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Knowledge Translation in Everyday Nursing

From Evidence-Based to Inquiry-Based Practice

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The interconnection of theory, evidence, and practice is most often conceptualized as an epistemological enterprise. In this article, we shift the discussion from one that is solely concerned with epistemology to one that considers the significance of ontology and the way in which epistemology and ontology are intricately intertwined in every nursing action. Drawing on deconstructive hermeneutics, we contend that to understand and affect the interconnection of theory, evidence, and practice, an ontological inquiry at the action level is required. Using a nursing practice example, we illustrate the complexities of knowledge translation and how effective integration of knowledge into practice involves an embodied process of ontological inquiry and action. This inquiry process draws on theory and evidence to enlarge and imagine possibilities for action in particular moments, situations, and contexts and rests in a *way-of-being* in which the interconnection of theory, evidence, and practice is embodied.
Key words: *embodiment*, *epistemology*, *hermeneutics*, *inquiry*, *knowledge translation*, *ontology*

THIS ARTICLE was inspired by our deeply felt concern with the profound disparity that often exists between what nurses *know* and what nurses *do.* Although many of the questions and ideas we raise here have been discussed in the nursing literature under various epistemological and/or theoretic topics, we enter the discussion of the interconnection among theory, evidence, and practice from a somewhat different vantage point—that of nursing action. We take this "action turn" because we believe that ultimately safe, competent, theoretically informed, evidence-based nursing practice is about action. As nurses, we are at the service and behest of society; thus, the significance of the interconnection lies in the difference it makes in the everyday actions in which nurses engage as they seek to promote people's health and healing. We also take this action turn because although as a profession we have engaged in critical work to explicate the interconnections among theory, evidence, and practice at the discursive level (eg, within the scholarly literature), where we seem to have run into problems is translating the interconnection into action. That is, at times we have had difficulty "walking the talk."

In this article, we contend that the difficulty in translating theoretic discourse into nursing action may lie in how we are conceptualizing the interconnection of nursing knowledge and nursing action. Specifically, the emphasis on epistemology may be inadvertently contributing to the problem. For example, despite nursing literature emphasizing the importance of ontology, discussions

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within the academic literature have framed the "theory practice gap" as an epistemological problem of a theoretic practice and emphasized the importance of integrating sound theory and evidence into practice. At the same, time practitioners have bemoaned the irrelevance of theories espoused in research, academic literature, codes, practice guidelines, and so forth. In both cases, the interconnection of theory, evidence, and practice is framed as an epistemological concern and the "gap" is framed as an epistemological problem. That is, the problem is discussed as though it is about knowledge—what is known and how knowledge is used or applied.

In this article, it is our intent to shift the discussion of knowledge translation from one that is primarily concerned with epistemology to one that considers the ontological dimension. That is, we contend that the relationship among theory, evidence, and practice is also a question of how we *are*—our ways of being and relating to ourselves, to knowledge, to one another, and to our environments. As others have done previously, we assert that ontology and ontological motivation are central to how we live/translate/enact knowledge in complex moments of practice. However, we take this assertion further by considering how an ontological understanding of the interconnection of theory, evidence, and practice offers new possibilities for nursing practice, education, and research. This ontological exploration is an attempt to respond to Gadow's assertion that within nursing we need to restore "the physical substance that has fallen away from the philosophical discourse"[1(p208)] to turn our attention to the tangible, embodied actions of giving and receiving nursing care.

LOST IN TRANSLATION? CRITIQUES OF KNOWLEDGE TRANSLATION

The interconnection among theory, evidence, and practice has been conceptualized and explored under various topics within the nursing literature including the theory-practice gap, nursing praxis, evidence-based practice (EBP), research utilization, knowledge transfer, research dissemination, research uptake, innovation diffusion, and so forth. Although it could be argued that while related, these terms and/or topics are somewhat distinct, Graham et al[2] explain that many of the terms are used interchangeably. As a whole, they encompass the subject of knowledge use—that of "how to get knowledge used" and "translated" into practice.[2–4]

An epistemological frame

There have been wide-ranging critiques of the way knowledge translation has been conceptualized within the various topic areas above. In undertaking these critiques, authors in nursing have often grappled with knowledge translation through an epistemological frame. That is, they have articulated the epistemological limitations inherent within both the conceptualizations of knowledge translation and the strategies meant to enhance the interconnection of theory, evidence, and practice. Examples include the long tradition of concern with and inquiry into research dissemination and utilization.[5–9] Similarly, nurses have explored extensively the idea of a theory-practice gap.[10,11] For example, it has been argued that the "theory-practice gap" is not "real" but rather the result of a particular epistemological stance—that any gap is due to the realist perspective that shapes the understanding of theory.[12–14] In other words, for a theory practice gap to be "real," theory must be conceptualized as a "real thing" that exists independent of practice. In contrast to the realist perspective of theory, discussions of nursing praxis have highlighted the integral connection of theory and practice and the way in which all practice is inherently theoretic, with every moment of practice already imbued with theory.[15]

A question of epistemology?

Given the epistemological frame that has been used within the topic of EBP, a central epistemological critique has been that

the perception of a knowledge "gap" has been fostered by the *kinds* of knowledge that are assumed to constitute valid theory or evidence and on which practice is subsequently based. For example, Kirkham Reimer et al describe that although EBP focuses on the integration of research evidence, clinical expertise, and patient values in clinical decision making, the overriding assumption has been that "epidemiological and statistical research findings could be useful for influencing the effectiveness of clinical practice."[4(p27)] These authors argue that the privileging of empirical knowledge has limited the consideration of evidence from a variety of other research methodologies and related knowledges emphasizing that "nurses clearly rely on knowledge beyond that which can be empirically verifiable."[4(p28)] According to these authors, the result is "incomplete epistemologies" that segregate empirical knowledge from other forms of knowledge and ultimately limit knowledge generation and application in everyday nursing practice. By privileging empirical knowledge and emphasizing the application of that knowledge in nursing practice, EBP strategies such as best practice guidelines favor evidence from randomized clinical trials and offer linear approaches that fail to address the complex realities of nursing practice situations.[4] Overall, epistemological critiques in EBP discussions highlight the way in which the *kinds* of knowledge privileged ultimately shape what "counts" as evidence, what knowledge is translated, where "translation" occurs, who is active in the translation process, and what constitutes "successful" EBP.

A question of ontology?

Ricoeur describes that both Heidegger and Gadamer challenged the assumption of interpretation and translation as being solely about epistemology. Both philosophers attempted "to dig beneath the epistemological enterprise itself to uncover its properly ontological conditions."[16(p64)] This was not to create a duality between the 2 and/or to subordinate epistemology to ontology. Rather the intent was to articulate the way in which epistemologies reflect the conscious and unconscious ontologies of their creators and vice versa. Ricoeur highlights the interrelationship of meaning, interpretation, subjectivity, and context. He contends that understanding, including interpretation and translation, is not simply mode of knowing but way of being and way of relating.

Cecci[14] has pointed to the significance of this ontological dimension within nursing knowledge. She contends that rather than focusing concern on the *kinds* of knowledge conceptualizations, there is a more fundamental question that might "change the tenor of the conversation ... (that of) how we understand ourselves as knowers to be related to what we think we know."[14(p58)] Cecci describes the way in which our ontological assumptions (eg, seeing people as disembodied and detached beings) shape our knowing processes. Drawing on Harding's[17] work (1991), Cecci explains that there is no possibility of disinterested knowledge that is separate from ourselves—from the values, beliefs, and assumptions we hold. Similarly, in highlighting this ontological dimension, writers in deconstructive hermeneutics (eg, Ricoeur, Derrida, and Caputo) have emphasized that epistemology is fundamentally a values matter—it arises through people and is inherently about what is of value, what is privileged, what is marginalized, and so forth. For example, Caputo explains that evidence (including that which arises empirically) is not a "given ... for what is important evidence in one view is not important in another."[18(p218)]

It is this value-laden, ontological dimension on which we wish to focus in considering the interconnection of theory, evidence, and practice. We assert that the interconnection is not only an epistemological matter. Rather, ontology and ontological motivation are central to how we live/translate/enact knowledge in complex moments of practice. Therefore, understanding and enacting the interconnection of theory, evidence, and practice require an examination of how epistemology and ontology are intricately intertwined in every nursing action.

MIND THE (ONTOLOGICAL) GAP

Our work as researchers and educators over the past several years has focused on addressing the chasm that often exists between nursing knowledge and nursing actions. Yet in some ways, rather than lessening, the chasm seems to be deepening. At the level of everyday bedside nursing, our research on ethical practice in nursing[19–21] and the work of others on moral distress[22–24] has illustrated the gulf between nurses' knowledge of "good" practice and their actions. Similarly, in response to epistemological discussions in the nursing literature, Cecci[14] and Thorne et al[25] have described the epistemological positioning and "othering" practices that are at times undertaken in the name of advancing nursing knowledge. For example, Thorne et al describe how during disputes over knowledge claims nurse scholars are inclined to rely on binaries (such as conceptualizing nursing theory into 2 competing paradigms—the simultaneity versus totality paradigms) and "in some cases, this adoption of a binary position has led to a passionately held form of 'othering' that prohibits a healthy and critical engagement with ideas."[25(p208)] Suggesting that fear is at the root of this binary positioning, Thorne et al emphasize the need to "begin to understand its dynamics as they play out in our intellectual engagements, and to learn what options there might be to reconsider its impact on our intellectual processes and products."[25(p210)]

These othering practices are enacted within nursing scholarship despite relational, caring values and goals, theories, and philosophic positions being espoused within that same scholarship. Thus, it seems that even those of us focused on knowledge development and "bridging the gap" between knowledge and action are not being all that successful in "translating" the theoretic and/or research knowledge we value into our everyday actions. Moreover, these considerations highlight that the gap is not only an epistemological problem. It is not merely that we privilege some epistemological camps over others or that there is a gap between what we know (theory and evidence) and what we do (practice). There seems to be a much more fundamental disconnect at the ontological level. To understand that disconnect, we turn to the site of everyday nursing practice. The following is a real experience of one of the authors, with minor details changed to protect the identity of the nurse involved.

An illustration: Beginning in everyday nursing action

I sit up and reach for the nasal prongs, I turn the oxygen on and take some slow, deep breaths. Funny, my breathing has been so stable over the past couple of days—why am I suddenly feeling so short of breath? Sitting upright I take my pulse and go over the possibilities in my mind. The cardiograms have been normal; my pulse is strong and steady. Maybe its just tightness from the fractured ribs. But why now? It could be an embolus—maybe the blow from the steering wheel injured more than my ribs—maybe I have more than contused lungs. I reach for the call bell and wait for the nurse. My nurse walks in smiling—"What can I do for you she asks cheerfully?" "I am feeling quite short of breath—it's different than it has been. I'm due to go home this afternoon so I am wondering if maybe I could get it checked before I leave just in case something has developed." The nurse frowns—"it's probably nothing—just your ribs." She takes my vital signs, shrugs and says "don't worry about it—it's nothing." "Well yes," I reply, "it may be just my ribs but I wonder if I could get checked out before I leave just to be on the safe side." The tone of her voice changes—gone is the friendly demeanour. In an authoritative tone she states "I'll think about it." With that she turns and walks out of the room.

I wait

An hour later she has not returned, my breathing has eased somewhat and lying in my bed I contemplate my next step—do I let it go or do I persist? An x ray porter calls out my name as she wheels a stretcher into the room. I raise my head to identify myself. "I'm having an x-ray?" I ask. The porter looks surprised. "That's what the requisition says." "Great," I reply as I attempt to move to the stretcher before she can question

further—I want that x-ray! ½ an hour later as I settle in my bed after returning from x-ray the nurse walks in. "Oh there you are. I just wanted to check that you were back and everything is ok." She smiles at me, "you know I didn't make the connection earlier." "The connection?" I ask, confused. "Yes, I read your articles when I was a nursing student—about relational practice. I so believe everything you write about." With great conviction in her eyes she declares, "and I practice exactly as you describe."

In considering this situation, it is important to emphasize that what is not known is what else was happening for the nurse that day, what the unit was like to work on, the demands she faced, and the contextual forces that were pressing in on her. However, we have chosen this experience because of what we *do know*. We know the baccalaureate nursing program that the nurse went through and thus that she was exposed to what we consider to be exemplary nursing knowledge and education. The curriculum was built on theoretic constructs such as health promotion, culture/context, personal meaning, social justice, and collaborative, relational practice. Within the curriculum, there is a concerted focus on praxis and "practice-based learning." As part of her nursing education, she would have been introduced to theories from human science and critical, feminist, interpretive, and biomedical paradigms and the way in which nursing practice requires the integration of those different knowledges. So how was it that this passionate, committed young nurse acted as she did? Obviously her actions were grounded in evidence and theory—she carried out an assessment and made a clinical decision to request an order for an x-ray. Yet, given the knowledge to which she had been exposed in her educational program, the theory and evidence she drew on was quite limited. For example, her actions did not reflect the collaborative, relational theories she had studied and with which she had obviously deeply resonated as a student. She "knew" them well enough to actually identify the theories with a particular author, yet did not enact them in her practice. What is perhaps more perplexing is that she believed that she *was* acting in a way that was congruent with the theories she had read in her nursing program and later described those "ways-of-knowing" and "ways-of-being" as being central to *who she was* as a nurse. However, as existing critiques have outlined and the above nursing experience illustrates, theoretic, evidence-based knowledge is not necessarily "translated" into nursing action.

AN ONTOLOGY OF KNOWING-IN-ACTION

We are interested in understanding the disconnect between the knowledge that the nurse in the above story valued and saw as integral to her identity and way-of-being as a nurse, the knowledge, and evidence that she used and/or did not use to inform her response and how that all translated into action. As we have grappled with trying to make sense of this situation, we have found current understandings of knowledge translation inadequate. Moreover, it seemed to us that some of the normative understandings that currently govern knowledge translation discourse are serving to limit understanding. Subsequently, we found ourselves turning toward Caputo's[26] description of an ontological approach to knowledge development.

Drawing on the work of Heidegger, Caputo[26] describes progress in science as possible on 2 levels. Knowledge can be developed to fill in the existing horizon—to build the known body of knowledge to confirm and refine predictions and hypotheses. However, consistent with Kuhn's[27] well-known description of scientific progress, Caputo argues that "it is possible, and sometimes necessary that the horizon undergo revision, and that can occur by a discontinuous revision or a shift of horizons ... (by) a reorganization of the whole field of disciplinary activity."[26(p164)] According to Caputo, this latter approach is carried out at the level of regional ontology—at the ontological horizon within which the work in the field is conducted.

This latter approach, that of developing knowledge at the level of regional ontology, seemed potentially fruitful for advancing understandings of knowledge translation and the interconnection of theory, evidence, and practice toward the particular goals of nursing. Toward that end, we have drawn on deconstructive hermeneutics and in particular, the work of Ricoeur, Derrida, and Caputo. Caputo[26] describes deconstructive hermeneutics as the ontology of understanding. Although a thorough consideration of deconstructive hermeneutics is well beyond the scope of this article, there are 2 particular ideas that we wish to draw forth for the purposes of this discussion. First, meaning, interpretation, and translation "begin where we are" and, therefore, are shaped by not only who we are but *where* we are—by the communities and contexts within which we know and act. Second, "the world of action is the basis for all meaning"[28] and action is fundamentally ontological.[16]

Knowing begins where we are

Ricoeur[16] argues that context is critical to interpretation and translation. Knowledge is translated through contextual features with both subjectivity and context shaping the capacity for knowing and knowledge translation. Drawing on the idea that epistemologies reflect the ontologies of their creators and vice versa, and taking into account the reciprocity between contexts and knowers, it has seemed to us that the ontology underlying the epistemological "cultural code" in nursing may be contributing to the experiential disconnect among theory, evidence, and practice. As Ricoeur contends, "epistemological difficulties, although perhaps diverse and irreducible to one another, often have the same origin. They stem from the very structure of a being that is never . . . capable of distancing itself from the totality of its conditioning."(p266) That is, what is often interpreted as inadequate knowledge or inadequate application of knowledge may from an ontological view be more related to how, as situated beings, we have come to be. The nurse in the situation we described did not necessarily lack knowledge—rather the problem seemed to be in translating knowledge (eg, knowledge of relational practice) ontologically.

In discussing the ontological foundation of knowing—of interpretation and translation—Ricoeur[16] describes the autonomization of action in which *action is detached from its agent and develops consequences of its own.* It has seemed to us that the nurse in the above story illustrated this autonomization of action. Although she had studied and resonated with other more collaborative models of practice, ontologically she responded by *being* the "knowing nurse" to the "unknowing patient" and *automatically* assumed the power and privilege of that knowing position. Her action became routine and automatic in the context within which she worked. Although her espoused theoretic claims were inconsistent with her actions in the situation, she was seemingly unaware of that inconsistency and thereby of the consequences of her action, including the effect of those actions on her patient.

According to Ricoeur, this autonomization is a social phenomenon in which individuals are conscripted into the actions of the social group. For example, the nurse's enactment of power evident in her statement "I'll think about it" does not merely reflect her actions. It also reflects her social conditioning into understandings that dominate healthcare settings—understandings regarding what knowledge is relevant, who is knowledgeable, how knowledge should be used, and so forth. The nurse's actions reflect how this particular nurse has taken up these ideologic features and how ontology and epistemology are mutually shaped within particular contexts.

Ricoeur is but one of many authors (eg, Derrida, Caputo, Dewey, Foucault, and so forth) who in differing ways have articulated the ideologic shaping of ontology, epistemology, and practice. "The interpretive code of ideology is something *in which* men (sic) live and think, rather than a conception *that* they

pose. In other words, an ideology is operative and not thematic. It operates behind our backs, rather than appearing as a theme before our eyes. We think from it rather than about it."[16(p251)] In this way, epistemology is intertwined with social relations. Ideology becomes the glue that shapes how theory, evidence, and practice are connected. "Ideology falls within what could be called a theory of social motivation ... something that justifies and something that carries along.... Hence ideology is both interpretation of the real and obturation of the possible."[16] In the above situation, the nurse acts from the ideology of the expert professional, justified by her position within the healthcare hierarchy. A consequence of this automization of action was the inability to see the impact of her actions and/or to consider other possibilities such as a collaborative relationship with the patient, despite her valuing of such theories and exposure to the evidence supporting his or her health-promoting outcomes.

Action is fundamentally ontological

Elias[29,30] offers a description of the way in which ideology including attitudes, beliefs, and social practices shapes people's experiences—even the way they experience themselves bodily. He describes, for example, how people in the Enlightenment era experienced a division between emotions and intellect because they were enmeshed in social controls and norms that perpetuated that way of being and thinking. Although those controls were externally perpetuated by Descartes and other thinkers of that time, people took this division up bodily. They experienced and knew themselves in that disembodied way. The division between intellect and emotion was not "the source of experience; rather, one of its products."[31(p18)] As people took up this division bodily, it became an ingrained and unconscious way-of-being in the world.

The above example of the nurse illustrates both the disembodied way-of-being Elias describes and also the way in which action is fundamentally ontological. For example, the nurse's actions arose out of her way-of-being as a knower into which she had been socialized. Moreover, her way-of-being shaped her actions and the way she drew on knowledge and evidence. The nurse's response that she would "*think* about it" is 1 illustration of the disembodied ideology that continues to dominate knowledge translation in healthcare. The patient's felt bodily sense that something was "different" was not only *not* explored, it was dismissed as the nurse took up a rationalist ontology telling the patient "it's probably nothing." This response implies that what mattered (what constituted valid evidence) was what could be measured by observable, physical evidence. Thus, as the "knowing nurse," she assumed the authority to determine, translate, and make the ultimate decisions for intervention based on that particular evidence.

There have been many discussions in the nursing literature about ideology and also about how the discipline has inadvertently adopted epistemologies that are contrary to nursing values and goals. However, such discussions tend to emphasize the *epistemological* aspect of ideology, without fully considering the *ontological* dimension. Similarly there have been discussions about embodiment and disembodied approaches to care. *However, there has been little exploration into embodiment/disembodiment and the living relation of epistemology and ontology*. Moreover, little consideration has been given to the way in which existing ideologies and in particular the ontological foundations and ways of relating to and around knowledge may be contrary to embodying our nursing goals and furthering the interconnection of theory, evidence, and practice.

Ricoeur describes that it is in moments of action—at the "level of the meaningful, mutually oriented, and socially integrated character of action that the ideological phenomenon appears in all its originality."[16(p249)] It is in particular moments of nursing action that one sees ideology and the ideologic shaping of people and ontology. For this reason,

Ricoeur contends that "the critique of ideology can be and must be assumed in a work of self-understanding, a work that organically implies a critique of the illusions of the subject."[16(p268)] That is, to understand and affect the interconnection of theory, evidence, and practice, an ontological inquiry at the action level is required because it is at the action level where the connections and disconnections of theory, evidence, and practice are experienced and embodied by people.

ONTOLOGICAL INQUIRY: EXAMINING KNOWING-IN-ACTION

Flaming[32] describes that when researching students' experiences of becoming a nurse, all of the participants in the study related "being a certain type of person" with good nursing practice. Moreover, asking students to translate their nursing actions through who they wished to be at an ontological level, through their ontological motivation, resulted in more responsive nursing actions. Flaming's research points to the significance and potential of ontological inquiry within everyday nursing practice.

From a deconstructive hermeneutics perspective, it is understood that any action and/or practice of knowledge translation proceeds from somewhere—from an already existing network of presuppositions. For example, who we are as people including how we identify ourselves to ourselves and how we identify ourselves to others is translated through a network of relations. The "kind of person I wish to be" is already relationally shaped by the discourses and practices of the larger world. Ontological motivation arises through this network of relations among oneself, others, and the contexts within which we are situated.

Ontological inquiry, like scientific inquiry, involves a conscious, intentional, and responsive process of reflexive inquiry into how particular ontologies and the knowledge and knowledge practices stemming from those ontologies are supporting the goals and values of nursing within particular practice situations. It involves recognizing the relational nature of one's own ontology and responding by questioning the meaning and consequences of that way-of-being. From this perspective, the central focus of knowledge translation is not how to get theory and research evidence used in practice. It is understood that practice is always, already evidence-based and theoretically informed. Therefore, the focus of knowledge translation becomes inquiring into one's way-of-being and how the prescribed intelligibility (and the automatization of being, knowing, and acting) is shaping the interconnection of theory, evidence, and practice—and in particular how it is limiting and/or enhancing action toward particular goals. The intent is to acknowledge and enlist existing knowledge and sensibility while simultaneously examining one's way-of-being (including the knowledge and sensibility informing that way-of-being).

A fundamental distinction within this knowing/translating process is in the ontological motivation. While existing theoretic knowledge and research evidence certainly inform one's actions ontologically, the nurse as subject does not so much follow and/or apply knowledge as *respond* to the possibilities any knowledge implies. The nurse does not act from "*behind* the text . . . but in *front of* it, at that which the work unfolds, discovers, reveals. Henceforth, to understand is *to understand oneself in front of the text* . . . (it is a matter of) exposing ourselves to the text and receiving from it an enlarged self . . . corresponding in the most suitable way to the world proposed."[16(p88)]

The nurse in the earlier example can be seen to have been acting from behind the text as reflected in her statement "I practice exactly like you describe." She did not appear to reflect on her actions within the particular situation and what those actions revealed about her way-of-being and knowing as a nurse and/or about the context within which she was practicing. Consequently, although she "knew" and valued relational theories, the opportunity to stand in front of

these theories, be enlarged by the possibilities they offered, and ultimately translate herself and her actions into effective, responsive nursing practice was hindered.

SHIFTING THE HORIZON: FROM EVIDENCE-BASED TO INQUIRY-BASED PRACTICE

As the ontological horizon of knowledge translation is reenvisioned to focus on what transpires in specific nursing situations, *knowledge translation becomes a process of apprehending a possibility of being*.[33] It involves active inquiry in which questions and answers arise through and in the everyday pragmatics of nursing situations.[12,15] As such, the form and emphasis of practice shift from *evidence-based* to *inquiry-based* practice.

Embodied knowing is central to inquiry-based practice. Within nursing, embodiment has been used to describe the use of the body as a vehicle for knowing the world, as an ethical stance of conscious action, as a material form of subjectivity and experience, and in reference to meaning-centered conceptualizations of culture rather than, for example, ethnicity-centered ones.[1,34] Interestingly, Gadow contends that nursing understandings of embodiment "remain discouragingly disembodied."[1(p90)] In this article, our use of the term *embodiment* is in line with Wilde's[34] explanation that embodiment "is not a theory, or a group of theories, but a different way of thinking about and knowing human beings." Somewhat in contrast with the goals of rationalist understandings, embodiment highlights the physical substance of knowing.[1] As Polanyi contends, whether we are aware of it or not "Every time we make sense of the world, we rely on our tacit knowledge of impacts made by the world on our body and the complex responses of our body to these impacts."[35(p147)] Our bodies are the site where knowledge converges in a far more intricate manner than any intellectual conceptualization.[36] "Our body is the ultimate instrument of all our external knowledge, whether intellectual or practical. In all our waking moments, we are *relying* on our awareness of contacts of our body with things outside for *attending* to those things."[37(p16)]

Inquiry-based nursing involves a conscious tuning into this implicit, intricate knowing process as a way-of-being in nursing situations.[38] Within inquiry-based practice, the first function of understanding is to orientate within a particular situation.[16] "To understand is to contextualize, to situate a thing within the contextual arrangement in which it belongs ... to 'cast' it in the appropriate terms."[26] The epistemological ground—the ground of knowing—is each person's tacit experiential presence in the world in relation with everyone and everything in the world.[15,39] The knowing process entails looking toward the primary constituents—people, context, research and theoretic knowledge, meaningful purposes, excellence of practices, and effectiveness of outcomes.[39] Evidence of successful knowledge translation lies in the pragmatic outcomes of any action, for example, how nursing actions respond to and correspond with people's health and healing experiences and ultimately effect health outcomes.

As an inquirer, the goal is to enter each situation experiencing theoretic and research knowledge anew. We attend to the possibilities seen in the light of a particular theory and are aware of the theory/evidence/knowledge in an active way. That is, theory/evidence is considered in relation to that which it opens up in terms of understanding, interpretation, selection, and action. Like a scientific inquiry, inquiry-based practice involves picking out clues that seem relevant to the present moment, examining what it is they appear to indicate while simultaneously responding with possibilities for action.[39] As Gendlin[36] describes, it involves "thinking with experiential intricacy." Through such experiential intricacy, practice is permitted to surprise theory and theory/evidence is translated into more intricate ways of acting.[36] For example, taking

an inquiry-based approach the nurse in the example we provided might have engaged herself differently by *inquiring into* the patient's sensation that "something was different." Purposefully attending to the interconnection of ontology ("who I want to be") and epistemology ("how/what knowledge might I enlist as a knower") she might have gone beyond the automized ontology/action of "knowing nurse to unknowing patient." Rather than limiting her evidence-gathering actions to vital signs she might have *been* with the patient in a more relationally responsive manner and as such expanded her actions to intentionally open the possibilities for other forms of knowledge and evidence to inform her clinical decision making. In this way, the interconnection among her espoused nursing values and goals, the theory and evidence she enlisted to inform her practice, and her actions might have been enhanced.

Remaking knowledge and ideology

In addition to promoting informed, responsive, competent actions in nursing situations, ontologically informed inquiry-based practice also serves to "make knowledge and ideology over." Purposefully theorizing and enacting epistemological and ontological possibilities that might better support the values and goals of nursing involve a meaning-making process in which knowledge and ideology are reinterpreted. As one examines the interconnection of ideology, theory, evidence and practice in a particular situation, that interconnection is understood and reshaped.[15] Moreover, the "doing" of nursing is melded with qualities of being and knowing through that translation process.

Reason and Torbet[40] describe that through such an inquiry process, "all movements of the attention, all knowing, all acting, and all gathering of evidence is based on at least implicit fragments of *normative theory of what act is timely now*."[40] This idea of normative theory is an important one given the ideologic shaping of knowledge and the experiential "gap" outlined earlier. For example, ideologically if one examines the nursing literature it is possible to see that "the gap between theory and practice" has become a common sensibility. Similar to Elias' example of people in the Enlightenment who experienced their own bodies in disembodied ways, the discourse of the theory-practice gap of EBP and so forth has served to normalize this sensibility to the point that the gap is a "real" "normal" experience. However, entering nursing situations as an inquirer automatically sets one up to remake the normative values and discursive practices within that dominant ideology. Translation becomes a process of reshaping our ways of being, knowing, relating, and acting.

This remaking of knowledge and ideology is in many ways akin to Dickoff and James'[41] description of "situation-producing theory." These authors contend that situation-producing theory is the highest level of theory because it exists and is produced for practice. Moreover, it has the potential to translate and reshape nursing knowledge and action to be more responsive in particular moments of practice. They have argued (and we concur) that "theory for a profession of practice discipline must provide for more than mere understanding or 'describing' or even predicting reality and must provide conceptualization especially intended to guide the shaping of reality to that profession's professional purpose."[41(p102)]

Derrida emphasizes the importance of this remaking process describing the "tension between memory, fidelity, the preservation of something which has been given to us, and at the same time heterogeneity, something absolutely new."[42(p6)] The goal of inquiry is to know and understand the intelligibility well enough that one can see through its gaps and inconsistencies to select, filter, interpret, and transform it. "Consequently and paradoxically, one can be faithful to one's heritage only in as much as one accepts to be unfaithful to it, to analyze it, to critique it, to interpret it, relentlessly."[43(p19)] In this way, reinterpreting the relationship among theory, evidence, and

action in nursing practice and the dominant conceptions of knowledge translation serves nursing goals.

TOWARD THE EMBODIMENT OF THEORY/EVIDENCE/PRACTICE

Recently there has been a call for theory to shape the design and implementation of knowledge translation.[3,44] Estabrooks et al[3] contend that theories are needed to develop testable and useful interventions. We concur that greater understanding of knowledge translation and better support of the interconnection of theory, evidence, and practice are needed. At the same time, we are cognizant of Caputo's[26] contention that we ought not to presuppose "a hard and fast distinction between practice and theory—as if theory did not have a praxis of its own, and practice did not have a 'sighting' of its own."(p159) That is, from a hermeneutic perspective any theory originates from our involvement in the world and any practice is already imbued with theory. Thus, it is important to think carefully about the theories one enlists to shape knowledge translation processes. If interpretation, translation, and action are relationally and ontologically mediated through subjectivity, context, and ideology, there is, as Cecci[14] has previously contended, no neutral, disinterested theory. Given the epistemological concerns that have already been raised about the limited conceptualizations of knowledge translation and the forms of nursing practice to which they give rise, a careful *ontological* consideration of the theories and ideologies shaping understandings of knowledge translation seems vital.

Within his theory of translation, Ricoeur[33] describes that a central characteristic of a spoken language is that it is in a sense "untranslatable" from one language to another. The question with which we are currently grappling in our own inquiry process is: Can any theory and/or group of theories "translate" across the complexity of nursing situations and result in competent, safe, ethical practice? Ricoeur[33] suggests that "it is through a 'doing' in the pursuit of theory that the translator gets over the (translation) obstacle."(p32) Might it be more fruitful to "stand in front" of Ricoeur's suggestion and focus on *acting* in the pursuit of theory?

Along this line, Caputo[26] contends that perhaps our best epistemological bet is to take up an antiessentialist open-ended nonknowing approach. This nonknowing keeps the door open to evidence that has not yet come in and will multiply the opportunities for seeing something we did not see coming—to potentialities we cannot presently conceive. Rather than focusing our attention on using and/or developing theory, Ricoeur[33] suggests that "we need to get beyond ... theoretical alternatives ... and replace them with practical alternatives, stemming from the very exercise of translation, the faithfulness versus betrayal alternatives, even if it means admitting that the practice of translation remains a risky operation which is always in search of theory."(p14)

Nursing education informed by an understanding of nursing as an embodied process of critical inquiry and translation might emphasize the development of ways of being. For example, while attending to questions such as "what do you need to know in this situation?," we ask our students continuously to consider "what kind of nurse do you want to be in this situation?" Such questions evoke commitment, engagement, and "response-ability," and help students bring together more effectively multiple forms of knowledge (eg, empirical, ethical, esthetic, contextual) and work within the potential contradictions between those differing knowledges. Similarly, nursing research informed by an ontological understanding might seek to derive implications and recommendations for nurse's ways-of-being with patients. For example, in the area of violence against women, ways-of-being that validate the woman's worth as a human being and abuse as undeserved are the most important aspects of an effective response and the foundation for a trusting relationship.[45,46]

Seeing competent nursing practice as involving more than the application of theory and evidence, as an embodied process of critical inquiry and translation, one that draws on theory and evidence to enlarge and imagine possibilities for action in particular moments, situations, and contexts offers a *way-of-being* in which the interconnection of theory, evidence, and practice is lived. Moreover, it sets us up to question the role and purpose of any knowledge and inquire into the ontological motivations that shape our knowing-in-action. Finally, an ontological understanding of the interconnections among theory, evidence, and practice highlights that any knowledge translation process should be guided by the question "how might (this) theory and evidence inform and enlarge the possibilities for being with and responding to this particular patient in this specific situation?" In this way an ongoing ontological inquiry not only enhances the interconnection of theory, evidence, and practice but also has the potential to transform the ideologies currently shaping nursing education, nursing scholarship, and nursing practice.

REFERENCES

1. Gadow S. Philosophy as falling: aiming for grace. *Nurs Philos.* 2000;1:89–97.
2. Graham ID, Logan J, Harrison MB, et al. Lost in translation: time for a map? *J Contin Educ Health Prof.* 2006;26(1):13–24.
3. Estabrooks C, Thompson D, Lovely J, Hofmeyer A. A guide to knowledge translation theory. *J Contin Educ Health Prof.* 2006;26(1):25–36.
4. Reimer Kirkham S, Baumbush JI, Schultz A, Anderson JM. Knowledge development and evidence-based practice. Insights and opportunities from a postcolonial feminist perspective for transformative nursing practice. *Adv Nurs Sci.* 2007;30(1):26–40.
5. Tarlier D. Mediating the meaning of evidence through epistemological diversity. In: Reed P, Shearer N, eds. *Perspectives on Nursing Theory*. 5th ed. Philadelphia, PA: Lippincott Williams & Wilkins; 2008:365–376.
6. Schultz P, Meleis AI. Nursing epistemology: traditions, insights, questions. In: Reed P, Shearer N, eds. *Perspectives on Nursing Theory*. 5th ed. Philadelphia, PA: Lippincott Williams & Wilkins; 2008:385–394.
7. Funk SG, Tornquist EM, Champagne MT. Barriers and facilitators of research utilization: an integrative review. *Nurs Clin North Am.* 1995;30:395–406.
8. Estabrooks CA. Mapping the research utilization field in nursing. *Can J Nurs Res.* 1999;31(1):53–72.
9. Dobbins M, Ciliska D, DiCenso A. *Dissemination and use of Research Evidence for Policy and Practice: A Framework for Developing, Implementing and Evaluating Strategies.* Ottawa: Canadian Nurses Association; 1998.
10. Reed P. The practice turn in nursing epistemology. In: Reed P, Shearer N, eds. *Perspectives on Nursing Theory*. 5th ed. Philadelphia, PA: Lippincott Williams & Wilkins; 2008:693–697.
11. Marrs J, Lowry LW. Nursing theory and practice: connecting the dots. In: Reed P, Shearer N, eds. *Perspectives on Nursing Theory*. 5th ed. Philadelphia, PA: Lippincott Williams & Wilkins; 2008:3–12.
12. Hartrick Doane G, Varcoe C. Toward compassionate action: pragmatism and the inseparability of theory/practice. *Adv Nurs Sci.* 2005;28(1):81–90.
13. Flaming D. Nursing theories as nursing ontologies. *Nurs Philos.* 2004;5:224–229.
14. Cecci C. Not innocent: relationships between knowers and knowledge. *Can J Nurs Res.* 2000;32(2):57–73.
15. Hartrick Doane G, Varcoe C. *Family Nursing as Relational Inquiry: Developing Health-Promoting Practice*. Philadelphia, PA: Lippincott Williams & Wilkins; 2005.
16. Ricoeur P. *From Text to Action. Essays in Hermeneutics, II.* Evanston, IL: Northwestern University Press; 1991.
17. Harding S. *Whose Science? Whose Knowledge? Thinking from Women's Lives.* New York: Cornell University Press; 1991.
18. Caputo J. *Radical Hermeneutics: Repetition, Deconstruction and the Hermeneutic Project.* Bloomington, IN: Indiana University Press; 1987.
19. Varcoe C, Doane G, Pauly B, et al. Ethical practice in nursing—working the in-betweens. *J Adv Nurs.* 2004;45(3):316–325.
20. Rodney P, Varcoe C, Storch J, et al. Navigating towards a moral horizon: a multisite qualitative study of ethical practice in nursing. *Can J Nurs Res.* 2002;34(3):75–102.
21. Doane GH, Pauly B, Brown H, McPherson G. Exploring the heart of ethical nursing practice: implications for ethics education. *Nurs Ethics.* 2004;11(3):240–253.
22. Hamric AB. Moral distress in everyday ethics. *Nurs Outlook.* 2000;48:199–201.

23. Peter E, Liaschenko J. Perils of proximity: a spatiotemporal analysis of moral distress and moral ambiguity. *Nurs Inq.* 2004;11(4):218–225.
24. Corley MC, Minick P, Elswick RK, Jacobs M. Nurse moral distress and ethical work environment. *Nurs Ethics.* 2005;12(4):381–390.
25. Thorne S, Henderson AD, McPherson G, Pesut BK. The problematic allure of the binary in nursing theoretical discourse. *Nurs Philos.* 2004;5:208–215.
26. Caputo J. *More Radical Hermeneutics*. Bloomington, IN: Indiana University Press; 2000.
27. Kuhn TS. *The Structure of Scientific Revolutions*. Chicago: University of Chicago Press; 1962.
28. Valdes MJ. Introduction: Paul Ricoeur's poststructuralist hermeneutics. *Ricoeur Reader: Reflection and Imagination*. Toronto: University of Toronto Press; 1991:3–40.
29. Elias NJ. *The History of Manners: The Civilizing Process.* Vol 1. Oxford: Blackwell; 1978.
30. Elias NJ. *State Formation and Civilization: The Civilizing Process.* Vol 2. Oxford: Blackwell; 1982.
31. Burkitt I. The shifting concept of the self. *Hist Human Sci.* 1994;7(2):7–28.
32. Flaming D. Becoming a nurse: "it's just who I am." *Med Humanitarian Rev.* 2005;31:95–100.
33. Ricoeur P. *On Translation*. Madison, NY: Routledge; 2006.
34. Wilde MH. Why embodiment now? *Adv Nurs Sci.* 1999;22(2):25–38.
35. Polanyi M. *Knowing and Being*. Chicago, IL: University of Chicago Press; 1969.
36. Gendlin ET. Thinking beyond patterns: body, language and situations. In: den Ouden B, Moen M, eds. *The Presence in Feeling and Thought*. New York: Peter Lang; 1992:21–51.
37. Polanyi M. *The Tacit Dimension*. Glouchester, MA: Peter Smith; 1983.
38. Doane G. Being an ethical practitioner: the embodiment of mind, emotion and action. In: Storch J, Rodney P, Starzomski R, eds. *Toward a Moral Horizon: Nursing Ethics for Leadership and Practice*. Toronto, Canada: Pearson Publishing; 2004:433–446.
39. Reason P, Bradbury H. Inquiry and participation in search of a world of worthy human aspiration. In: Reason P, Bradury H, eds. *Handbook of Action Research: Participative Inquiry and Practice*. London: Sage; 2001:1–14.
40. Reason P, Torbert WR. Toward a transformational social science: a further look at the scientific merits of action research. *Concepts Transform.* 2001;6(1):1–37.
41. Dickoff J, James PJ. A theory of theories: a position paper. In: Nicholl LH, ed. *Perspectives on Nursing Theory*. Glenview, IL: Scott, Foresman & Co; 1968/1986.
42. Derrida J. The Villanova roundtable: a conversation with Jacques Derrida. In: Caputo J, ed. *Deconstruction in a Nutshell. A Conversation With Jacques Derrida*. New York: Fordham University Press; 1997:3–30.
43. Egea-Kuehne D. The teaching of philosophy: renewed rights and responsibilities. In: Trifonas P, Peters M, eds. *Derrida, Deconstruction and Education. Ethics of Pedagogy and Research*. Victoria, Australia: Philosophy of Education Society of Australasia; 2004:17–30.
44. Eccles M, Grimshaw J, Walker A, Johnston M, Pitts N. Changing the behavior of healthcare professionals: the use of theory in promoting the uptake of research findings. *J Clin Epidemiol.* 2005;58:107–112.
45. Gerbert B, Caspers N, Bronstone A, Moe J, Abercrombie P. A qualitative analysis of how physicians with expertise in domestic violence approach the identification of victims. *Ann Intern Med.* 1999;131(8):578–584.
46. Gerbert B, Caspers N, Milliken N, Berlia M, Bronstone A, Mof J. Interventions that help victims of domestic violence. *J Fam Pract.* 2000;49(10):889.