

Values-Based Practice and Evidence-Based Care: Pursuing Fundamental Questions in Nursing Philosophy and Theory

William K. Cody, RN, PhD, FAAN

Possibly the single most important philosophical question to be posed within a practice discipline is “what guides practice?” In nursing, historically, a long list of traditions and rules from a variety of sources served to guide practice before (and since) the advent of nursing theories. In science, traditionally, the short answer to the question “what guides practice?” usually has been rendered as theory, and nursing has developed a strong body of theories; however, many powerful and subtle forces influence choices in practice. By reflecting on the manifold influences on one’s choices in practice, the practitioner can construct a personal answer to the fundamental question “what guides my practice?”

A clear understanding of what guides practice helps the practitioner to pursue useful knowledge more efficiently, to represent one’s disciplinary perspective more articulately, and to communicate more effectively with clients and the multidisciplinary team. This book is concerned with philosophical and theoretical perspectives to guide nursing practice. It is important to note that nursing could not take its place in the academic sun and be recognized as the distinct discipline that it is today until it could point to a domain of human knowledge specific to the discipline, knowable only through the formal study of nursing (Coyne, 1981). This domain was mapped through the creative,

deliberative construction of nursing theories over the past 50 years.

Value-Laden Theory and the Fallacy of Value-Free Science

A theory's power is proportionate to the breadth of situations and events it can encompass. There are a number of frameworks in nursing that are capable of guiding nursing practice across a range of situations and events, which reflects the maturity of nursing's knowledge base. Some nurse scholars have expressed doubt that these frameworks can guide practice broadly because they are abstract or because they are humanistic in orientation or because they include nonobjective dimensions or because many have not been extensively tested under controlled conditions. Grounding of a theoretical framework in an underlying philosophy, however, strengthens the theory as a guide to practice by making explicit the assumptions and values that form its underpinnings. Many nursing frameworks have explicitly incorporated values such as caring, profound respect for all persons, and attentive presence into their conceptualizations and propositions. Learning these frameworks has profoundly changed the lives of many advanced practice nurses.

In the mid twentieth century, a movement for "value-free" science rooted in the philosophies of science known as positivism, logical positivism, and logical empiricism wielded pervasive influence. This movement in its

various guises sought essentially to purge science of all thought not arising from either empirical observation or strict rules of logic. Its influence on the sciences has lingered despite subsequent developments in philosophy of science that weakened or refuted most of its claims (Proctor, 1991). The fact that scientists are human means that science cannot be value free. Values are fundamental constituents of the human lifeworld. Indeed, there is warrant to say even that science itself is a value. That nursing's body of theory is heavily and explicitly value laden can today be seen as a strength, not a weakness, of our body of knowledge.

The hopes and expectations that grew strong in the 1980s, that nurses, nursing units, and nursing schools would adopt, use, support, and grow nursing's own theories have today been somewhat diminished by the influences of other forces converging upon the practice of nursing. These forces are multifarious and include the advent of prospective payment systems, shortened hospital lengths of stay, digitization of healthcare documentation, higher education of influential nurses in nonnursing disciplines, and the persistent need for two-year nursing programs to meet workforce demands. Along with all of these factors, the attenuated growth of the nursing theory movement can also be attributed to the failure of many members of our own discipline to recognize the uniqueness and value of our own body of knowledge and to face down criticisms from other quarters courageously.

The Clarion Call for Evidence-Based Practice

In contemporary nursing, there is a persistent clarion call to adopt evidence-based practice, implement it, teach it, study it, and standardize it (Melnyk & Fineout-Overholt, 2004). Many nurse leaders holding advanced degrees would answer the question “what guides nursing practice?” today by saying without hesitation, “Evidence.” Evidence-based practice refers, in the main, to the use of rigorously derived empirical findings preferentially as the basis for intervention and nonintervention. It is not unique to nursing. The nomenclature for this movement varies, and one sees literature referring to evidence-based practice and literature referring to evidence-based care. In this chapter, a basis for differentiating the two will be proposed.

The evidence-based practice movement, although centered on the findings of empirical research and the findings of integrative reviews of empirical research, includes proponents of various different kinds of evidence, including ethical considerations and other dimensions of life (Goodman, 2003). The movement is not without its internal controversies and divergent views (e.g., Franks, 2004; Timmermans & Berg, 2003; Welsh & Lyons, 2001). Still, for the most part, the movement and the vast majority of the related literature focus on the use rigorous and replicable research findings to inform, or even determine, questions of intervention and nonintervention in healthcare.

Standards of care can be said to approximate the state of the art in evidence-based practice. Note here the difference in terminology (standards of care), which is significant. A set of standards of care is typically based on multiple research studies accumulated over time. It is constructed by large panels of experts to provide practitioners with a well-thought out synthesis of the available evidence for intervention and nonintervention. These standards of care adhere predominantly to the medical model in their approach, but they are commonly used by nurses, health educators, and others. Some sets of standards achieve such familiarity among practitioners across disciplines that they are known chiefly by brief acronyms such as “JNC-7,” which is the Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure (U.S. Department of Health and Human Services, 2004). Equivalent sets of guidelines exist for many diseases and conditions. It would be difficult to argue against such standards of care within the parameters for which they are designed because they represent feats of combined intellectual achievement that no one person could conceivably match. They help to ensure the availability of the consensus of best reasoned options for care to millions of people.

The evidence base for many of the conventions of tradition-laden and routinized healthcare, however, the truth be told, can be rather weak. Also, for any number of possible unique acts of intervention or caregiving, there may be no research evidence at all. Does this mean,

then, that we have no guide for practice in human situations in which there is insufficient research to support recommendations? Or does it mean that knowledge resources other than strongly conclusive research must be brought to bear on situations as guides to practice? Goodman (2003) proposes dealing with uncertainty (as to treatment) in medicine through “management, acknowledgement, and reduction [of the uncertainty]” (p. 131). Interestingly, Goodman does not turn to values for guidance in the absence of convincing evidence one way or another. One aim of the evidence-based practice movement is to minimize bias, and attention to the values of the practitioner can be read as an open invitation to allow bias to rule. Such an interpretation of the dynamics of personal and professional values in practice ignores the fact that many or most healthcare practitioners in fact have a value (i.e., a bias) for objective evidence of efficacy and for the use of good evidence in planning care. With or without evidence, it is the practitioner’s values that drive her or his performance in providing care.

In reality, no formal guide to practice or any body of knowledge in any discipline can be both broad and specific enough to guide all actions in every situation. Practitioners are human, and life is complex, ever-changing, and unpredictable. Historically, this philosophical problem has been discussed in the discourse concerned with praxis.

Understanding Praxis

The discourse on evidence-based practice in nursing could benefit from an exploration

of the literature on praxis, a concept that has been well examined from ancient times to the present. In demurring from engagement with the literature on praxis, the proponents of evidence-based practice limit discussion of considerations other than evidence that have a strong bearing on practice.

Praxis has been defined and described in several different ways. Aristotle related praxis to human situations requiring practical reasoning to inform action. Habermas (1973), Freire (1993), and Bernstein (1999), in the 20th century, have contributed to our contemporary understandings of praxis, which always unfolds embedded in human situations replete with the complications of multidimensional human interactions, the uncertain, and the unknowable. Persons pursue reasoning related to their peculiar situations based on an understanding of what is good and what contributes to human well-being. Praxis and practical reasoning always unfold in a context that is profoundly interpersonal and relatively unpredictable. The end is not predetermined, and as possible ends evolve situationally, possible means evolve as well. Thus, praxis is creative and dialogical. In political and pedagogical discourse, praxis has even been explicated as the practice of freedom.

Practice as Praxis

If practice is examined in the light of this voluminous literature of over 2,000 years, it must be viewed as driven by far more than scientific evidence alone. Even the most die-hard logical positivist would concede, at a

minimum, the need for a code of ethics to provide parameters of conduct for science-based practice. Many considerations other than scientific evidence can be identified as reasons for action and as knowledge to guide practice.

The practice of nursing is intentional and deliberate action, guided by nursing science and other sources of knowledge, performed by nurses, and intended for the benefit of persons and society. In this regard, it is comparable to other professional practices. The moment-to-moment acts of nursing practice are chosen from a wide variety of options by each individual nurse in the ever-unfolding and unpredictable context of interrelationships with persons, families and communities, their meanings to the persons involved, and the values that are interwoven among the meanings. The animus underlying nursing practice is the intention to benefit people. However, the actions, behaviors, and words that provide the benefits change from moment to moment with the situation.

Each nurse is responsible for her or his own practice in a fundamental and inescapable way. The actions entailed in professional nursing practice are also the responsibility of, and occur under the stewardship of, the nursing profession itself, by way of its regulatory bodies and professional associations. These bodies determine the expectations of all the nurses within their spheres of influence, and these expectations are laid out in accord with conventions such as the nursing process and standards of ethics. In short, practice is predominantly driven by the personal and professional values of the nurse. It is owned and controlled by the individual nurse to a great

extent although governed by certain bodies representing the profession and the state.

Care

Human care is a recognizable and structured interaction in human societies through which persons give and receive assistance with basic human needs, in wellness and in illness, across the lifespan, before birth, throughout life, and beyond death. Specialized care of various kinds is delivered by professionals and is largely deemed to be deliverable only by such professionals. In contemporary society, human care, hereinafter care, should be and is largely consumer driven. Care delivery is governed, at the individual level, largely by the recipient of care or the guardian or designee of the recipient, who has the right to accept or refuse whatever care is offered.

It is axiomatic across healthcare disciplines that clients have a right to be offered care based on the best evidence available. It is not for the practitioner to decide ultimately what intervention, if any, the client will receive; rather, this decision rests with the client, who has the right to be well-informed about the evidence and to make a choice. What evidence is most valued by the practitioner varies from one practitioner to the other, but all are expected to adduce evidence to justify their recommendations and offerings to clients. It is important to note that from the practitioner perspective care is offered and, within the bounds of ethics, not ordered, required, or forced, for care, in a fundamental sense, belongs to the consumer. It is the consumer's to request, accept, or reject in accord with personal values. It is

the professional's responsibility to offer that for which there is best evidence. As demonstrated above, this expectation is exemplified in the standards of care that delineate the best knowledge that the health sciences have to offer at a given time.

Differentiating Practice and Care

The discourse on evidence-based practice does not differentiate clearly between practice and care. This conflation of what should be two distinct concepts is especially troubling in nursing, wherein scholars have emphasized nursing's special commitment to care and caring for generations. Upon reflection, however, one can discern a fundamental difference between the nature and structure of professional practice on the one hand and the care that is delivered by professionals on the other. In **Table 1–1**, four ways of differentiating practice and care are specified.

Practice belongs to the practitioner and is driven by values. Only the actor has

the agency to initiate and cease deliberate actions. The practitioner is assumed to have control over her or his own actions and to be responsible for them. Nothing can remove the onus of individual responsibility from any professional practitioner, neither haste in service to one's charges, nor pressure from one's hierarchical superiors, nor lack of key information. This responsibility and relative autonomy is further emphasized at the societal level by assigning control and governance of the profession largely to the members of the profession itself. Professional practice is governed by the individual practitioner, her or his discipline, the governments of states and countries, laws, and societal norms. Professional practice is relatively discipline specific in that education and licensure to perform complex and sophisticated tasks to benefit others, for pay, is typically regulated in a context of disciplinary knowledge, expertise, socialization, and customary expectations.

Practice is necessarily and profoundly practitioner driven. The knowledge base and decision-making capacity of the practitioner

Table 1–1 Differentiating Practice and Care

Practice	Care
Belongs to the practitioner	Belongs to the consumer
Controlled by the practitioner, by the profession, and by society	Controlled by the consumer, by rules/laws, and by society
More discipline-specific, because it is more practitioner driven	More interdisciplinary, because it is more consumer driven
Values based	Evidence based

are among the very defining factors of professional practice. Practice, as stated before, is highly contextual and situational. Many factors impinge on moment-to-moment decision-making in practice. No external resource for decision-making can be absorbed by the practitioner thoroughly and rapidly enough to inform all action or inaction in situation to an extent equal to individual knowledge and experience. This immediacy of intention and action is in the nature of all multi-dimensional, deliberative interactions among human beings.

That which most fundamentally drives one's practice is one's values. Values are by definition the cherished beliefs that prompt and inspire choices and actions over time. Making similar choices repeatedly and performing similar actions repeatedly over time confirms the value as an abiding cherished belief within one's world of meaning (Parse, 1998). The way a nurse practices and the way she or he provides care to persons reflects her or his personal and professional values (Woodbridge & Fulford, 2003). Spending time with clients may reflect a value for offering attentive presence. Frequently urging clients to make changes in health maintenance routines may reflect the values of norms or problem solving. One's values are constituents of who one is and thus are reflected in all that one does.

Care is the prerogative of the consumer and is structured by evidence. Only the consumer/client (or her/his legitimate designee) has the right to accept or reject care, even though typically care is designed and prescribed or recommended by others

(i.e., professionals). This assertion is an outgrowth of the ongoing paradigm shift toward person-centered care, attending to the whole person, and respect for individual and cultural differences. The professional caregiver's responsibility is to see that the consumer's choice of care is informed and that the delivery of care is carried out competently. Legal protections and social sanctions exist to ensure that the consumer's rights to be well-informed and to receive competent care are protected.

As described above, standards of care represent something close to the consensus state of the art of evidence-based care. All clients of healthcare professionals have the right to expect that care will be offered that is structured to the extent possible in accord with broadly recognized standards of care.

Values-Based Practice and Evidence-Based Care

We live our values. The strongest confirmation of a value is to act on it repeatedly, which also describes rather precisely how we construe professional practice. The practitioner chooses how to practice based on personal values. The client chooses what care to receive based on personal values. The practitioner offers care to address the client's needs and desires, care that is structured based on the best evidence available.

As the philosopher Raz (2003) has pointed out in his book *The Practice of Value*, "Concepts of false values cannot have instances" (p. 24). This is another way of

saying essentially that we live our values. To frame this proposition more colloquially, if you don't live it, it's not your value. In contrast, there can be false evidence. Indeed, the history of science is replete with instances of evidence misinterpreted and misunderstood. Evidence is a phenomenon that emerges only as evidence of something. The answer is already halfway there when the question is posed.

Standards of care are rewritten periodically based on newly emergent evidence, and it is not unusual for standards to seesaw back and forth between yea and nay to certain procedures between one edition of guidelines and the next. Surely something more substantial, lasting, and meaningful to both nurse and client must underpin nursing practice. To this author's way of thinking, that underpinning is found in the interface of personal meanings and values with the meanings and values structured in a theoretical framework for nursing practice. Readers are invited to use this text to assist them in identifying the values and meanings that inform and inspire their practice.

Suggestions for Further Reflection

In this chapter, I have sought to inspire and facilitate reflection on the question "what guides practice?" Many of the readings throughout the rest of this book put forward ideas about philosophy and theory in nursing that will prompt further reflection, and hopefully dialogue and debate, about the question.

In Chapter 3, Carper provides a schema for organizing the knowledge necessary for nursing practice, categorized as empirics, esthetic knowing, ethical knowing, and personal knowing. How do values and evidence relate to Carper's ways of knowing? Are values and evidence equally relevant to all types of knowing, or is evidence more pertinent to one type and are values more pertinent to another? In Chapter 4, Monti and Tingen present multiple paradigms of nursing science, in which vastly different worldviews underpin theory development and practice. Does this then mean that different values underpin practice and evidence is considered differently from different perspectives?

In Chapter 8, Parse describes how adopting an explicitly values-based theoretical perspective transforms practice. In Chapter 9, Bunkers puts forward 16 tenets for framing nursing knowledge for the 21st century, all of which are explicitly value laden. Evidence is scarcely mentioned at all. Does this mean that a philosophy that is explicitly values driven does not value evidence? Or does it mean that evidence accrues when one abides with the 16 value-laden tenets? In Chapter 10, Wuest discusses the contrast between traditional values of professionalism and the values of caring and justice reflected in the feminist literature. In Chapter 11, Ketefian and Redman propose that the process of knowledge development itself is embedded in systems of cultural values and perspectives and question whether it is appropriate for Western values by their dominance in science and the professions to shape knowledge development in non-Western societies.

One might well ask, “How can one accurately perceive evidence if one is using the wrong cultural lens to seek it?”

In Johnson’s examination of nursing art in Chapter 15, it is easy to see that values are threaded throughout the five conceptualizations of nursing art that she puts forth, but perhaps not so easy to ferret out the role of evidence in the performance of nursing art. Cowling, in Chapter 17, and Gadow, in Chapter 18, explicitly connect with a values-laden ontology in describing an appreciative practice methodology and describing an ethos of relational narrative, respectively. In Chapter 19, Butterfield points out that in many cases, the evidence one seeks in order to understand health concerns may be found not at the individual level but at the societal level. How counterproductive, and arguably inhumane, for example, to press for behavior change at the individual level to resolve a difficulty that stems fundamentally from societal neglect?

In Chapter 21, Boykin and Schoenhofer reconceptualize outcomes in a way that challenges the hegemony within the outcomes literature of strict adherence to objective and quantifiable outcomes. In the theory of nursing as caring, rather, enhancing personhood is conceptualized as the central desired outcome. Chapters 23, 24, and 25 reflect three different attitudes toward the place of human values, meanings, hopes, and dreams in relation to science, reflecting three divergent ways of organizing constructs of science, values, and evidence. In Chapter 26, Carper’s categories of knowing are revisited and the meaning of evidence in each way of knowing is specified. Chapters 27 and 28 explicitly

focus on issues surrounding the use of evidence from two competing perspectives.

The interplay of values and evidence in determining how to practice and what kind of care to deliver occurs at the very core of healthcare decision-making. The contemporary advanced practice nurse is challenged to develop the ability to appreciate and understand a wide variety of human values in a rapidly changing multicultural society. She or he is equally challenged to develop the ability to discern strong and weak evidence and how to structure healthcare services based on the preponderance of the evidence. Both abilities are cultivated best within the context of a broad and deep appreciation of theoretical and philosophical perspectives of nursing offered in this text.

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