The Value and Significance of Knowing the Patient for Professional Practice, according to the Carper's Patterns of Knowing

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Abstract

Background: The scientific value of man relies upon an extension of a continuous effort of mankind to explain the nature of man. The core issue in nursing is man within his entirety. The aim of the present study was to review the literature about the Knowing the Patient for Professional Practice, according to the Carper's Patterns of Knowing.
Method and material: In this paper the four patterns of knowing according to Carper will be analysed. According to these patterns, a description of the meaning and strategies of " knowing the patient will be made. Finally the significance and value of it will be discussed, with specific referance to: skilled clinical judgement, involvement, patient advocacy, and clinical learning about larger populations. CINAHL and Medline were the basic data bases used for this literature review.
Results: The process of knowing encompasses empiric, aesthetic ethic and personal elementsOn the other hand, " knowing the patient" acquires two broad dimensions: a) knowing the patient's patterns of responses and b) knowing the patient as a person. Patterns of responses are essential components for problem solving.
Conclusions: The process of knowing the patient appears to be an integration of the four patterns that Carper identified. Moreover, knowing the patient was found important for clinical judgement personal involvement, patient advocacy and clinical learning. In order to enhance the ability of nurses to integrate the different patterns of knowing the person, educators should review the current teaching strategies to develop cognitive, intuitive, experiential, and personal knowledge.

Keywords :patterns of knowing, nursing knowledge, personal knowledge, empirics, intuition, esthetic knowledge

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Introduction

Michael Polanyi once wrote that the existence of plants and animals was not discovered by botanists and zoologists, and the scientific value of these sciences relies upon the development of man's pre scientific interests in nature.[1]

In the same way, Martha Rogers states that man was not discovered by nursing and its scientific value relies upon an extension of a continuous effort of mankind to explain the nature of man.[2] She continues saying that the core issue in nursing is man within his entirety.

Nursing's effort to know man is "a weaving of threads of conceptions, perceptions, remembrances, and reflections into a fabric of meaning". This threads may be coming from the nursing science or other sciences, arts life, or experiences. However, as the weavers, nursing creates a unique process and product.[3]

The writer will refer to this process of knowing which as described by Carper encompasses empiric, aesthetic ethic and personal patterns.[4] According to these patterns, a description of the meaning and strategies of " knowing the patient will be made. Finally the significance and value of it will be discussed, with specific referance to: skilled clinical judgement, involvement, patient advocacy, and clinical learning about larger populations.

Carper's patterns of knowing.

According to rationalism the only source of knowledge, is reason rather than experience. This philosophy has influenced nursing for many years so as to get involved in formalising knowledge in order to become explicit and legitimate. However, human meanings and concerns are difficult to be formalised. Consequently, nursing theorists have considered other legitimate ways of knowing.[5]

Carper's paper on "patterns of knowing" was a landmark in the nursing literature which extended in a new perspective our understanding of types of knowledge and theory needed in a practice oriented discipline such as nursing.[6] Her work was published in a time that nursing was struggling to obtain a consensus of identity with a unique body of knowledge.[7] Nursing was very much influenced by scientism which holds the positivistic view that the only reality is the one which can be empirically verified.[6] Carper, stated that the only valid and reliable knowledge of that time in nursing was "empirical, factual, objectively descriptive, and generizable".[4]

However, in addition to empirical knowledge, Carper identified ethics aesthetics, and personal knowing. She suggested that these patterns are all "necessary, interrelated, interdependent and overlapping, and create the whole of knowing.

Carper's work counted upon the assumption that the patterns and structure of nursing knowledge provide the unique perspectives of the discipline. However, Boykin et al reject this thesis, proposing that is the conception of nursing which provides the structure of nursing knowledge rather than the patterns of knowing.[7] In addition, they comment on her failure to distinguish between knowing and knowledge. They claim that this can lead to criticism of her work by saying that she believes that specific patterns of knowing create different types of nursing knowledge which disintegrates its unity. Nevertheless, her evolutionary work, stimulated and motivated action in order to define and develop nursing knowledge which would truly be unique and congruent with its nature.[7]

Empirics: the science of nursing.

Empirical knowledge has been a synonymous with science for many years as its purpose was to describe, explain and predict natural and social phenomena.[8] In these traditional views of science, reality can be validated by different observers, and knowledge can be only obtained through the senses. Nursing broadened the legimate ways of inquiry which apart from hupothesis testing, now includes inductive and deductive reasoning and phenomenology description.[9]

Knowledge expression of empirics includes facts, organised descriptions, conceptual models and theories which explain and predict relationships.[9] The expression of knowledge is important when the credibility is assessed at the assessment dimension. In empirics assessment, the critical question asks what the knowledge represents and how it is representative.At the assesment of empirics, the credibility index is validity of knowledge which must appear as it was first predicted to be. However, the ultimate credibility of each knowledge pattern is judged when the pattern is integrated with other ways of knowing and proved to be adequate in a care situation.[10]

It is remarkable that Carper criticize the empirical knowledge while at the same time he accepts its need for achieving what Kuhn calls a scientific paradigm.[11] As Carper mentions, there is a critical need for nursing to expand empirical knowledge as it has not achieved what Kuhn calls a scientific paradigm.[4,11] Chinn & Kramer suggest that many nursing theories reflect an "ideal" of scientific inquiry but when nursing is judged against these ideals it is proved inadequate.[9] This is partially due to the use of other patterns of knowing in nursing, which can not be translated in an empirical reality. However, when the same theories are being judged on the whole of knowing their importance expands beyond the traditional scientific ideals. In this context, health is no more addressed according to observable characteristics and behaviours only, but it is related to the human life process and reflects the individual's values and beliefs.[4,9]

Aesthetics: the art of nursing.

Carper described aesthetics as the art of nursing which is based on the "direct feeling of experience.[4] Both Carper and Chinn & Kramer regard aesthetic knowledge as unique and subjective.[4,9] However Benner suggests that experience is not entirely subjective and the knowledge derived from experience can be described in language and practices.[12] It is the understanding of knowledge and experience that can change our view of how nurses might know their patients.

The art of nursing, described by Parse includes valuing the human presence, showing respect to different opinions that a client may holds, and connecting with him.[13] Curl & Koerner argue that the art of nursing is a creative art, which can not be shared retrospectively.[14] On the other hand, Chinn & Kramer imply that it can be communicated retrospectively and components of skills of interactions and tasks such as active listening, can be shared with others.[9] Although they believe that aesthetics can not be shared in languages, they suggest that the art/act, can be expressed. This reflects the adoption of Benner's and Wrubel's connection of nursing art to artful ways of nursing interactions and skilled tasks.[15]

As Augros and Stanciu say, aesthetic knowing occurs in enlighten moments as a result of creating a composure of unity, clarity and completeness.[16] Aesthetics require from the nurse to be fully engaged in the moment of the experience and interpret a client situation all at once by elucidating the meaning of the process and looking beyond the situation to focus on what might be(envisioning), so as to act according to what has been envisioned.[17]

The artful enfoldment of the other patterns is where actually the creation of aesthetics depends upon. Smith proposes that a caring presence reflects all the dimensions of knowing and demonstrates the art/act of aesthetic knowing.[17]

In order to elaborate on the meaning of aesthetic knowledge, the conception of nursing must be made more explicit. Boykin et al suggest that Carper fails to provide an explicit conception of nursing which will facilitate the creation of structures and patterns.[7] In order to facilitate the finding of the meaning of aesthetic knowing, Boykin & Schoenhofer reflected on nursing's main goal, as “nurturing persons living caring and growing in caring”, a conception that regards all persons as caring as a result of their humanness.[18] Caring is a human experience based on aesthetic qualities, which actualises beauty in a nurse-client

relationship.[17] This beauty makes persons to realise their common humanity.[19] The caring process in nursing widens our understanding of the world and evokes a fuller sense of aesthetic knowing about the core qualities of human links and interrelations.[17]

Ethics: the moral component.

Ethics, identified by Carper as the moral component of nursing, constitutes a fundamental pattern of knowing.[4] Both Carper and Chinn & Kramer suggest that this pattern goes beyond the knowledge of the ethical codes of the discipline to include "moment to moment moral judgements according to motives, intentions and personal characteristics.[4,9]

According to Chinn & Kramer, the creative dimension of ethical knowledge involves valuing, clarifying and advocating.[10] Clarifying and valuing constitute the base for a personal ethic after developing different philosophical positions. Nurses act as advocates of their patients and themselves through these processes.[9]

Ethical knowledge is expressed through codes, standards, normative ethical theories as well as through descriptions of ethical decision making. In the same way as empirics, ethical knowledge can be expressed in languages and in a theoretical form. Empirics is assessed on credibility, while ethics is judged on justness rightness and responsiblness. Dialogue rather than codes and standards is required to analyse an ethical decision.[10]

For nurses the processes of ethical knowing such as advocating for their patients, and clarifying the meaning of life and living, can change all the existing values in health care.[9]

Personal knowing

The nature of personal knowing has been explored by many authors and in different ways. Carper suggests that "it promotes wholeness and integrity in the personal encounter".[4] She continues to say that there is a continuous process toward knowing the self since:

"One does not know about the self
one strives simply to know the self" (p.18).

Chinn & Kramer suggest that trough knowing the self one can truly know another person.[9] As Carper states, none of the empirical categories of personal characteristics and behaviours provide a deep understanding of a human being as a person; as a self.[4] In addition, Carper highlights the importance of the "therapeutic use of self" which only becomes possible through the personal knowing. In the therapeutic use of self, the nurses bring as much of themselves as possible to the relationship with the patients and use themselves for their benefit.[20] In this relationship the nurses and the clients interrelate openly toward "fulfilment of human potential".[4]

The nurses need to be authentic which means that they reflect their true selves, not hiding behind their roles, but enacting the role so as to express their uniqueness as persons.[20] This authentic personal relationship, rests upon the acceptance of the freedom of each individual for self-creation and constant change in the midst of becoming.[4] Self-awareness is an important element in the therapeutic use of self so as to absorb in an interaction.[20]

Self-awareness can be increased by engaging in self reflection, by perceiving and accepting input from others and openly disclosing oneself. According to Chinn & Kramer, the self awareness of the person in interaction as well as the full understanding of the moment and the context of interaction, facilitates sharing a meaningful experience.[9] They describe the creative dimension of personal knowing as experiencing the self and encountering and focusing on self. In a similar way, Moch describes the elements of personal knowing as: "wholeness, encountering, passion, and commitment".[21] Passion is identified as the vital and valuable nature of personal knowing. The assessment of personal knowing involves examining the congruity of the expressed self with the authentic self.[9] Smith argues that personal knowing requires

awareness of the self as well as with the self.[17] She advocates that knowing is closely related to being. She concludes saying that "personal knowing is primary to all knowing". So, nursing theories are chosen by nurses according to personal values, aesthetic perception is personal knowing, and choosing ethically right actions result from a correspondence with the authentic self.

According to this view, the distinction of knowing by Carper, in logical types, is incongruent with the holistic nature of knowing.[17] Polanyi, advocates that knowing is personal and holistic as it aims at finding the reality through the process of science, aesthetics and ethics.[1] According to the different views of Polanyi and Carper, Egan et al, who responded on Carper's work, said that Carper's personal knowledge refers to knowing self which is different from Polanyi's different view mentioned above.[22]

In Jenks' study, personal knowledge was explored in the context of clinical decision making.[23] The nurse informants referred to the pattern of personal knowing as "knowing" and attributed successful decision making to high quality of interpersonal relationships with patients.

Both personal and aesthetic patterns of knowing are used in the development of knowledge in the humanistic nursing model. This approach complements others in patient care and offers a framework in the therapeutic nurse patient relationship. It also describes phenomena derived entirely from the lived experiences of patients which is important to clinical nursing practice.[24]

Clinical Knowledge

Aesthetic and personal knowing involves the subject while empirical involves the object. The link between the subject and the object is the process of knowing the patient which is a process of acquiring and using clinical knowledge. Clinical knowledge has been identified by Schultz & Meleis as one of the three types related to nursing along with conceptual and empirical knowledge.[25] They described clinical knowledge as manifested in nursing practice resulting from the nurses engagement in the gestalt of caring.

Nursing studies showed the complexity variance of decision- making task for nurses which include "cognitive", "intuitive", and experiential aspects.[23] Many authors, including Rew and Benner explored the intuitive pattern of knowing in clinical decision making.[26-28]

Agan relates intuitive knowledge to patterns of personal knowledge, suggesting that nurse can prove its credibility through reflection and actualisation. He suggests that if they use experiencing, realising and centering, which, according to Chinn & Kramer, constitute personal knowledge, they can determine the usefulness of intuition, and express it through themselves, in the same way that personal knowledge is expressed through authentic self. In the same way, Agan argues that intuitive knowing fits with the pattern of personal knowledge identified by Carper and described by Chinn & Jacobs.[29] In addition, Young advocates that intuition bridges all patterns described by Carper, since the product of intuition synthesises "isolated cues", "images","memories" and "feelings".[30]

Benner defines intuition as " understanding without a rationale ", while, Ruth-Sahd calls it the "sixth sense".[12,31] Schraeder & Fischer argue that intuition manifests the artful expression of Nursing and is a core element of holistic nursing.[32]

Ruth-Sahd suggest that intuition expands beyond empirical knowledge, even to knowing events which may happen in the future.[31]

Dreufus identified six key aspects of intuition: a) pattern recognition, b) similarity recognition, c) common-sense understanding, d) skilled know-how, e) sense of salience and f) deliberative rationality.[33]

Benner suggests that through these processes, expert nurses who have an enormous background of experiences, can have an intuitive grasp of situations and deal with problems holistically, without wasting valuable time.[34]

This holistic view of situations, using previous knowledge in practice without

conscious problem solving, is called by Polanyi tacit knowledge.[35]

Benner's ideas about the holistic view of situations relies on the experiential pattern of knowing, which describes nurses moving from novice stage, in which they rely on theory for decision making, to a stage of expert decision making.[23]

In a study by Smith et al., [36] it was found that intuition used by nursing students can be measured according to physical sensations, premonitions, spiritual connections, reading of cues, sensing energy, apprehension and reassuring feelings. Another study by da Silva, showed that novice, standard and veteran nurses have different levels of intuitive abilities but they confirmed its value for decision making especially in doubtful and conflicting situations.[37] Ruth-Sahd emphasizes the importance to adopt pedagogical strategies so as toinculcate intuition as a valued means of knowing in the multicultural curriculum.[38]

It has been showed by numerous studies that clinical knowledge includes cognitive, intuitive and experienced based processes. However, clinical decision making, happens in a complex human context which makes it difficult to understand its dimensions.[23]

Many studies tried to get insight into the different dimensions of clinical knowledge. In some of them, the issue of using a particularistic clinical knowledge arisen, and especially, the issue of knowing the patient.[39]

Knowing the patient

Jenny & Logan carried out a qualitative study using grounded theory methodology, in order to show how expert nurses gradually disconnect patients from mechanical ventilation.[39] In the study, nurses referred to "knowing the patient" as a cognitive and rational process of exploring important aspects of the patient and the situation.

According to Tanner et al, knowing the patient is very different from the formal, explicit scientific knowing, but, is a core element of clinical judgement.[5] In their study about the development of expertise in critical care nursing, knowing the patients was an important theme in nurse informants narratives on their practice.

In another study by Jenks, knowing was demonstrated as personal knowledge about another human being by establishing interpersonal relationships.[23] The informants referred to knowing as the process of creating interpersonal relationships which influences their clinical decision making. The importance of knowing the patient was also shown in a study of experienced staff nurses of a Scottish hospital, about the appropriate basis for nurse - patient relationships. The informants related the knowing the patient process, to involvement which includes actions in which the nurses not only learn about their patients as the objects of clinical attention, but also, as active participants on the social interaction of the hospital.

In Jenny & Logan's study the nurses described some intervening conditions which facilitated or constrained the knowing process.[39] These conditions may be: special features of the patient, the time that was spent together, the nurse's expertise, and empathy. An example of specific attributes is the cooperation of the patient which facilitates learning the objective clinical condition as well as the subjective perceptions. This cooperation requires an awareness of the patient about his or hers condition, as well as a physical and mental capacity to communicate.[39]

The contact with the patient is another important factor, as the nurse and the patient need time to know each other. Moreover, the nurse needs to engage his or herself in perceiving the client's condition, communicating, presenting herself and showing concern by caring.[39]

The " knowing the patient " process rely very much on the nurse's expertise. Jenny & Logan argue that expertise facilitates the above actions and trust from the patient and confidence in nurse as she possesses an acute awareness which sometimes precedes clinical evidences.[39] According to English, the expert nurse usually has an extensive experience of

certain types of patients which provides her with an internal representation of the possible outcomes she should expect while viewing a patient situation.[40]

In Jenny & Logan's study, informants mentioned empathy as one of the contributing conditions in the knowing process.[39] Some of them doubted its usefulness, as it sometimes makes nurses emotionally involved, in a way that they become unable to practice, while, others regarded it as a way to become more sensitive to salient personal concerns of the patient.

Carper reflected on empathy as an important element of aesthetic knowing, since it enables persons to experience someone else's experiences.[4] She continues, by arguing that when the nurse learns to empathise with the lives of the patients, she will understand more the different ways of perceiving reality. Rogers having the experience of psychotherapy, defined empathy as:

" to sense the client's private world as if it were
your own without ever losing the " as if " quality "[2]

Zderad define empathy as the accessibility and presence which engage the whole of oneself.[41] However, empathy arose diverse responses, especially during the evolution of nursing as a scientific discipline. According to Chapman, nursing demands a high awareness of empathetic processes, while Agleton finds it inappropriate for professional practice.[42,43] However, empathy helps the nurse accept the "otherness" of the client, perceive and share his feelings, understand his perspective and predict his thoughts. The ability to understand and concern for the patient empathetically depends on one's communicative skills, in order to use both verbal and non-verbal signs, so as to understand the other's perspective.[44]

Of course, in order to empathise and enter the world of the other, the nurse needs a strong sense of self and awareness of his/hers perspective.[20]

Dimensions of " knowing the patient "

Research in clinical practice has showed that nurses acquire both objective information about their patients condition as well as personal information concerning their family and social history, coping resources e.t.c.[45]

This information facilitates understanding and caring for the patient. In Tanner's et al study “knowing the patient acquire two broad dimensions: a) knowing the patient's patterns of responses and b) knowing the patient as a person”.[5] According to Tanner et al, the patterns of responses include how they respond to interventions, their personal habits and customs, their physical condition, their body topology and special features.[5] Their study showed that nurses learn to recognise these patterns by personalising their theoretical knowledge and by drawing from past experiences. Patterns of responses are essential components for problem solving.

According to Draucker & Lannin, problem solving requires "conceptual reasoning" and "perceptual awareness" which requires engagement attentiveness and sensitivity.[46] Through intimacy and involvement a nurse recognises patient responses indicative of a change in his/her condition before this becomes visible. Tanner et al state that in their study, nurses described situations of recognising specific responses of patients, but all they manage to know about the patient, how they recognise slight differences and understand situations can not be fully expressed.[5] However, "knowing the patient" as described by the informants of Jenk's study, is more than knowing about the patient.[23] It involves personal relationships in which they get to know the patient as a person. In Tanner's et al study, nurses described an uninvolved detached position which is the result of not knowing the patient as a person.[5] Tanner et al argue that the detached stance is quite often among nurses.[5] Benner advocates that the preference of some nurses to hold a detached position, and use reflective reasoning and formal knowledge, is not

congruent with the nursing role of caring.[15] She states that caring considers emotions, unclear feelings, a sense of a coming problem, and results in a creative exploration and cue sensitivity. Tanner et al argue that the detached stance results in clinical decisions which are only based on external interpretations and not on how the patient view situations.[5] Mitchell reflects on this practice which is based on the totality paradigm as defined by Parse in 1987.[47] She says that nurses who practice within this paradigm, assesses and judge people according to observed behaviours and physical tests which results in labelling people with different than the expected responses. However, according to Parse, health is a coconstituted process defined by the individual.[13] She regards health as human becoming which is a free chose of meaning of the situations by the person according to his value priorities. According to this view of health, the nurse should provide care so as to enhance the quality of life that the person chooses for himself.[47] So, the nurse by being " there " for the patient illuminates meanings and gets to know the values and hopes the individual chooses to reveal in his personal health description. In this way, clinical practice and decision making changes so as to reflect the personal prospects.

Strategies

According to the results of Jenny & Logan's study, "knowing the patient is a difficult interpersonal process which requires":

a)Perceiving/envisioning: this process involves transforming the information gathered from the patient observation, to a non mediated perception of the most important part. Carper states that this helps the nurse to understand the patients needs and envision useful actions according to the desired outcome.[39]

b)Communication: According to Jenny & Logan, communication with the patient requires interpersonal skills rather than instrumental and skills in performing tasks.[39]

c)Self-presentation: requires a display of high standard professional knowledge, self-confidence and concern from the nurse so as to gain the patients trust.

d)Showing concern: Parbury states that nurses express their concern to patients by coming to know them.[20] Benner defines concern as "a way of being involved in one's own world" and suggests that concern defines an involvement.[15] A nurse's concern derives from her personal and professional history and the specific patient situation. Through empathy, nurses can develop concern for their patients.[15] Caring behaviours indicative of concern can be informing, consoling, presencing, and assisting.[39]

Another possible way of knowing the patient is through observing his relationship with his family, which reveals a lot about his every day life, his personality, his normal mode of expressions, habits and choices. The role of the family is far more important when the patient is unconscious, so that the information the family gives, will help the nurse asses his recovery by recognising usual cues that are indicative of recovery. The signs that could worry a nurse e.g. irritation, anxiety or demanding behaviour could be signs of returning to a normal behaviour. On the other hand, the family can alert a nurse about unusual behaviour.[5] In this point, it could be argued that nurses should respect a patients freedom to present himself in a different way than in his personal life. As far as this behaviour is not warning for physical problems, it should be accepted as a personal right.

Difference in patient care.

Knowing the patient is significant for professional practice as a) it is central to skilled clinical judgement, and broader than physical assessments, b) it includes the skills of seeing and involvement, c) it enables advocacy and d) is a part of clinical learning.[5]

a) Knowing the patient as central to skilled judgement: In Tanner's et al study, nurse participants referred to particularisation of care which relies on knowing the patient.[5] By knowing the patient nurses can make judgements about the nature of the patients and their clinical condition which enables

choosing the most appropriate therapeutic measures.[39] When the nurses know how the patient typically responds they recognise the most important parts of a situation and are able to compare current picture to typical responds.[5] The significance and the practical discourse of knowing the patient is devalued by nurse plans, diagnoses and protocols deriving from a rational model of practice which counts upon context free formalised processes and rules.[5]

b) Involvement: May suggests that involvement is the part of practice which includes knowing the patient, reciprocity and investment.[48] In her study, nurses described circumstances that in the process of learning about the patients character and everyday life, the patients reciprocated which resulted in recognising nurse as a person. Benner states that our culture consider involvement as a talent rather than a knowledge which can be learned through experience.[49] She advocates that the skill of involvement requires "being open to the concrete other". Nurses usually experiencing problems of finding the right level and amount of involvement. According to Benner, the right kind of involvement, should be being tuned with the patient and his family, understanding and some times just being present in silence and tears.[49]

c) Advocacy: The advocate model of the nurse patient relationship reflects the basic value of nursing which is the best possible care for the patients.[50] Nurses who have a deep understanding of the patient and his needs, can stand up as advocates so as to make sure that he will have the appropriate medical therapy.[5] From their contextual knowledge that sometimes physicians may not have, nurses can propose alternative interventions and advocate for resources they think necessary.[39]

d) Knowing the patient as part of clinical learning: By knowing specific patients, a nurse can learn common features and qualitative distinctions in particular patient populations. In this way, assessments become differentiated according to historic specific knowledge. Finally, by knowing a patient population, it is possible to know he variations and particularity of the particular population.[5]

Conclusion

The process of knowing the patient appears to be an integration of the four patterns that Carper identified and described; empirics. aesthetics, ethics and personal knowing.[39] The knowing process requires scientific knowledge and skills that constitute the empirical knowing. The aesthetic knowing is apparent in the way nurses perceive the patients reality. The personal knowing involves the therapeutic use of self in which nurses interrelate openly with the client, expressing their authentic self, for his benefit. Finally, the ethical knowing is reflected upon their efforts to provide an individualised holistic care.

In order to enhance the ability of nurses to integrate the different patterns of knowing the person, educators should review the current teaching strategies to develop cognitive, intuitive, experiential, and personal knowledge.

These ways of knowing, are rooted in nurses role as women healers and reflect a feminine perspective. In order to preserve the spirit of nursing, we should integrate the woman-centred perspective, appreciate the values of caring and commitment and use all the alternative ways of knowing including our nursing wisdom.

It is argued that “it is partially the result of weaknesses in the alternative patterns of ethical, personal, and esthetic knowing, the ineffability of which compromises accountability. This ineffability can be countered only by introducing a wider form of empirics than countenanced by evidence-based practice into all patterns of knowing, to demonstrate their salience and to make their use in practice transparent”.

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