

Knowing is not Enough

It is good to rub, and polish our brain against that of others.

– *Michel Eyquem de Montaigne*

Garnered through learning, experience, perceiving and discovering, we all have a breadth and depth of knowledge accrued throughout a lifetime. The extent to which we have knowledge about, and learned to do certain things is clearly the end result of a multiplicity of inputs. And it is at times puzzling as to where, when or how we have come to know what we know. The recollection of facts, details, and experiences from the recesses of our memories often serves us well day to day, even if only to net completing the daily crossword, being first to answer a Jeopardy question or winning a game of Trivial Pursuit. Demonstrating our possession of obscure or inconsequential knowledge or capabilities can by times be down right dazzling to others, if not ourselves. And we've all met the insufferable know-it-all or the person who never forgets anything, ever ... but at the end of the day, knowing is not enough!

Epistemology or the study of knowledge is primarily concerned with aspects of *knowing that* and *knowing how*. Over the years, how we come to know and use knowledge in nursing has been examined by many nurse theorists, educators and researchers. In 1978, Carper (1978) published a seminal paper on the “ways of knowing” in nursing. This treatise identified four essential ways of knowing – personal, empirical, aesthetic, and ethical. Although initially introduced to this piece some 30 years ago, I have had cause to periodically revisit the ideas she raised about ways of knowing; most recently, positing the possible existence and influence of a domain of technological knowing in nursing practice (Nagle and Yetman 2009).

But as important if not more so than *how we know what we know*, is what we do with that knowledge. In professional realms, practice knowledge and expertise can be of significant benefit: optimizing outcomes, advocating and advancing policy, extending knowledge or inspiring others to pursue its attainment.

At the heart of epistemology in nursing are concepts such as knowledge translation, knowledge transfer, knowledge exchange, knowledge brokering, and knowledge or evidence-informed practice. Over the years, the terms knowledge transfer, knowledge exchange or research utilization have been commonly, at times interchangeably, used to describe the process of moving knowledge from researchers to users. Today, the phrase *knowledge translation* is mostly used among Canadian health disciplines to capture all of the steps from knowledge creation to its application in practice. Use of this broader term has been largely driven by the Canadian Institutes of Health Research (CIHR) advancing this definition of knowledge translation: *a dynamic and iterative process that includes synthesis, dissemination, exchange and ethically-sound application of knowledge to improve the health of Canadians, provide more effective health services and products and strengthen the health care system* (CIHR 2015). For those readers interested in achieving greater clarity of the distinctions between these terms, I refer you to Graham and colleagues (2006) among others who are far more erudite in the knowledge translation space than myself. What I do know from my own work is that there is much yet to be understood as to what processes, supports, and strategies most effectively ensure the instillation and use of new knowledge.

Among the contributions to the special focus of this issue are two papers that impel a reflection on our various uses of the term “knowledge,” and its translation. Catallo focuses on the role of nurses as knowledge brokers. She defines knowledge brokering as: *a type of knowledge translation strategy that involves planned opportunities for research to be disseminated to, exchanged with and applied by research users whether they be clinicians, policymakers or other decision makers* (p. 24). She advances the position that nurse leaders can support effective knowledge brokering by fostering cultures that value the use of evidence in support of advocacy efforts and ensuring appropriate material and physical resources to support nurses’ access to evidence.


Kilpatrick and colleagues report on a study of the preferred knowledge transfer strategies of providers, policy-makers and administrators in relation to the effectiveness of advanced nurse practice roles. Focused on strengthening our knowledge translation efforts to key stakeholders, they conclude that more research is needed to more clearly understand the effectiveness and preference for different knowledge transfer strategies.

While we may assume that what we know is worth sharing, particularly if a novel or impactful discovery, we cannot assume that others will be prepared to listen, act or learn in response. But as individuals and as a profession, I *know* that we have an ethical obligation to take action and figure out how to move knowledge into practice when it could make a difference in the lives of our clients, students or colleagues. *Knowing is not enough.*

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References

- Carper, B. 1978. "Fundamental Patterns of Knowing in Nursing." *Advances in Nursing Science* 1(1): 13-24.
- Canadian Institutes of Health Research. 2015. *More About Knowledge Translation at CIHR*. Retrieved April 29, 2015. <<http://www.cihr-irsc.gc.ca/e/39033.html#>>
- Graham, I.D.,J. Logan, M.B Harrison, S.E. Straus, J. Tetroe, W. Caswell, and N. Robinson. 2006. "Lost in Knowledge Translation: Time for a Map?" *The Journal of Continuing Education in the Health Professions* 26, 13–24.
- Nagle, L.M. and L. Yetman. 2009. "Creating a Culture of Nurse as Knowledge Worker and a New Way of Knowing in Nursing." In K. Saranto, P. Flatley Brennan, H.A. Park, M. Tallberg, A. Ensio, Eds., *Connecting Health and Humans: Proceedings of NI 2009* (pp. 467-472). IOS Press: Amsterdam.



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