Betty Irene Moore Speaker Series
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Chapter 1: Giving Language to Nursing Practice

As you have done your international work with research and articulation of knowledge development for nurses in practice how did you become interested in that area of study? Why is that so important to us?

I think I was very profoundly lucky again to really stumble into Bert Dreyfus' courses in philosophy at Berkley. I spent seven years taking those courses. Some of my friends said, "This is quite a detour you are taking". I suddenly had the language I needed for practice discipline. I suddenly had the language I needed for a discipline that had so much complexity and levels of attentiveness and interest. We were interested in life world. That was a new term for me. We don't think of life world in the US. That is a continental term; a European term. It is the air we breathe and what we dwell in daily.

I began to realize that articulation research was really important to a practice as long and distinguished as nursing. We had so much knowledge imbedded in our practice that had not been described well. There was this societal lack of understanding of what nurses did and even nurses didn't have good language to claim their own knowledge. Here we were concerned with what happens when someone is ill or injured or at the time of these major human passages of birth and accident, injury, illness and death. Nurses are very up close with that but we are also equally involved in the medical aspects of the care of the patients. My entry into nursing was about the same time also as the development of all the instantaneous therapies where the nurses really had to make judgments based on how the patient responded. They had to titrate the instantaneous therapies.

This is really frontline work with a lot of on the ground knowledge.
I became fascinated with how do we develop language in a society where all of health care is pretty much medicalized. In fact even the social care problems that we face in our society and particularly our aging society gain entry through a medical diagnosis. I can remember as a visiting nurse being slightly pleased if there was a pressure ulcer beginning because I could get in and work with that with a diagnostic label even though this was a fragile care system that needed to be shored up to keep these people out of the hospital.

We are a very medicalized system and if you notice in the media the language of care is almost absent. The language of the sentient embodied person who falls ill becomes vulnerable - we lack language. We only talk about physiology and the substrates of physiology. I have been really working very hard to give language to the aspect of the human experience of illness and the human experience of care. The way that care - what we are concerned about, what we care about holds open our world. The other area is how absolutely meaningful it is and the way it opens up a world to become skillful in any practice. You literally can see new things. You have capacities to act in new ways. I became very interested in skill knowhow, skill acquisition, getting around in a practice and articulating all the ways that practice is a way of knowing in its own right.

I hope as nurses we will become better and better at describing and having taken seriously the level and kind of work we do. For that I think we owe Betty Irene Moore a great debt of

gratitude. She got it. She understood and I am afraid she suffered from the ill effects of poor care. We need to be just so aware of the extent to which nurses frame all of the problems that come to physician's attention as long as the patient is hospitalized and even in home care and even in the community. I am still obviously very engaged in articulation work. I think for nursing giving language to what nurses know in their practice is a very important political action. It is a very important leadership action and it is a very, very important knowledge development action.

That work then led from novice to expert?

Right.

Tell us about how that came to be.

I was doing a study of trying to figure out here in the Bay Area why the nursing practice people thought that new graduates could only do three low level nurses aid skills. Now obviously that was an exaggeration. Why was their appraisal so low? The new graduates appraisal was quite high and the nurse educators was in between respectable or middle. I began studying why this different perception of the judgment and reasoning and ability to deliver care. I was interviewing new graduate nurses. I was interviewing expert nurses and I came across and expert nurse who described the situation where a new graduate was taking care of a patient and the patient had a sudden arterial bleed here in the neck. It was frightening. The new graduate called and this person went to the room and she already on the way to the room knew it wasn't a code blue just from the tone of voice but knew it was an emergency. It is this sort of reading the nature of the situation that you learn over time experientially. She comes to the door. She had seen both an innominate bleed and a carotid bleed. She worried about if it were an innominate bleed, artery bleed it was going to be harder to deal with. The story is that she got the patient - they really mobilized and got the patient in the OR and got the resources and saved the patient's life.

When she described it, it was so seamless she obviously recognized the nature of the situation, which is at the heart of all practical reasoning. Clinical reasoning is a form of practical reasoning. Reasoning across time about the particular through changes in the patient and or changes in the clinicians understanding.

Academia has been slow to catch on to practical reasoning. In academia we prefer formal models and decision making models - trees. We have not given and there is a recent book on this by Sullivan and Rosen out of the Carnegie foundation saying we really need a new agenda on higher education where we pay attention for business, for education, for nursing and for all the professions of practical reasoning. The very heart of the logic of practical reasoning is recognizing the nature of the situation. I said, "I can tell you what a new graduate would sound like in this situation." And she said, "Oh really" at that point I didn't know a new graduate was involved. I said, "Yes". It would be much more textbook language. They would be giving me lots of extraneous detail trying to assess the whole situation. This is no deficit on their part. You just have not lived through enough situations to have this perceptual grasp, this ability to see qualitative distinctions in a situation.

I said you would have extraneous information all well intentioned trying to figure out. She said, "I will get you an account" and she went and got the account of the new graduate and it

did sound very much like I had described. I had been interviewing a lot of new graduates. Then I was telling my friends at Berkeley about this and Jane Ruben said, "This is very much like Bert and Stewart Dreyfus' work with the air force on teaching pilots." I was just drunk with power. I went to Bert and asked for a consultation and hired him as a consultant on our project. We actually based on the research on nurses added a level to the skill acquisition. They had not had advanced beginner before. Certainly new graduate nurses are not novices. You have to be a first year nursing student to be a novice. People kind of in slang often call new graduates novices. You cannot get through nursing school and be a true novice.

They were advanced beginners. We added that at the very beginning of the research we added that term and then confident and proficient and expert. Now we are talking a lot about mastery, which is beyond expertise where you have a fluid response to situations that is so innovative that it is a novel solution to the problem. I think that is a very exciting thing to think about. I think for me it is daunting enough to go for expertise. We do have people who are real masters in the field.

Chapter 2: The Importance of Clinical Reasoning

We have talked a lot in nursing education and I think a lot of nursing about critical thinking. You talk about clinical reasoning. Help us understand how those two are different.

I think it is important to talk about both. Nursing educators have done this wonderful end run; the famous nursing work around. They call thinking critical thinking - end of story. That is what is required for accreditation. Every kind of thinking is ipso facto critical thinking.

That is true.

It has not been that dangerous to our health because in fact we do know that most of the time we spend in clinical reasoning that analogue practical reasoning - reasoning across time about the particular through grasp of changes in the patient an or changes in your understanding of the situation. That is clinical reasoning. That is our stock and trade. Critical reasoning by comparison engages - and it only really comes up, the need for it really comes up when the received view or the old practice isn't working. You have practice breakdown and you desperately need to deconstruct what you have been doing and question everything. Then you need even some creative thinking to figure out what to do about the situation that is not working. Our students desperately need critical thinking.

We are going to talk about interdisciplinary. I am just doing a side here about interdisciplinary education. One of the fallouts of high emphasis on critical thinking is that we tend to teach in all professions; law, medicine - not so much clergy but engineering and all of the professional schools we tend to teach critical thinking in the stance of adversarialism. You should be critical of what your colleague is doing because they may not be doing it right. That makes it more difficult. William May has written this wonderful article that is kind of old now on the problem of importing this kind of interpersonal adversarialism into the professional education by emphasizing critical thinking to the exclusion of trust, shared goals and shared aims. I think we do need to really emphasize clinical reasoning. After all when you go to a resuscitation you don't stand around and deconstruct for a long time. "Do we really have it right * was Harvey really right when he predicted the direction of the flow of the blood."You just don't do that. You do what is proven. If you know nothing about the patient you use

algorithms. If you know the patient well you adjust those algorithms to the patients drug sensitivities and their particular illness condition.

We recommend in the Carnegie study that we really emphasized clinical reasoning. I think that will help with team building. Everybody is really on the same page there. The physicians are more focused on diagnostic reasoning and we need to bring them into the fold on clinical reasoning a little bit more. We do need to teach critical thinking. We need to teach creative thinking as well. Most of all I really believe that we need to teach a student to look at each situation for multiple frames of reference and not just one. That will do more than anything I think to help interdisciplinary thinking. We need the medical frame. We need the nursing psychosocial frame. We need the notions that we have about recovery processes and reentering a shutdown, closedown world. I think it is important that we make clear distinctions between critical thinking and clinical reasoning.

Chapter 3: Enhancing Student Learning: Knowledge Use and Situated Thinking

I want you to give us some words to the wise for those of us who are working with students.

We jointly; educators and practice people hold the future of those students in our hands. It does not belong to one of us alone. It belongs to both of us.

We have all been there. So give us your words - give us a mantra whether we are the preceptor, the faculty member, the student - where should we be focusing our thinking?

I think if I were to say - well I will have to say two phrases. One is "Knowledge use, knowledge use, knowledge use and integrate knowledge acquisition with knowledge use". The other thing is situated thinking. There is now a whole Cambridge handbook on situated cognition and embodied intelligence. This is a core interest and project in education. It is a very important project in medicine and nursing. So much of our work is that knowledge use in particular situations. It is a very productive. It is not really application. That is kind of a misnomer. It is really productively using the right knowledge for the particular situation. In education we really have to learn to teach those two things together.

How do we help that student do that?

I think we need to do a lot more with integrating classroom and clinical, with simulation, with teaching with unfolding case studies and I am excited about Tom Aaron's new program that has over 1000 simulations and has the knowledge acquisition and then you go right into practice cases where you use the knowledge. I think that is a very dynamic way to figure out what is the significance of that knowledge. What does it mean?

Those unfolding cases.

Unfolding cases and integrating knowledge acquisition and knowledge use and classroom and clinical teaching. That narrow rational technical model that we had basically from the universities when moved - I really am old - when we moved nursing into the university was this skills were unimportant. Skills were mere application. They are not mere application! The

skill knowhow and capacity is a way of knowing and contains a lot of knowledge in itself. We have to breakdown that old Greek hierarchy of theory and practice because they are equal.

Chapter 4: Lessons from the Carnegie Study and IOM Future of Nursing Recommendations

Let's talk then in some detail about the - I get the name right - the National Education Research Project for the Carnegie Foundation for the Advancement of Nursing. That was pivotal for you. That was critical.

It really was. Part of the reason it was so pivotal was that I was interviewed; I was invited to the Carnegie to be interviewed for this job. Lee Schulman who was president of Carnegie and a really well known educational researcher who had worked in medicine and in teaching interviewed me. The other interesting thing and one of the books that is near and dear to my heart is the Clinical Wisdom Book, which we have just done a second edition of. He had written about wisdom in teaching practice so he understood what I had been about in my articulation work, which is kind of rare. It is not a traditional research agenda. He said, "Everything you have done to this point has led you up to this project" and I thought "He is right". I had tons of stuff on my plate at the time and I said, "I have still got to do this" I had been studying for the last 25 years articulating knowledge embedded in practice. To take that into education.

The other hook for me was that they really - the Carnegie Foundation team at that time; the administrative and scholar team wanted to bring back a broader notion of civic professionalism instead of this narrow technical professionalism where you really considered the civic responsibilities of the professional. The awesome responsibilities you have in unequal knowledge and power relationships and also bringing back the memory and the understanding of how important the professionals are to any democracy. It is not clear we could have a democracy without well functioning professionals. Of course this is ten years ago and the Enron scandal was afoot and the Arthur D Andersen problem was afoot so they were very interested in reintroducing civic professionalism. I think that hooked me.

So on the heels of your work out come these other major studies: The institute of Medicine Robert Wood Johnson Initiative on the Future of Nursing.

Right.

Do they agree? Do the recommendations and the substance agree?

They really do agree in a tremendous way. I think they really want the responsibility and the role of the nurse to be acknowledged more, for nursing to be given more of a voice and I think that is one of the major agreements. They also agree with us that new graduate nurses given the complexity of our practice need a residency - at least a year. The Carnegie foundation supported that. They also encourage more education for nurses. Like public school teachers we really encourage nurses to get their masters degree within ten years of graduation and sooner if possible.

Now of course with the DNP coming along that pathway will be DNP. I think we had major areas - the encouragement to go into policy work and I think of Leanne Haines study of

associate degree nurses spending 4.65 and I think I got that right - almost four years to get an associate degree. We need a seamless transition from our associate degree programs to graduate programs. I think another finding is that we need to incentivize ADN students go on and do their masters. We need more ADN masters programs. If you are an ADN student see if you can find one of those programs. I really recommend it.

I think it was a real synergy in coming together of these reports. It was as if the nation woke up and said, "Oh yes we are interested in population - we are interested in health of the society." We have far to acute to critical care focus. We need more prevention. If you look at nursing's goals and nursing's practice we have a major role to play. What we need is to really create the public space and I think these three studies really help with that - of recognizing the importance of nursing for a healthier society. For managing multiple chronic illnesses with an aging society and much more preventive work. Keeping much better prenatal care - let's prevent.

One community got together and decided they would prevent premature infants and they did it by preventive care. Probably all amputations due to circulatory problems or leg ulcers could be 80% prevented. We know we need a new emphasis. We know we need new leadership. I think society suddenly caught on that nursing is this large body and we just have wake up and begin to realize our leadership in all the local places.

We know we need to have more nurses prepared at the baccalaureate level. We know we have a recommendation to double the number of doctorally prepared nurses. The fact we were having apoplexy about this in terms of how we are going to make this happen.

In your book you talk a great deal about integrating more the clinical lab theory. How do we make room for all of that? Are we teaching things we ought not to be teaching?

We are. The other mantra that I should have mentioned is "Less is more". Really much more deep learning and much more focus on the frequently encountered issues in healthcare. Really preparing our students to be good clinical learners, good clinical inquirers to they are actively learning from practice daily. So that practice does not become rote or routinized to the point that you are not longer growing or thinking and finding ways to really engage yourself in your practice and in your practice learning.

If I were to choose a profession in which I could become a wise human I think I would choose nursing. What you encounter is so amazing and so diverse.

One of the other recommendations from the IFN has to do with nurses practicing at the full scope of their practice. I know you have some thoughts about that as well.

Right. I think that recommendation really refers to our incredible advanced practice nurse contrary. I think for undergraduates it is really an interesting comparison between graduating nurses and the pre-licensure program and engineers. Engineers are taught arduously about the organization and working in the organization and they are given too little responsibility when they graduate.

In nursing we have it all - more responsibility than any new graduate should be expected to handle. I think that was one of the observations that I made during the heights of equal rights

feminism that I suddenly realized that in nursing we were not demanding more responsibility - why was that? We already had it all! We were running the show it is just that we were doing it rather invisibly and without much public acknowledgment of it.

I know you wanted to say some more about inter-professional work.

Yes. I think that that really is a key. I think we have to figure out a way in education. We have a lot of lip service to interdisciplinary education but we have almost no practical working that out. I think we have to do that. Until we learn together more we will have this - I hate to say this - but this dominate subordinate model where in the hierarchy - the ones high on the hierarchy don't think it is so important to know what people at the rest of the levels know. They are after all the pinnacle. Of course that is a faulty position. It is almost fraudulent in that there very success depends on what everyone else is doing. In healthcare - we will come to that in a minute - you call it a team sport. You cannot pull it off all by yourself nor would you want to. Why is teamwork so hard? We could not do without it.

How do we accomplish this? What do we need to do to really have inter-professional education which will then lead to inter-professional practice?

I think we have to have - it is perhaps a good place to start with some of the core courses like policy and ethics and cross cultural communication. That is an easy low hanging fruit. It is easy to start there. I think we have to have really good clinical seminars where we really look at the mutual goals of the two professions. It is very interesting to me. Some of it is quite functional that when you are a prescribing professional you would rather error on the side of doing nothing than doing harm - taking an action that would be harmful. That is a good safe maxim. In nursing you would rather error - although you always take it seriously when you give a warning. You would rather error on the side of giving a false warning than withholding a warning that might be important. That is a very functional kind of difference.

If we understood each other's roles better rather than contentious adversary we would say I know there is a risk in this but I really think this baby isn't tolerating that hole in the heart, that patent ductus. You don't rush the infant off to surgery based on that. You do the lab work and you do more observation but you had better get on it because you don't have very much time.

We need the kind of collaborative effort that the disciplines bring with real respect for the differences in the aims but also a much better grasp of the shared aims among the professions.

Can we do this at the same time that we are being told that we have to completely reform the healthcare system? We are going to have many more people who need our care. We are going to have much reduced revenue.

I have taken a stand on what I think is a bit unrealistic to imagine that we could go in one fell swoop to DNP programs. I think we have to hold on to the two stage with the advanced practice programs simply because it is not civically responsible not to keep that workforce up to meet the needs of health care reform. I think it is a citizen duty to keep that work force moving and also to really have a vision for that DNP that is a new kind of health care professional that fills a new niche of prevention, health promotion, primary care, managing well multiple chronic illnesses. Doing a lot more innovative things about - such as the phone.

They are doing this so brilliantly in Chile - the phone counseling with a whole population of diabetic patients to keep them on tract and linking that phone counseling in with the clinic visits.

It is a wonderful time and it is like riding white water. It is very exciting.

Ups and downs for sure. I found it particularly interesting that the IFN talked about the importance of lifelong learning. I am not sure we are all thinking that means the same thing. What do you think they are referring to?

Don't you think we need better continuing education and we need to be better stewards of our continuing education. I cannot imagine how we can practice now with the demands of the new patient safety initiatives and the new electronic healthcare record and information age and the demands for nursing to be really astute in these late adult onset multiple gene kinds of illnesses. It is really going to fall to the nurses to be the genetic counselors. There is no other group that has large enough numbers and presence in the health care system to do that. Yes we are going to have to do more continuing education and we are going to need to upgrade our continuing education.

I have to say I agree with you. I was in a meeting recently with Marilyn Chow and we talked about the fact that California requires continuing ed. and not all states do. There are no real strict regulations on what it is you do your 30 hours in.

Right. They have never had the state money to regulate or really even adequately enforce the requirement.

The importance of linking that continuing education to the role that that nurse is actually in and having it with a focus and some goal setting around what it is intended to accomplish.

Right. There is a real movement afoot in Texas and some other states lead by the National Council of State Boards of Nursing to really increase assessment for continued licensure. It would put some real teeth in things if we really had effective assessment of currency.

Chapter 5: Listening and Learning: Driving effective Leadership

I would like to spend the last ten minutes before we go to the Q&A talking more about leadership and the importance of leadership in nursing. Especially in the Bay Area what do we all need to be doing to make sure we are leading, we are at the table, we are contributing from a position of leadership in health care?

I think it is terribly important for those who are in formal leadership positions to really be in touch with the front line workers so that you are getting their front line knowledge. Don't just study the deficits or the problems. We have to be careful. I think it is terribly important that we initiate the checklists for monitoring and controlling our systems and that we do a better job of analyzing practice breakdown and errors. We also have to be very careful not to marginalize that central direct patient care delivery. That is where it happens. If you imagine that it is only distant managerial practices that make that better you are living in a kind of fantasy. You really have to listen and pay attention to - improve the staff development so that

you have more situated coaching and development and that we truly make our hospitals and medical centers better learning organizations so that we are teaching to all of the changes that are occurring all the time.

You talk about in your work the positional verses influence leaders.

I think the positional leader will become a better influence leader if they really listen to on the ground knowledge and not just fill their ears with problems. It is important for them to be aware of problems but they also want to find excellence. I think there is a real risk in always just blindly adopting standards of practice. In an area where practice is below standards that will be remedial and it will bring practice up to standard. In areas where you have practices way above the standard that will level and bring down the practice. We need to understand what centralization and standardization - it cuts in several different ways. You cannot get beyond in terms of leadership knowing what is going on at the blunt end of practice. Without a really great appreciation that that nurse is the patients first and last line of defense.

Our nursing students who say, "I am not a leader. I don't have to pay much attention to that".

You are leader by virtue of being a professional. You are a knowledge worker. You take seriously your civic responsibility to lead and to engage in a self-improving practice. That was one of the things I loved finding in the national Carnegie study was that - first of all I really loved those clinical debriefing sessions where 80% of our schools still do that and I think it is fabulous. It is better than anything on the horizon in the other professions. We will get called as outstanding in that area. But what I really loved about that is in all of those session you would hear at the end of the session, "How can you improve today upon what you do tomorrow"? That is at the heart of being a self improving practice. Everyone is engaged in making their practice today better than it was yesterday and tomorrow better than it was yesterday. That makes all of us leaders. I think by being a professional you are a leader.

I have to agree