

Over the past several decades, the discipline of nursing has struggled with the uptake of research-based knowledge at the point of care. EBP has been adapted from medicine and applied to nursing, although not without wide-ranging critique of this approach to knowledge uptake. To these critiques, we have added the perspectives of PCF regarding the shortcomings of EBP, and have recommended an expansion to EBP, in the form of translation of transformative knowledge, as a viable approach to knowledge uptake in clinical settings. This transformative knowledge draws not just on narrow notions of evidence, but seeks inclusive epistemologies that represent the realities of multiple sources of knowledge, including previously marginalized knowledge. The translation of transformative knowledge also guards against discourses of standardization associated with EBP, striving instead to understand the particularities of each situation; and how these particularities are structured by larger historically embedded systems of social classification such as racialization, class, and gender. When employed in this way, knowledge translation has the potential to enhance nursing practice through understanding, reflection, and action.

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