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Authors(s)	Hyde, Abbey
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abbey.hyde@ucd.ie

Reflective endeavours and evidence-based practice: directions in health sciences theory and practice

Abbey Hyde

In this reflective account, I will explore the tensions between two discourses that are invoked by educators in the health sciences, namely, the *reflective* discourse and the *evidence-based*, '*best practice*' discourse. Reflective learning, through its related concept of reflection-on-action was identified by Donald Schön as one of the defining features of professional practice. Schön criticised the 'battery' model with its heavy emphasis on technical rationality as an inappropriate model of professional education in the fluid and dynamic contemporary world. Yet the discourse of standardised 'best-practice', awash with guidelines, standards, and protocols has increasingly come to dominate health science educational programmes. In this commentary, I will consider the growing dominance of the discourse of evidence-based healthcare, with its emphasis on channelling individual healthcare providers to base their practice on very specific recommendations from systematic evaluations of scientific research, and how this relates to the deep-level, relativistic thinking advocated within the reflective discourse.

The discourse of reflective practice and the more recent emphasis on reflective learning have grown in popularity in health care education, research and scholarship since Schön's seminal work in 1983, facilitated by the epistemologically compatible radical shifts in social theory during the 1970s (or even earlier according to some commentators), that problematised the reification of knowledge in research practices that had hitherto prevailed (May 2005). Thus, perspectives in the social sciences began to shift away from an almost exclusive focus on the generation and use of (putatively) objectively-derived knowledge and the influence of positivism to a methodological pluralism that encompassed qualitative methods that emphasize subjectivity and experience. Feminist theorists such as Ann Oakley initiated an influential critique of traditional methods of research that divide human experiences up into measurable parts and ignored the influence of subjectivity; instead, her work and that of her contemporaries brought to the fore the need for reflexivity and an acknowledgement of subjectivity mediating the research process. Since then, as the sociologist, Carl May, has observed, *subjectivity* appears to have become a dominant preoccupation with British sociology. With the incorporation of sociology and social theory into healthcare models and research, particularly in fields such as nursing, the 1990s saw the growth of attempts to harness the capacity of subjective reflection in healthcare settings.

For a period during the 1990s, reflective practice appeared to become the new mantra in nursing curricula as staff and students began to grapple with novel

learning strategies in the form of critical reflection exercises. Teachers like myself struggled with the different rules that seemed to apply to these new endeavours, and with the seemingly contradictory advice that we were giving to students about adopting a formal and detached disposition in regular essays and the license to shift their writing style for reflective assignments. As a reviewer for a major nursing education journal throughout the 1990s, it seemed like everyone was writing about reflection. Since nursing was attempting to register its difference as a caring endeavour with a separate knowledge base from biomedicine, many nurse educators imbibed the discourse of reflective practice. While there were of course those who dismissed it, it offered intellectual respectability to the 'softer' areas of healing and facilitated nursing in define itself as a discipline. And then, something else began to make stronger waves in healthcare lexicon, namely the rise of evidence-based practice discourses.

The growing cultural dominance of evidence-based practice has come about from an amalgamation of a number of societal changes such as the emphasis on accountability, and the attempt by particular occupational groups to manage and control their knowledge base and defend themselves against litigation. In addition, recent decades have witnessed the rise of a cultural obsession with health, risk and the future. The result has been a renewed shift towards standardization and managerialism across the health sciences, and health policy increasingly based on evidence derived from the strategies that I will outline below. Let me tease out what evidence-based health care means, why it has attained a cultural authority in healthcare and the possible implications of this for reflective endeavours.

Evidence-based approaches in health sciences are generally those research strategies that purport to offer the best available research evidence to bring to bear on health care delivery across a range of disciplines such as nursing, midwifery, medicine, social work, public health and so forth. Specifically, they involve knowledge synthesis by systematic reviews and by meta-analyses. The Cochrane Collaboration is an international evidence-based enterprise that produces systematic reviews of research studies in which the therapeutic effectiveness of interventions is assessed. In comprising reviews for a particular intervention, all relevant research is considered, irrespective of nationality or language. However, what tends to galling critics is the standardized hierarchy of evidence that underpins and structures the reviews. At the top of the hierarchy are randomized controlled trials, while at the bottom are case studies and anecdotal reports (that may comprise reflective accounts). The aim of systematic reviews is to thus to attain comparability across a range of studies by judging them against apparently rigorous criteria. A more sophisticated comparison and bringing together of studies is through meta analysis and meta regression which attempt to synthesise quantitative results across a range of studies through statistical testing designed to offset small sample sizes and to mitigate against biases in the reporting of statistical data. Through the collation of the results of numerous studies, the aspiration is that a more refined result can be achieved in terms of the status of a particular intervention. This synthesis of evidence is subsequently set out in the form of practice guidelines for implementation. While advocates of evidence-based practice acknowledge the importance of patient participation and choice, critical commentators propose that even these may ultimately be subsumed into practice protocols (see Sandelowski 2004).

While scholars in the field of reflection, whose aim is to improve clinical practice, have rightly advocated a healthy respect for scientific evidence as a basis for good

practice, the concern that I register here is that evidence-based practice has recently tended to become interchangeable with the notion of *best* practice in health care circles. Other sources of knowledge that contribute to good clinical decision-making, such as interpretative knowledge, self-knowledge and experiential knowledge may be in danger of becoming increasingly invisible in healthcare discourses. While reflective commentators have noted that these knowledge forms have historically been subjugated in any case, the recent dominance of the evidence-based discourses appears to exacerbate that subjugation with greater intensity, a pattern that looks set to continue. This is particularly the case because scientific evidence is granted a formal legitimacy through the hierarchy of evidence which obscures the subjective aspects of health. Moreover, the highest value in clinical decision-making is thus placed on secondary evidence rather than expert opinion, intuition and so forth. The increasing emphasis on accountability in health care also contributes to more streamlined standardization and propensity towards concrete protocols and procedures.

Funding bodies for nursing research in Ireland, for example, have responded to the shift towards evidenced-based practice by the tendency to favour randomized control trials over and above other ways of creating nursing knowledge, potentially (and actually) reducing the attraction of methodologies that invoke more reflective-type strategies.

While the advent of evidence synthesis is to be welcomed in a world where swathes of often dubious knowledge are produced in an increasingly complex and confusing information age, the artistic dimension of the work of those at the coalface of healthcare needs to be nurtured, valued and made visible if the standard of practice is really to be 'best practice' in its broad sense. The personal-practical knowledge that mediates healthcare delivery and that cannot be pinned down completely in protocols and procedures needs to be captured and developed. Evidence-based protocols are never likely to fill the 'indeterminate zone of practice' (Schön, 1997:6) since they are derived from quite specific epistemological domains. The need for other sources of evidence for practice development needs to be recognized; these may take the form, for example, of locally-derived recorded agreements and the negotiations and thought processes that led to them.

At a very different level of reflection, theorists working in the realm of the sociology of science and technology need to continue to problematise, critique and expose hidden biases and vested interests that influence the production of scientific knowledge. These theorists have drawn attention to the manner in which scientific knowledge, while presented as value-free 'fact', is actually socially produced and culturally shaped. They argue that scientific enquiry is always mediated by the subjective component although this is conveniently obscured.

I am not suggesting for a minute that evidence-based protocols, where they are in place, should not be followed; however *best* practice requires more than the robotic implementation of scientifically-grounded protocols. Educators and practitioners in health care need to be mindful of this when developing future curricula for tomorrow's practitioners.

References

May, C. (2005) Methodological pluralism, British sociology and the evidence-based state: a reply to Payne et al. *Sociology*, 39(3), 59-528.

Sandelowski, M. (2004) Using qualitative research. *Qualitative Health Research*, 14(10), 1366-1386.

Schön, D. (1983) *The Reflective Practitioner*. Avebury: Aldershot.

Schön, D. (1997) *Educating the Reflective Practitioner*. London: Jossey-Bass.