

ORIGINAL ARTICLE

Rethinking Carper's personal knowing for 21st century nursing

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Email: sally.thorne@nursing.ubc.ca**Abstract**

In 1978, Barbara Carper named personal knowing as a fundamental way of knowing in our discipline. By that, she meant the discovery of self-and-other, arrived at through reflection, synthesis of perceptions and connecting with what is known. Along with empirics, aesthetics and ethics, personal knowing was understood as an essential attribute of nursing knowledge evolution, setting the context for the nurse to become receptively attentive to and engaged within the interpersonal processes of practice. Although much has been done over the 40 years since Carper described these ways of knowing, and we have seen enormous advances in empirics and ethics, and I would argue even in aesthetics (understanding the subtle craft of nursing in action), personal knowing may not have attracted its fair share of critical unpacking. Further, we see increasing evidence of a distortion on how forms of personal knowledge, including beliefs and attitudes, are being taken up within segments of the profession; these include legitimizing idiosyncratic positionings and, most worrisome, challenges to the idea that there are and ought to be fundamental truths within nursing that stand as central to disciplinary knowledge. In this paper, the author reflects on the confusion that a continued uncritical deference to personal knowing may be creating and the evolving interests it seems to serve.

KEYWORDS

advocacy, evidence-based practice, nursing philosophy, social mandate, ways of knowing

1 | A CHALLENGE TO THE PHILOSOPHICAL CORE

Despite the well known conundrums we encounter when we try to create an operational definition of the discipline of nursing, I have always been convinced that it is characterized by a strong and enduring set of core values and principles. I have understood the disciplinary lens of nursing—the manner in which one sees the world when that seeing is grounded within the social mandate of our profession—to represent a distinctive epistemological perspective on the universe. I have been confident that this distinctive perspective

can be known and taught, and that it is of inherent value to society, even though society may not always understand or be able to articulate that value. I have also known, with as profound a conviction as one can have in the world of complex ideas, that a core constituent of nursing exists and that it can be recognized, even across a diversity of linguistic, national and practice setting contexts. My read of our history and our literature assures me that, while the technical detail of our practice in this discipline may differ from era to era, place to place and setting to setting, how we think and the value proposition that we bring to the domain of human experience in health and illness does not.

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However, several recent experiences have led me to wonder if I had been doggedly clinging to an outdated way of thinking about my discipline or, alternatively, if my discipline may be losing its grip on that coherence and allowing the winds of change to disrupt that epistemological centre. A couple of years ago, I was part of a discussion at a conference of nursing editors, held in the USA, in which the topic of politics as they affect editors of nursing journals was under consideration. A number of the participants in that particular discussion were nursing deans and directors—exemplars of strong and confident scholars in our discipline. As the dialogue advanced, it became apparent that there was a shared understanding that it was no longer “safe” for faculty members to talk about issues of racism within the nursing undergraduate classroom. Their explanation was that any such activity in the nursing education environment was considered politically partisan and, therefore, unacceptable. I was deeply shocked by what I was hearing, recognizing that these were nurses charged with shaping the core values of the next generation of nursing without the tools to enact a core component of a nursing’s mandate. And to be entirely clear, I understood all of these colleagues, without exception, to be expressing moral distress about this situation, as they clearly knew what was right in terms of guiding the profession forward but felt themselves to be structurally prevented from enacting it.

To cope with my distress around what I interpreted as a disjuncture between good nursing thought and action, I wrote an editorial entitled *For What Do We Stand?*, in which I called on nurses to remind themselves of the need to retain and enact those core values even under, and perhaps especially under, difficult political times. I wrote:

Protectionism, racial profiling, and the ideology of defending the privilege of some over the basic human rights of others are all products of the inability to move beyond simplistic thinking and into the domain of values, virtues, and high ideals. They reflect an immaturity of the human spirit, focusing on the self rather than the other, privileging the moment over the long game. It is not at all difficult to see how the story unfolds when the forces of fear, hatred, intolerance, and privilege gain influence at the expense of decency, compassion, and mutual respect. Clearly there is a need for the skill set that nurses so clearly exemplify in their individual practice context to be enacted at the societal level. Not only do we need to support and encourage those among us who do this kind of work as their practice—work such as refugee and immigrant health, harm reduction, reproductive rights advocacy—but we also need to champion the values that underpin this work within the larger community. We need to help teach society how to overcome fear, distrust, and personal insecurity in order to do what is right, to meet the call of those who are the most small and

vulnerable among us, and to enact those central ideals that are consistent with valuing health for all.

(Thorne, 2017, np)

Editorials are written with the intention to provoke dialogue. But somewhat to my surprise, I was directly challenged on that argument in a manner that made it clear that the notion that nursing could and should claim fundamental values in this manner was not as self-evident or shared as I had presumed it to be. In a response to that editorial, my learned friend Martin Lipscomb took issue with my assumptions, writing:

Often it is argued or assumed that nurses share values. Specifically, it is supposed that “the profession” possesses and promotes values, and nurses, as individuals, purportedly hold these values because they are members of the profession. Evidence in support of this assertion is rarely offered. Nonetheless, proclaiming that nurses share values serves multiple purposes. The claim bolsters conceptions of professional identity. It also masks the promulgation of political opinions that, if overtly stated, would be rejected by some and possibly many nurses. ... The notion that a collective stance on politically sensitive issues could be formed or sustained is implausible and, perhaps, our voices might be better heard if we ditched the pretence that beyond abstractions, substantive professional values exist or are desirable.

(Lipscomb, 2017, np)

I sincerely respect the logic of the argument that Lipscomb was making in that commentary and was grateful that he articulated it so thoughtfully. Our exchange of ideas led me to further reflect on the extent to which diversity of thought can and should be welcomed within our discipline. The idea that we may no longer be able to answer that question perturbed me greatly.

In the context of that troubled reflection, I found myself drawn back to the notion of personal knowing that has been with us over the past 40 years of nursing thought, and perhaps taken on the stature of an uncritically held assumption with respect to our individual freedom with regard to those core commitments. In this paper, I take up the invitation to further wrestle with that idea.

2 | CARPER'S IMPACT ON NURSING THINKING

I begin with a brief review of what I believe Barbara Carper was attempting to accomplish and how this aspect of our disciplinary epistemological hardwiring seems to have evolved over time. In 1978, Carper published a paper based on her 1975 doctoral dissertation entitled “Fundamental patterns of knowing in nursing;” that paper appeared in the very first edition of *Advances in Nursing Science*

(Carper, 1978). Over time, it became one of the most influential of early nursing theoretical papers (Chinn & Kramer, 2018). In a 2015 interview, the essence of which was also published in that journal, Carper described her motivation for that work as encouraging reflective nursing practice (Eisenhauer, 2015). She had been concerned that nursing curricula in the late 1960s had become overly focused on science to the extent that there was an “exclusion of everything else” (Eisenhauer, 2015, p. 76), and her conviction was that what was essential to the practice of nursing entailed a great deal more than just science. Although she had initially limited her focus to trying to work out how to add ethics into the nursing curricula of the day, the philosophy courses in her doctoral program at Columbia University had ultimately led her to propose the four-part model of patterns of knowing that we recognize today as Carper's “Ways of Knowing.”

Carper did not see her work as being in any kind of competition with the nursing theories that were being debated in that era of our disciplinary history, but instead as an adjunct to them (Carper, 1988). In her view, they helped to justify the broader humanistic aspect of excellent nursing practice—a counterargument to the excessive influence of scientific thinking on the way we taught and wrote about the discipline. Interestingly, despite the wide uptake of her ideas, she did not much engage in the ongoing discussion, preferring instead to let others find what interpretations they might in the insights she offered (Eisenhauer, 2015). However, as the uptake of her work within the wider body of theoretical literature made apparent, many of her contemporaries considered her patterns of knowing as triggering a paradigmatic shift in their own thinking (Chinn & Kramer, 2018; Jacobs-Kramer & Chinn, 1988; Johns, 1995).

Although it may be difficult to stretch our minds back to why that might have been, it is instructive to consider that Howard Gardner's book, *Frames of Mind: The Theory of Multiple Intelligences*, was not published until 1983. His view differentiated human intelligence into specific modalities (such as visual-spatial, verbal-linguistic, logical-mathematical, bodily kinaesthetic, interpersonal, naturalistic, existential and moral) instead of thinking about it as a single general ability. In a somewhat similar manner, Edward de Bono's *Six Thinking Hats*, which was first published in 1985, was an idea that was originally conceived of as a way of understanding different styles of business decision making but also found an audience in applied disciplines such as nursing (Cioffi, 2016). Using the heuristic of differently coloured hats, de Bono identified six characteristic approaches to working through complex challenges, each with potential merits towards a particular decision and each with its own set of limitations. The “blue hat,” which de Bono referred to as the “manager,” or “big picture thinker” was essential to optimally capitalizing on each of the aptitudes brought to the table by different members of a business team, but without falling prey to the inevitable problems if each style was used alone. In a subsequent analogy to nursing applications, this “blue hat” thinking became known as the “critical thinking” required to examine multiple possible approaches to a complex problem, and incorporating and understanding of their implications into a final decision (Price & Harrington, 2018). Thus, in Carper's time, the wider scholarly community was only just beginning to push past a more

global understanding of knowledge and knowing within an applied discipline and to see it as a multifaceted and dynamic kind of activity. Her thinking was therefore quite provocative for its time, and it is understandable that it had such a profound and lasting impact.

Over time, Carper's four “ways of knowing” became ubiquitous in nursing curricula and served to justify many of the later trends in thinking about the nature of the discipline (Garrett & Cutting, 2014). We began to see creative approaches, such as personal stories, criticism of works of art, principles and codes, dialogic justifications, appreciative inspiration being used to teach the thought processes of nursing and to enter into our lexicon as frames of reference for nursing knowledge. Although there was very little challenge to the basic four ways of knowing, scholars began to augment them, extending theorizing into other possible options to explain the complexity that is excellent thought within nursing. For example, in 1993, Munhall proposed that knowing could lead to closure based on false confidence in one's own interpretation. She accordingly proposed “Unknowing” (or not knowing) as a fifth pattern of knowing (Heath, 1998). In 1995, White re-examined the fundamental patterns of knowing and added one she termed “Sociopolitical Knowing.” She conceptualized this as occurring on two levels: the sociopolitical context of persons (both the nurse and patient) and the sociopolitical context of nursing as a practice profession, including both society's understanding of nursing and nursing's understanding of society and its politics. “Emancipatory Knowing” was added to the lexicon in 2008, in the 7th edition of Chinn and Kramer's popular *Integrated Theory and Knowledge Development in Nursing* text—a text that has been widely used to introduce nursing graduate students to the world of nursing theory. For Chinn and Kramer, this pattern of knowing reflected an aptitude to acknowledge social and political “injustice or inequity, to realize that things could be different, and to piece together complex elements of experience and context to change a situation as it is to a situation that improves people's lives” (2011, p. 64). It was an essential competency, from their perspective, if nursing was to focus its attention on developing an awareness of social problems and taking action to create social change. More recently, the ideas of “Organizational Knowing” (Terry, Carr, & Curzio, 2017) and “Spiritual Knowing” (Willis & Leone-Sheenan, 2019) have been proposed as additional fundamental patterns of knowing that nursing requires in order to fulfil the mandate of the profession—the latter being a particular issue to which I will return later in this discussion.

3 | THE PARTICULAR INSTANCE OF PERSONAL KNOWING

Although each of the original and augmented ways of knowing deserves deep reflection and attention, it is Carper's original pattern of “personal knowing” that seems most urgently in need of a careful unpacking and reconsideration in the context of current thought within the discipline. Carper's understanding of this form of knowing was that it was the most difficult to master and teach and also the most essential to understanding the essence of patient care (p. 18).

She described it as the knowledge needed to engage in authentic interpersonal relationships, a “standing in relation to another human being... unmediated by conceptual categories or particulars abstracted from complex organic wholes” (p. 18), something that was arrived at through reflection, synthesis of perceptions and connecting with what is known.

Although, comparatively speaking, there has been relatively little critical reflection in our literature on the concept of personal knowing (Porter, 2010), we can see the potential in the 1990 writing of Moch, who noted that “Any encounter with a person or event is an opportunity for personal knowing, provided the person has attempted to eliminate preconceived notions and has cultivated a *receptive attending*.” (p. 155). In this way, it would seem that the original notion of personal knowing, which was intended as a critically reflective approach to knowing and understanding one's role in the clinical encounter and in relational practice, is being taken up within certain segments of the profession in support of ideas that extend well beyond that initial context. And this becomes especially concerning in the context of an intellectual climate within which personal knowing is understood to reference holistic thinking and, therefore, to uncritically trump the other components. As Smith argued in 1992, because all knowing is personal knowing, personal knowing ought to have a central and primary place in nursing thought (1992, p. 3).

In 1995, Silva, Sorrell and Sorrell questioned the application of Carper's four ways of knowing, pointing out that they had come to address all aspects of both knowing (epistemology) and also being (ontology) in the discipline. They also noted that personal knowing was in fact most problematic among the four, in that it validated “unique” stories of everyday existence, such that multiple realities that can come from personal knowing are expected and become justified. This seems to suggest an is/ought dichotomy. Because personal knowledge is fundamental, what is contained in personal knowledge takes on the cache of legitimacy as valid epistemology and even ontology for the discipline. Although Benner's (1984) early work in particular has helped us appreciate that pattern recognition is a basic mechanism for advancing one's knowledge from novice to expert in the practice application domain, presumably we would not accept the corollary that all patterns that develop are evidence of expert thinking. Consider, for example, what we know all too well about stereotypical patterns that can be discerned on the basis of prior conditioning or selective attention, such as might derive from ingrained theoretical or attitudinal biases.

Thus reflecting on both the intention and the subsequent application of the idea of personal knowing, it becomes important to put some thought towards how vulnerable our discipline's core values ought to be in relation to the changing external forces that may exert an influence on the reflective capacity of individual nurses. In a world in which new technologies, corporate interests, political ideologies, social media and many other often pernicious forces are at play (Porter-O'Grady, 2001; Scott, Matthews, & Kirwan, 2013), we clearly need to ensure we have a strong grip on what it is that nursing is saying when it takes the position that personal knowing is a legitimate, and in fact dominant, form of professional practice expertise.

4 | SLIDING OFF THE EPISTEMOLOGICAL RAILS

It is widely recognized within the nursing philosophical community that a healthy critique of empirical science as the predominant form of credible knowledge in the health field is both useful and appropriate. We see widespread evidence of the untoward impact of an over-reliance on science in excessive standardization and depersonalization within care systems. The capacity to conceptualize and enact care that is individualized, which can be seen as the antithesis of standardized practice, has a long history as a central feature of nursing's distinctive mandate (Liaschenko, 1997). However, having legitimized and welcomed something of an open challenge to evidence-based practice, we may have allowed those other ways of knowing to occupy more privilege in our discipline's identity than was intended.

To illustrate, we might look to the worrisome wave of antisience showing up in nursing internationally (Garrett, 2018). As is most evident in the sphere of social media, we hear of self-identified nurses publicly expressing overt endorsement of an antivax position, especially on social media. And we also see confusing interpretations of what constitutes science made by nurses to their patients, such as justifying various holistic practices (such as body therapies, devices, and natural products) to their patients as “evidence based.” Further, our literature frequently references such claims by virtue of the conviction that there are “multiple forms of evidence” (e.g. Rycroft-Malone et al., 2004). As a qualitative researcher, I am greatly concerned when I read findings of small qualitative investigations of various patient phenomena being reported as “evidence” justifying the efficacy of a therapeutic approach or the appropriateness of a particular policy direction. This kind of slippage around what the wider world intends when it refers to a piece of knowledge as “evidence based” suggests that we are all too often conflating the idea that there are multiple forms of knowing something with the assertion that what we believe we know is, by default, a product of evidence. Do we have disciplinary clarity on what the boundary really is between a substantive logical assertion made on behalf of the profession and a spurious idiosyncratic claim based entirely on belief or opinion? Or, in a climate of trying to be respectful of diverse perspectives, have we lost the foundational core that keeps our profession grounded?

In a similar vein, as I referenced earlier, we seem to be seeing hesitation in some sectors of nursing and within nursing organizations to step into policy issues in which a clear nursing voice supported by established evidence would seem entirely appropriate if we had confidence in that moral core. By this, I am thinking about issues that are prominent in our public press in recent years—issues such as universal health coverage, equitable access to health services, gun control, protesting the detention of migrant children, decriminalizing persons who use substances, LGBTQ+ rights, threats to women's reproductive rights and nursing's complicity in health inequities for indigenous persons. Especially in politically explosive times, perhaps because they expect some diversity in

opinion among individual members of the profession, we start to see our professional nursing bodies shying away from strong policy advocacy on the very issues that would seem to most benefit from a coherent nursing perspective. All of these issues are matters in which there is a history of strong and powerful nursing advocacy and which are easily justified by virtue of our knowledge of the social determinants of health and the mandate nursing has with respect to the dignity of all persons.

5 | RETURNING TO THE INTENDED FOCUS

Carper's idea of personal knowing was never intended to justify the correctness of individual nursing opinions and beliefs; rather it was proposed as a way of thinking about the kind of relational authenticity that that nursing excellent inevitably requires within the multiplicity of encounters in the practice context. It acknowledged that the building of this skill set draws into the nursing knowledge equation ideas from multiple sources including one's own experiences, ideas and values; it was never meant to condone relying on them exclusively, any more than using evidence in practice should imply allowing that which has been convincingly quantified in populations to unilaterally dominate decisions on behalf of individuals. And it was never meant to legitimize prioritizing a personal idea or bias over a coherent grounding in nursing knowledge.

If we reflect back on the ideas from Carper, Gardner and de Bono, what we were seeing in this movement was a way of addressing the complexity of excellent thinking—confirming that the capacity to see a situation from multiple perspectives offers us the opportunity to approach higher quality, more robust and better informed decisions. Science denial, therefore, is clearly inconsistent with this ideal. What is consistent with the intended purpose is being in possession of a solid understanding of the science and yet coming to a reasoned determination on the basis of other patterns of knowing that it does or does not apply to the particular case I have before me at this juncture in time.

In order to keep the multiple intelligences and differing patterns of knowing in perspective, and in a balanced relationship with one another, nursing must have the capacity to uphold a set of shared core values that constitute its professional and disciplinary angle of vision. Arguably, we once had such convictions, and perhaps the forces of social change have weakened our collective confidence that these remain relevant. Our advanced education within professional nursing is increasingly being dominated by clinical training rather than a strong theoretical and philosophical grounding within the nature and tradition of what constitutes nursing knowledge (Grace, Willis, Roy, & Jones, 2016). We are also growing more comfortable with interdisciplinary learning and training opportunities in which core nursing disciplinary knowledge may not feature at all in curriculum. However, without solid grounding in what it means to be a nurse, and what serve as core disciplinary values, a new generation of nurses may be increasingly at risk for confusion over what

differentiates the ideas we hold as individuals and the ideas that we claim to share.

As a case in point, I turn to the example of Medical Assistant in Dying (MAiD) in Canada as new development that has significantly challenged the profession. Historically, most of our nations have upheld prohibitions against anything that might hasten death, and nurses have walked a fine line to ensure that our comfort measures were in balance with that prohibition. However, in Canada, as in a number of other nations, the context of what this might mean it is evolving. Our particular legislation around this explicitly allowed for “conscientious objectors”—those for whom the idea was unacceptable and who needed to be protected from having to participate in it. In implementing this, Canadian nurses have drawn upon their experience with abortion, in which the profession has never faltered in its policy commitments in support of a woman's right to choose, even as it has made room for individual nurses who may have difficulty with such practices for personal reasons. In the MAiD context, nursing organizations have been consistently strong in their advocacy for a patient's right to a preferred death and to systems that respectfully and expertly support that, even as our care systems manage the reality of differing personal perspectives. Interestingly, this nuanced perspective is also exemplified in Canada's only faith based nursing education program at Trinity Western University. That program secured its approval to provide nursing education by demonstrating a commitment to values clarification consistent with provincial nursing practice standards. The faculty have become exemplary role models of high quality critically reflective practice knowledge on behalf of nursing. Individual students may enter that program with firm ideas, biases and religious convictions, but they leave their educational programs knowing how to ensure that such views never inflict harm on their patients.

To me, this stands in direct contrast to the conception of “spiritual knowing” that I referenced earlier—which seems an extension of the problem I have been articulating in relation to personal knowing. As I read some of this work, I interpret authors as taking the argument in an entirely different direction, endorsing specific religions as the appropriate source of core nursing values. To illustrate:

We live within a complicated social, historical, and political time throughout the universe, existing in a world marked by myriad threats to well-being: violence, environmental hazards, climate change, health inequities, drug crises, toxic stress, ruthless killings, suicide, technology/information explosion, and other humanitarian crises. These are conditions that can be seen as mirroring ways of knowing antithetical to spiritual qualities (Willis & Leone-Sheenan, 2019, p. 60). ...Explicating spiritual knowing as a pattern of knowing in nursing is an important contribution, given that nursing has been grounded in a wholistic view of the

human being, accounting for the spiritual nature of human beings from a Christian call to service. (p. 63)

Thus, I conclude that if we are unable to re-engage with the core theoretical values proposition that nursing represents in the world, we run the serious risk of allowing ourselves to be caught in the winds of political and religious persuasion, rather than the fundamental mission and mandate of our discipline. If we claim that nursing does not in and of itself have core values, then we expose ourselves and our work on behalf of this discipline to the same kinds of forces that made those strong nursing leaders I mentioned earlier uncomfortable addressing racism in the classroom.

6 | AND LOOKING FORWARD

If we can agree to stand firm on the idea that nursing does constitute core values, I think we are capable of being a force for enacting the social mandate that our discipline has always claimed. To illustrate this, I return to the example of how MAiD is being implemented by nursing in Canada. Regardless of the convictions of individual nurses, or the presence or absence of their declarations of conscientious objection, the nursing collective priority has become creating the envelope of safe and supported care surrounding any patient who may be considering this as an end-of-life option (Pesut, Thorne, Schiller, Greig, & Roussel, 2020). Such a collective priority clearly relies on a confident sense of a disciplinary core value, which is the safeguarding of patients and their families, regardless of their end-of-life decisions, during such a delicate and complex phase of their lives. Interestingly, for many nurses who began with the belief that they opposed MAiD for reasons of faith or conviction, when faced with the reality of a real patient situation, they often conclude that “being fully present” to making that patient's experience as positive as it could be is actually the higher order value and entirely consistent with their understanding of what nursing is and does. To me, this exemplifies the existence of core nursing values as a fundamental reason that multiple ways of knowing, including personal knowing, can work in the everyday practice world. We come to know those core values—to engage with them, reflect on them and wrestle with them—through the dialectic of our disciplinary theorizing and philosophical work.

7 | CONCLUSION

In 2020, in conjunction with the *World Health Organization's* declared Year of the Nurse and Midwife, we may have a once in a generation opportunity to demonstrate to the broader world what nursing is and what it stands for. In justifying such an international focus, Director General Dr. Tedros Adhanom Ghebreyesus explained “We simply cannot achieve universal health coverage and the health-related targets in the Sustainable Development Goals unless we empower and equip nurses and midwives, and harness their power”

(Branigan, 2019, np). Such strong positions on issues of equity, access and public health policy around social determinants of health are unquestionably values driven initiatives. One hopes that nursing can fully capitalize on this game changing opportunity in a manner that showcases not only the technical competencies it brings to a care delivery system but also, and as importantly, the powerful set of core values it brings to health advocacy and public policy.

Personal knowing out of context can be dangerous. Within the context of nursing theoretical or epistemological frameworks and philosophies that guide us to attend to the multiplicities of factors involved in determining action, and—in the context of the core values that are an inherent part of all of those frameworks—personal knowing can spur us into action, provide us with the nuanced capacity to engage in difficult circumstances and help us make creative and strategic choices in how each of us can act to mobilize our collective social mandate.

If we accept the argument that a shared set of values is consistent with nursing's social mandate, then these might be some of its manifestations: that no person should ever be denied health service by virtue of religion, skin colour, sexual or gender orientation, politics and even economic status; that it is unacceptable to treat anyone in an undignified manner, regardless of that person's capacity to engage in with us in a manner that shows dignity; that the smallest, most marginalized vulnerable voice in our society would be supported to speak out and receive the care that is needed and deserved; and that every person who enters into the care of a nurse should be able to feel confident in the knowledge that the care will be culturally safe and respectful. In the policy domain, nursing will use the public trust it has engendered to advance ethical person-centred policies, such as harm reduction, even when they may be politically controversial. Within the healthcare arena, nursing must embrace the guidance that science can provide us while also being vigilant for the diversity of persons for whom “best practices” are not reflective of individual needs.

In this context, we need the nursing philosophy community to be strong and relevant, and to fully engage with the advocacy arm of nursing to express and enact the core values that underlie those kinds of commitment. As Yeo has reminded us “The future of nursing care will depend in some measure on how nursing positions itself in relation to the politics of knowledge” (2014, p. 241). While personal knowing is and will continue to be an important experiential aspect of our collective knowledge work, we need to understand it in its full complexity such that we can detect and act on its abuses. We need to ensure that it is brought to bear in ways that serve the discipline, and not the self-interest of individual nurses. Finally, if nursing is to be what the world wants and needs it to be as a global force for health in the 21st century, then its values driver must remain a strong, coherent and fundamentally moral shared disciplinary mandate.

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CONFLICT OF INTEREST

None declared.

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REFERENCES

- Benner, P. (1984). *From novice to expert: Excellence and power in clinical nursing*. Menlo Park, CA: Addison-Wesley.
- Branigan, D. (2019). *Dr. Tedros calls for investment in nurses, highlights WHA2020 focus on nurses & midwives*. Geneva, Switzerland: Health Policy Watch. Retrieved from <https://www.healthpolicy-watch.org/dr-tedros-calls-for-investment-in-nurses-highlights-wha-2020-focus-on-nurses-midwives/>
- Carper, B. (1978). Fundamental patterns of knowing in nursing. *Advances in Nursing Science*, 1(1), 13–23. <https://doi.org/10.1097/00012272-197810000-00004>
- Carper, B. (1988). Response to "Perspectives on knowing: A model of nursing knowledge". *Scholarly Inquiry for Nursing Practice*, 2(2), 141–144.
- Chinn, P. L., & Kramer, M. K. (2008). *Integrated theory and knowledge development in nursing* (7th ed.). St Louis, MO: Mosby.
- Chinn, P. L., & Kramer, M. K. (2011). *Integrated theory and knowledge development in nursing* (8th ed.). St Louis, MO: Mosby.
- Chinn, P. L., & Kramer, M. K. (2018). *Knowledge development in nursing: Theory and process* (10th ed.). St. Louis, MO: Elsevier.
- Cioffi, J. M. (2016). Collaborative care: Using six thinking hats for decision making. *International Journal of Nursing Practice*, 23(6), e12593. <https://doi.org/10.1111/ijn.12593>
- de Bono, E. (1985). *Six thinking hats: An essential approach to business management*. New York, NY: Little, Brown, & Company.
- Eisenhauer, E. R. (2015). An interview with Dr. Barbara A. Carper". *Advances in Nursing Science*, 38(2), 73–82. <https://doi.org/10.1097/ANS.0000000000000067>
- Gardner, H. (1983). *Frames of mind: The theory of multiple intelligences*. New York, NY: Basic Books.
- Garrett, B. M. (2018). *Empirical nursing: The art of evidence-based care*. Bingley, UK: Emerald Publishing.
- Garrett, B. M., & Cutting, R. L. (2014). Ways of knowing: Realism, non-realism, nominalism and a typology revisited with a counter perspective for nursing science. *Nursing Inquiry*, 22(2), 95–105. <https://doi.org/10.1111/nin.12070>
- Grace, P. J., Willis, D. G., Roy, C. Sr, & Jones, D. A. (2016). Profession at the crossroads: A dialog concerning the preparation of nursing scholars and leaders. *Nursing Outlook*, 64(1), 61–70. <https://doi.org/10.1016/j.outlook.2015.10.002>
- Heath, H. (1998). Reflection and patterns of knowing in nursing. *Journal of Advanced Nursing*, 17(5), 1054–1059. <https://doi.org/10.1046/j.1365-2648.1998.00593.x>
- Jacobs-Kramer, M. K., & Chinn, P. L. (1988). Perspectives on knowing: A model of nursing knowledge. *Scholarly Inquiry for Nursing Practice*, 2(2), 129–139.
- Johns, C. (1995). Framing learning through reflection within actions, Carper's fundamental ways of knowing in nursing. *Journal of Advanced Nursing*, 22(2), 226–234.
- Liaschenko, J. (1997). Knowing the patient? In S. Thorne, & V. Hayes (Eds.), *Nursing praxis: Knowledge and action* (pp. 23–38). Thousand Oaks, CA: Sage.
- Lipscomb, M. (2017). Nursing values: Divided we stand. *Nursing Inquiry*, 24(2), e12209. <https://doi.org/10.1111/nin.12209>
- Moch, S. D. (1990). Personal knowing: Evolving research and practice. *Scholarly Inquiry for Nursing Practice*, 4(2), 155–165.
- Munhall, P. (1993). 'Unknowing': Towards another pattern of knowing in nursing. *Nursing Outlook*, 41(3), 125–128.
- Pesut, B., Thorne, S., Schiller, C. J., Greig, M., & Roussel, J. (2020). The rocks and hard places of MAiD: A qualitative study of nursing practice in the context of legislated assisted death. *BMC Nursing*, 19, art.12. <https://doi.org/10.1186/s12912-020-0404-5>
- Porter, S. (2010). Fundamental patterns of knowing in nursing: The challenge of evidence-based practice. *Advances in Nursing Science*, 33(1), 3–14. <https://doi.org/10.1097/ANS.0b013e3181c9d5eb>
- Porter-O'Grady, T. (2001). Profound change: 21st century nursing. *Nursing Outlook*, 49(4), 182–186. <https://doi.org/10.1067/mno.2001.112789>
- Price, B., & Harrington, A. (2018). *Critical thinking and writing in nursing* (4th ed.). London, UK: Sage.
- Rycroft-Malone, J., Seers, K., Titchen, A., Harvey, G., Kitson, A., & McCormack, B. (2004). What counts as evidence in evidence-based practice? *Journal of Advanced Nursing*, 47(1), 81–90.
- Scott, P. A., Matthews, A., & Kirwan, M. (2013). What is nursing in the 21st century and what does the 21st century health system require of nursing? *Nursing Philosophy*, 15, 23–34. <https://doi.org/10.1111/nup.12032>
- Silva, M. C., Sorrell, J. M., & Sorrell, C. D. (1995). From Carper's patterns of knowing to ways of being: An ontological philosophical shift in nursing. *Advances in Nursing Science*, 18, 1–13. <https://doi.org/10.1097/00012272-199509000-00002>
- Smith, M. (1992). Is all knowing personal knowing? *Nursing Science Quarterly*, 5(1), 2–3. <https://doi.org/10.1177/089431849200500102>
- Terry, L., Carr, G., & Curzio, J. (2017). Expert nurses' perceptions of the relevance of Carper's patterns of knowing to junior nurses. *Advances in Nursing Science*, 40(1), 85–102.
- Thorne, S. (2017). Editorial – For what do we stand? *Nursing Inquiry*, 24(2), e12195. <https://doi.org/10.1111/nin.12195>
- White, J. (1995). Patterns of knowing: Review, critique and update. *Advances in Nursing Science*, 17(4), 73–86. <https://doi.org/10.1097/00012272-199506000-00007>
- Willis, D. G., & Leone-Sheenan, D. M. (2019). Spiritual knowing: Another pattern of knowing in the discipline. *Advances in Nursing Science*, 42(1), 58–68. <https://doi.org/10.1097/ANS.0000000000000236>
- Yeo, M. (2014). Implications of 21st century science for nursing care: Interpretations and issues. *Nursing Philosophy*, 15, 238–249. <https://doi.org/10.1111/nup.12066>

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