

# **Fitting Square Pegs Into Round Holes: Doing Qualitative Nursing Research in a Quantitative World**

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The authors, as doctoral candidates and registered nurses, took on a qualitative research project investigating nursing practice in a research-intensive organization. Their aims were to explore and describe how nurses in the ambulatory care setting assist patients and families, including how nursing practice was carried out, constraints to practice, and the influence of the interprofessional milieu. Their first finding, in part because of the qualitative research design used, concerned the potential impact of the organizational ethics review process on the project. The authors discuss how the language, definition of risk, and notion of informed consent articulated in the organizational review process influenced both the research timeline and (potentially) the study itself. While not dismissing the value of ethics review, they explore the tension of overlaying generic criteria for quantitative research, specifically randomized controlled trials, on nursing research from other traditions.

Keywords: nursing research, qualitative research approaches, human subjects, ethics review, informed consent

## **Enfoncer des chevilles carrées dans des trous ronds : la recherche qualitative dans un monde axé sur le quantitatif**

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À titre de doctorantes et d'infirmières, les auteures ont entrepris un projet de recherche qualitative visant à examiner les pratiques infirmières au sein d'une organisation axée sur la recherche. Cette étude a pour objectif d'explorer et de décrire la façon dont les infirmières en soins ambulatoires œuvrent auprès des patients et des familles, y compris la prestation des soins infirmiers, les contraintes de la pratique et l'influence du milieu interprofessionnel. En raison du choix de la méthode de recherche qualitative utilisée, les premiers résultats de l'étude portent sur l'impact potentiel du processus d'examen déontologique organisationnel sur le projet. Les auteures se penchent sur l'influence qu'exercent le langage, la définition du risque et la notion de consentement éclairé établie dans le processus d'examen organisationnel sur l'échéancier de recherche et (potentiellement) sur l'étude même. Bien qu'elles ne minimisent aucunement la valeur de l'examen déontologique, elles explorent la tension qu'entraîne la superposition de critères génériques en recherche quantitative, particulièrement les essais cliniques randomisés, sur la recherche infirmière issue d'autres traditions.

Mots clés : recherche infirmière, recherche qualitative, examen déontologique, risque, consentement éclairé

Many health-care organizations value and commit to research practices as part of their mission to improve the quality of life of those they serve. Our experience as doctoral candidates and registered nurses conducting qualitative research suggests that enacting those values and commitments is not always a straightforward matter. Our study was focused on nursing practice in an ambulatory care nurse-run patient support clinic (PSC) within a research-intensive cancer care organization. When we initiated the project, titled *An Examination of Activities in the Patient Support Clinic: A Descriptive and Exploratory Study*, we assumed that the research environment and attendant procedures would be supportive. However, it became challenging to conduct qualitative nursing research in an organization that explicitly and implicitly privileges quantitative medical research and the worldviews that support the dominance of this kind of research.

Perhaps most challenging was the ethics review and approval process, in particular having to fit elements of our qualitative research proposal into criteria and categories established for clinical trials and other traditional scientific research — primarily randomized controlled trials (RCTs) — conducted in this setting. Assumptions about what constitutes an ethical research endeavour, and changes required of qualitative researchers by human research ethics boards to reflect them, have a significant impact on nursing research and the knowledge it generates.

In this article we describe the language, definition of risk, and concept of informed consent embedded in the research ethics board (REB) application, which is designed mainly to protect participants in *quantitative* studies from harm. The REB in question is specific to this cancer care organization and does not review applications for research in acute care or community settings. We also comment on the ways in which these elements shaped the ethics approval process we undertook and the implementation of our study. Our aim is to explore tensions arising from applying generic criteria for quantitative research to nursing research in other traditions. We raise important questions about what it means to conduct qualitative nursing research ethically in traditional scientific research environments and suggest ways to ameliorate the ensuing difficulties.

### **Background, Setting, and Proposed Research Project**

Our nursing research was conducted in a medically dominated cancer care organization in western Canada. Several years earlier, the organization had established RN-run PSCs in the ambulatory care setting in order to create time and space for nursing assessment and intervention, facilitate interprofessional communication, and help patients to navigate

the complexities of the organization itself and related community-based services. Previously, RNs had worked directly with physicians and their practice had been largely directed by physicians in the ambulatory care setting. The nurse-run PSCs were designed to allow RNs to address patient needs regarding symptom management, education, and referral to community services outside of scheduled physician appointments.

Our project was intended to explore and describe RNs' practice in the PSCs to determine the nature of the assistance they were providing to patients and their families, how nursing practice was being conducted in this setting (including constraints to practice), and the influence of the interprofessional milieu, including referral practices of non-nursing professionals to nursing care.

Ours was a descriptive, exploratory qualitative research design consisting of (a) observations of nurses practising in the PSC; (b) in-depth interviews with these observed nurses and with other PSC nurses (not all wished to be observed); (c) post-observation interviews with patients about their experience with the nurse; and (d) in-depth interviews with various other organizational stakeholders whose professional practice intersected with that of PSC nurses: medical oncologists, care aides, counsellors, volunteers, and administrative personnel. All interviews were to be semi-structured and individual. All research activities were to take place within the organization; none were planned off-site or outside working hours (8:30 a.m.–4:30 p.m., Monday to Friday).

### **Registered Nurses and Research Ethics**

Traditionally in this organization, RNs' involvement in research typically entailed collecting data as part of medical and/or pharmaceutical research protocols, in particular RCTs. Indeed, during one shift we observed RNs collecting data for up to 14 different RCTs. Although there are various quantitative approaches to inquiry, in this environment the RCT is considered the gold standard and dominates the research landscape.

The REB in this organization consisted primarily of physicians with extensive RCT training and experience. It also included a senior nurse administrator with a doctorate in nursing and considerable qualitative research experience. She was involved in our project and had to recuse herself from the review to allay concerns about conflict of interest. To our knowledge, no other professional in the organization had the experience or knowledge necessary to review applications for qualitative research. A substitute was not enlisted, as far as we can ascertain, nor were we invited to meet with any members of the REB. The organization appeared to have no mechanism in place for researchers to consult directly with the REB prior to submitting an application, nor did we

consider this necessary based on our experience with submitting ethics applications elsewhere.

We are not implying that qualitative research is somehow superior to quantitative. We agree with Ercikan and Roth (2006) that to take quantitative and qualitative approaches dualistically is potentially polemic. As Blegen (2009) reminds us, debate about the relative merits of the two approaches is “beside the point” (p. 381); knowledge generated through research potentially informs practice decisions and must align with desired outcomes. This applies equally to quantitative and qualitative research. We do not wish to engage in a polarizing debate about research approaches. Rather, our aim is to highlight the effects on one nursing study conducted qualitatively of a review by one REB whose focus and knowledge base were primarily quantitative.

We respect the value of the ethics review process even while exploring the tensions arising when generic criteria for clinical trials are applied to research using other approaches. Points of tension were evident in three aspects of the ethics review process.

Firstly, the language used in and required for the human research ethics application process, such as establishing the “subjects” of the study, and the need for a particular kind of research protocol, revealed different (and sometimes conflicting) understandings of research design.

Secondly, the protocol governing informed consent for patient participants constrained our efforts to have informed consent procedures approved; obtaining informed consent differed significantly from our expectations (and those of the REB).

Lastly, the definition of “risk” drawn from its application to clinical trials was applied stringently (and, we believe, inappropriately) to our proposal, with the REB ignoring the stated objectives and method of our qualitative study. Although the focus of risk was patients as research participants, this emphasis inadvertently challenged aspects of our approach as problematic; paradoxically, it also minimized the risk of exposure of employee participants working in a relatively small organization, something we as researchers constantly grappled with, apart from the formal ethics review.

### **Ethics Review Process: Square Pegs in Round Holes**

The application forms we were required to complete for the ethics review had been drawn up within a worldview in which the research being conducted is assumed to be quantitative. As qualitative researchers, we felt we were reading an application form meant for another group of researchers, questioning the pertinence of various categories to our

research (and to a qualitative approach). We were like square pegs trying to fit into round holes.

Although not intentionally, the application forms constructed a binary between objective (*value-free*) and subjective (*value-laden*) research approaches, with objectivity being highly valued. Simply put, not only did we have to tailor our application to its requirements (and language), the REB missed, or misread, or failed to recognize our intention to conduct research with a variety of participants using a qualitative interview-based approach. We had to rewrite several parts of the application to meet requirements that could pertain only to quantitative studies (e.g., develop a detailed prescriptive research protocol). Such constraints are not without effects. Unlike the university ethics approval process familiar to those doing qualitative nursing research, which, for us, took 2 months, this review process extended over several months, greatly impacting our research timelines and funding deadlines. Such implications are explored in the literature on education research (Lincoln & Tierney, 2004) and sociology research (Tolich & Fitzgerald, 2006).

### ***The “Subject” of Language Games***

With respect to language, tension mounted because of the REB’s difficulty recognizing the “subject” of our research. We were proposing to conduct short, semi-structured qualitative interviews with patients *after* they had been seen by RNs in the PSC, but also to interview RNs after observing their practice in the PSC as well as nurse participants whose practice we had not observed. We also proposed to interview other stakeholders in the organization, such as care aides, managers, counsellors, clerks, and physicians.

The REB’s difficulty recognizing the subject of the research was compounded by our own challenges in identifying the subject, given the positivistic definition of “subject” implicit in the pro forma application: “an organism (human or otherwise) that is observed for purposes of research” or “person upon whom an experiment is made” (*Oxford English Dictionary [OED]*, 2014). For example, the section of the application form on inclusion criteria stated: “Describe the subjects being selected for this study, and list the criteria for their inclusion. For research involving human pluripotent stem cells, provide a detailed description of the stem cells being used in the research.” Other examples: “A. How many subjects (including controls) will be enrolled in the entire study? (i.e., the entire study, world-wide) . . . B. How many subjects (including controls) will be enrolled at institutions covered by this Research Ethics Approval? (i.e., only at the institutions covered by this approval)? Of these, how many are controls?” We were stymied by this requirement, particularly as there was no “not applicable” option on the form.

Given our qualitative methodological orientation, we understood that there were no “subjects” in our study. We indicated this to the REB in plain language and completed the form, stating that there were many potential *participants* in the research, such as RNs, patients, physicians, care aides, counsellors, and administrative staff. After the first revision in which we explicated our conceptualization of participants, our proposal was returned to us for revisions, with the following question: “If the patient is not the subject, and the RN is not the subject, then what is the subject?”

At this point we realized that we would have to use the quantitative language of RCTs — to identify a subject fitting this REB’s criteria for research subjects. We informed the REB that the “subject” (in our language, the “phenomenon of interest”) was the practice of RNs in the nurse-run PSC, that we had planned a study with a variety of participants who would speak about their understanding of nursing practice (the subject) in this setting, and, for those not working in this setting, how their work intersected with nursing practice (the subject).

As well as making these revisions acceptable (and understandable) to the REB, we were required to construct a “protocol” for the study — another source of tension for us. By definition, a protocol is an essential component of an RCT. It constitutes detailed instructions for the “method or procedure for carrying out an experiment, investigation, or course of medical treatment” (*OED*, 2014). Underlying the demand that we construct a protocol, as for an RCT, was the “assumption that the world is knowable in advance and the research and its outcomes are predictable” (Tolich & Fitzgerald, 2006, p. 72). The foundation of our understanding of research, conversely, is that the design is emergent and the world is contextual, socially constructed, and ultimately unknowable in advance. This tension contributed to our sense that the application process was something of “a charade,” in the words of Tolich and Fitzgerald (p. 72).

As qualitative researchers, we were stymied by the demand for a protocol. In the qualitative tradition in which we were educated as nursing doctoral students, the word “protocol” is not in common usage. We realized that, for this organization, it had a specific non-qualitative research meaning. We were also accustomed to relying on emergent design, appropriate to our research activities, which would not require step-by-step instructions. In addition, we believed that it would be misleading to prescribe a protocol for an anticipated emergent design, given the flexibility we relied upon as the research unfolded.

We decided to develop a shortened version of our research proposal, outlining our method and including as much detail as possible. Our concern was that a specific protocol might constrain our flexibility in

responding to local conditions as they emerged in what was an exploratory descriptive study. As qualitative researchers, we were oriented to being open, responsive, and reflexive with respect to the phenomenon of interest, adjusting the research process as needed during the investigation while carefully attending to ethics considerations and requirements.

Our approach and our dilemma are reflected in Tolich and Fitzgerald's (2006) description of navigating ethics approval for their ethnographic studies. If we had been cognizant of ethics review challenges prior to submitting the application, we could have followed the recommendations of Ells (2011) and van den Hoonaard (2002b) and perhaps experienced less difficulty. However, we found few such discussions in the nursing literature (e.g., Munhall, 2007), particularly in a Canadian context, and had not had explicit conversations about this issue over the course of our graduate studies.

In the end, our creative response to the REB proved satisfactory, given the stated requirements, yet we were not informed of the rationale for the REB's approval of our approach to protocol. REB members may have felt uncomfortable with how our research was described — we initially submitted an account of how it *might* progress. Protocol can also mean “the accepted or established code of behaviour in any group, organization, or situation” (OED, 2014). We believe that tension between worldviews can expand the code of behaviour embedded in organizational research practices, resulting in a more robust examination of a variety of relevant phenomena.

Still, as we had no experience with REBs unacquainted with qualitative research methods, this was not our only hurdle. As we completed this part of the REB application, we faced another challenge.

### ***Informed Consent***

Historically, informed consent evolved as a response to unethical research practices that resulted in harm to human beings. The Nuremberg Code (National Institutes of Health, 1949) (which begins with the statement “The voluntary consent of the human subject is absolutely essential”), the WMA Declaration of Helsinki (World Medical Association, 1964/2008), and the Belmont Report (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979) are documents that inform international ethics guidelines, including the guiding document for Canadian university and health-care research ethics boards, the Tri-Council Policy Statement (TCPS) (Canadian Institutes of Health Research [CIHR], 2010).

The right to free and informed consent when participating in research is unequivocal. Over the past two decades, largely in response to legal action in the United States, informed consent has become a focus

of research ethics conversations to the extent that “one might be led to think erroneously that other ethical issues (e.g. research design, selection of participants) are either less important or more satisfactorily resolved” (Levine, 2003, p. 197). Failure to obtain informed consent is considered a form of negligence in both the United States and Canada, with possible legal consequences (Levine, 2003). An organization’s ethics board could be held accountable if informed consent procedures are not specified in ethics review applications.

RCTs customarily allow prospective subjects at least 24 hours to decide whether to participate so that they do not feel coerced. However, our research design did not require participants to submit to a medical procedure or to ingest a medication. Our intention was to observe patients and RNs together and to conduct interviews. RNs working in the PSC do not know 24 hours in advance who they will be seeing in the clinic on any given day (including on our scheduled observation days). Also, it was impossible for us to identify patient participants in advance of their referral (usually on the same day) to the clinic; informed consent could be obtained only in the clinic when we met the patients for the first time. Because of this, and because of the unpredictable nature of RNs’ practice in the clinic, our proposed informed consent process did not (and could not) allow patients 24 hours to make their decision.

The REB required us to justify this digression from informed consent guidelines and indicated concern that our patient participants would be vulnerable to coercion. We also had concerns about coercion, in particular about approaching patients immediately prior to their seeing an RN, disrupting the flow of RNs’ work, and troubling patients who might already be emotionally and physically compromised, distressed, or vulnerable. Qualitative researchers often do have difficulty ensuring confidentiality (Snyder, 2002); however, in-the-moment consenting processes are common in qualitative nursing research and are within the ethical boundaries outlined by the TCPS (CIHR, 2010).

We knew the importance of informing patients that they had the option of not participating and of quitting the research if it became uncomfortable, exhausting, or onerous at any time during the observations or interviews. Wording the informed consent section of the application in ways that would satisfy the REB included this option for patient participants, along with several scenarios based on our understanding of the referral processes to the clinic. Our concern was to explain to the REB that referral processes could influence the amount of time available to patients to consider whether to participate, and these differed from patient to patient.

Our revision asserted that our study was designed to consider current referral practices (and their influence on RN practice in the PSC) and

that we had incorporated these into the informed consent process in part to minimize any added burden and anxiety for patients. We reiterated that our study was designed to capture patient–nurse interactions verbatim as they occur in everyday practice rather than recollections, which can be inaccurate.

Ironically, later, as we entered the field and began our observations of RN–patient interactions, the REB’s heightened concern over patient informed consent proved to be moot. Every patient of this cancer care organization receives a detailed orientation to its practices, procedures, and personnel, delivered electronically and most often accessed at home. The orientation stresses the values of the organization, explaining repeatedly that it actively engages in research and that patients and their caregivers may be asked by staff to participate in various research projects. When seeking informed consent in the field, we directly benefited from this socialization/education of patients in the research culture of the organization, something the REB did not take into account when considering our qualitative design. While we had been concerned that it might be a clumsy, disruptive process, patients readily consented, most citing a desire to contribute or to make a difference for others. Such a response justifies the call for a re-evaluation of the notion of informed consent, particularly in terms of risk, and for the incorporation of greater flexibility (van den Hoonaard, 2002a).

### **Risk**

The notion of risk is important in health–care research because of the Western bioethics principle of non-maleficence, a principle that encompasses many explicit ethical imperatives such as “do not kill,” “do not cause harm,” and “do not incapacitate” (Beauchamp & Childress, 2013, p. 154). Risk, in this sense, is the potential for harm to the participant. Taking potential benefits into account, “the level of foreseeable risk posed to participants by their involvement in research is assessed by considering the magnitude or seriousness of the harm and the probability that it will occur” (CIHR, 2010, p. 196). Research projects deemed to be of minimal risk usually receive an expedited review, while those assessed as higher than minimal risk require an intensive, extensive full board review and progress reports at regular intervals. We agree that scrutiny of risk is an important consideration for every research project, and we are curious about how concepts like risk are interpreted by members of ethics review boards, including how such concepts might disadvantage those doing qualitative research.

Before we were asked to undertake this project, the researchers previously responsible for it submitted an application for ethics review proposing a participatory action research (PAR) design. In this organization,

we were surprised to discover, action research is automatically categorized as above minimal risk and requires a full REB review. The project had been considered above minimal risk because it would involve RN participants in the (action research) design and implementation. The risk category at which that project was assessed was also applied to our project, and the REB met only once a month, which meant that any revisions we were required to make because of the initial designation as above minimal risk would significantly delay our project.

When we assumed responsibility for the project we changed the research approach and expected that the former design would have no relevance for the ethics review. But from the perspective of the quantitatively oriented REB our proposal did not differ substantially (along the parameters with which they were familiar) from the initial one; thus it treated our project as a PAR study, in terms of risk, despite the changed approach (and, we believed, lower risk category). The PAR designation could not be removed from the application: we would have to submit a new application, which our funding timelines did not permit.

It appears that the majority of REB reviewers were not sufficiently familiar with PAR, nor, for that matter, with qualitative interview design, to see that our design was not PAR — although we acknowledge that we should have been more explicit, in our application, about the difference. Our project would have looked very different had we used a PAR method. Perhaps the REB's focus was the above minimal risk element, not the more-or-less generic qualitative interview design described in our application, which we understood to be of minimal risk. We have since discovered that qualitative nursing studies are often assessed by health-care REBs as entailing substantial risk and are classified as “behavioural studies” requiring full board review. This classification baffles us given that some RCTs involving experimental medications could be designated as minimal risk, depending on the protocol. It transpires that an emphasis by REBs on risk in qualitative research designs is not unusual (van den Hoonaard, 2002a). The main purpose of such organizational practices could be to protect the legal interests of the organization (Lincoln & Tierney, 2004).

The REB expressed no specific concerns about the risk to other participants, including RNs, despite the small size of the organization and the challenges to confidentiality that we imagined. We struggled constantly with this aspect of risk, and we modified our research design to ensure the confidentiality of RNs and other stakeholders, a challenge inherent in qualitative interview research in smaller health-care organizations. For example, a portion of the research budget was dedicated to backfill or release time so that RNs could be interviewed during their shifts in meeting rooms away from the PSC, thus both ensuring that staff

would be available to meet patient needs and minimizing the amount of time an RN would be seen with us in the PSC.

We discovered, however, that the organization had very particular and stringent requirements for obtaining approval for release time. Making a request on behalf of RNs for paid release time for the purpose of an in-depth interview would immediately identify the participant to the manager (and others). To substitute for this process, with its risk to confidentiality, we were required to spend much more time within the organization waiting for nurses' downtime in the ebb and flow of clinical practice in order to interview them during regular working hours. We did ask nurses if they preferred to be interviewed outside the workplace but all declined. We also arranged with managers to have them not enter the PSC during specified, agreed-upon periods when we would be observing practice. While we never disclosed the name of an RN we were observing, we did inform the manager of exactly when we would be observing in the PSC.

The RNs working in the PSC were aware of the risk. We had difficulty with recruitment because they believed it would be difficult for us to protect their confidentiality. Such organizational difficulties are not uncommon; we encourage nurse leaders and nurse researchers to carefully consider how organizational structures affect nurses' participation in research. If we are to build on current nursing knowledge and support the implementation of nursing research, while drawing on the expertise of nurses in practice (beyond their traditional role as RCT data collectors), it is crucial that we recognize the kinds of barriers described here and institute formal structural processes to facilitate nursing research (Weierbach, Glick, Fletcher, Rowlands, & Lyder, 2010).

### **Discussion: Imagining Our Fathers' Ethics Board**

Initially we believed our experience to be unique; there is a dearth of discussion in the nursing literature regarding the politics of submitting an ethics application. While there is much discussion regarding the tensions between qualitative and quantitative research perspectives, and extensive debate about what constitutes the gold standard of health-care research (e.g., Blegen, 2009), there is little on the translation of such tensions into the practice of research and the issues that emerge from that translation. Thus, the extent of the problem for Canadian nurse researchers is not clear. Informal polling of our research and doctoral colleagues in nursing revealed that the kind of tension we describe is common, a finding that is congruent with descriptions and analyses of the issue amongst qualitative education researchers a decade ago (Lincoln & Tierney, 2004).

Anecdotal evidence points to the need for close attention to this issue. Some of the nurse researchers with whom we discussed our experience remarked that they have been told by members of REBs that their proposed qualitative research (such as action research) was “not even research” or have been required to construct detailed protocols to address exaggerated risks to participants, such as death during qualitative interviews. In light of the competition for research funding, it is vital that REB knowledge gaps regarding qualitative design be addressed. Nurse researchers risk having their studies discounted or substantially altered during ethics approval, as they shape their research projects to the quantitative orientation of traditional REBs.

The privileging of quantitative methods and philosophical perspectives by REBs can be seen not as a research practice but as an organizational practice that serves “methodological conservatism” (Lincoln & Canella, 2004, p. 7), reminding nurse researchers and other nurses that the RCT is the gold standard of knowledge production. Like other organizational aspects of health care and research, REBs need to be evolving constantly, to account for innovative research methods that address contemporary health care and ethical issues unimagined by the ethics boards of our fathers.

Further reflection on our experience prompted us to consider how nursing knowledge is shaped during the ethics approval process. We therefore offer some suggestions to supervisors and mentors of doctoral students, REB members, and qualitative nurse researchers. Our purpose is to engage nurse researchers in exploring this topic and shaping the context of nursing research.

### ***Supervisors/Mentors***

Within the supervisor–doctoral student relationship, the ethics application can be seen as a vehicle for discussing the politics of nursing research. This goes beyond what Hemmings (2006) describes as strategies for enabling doctoral students to complete their degrees and resist the undermining effects of rejection by REBs. As Hemmings points out, doctoral students with difficult research questions may abandon their original interests and pursue topics that have already been investigated or that are without controversy, in response to difficulties encountered during ethics review. Organizational research practices that reject innovative or boundary–pushing inquiries can also have the effect of further depleting the number of qualitative researchers in the field (Hemmings, 2006). Such redirection of nursing research is unfortunate for the profession and discipline of nursing.

We suggest that doctoral students meet ahead of time, if possible, with the REB coordinator. The purpose of the ethics application process is to

ensure the safety and consent of participants, not to inflict hardship or to discredit any research tradition or methodology. Supervisors should, if necessary, “speak with [REB] members, defend the research that they or their students are undertaking, and seek to educate [REBs] more broadly concerning issues of level of risk and potential direct benefits” (Lincoln & Tierney, 2004, p. 233). Such actions go hand in hand with the supervisor’s guidance in helping students see the difference between filling out application forms incorrectly and recognizing the inherent privileging of certain research traditions. Inexperience and incomplete or carelessly completed applications are salient factors in prolonged and inadequate approval processes (Burke, 2005; Hemmings, 2006) and can be viewed as disrespectful of REB members’ time and efforts.

We believe it is vital that doctoral supervisors discuss ethics applications and the ethics review process with their students in a fair manner, rejecting the idea that the process is a barrier to research or that the application form is a stagnant document. The ethics review process could be discussed as a potential issue for qualitative nursing researchers in the field. Ethics review can be a deep-rooted research issue requiring skilful management and re-imagination by qualitative researchers present and future. The ethics application can also be, as it was for us, the beginning of a process of informing nurse researchers about the power dynamics and values of the organizations in which nurses work and where nurse researchers conduct research.

### ***Research Ethics Boards***

Based on our experience and our review of the literature, we concur with van den Hoonaard (2002a) that the detrimental effects of privileging certain research traditions are most keenly felt by doctoral students. Doctoral students are particularly vulnerable and have not yet had an opportunity to build a strategic research network. We wish to contribute to the strengthening of REB–doctoral student relationships in order to support the development and sustainment of researchers from a variety of traditions. We echo van den Hoonaard’s (2002b) call for REBs to “look at education, not policing”: “REBs should concentrate on ethical issues, not scientific, legal” or on risk management considerations (p. 183). Education and translation of ideas are not unidirectional, and they involve critical consideration of language as well as the need for collaboration and communication.

It is of the utmost importance that more inclusive language be incorporated into the ethics application process (van den Hoonaard, 2002a). This includes language around notions of risk and protocol. If risks to a participant are known, as they purportedly are in RCTs, then “ethics review can be more structured and less ambiguous” and thus more acces-

sible to applicants (Tolich & Fitzgerald, 2006, p. 76). While, on the surface, the requirement of a traditional protocol seems a tidy solution, ambiguity is, in the 21st century, inherent to all research. According to Ells and Gutfreund (2006), it is a myth that all “risks and benefits must be known in advance” (p. 368). The TCPS concurs: “[C]ertain accepted research paradigms bring inherent limitations to the prior identification of risk. For example, when research in the social sciences employs emergent design, the manner in which the research project will proceed and any associated risks may be known only as it unfolds” (CIHR, 2010, p. 23).

It is illusory to believe that any protocol will remain unchanged after it is presented to and approved by an REB. Researchers need to acknowledge and account for both ambiguity and flexibility during the ethics review process, without overstating (or understating) the risks entailed in qualitative methodologies. Acknowledging this reality can encourage REBs to focus on ethical principles rather than on the mechanics of “proper” application, such as “Is there a hypothesis?” or “Is anonymity of the participants protected?” (Ells & Gutfreund, 2006, p. 372).

While we recommend the use of inclusive language in REB applications, REBs could adopt collaborative organizational practices that promote mutual trust and instil confidence in the assertion “that investigators will follow the human subjects [participants] aspects of their protocols” and that REBs “are interested in advancing research” (Burke, 2005, p. 924). A good example of organizational collaboration would be an REB comprising representatives from multiple disciplines with different perspectives and research interests, extending beyond one token nurse or even one qualitative researcher. If interested parties are not available within the organization, cross-appointments with affiliated academic units might be considered (Lincoln & Tierney, 2004). This could serve not only to facilitate the ethics review of qualitative research applications but also to educate other board members in qualitative methods (Lincoln & Tierney, 2004). Interdisciplinary collaboration supports communication between boards and researchers, resulting in learning opportunities and minimizing organizational practices that tend to “normalize” one particular research tradition (Burke, 2005; van den Hoonaard, 2002a).

### ***Qualitative Nurse Researchers***

While supporting Blegen’s (2009) call for a reframing of the tired qualitative–quantitative debate, we also offer several suggestions to qualitative nurse researchers. First and foremost, they might consider joining an REB as a vital aspect of knowledge translation. Our experience illustrates how REBs inherently influence research practices embedded in organi-

zational power arrangements and play a key role in the generation of new nursing knowledge. Knowledge translation is as much about power relations as it is about evidence (Newton, 2012). The translation of innovative research designs and of REB processes and politics in ways that are meaningful for doctoral students is vital to the future of qualitative nursing research.

We have also come to see the value of approaching an REB with the expectation that a collaborative process will enhance mutual understanding and strengthen the proposed research (Burke, 2005). We encourage researchers to include an explicit ethics discussion in their research proposal as part of the methods section (not as an appendix), as such discussion “permeates method and theory” (van den Hoonaard, 2002b, p. 181). As Lincoln and Canella (2004) state, “multiple kinds of knowledge, produced by multiple epistemologies and methodologies, are not only worth having but also demanded in policy, legislation and practice” (p. 7). In our own work, we consider comments from different perspectives.

The researcher has a responsibility to submit a clear and polished application (Ells, 2011; Hemmings, 2006). As our experience shows, good communication (Ells, 2011) and an accurate, clear application can ease many of the difficulties encountered during the review process. In the words of Morse (2003), it is the “responsibility of the applicant to prepare a persuasive yet balanced, comprehensive application . . . [and] the responsibility of the agency to provide a competent, valid and fair review” (p. 850).

Finally, we recommend that qualitative nurse researchers share their stories with neophytes. There is no doubt that many nurse researchers have creatively and innovatively met the challenges that we have outlined and have been steadfastly submitting high-quality work to REBs, perhaps having to defend their work to misinformed or biased REBs in order to continue the research necessary to advance nursing as a profession and discipline. We did not realize until we spoke about our experience that prominent Canadian nurse researchers have been practising at the margins of tolerability in the current Canadian research ethics landscape, where the difficulties we describe have affected funding opportunities as well as the generation of new nursing knowledge.

## **Conclusion**

We acknowledge that the ethics review process is a crucial mechanism for protecting the safety and rights of all participants; without it the potential for harm would be significant. Our experience demonstrates that the taken-for-granted criteria used to ethically review and assess RCTs cannot be universally applied to qualitative research (nor, for that

matter, to other forms of quantitative research). Different interpretations of language, informed consent, and risk embedded in the review process reveal tensions among various research approaches, and consequences for nursing research practice. In our case, the consequences included unnecessary delays and other problems, requiring us repeatedly (and creatively) to fit a square peg into a round hole.

Beyond our own research challenges in this reality, we are concerned about the trend towards what Lincoln (2004) refers to as “methodological conservatism” (p. 165) with its power to shape the design and implementation of any qualitative study. While it has long been acknowledged that qualitative traditions are necessary to examine many phenomena of concern to nursing, traditional institutional research supports in health care are organized around the implicit privileging of quantitative methods. Such organizational arrangements have the power not only to influence how nursing research is implemented, but also to shape new nursing knowledge before it is even generated.

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## *Doing Qualitative Nursing Research in a Quantitative World*

Lorelei Newton, Sally Kimpson

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