

CLINICAL NURSING RESEARCH

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THE BULK of nursing research in the past has been concerned with the study of the people doing nursing and the bureaucratic systems within which nursing takes place. Gradually the realization has grown that what is needed is more study of the process of nursing itself. This includes a study of what individuals are like in health and illness and how they respond to the stress of illness, changes in their way of life, and modifications of family structure. It includes as well an appraisal of nursing action in its attempt to modify these stresses and help individuals move toward health.¹

Clinical nursing research is the way in which nurse-researchers study these processes trying to build a theoretical framework on which to base nursing actions. There are many difficulties involved in identifying problems for study and in planning this research. In this paper a look will be taken at specific problems in carrying out clinical nursing research.

These problems can be broadly grouped into two classes —

- 1) Problems related to the fact that the researcher is also a nurse, and
- 2) Problems related to the setting in which the research is carried out.

The nurse doing research is subject to all the difficulties inherent in field research in any area. Her view may be biased and distorted by her previous experience, her expectations of what she will find and her lack of objectivity. These problems must be largely attacked in the research design by building in safe-guards so that the researcher cannot, even unconsciously, manipulate the data to fit her expectations. It is an all too common human failing to see the evidence which supports our hypotheses, yet fail to see the contradictory evidence.

The nurse as researcher is generally subject to role-conflict: she

is often in a position in which she finds herself exposed to demands which seem contradictory and incompatible. Conant has expressed the belief that the successful study of nursing practice will be done by nurse practitioners who also do research.² While agreeing with the value of linking research to practice, one must look objectively at the nurse who is involved. How often students of research in nursing have expressed difficulty in carrying out their research tasks, when in the course of these, they see needs of patients which are not being met. Picture the nurse-researcher who has set herself the task of collecting detailed observations of children in a selected hospital setting; since she is not invisible and the fact that she is a nurse is known, she may be subjected to demands from the busy staff to help out, to watch some piece of equipment or to watch a patient. She has further ambivalence within herself when she sees a distressed child; the nurse part of her wants to pick him up and soothe him. It is difficult for nurses to differentiate the nursing process itself from the study of this process, and the nurse-researcher is frequently in conflict with herself, as well as having difficulty in interpreting her role to her nursing colleagues.

Nursing research can be carried out in any setting in which nursing is practised. In most cases this involves some sort of bureaucratic structure, whether hospital, clinic or other agency. In order to obtain permission to do research, it must be shown that the study is possible within the organizational structure, that it will not disrupt services, that it will not involve unanticipated cost to the agency, and that the welfare of patients will be safeguarded. This means that the research design, including measuring tools must be presented to administrative personnel. The response to a request to use an agency for research varies, depending on pre-existing beliefs of administrators, as well as the skill of the researcher in presenting her case. There are administrators who automatically turn down requests to do clinical nursing research, usually on the ground that they cannot allow outsiders to interfere with patient care. There are, fortunately, more and more administrators who are receptive to research proposals, and who will assess these individually and try to help in implementing them. It is the researcher's responsibility to show that her study can be done within the setting, and it is helpful if she can also show that the study will be of benefit to the organization in the provision of new ideas or information.

There may be specific conflicts with doctors in defining limits of nursing research and action. These may be gradually lessened

as nurses more clearly define their sphere of action. The problem will be resolved, not so much by writing and arguing, as by the actions of educated, thoughtful nurse practitioners in their day-to-day interaction with other members of the health team.

To move from the institutional level to the specific area in which research is done, we must look at the subject of clinical nursing research, the patient, or more frequently the nurse and patient together. There is often conflict about how much to tell the subjects of research about what is being studied. Obviously, data can be distorted if the subjects know exactly what is being looked for, and nurses can become quite sensitive in figuring out what the researcher wants. Saying that you are interested in how long it takes for call bells to be answered is certain to alter the way nurses answer them. And it is hard to imagine beginning an interview with a patient by saying, "I'm trying to find out what patients are like who've been labelled 'uncooperative' by nurses". At the other extreme it would be hypothetically possible to collect data with subjects totally unaware, but there are considerable ethical problems in hidden cameras and tape-recorders or even in assuming another role while collecting data.

How this difficulty is solved will depend on the particular problem being studied and the researcher herself. The rights of patients must be protected and the good will and cooperation of the nursing staff is usually essential.

For some kinds of information, patients may distort their answers in a deliberate attempt to be good or to please the nursing staff. They may be unwilling to express their ideas about the care they are receiving while they are still in hospital — there may be considerable divergence in reports of nursing care given while in hospital and those given after discharge. More sophisticated patients may identify the purpose of particular tools and try to supply information they feel fits the researcher's expectations.

Within the clinical setting there are also what might be called interaction effects: How much does the presence of the researcher affect what is being observed? Clinical nursing research can likely never be "pure" in the sense that laboratory study can be. What is happening at a particular moment is dependent on many factors within and outside the present situation. It is the aim of research design to control for or minimize the effect of the many variables present. This leads to the question of how clinical research is developed and how the findings will finally be used to develop a body of nursing knowledge.

It has been said that every event which occurs is unique. It is also quite apparent that no two patients are identical in every way. At the same time, advancement in nursing knowledge is dependent on identifying patterns of behavior, so that we can make predictions of what care patients may need, or of how they may respond to a particular experience.

Many skilled nurses operate largely on what they call intuition. They can say, with considerable assurance, that a patient looks better, or worse, today. It is often hard to translate this intuitive feeling into objective terms. Much nursing action is based on feelings, previous experience, trial and error, and habit. This largely non-rational decision-making process has provided some excellent nursing care, but also makes it likely that there will be much poor nursing care. Operating largely on feelings leads nurses to categorize patients as "good", "cooperative", "difficult", "confused", and to apply nursing in stereotyped ways.

Nursing research aims to show more effective ways of doing nursing, to help in educating better practitioners and to make more rational demands and decisions about what nursing care patients need. The most basic research question is: If this action is taken will it be of benefit to the patient? Benefit may broadly include any progression toward health — he feels better or more comfortable, he recovers more quickly, he is subjected to less stress, his anxiety is less. A major problem in clinical research is the development of ways of measuring effects of nursing actions.

At this time, when clinical nursing research is really in its infancy, much exploratory study is needed. The researcher needs to immerse herself in the study of clinical material, to watch day to day behavior of patients and nurses, to collect detailed descriptions of what is said, of facial expressions and posture, body movement, responses to events surrounding and occurring to patients. For this the researcher needs clear vision, time and knowledge of the pitfalls of observation. Time is a crucial factor because she cannot begin to see recurrent themes or patterns until she has seen a fairly large number of patients. Insights come as the researcher studies and reviews her observations, and discovers that some events occur repeatedly. These recurring patterns lead to questions of "why" and "what is happening", which lead to further observation to see if what has been discovered also occurs in other similar situations. Eventually, this sort of exploration may lead to formulation of hypotheses, statements of expected relationships between events which can be tested experimentally.³

The nurse-researcher may well use theories from other disciplines, for example the social sciences, to try to understand and explain things she has discovered. Her background of study in other fields gives her added insight into the meaning of what she sees and does. But basically, a body of nursing knowledge will be developed by nurses studying nursing. As this knowledge increases and becomes organized, we will have a much more precise and predictable way of transmitting nursing knowledge and skills to students as they learn to become practitioners.

The final beneficiary of this knowledge must be the patient. As we learn to understand better what he is like, what he is experiencing in illness, what his behavior may mean, and can identify changes from day to day, we are in a better position to plan care which is appropriate for him in terms of his immediate and future needs. Because patients are individuals, nursing care can never be stereotyped or the same for everyone, but increased knowledge helps us to select ways of acting which are likely to be useful, and to assess the patients' responses to our actions and to modify the plan of care as needed.

Possibly one of the greatest problems in clinical nursing research is transmitting findings and incorporating them in practice. Much research ends in the journal in which it is published. The solution will lie in better preparation of nurse-practitioners and in having more researchers who are intimately involved in the provision of nursing care. As Conant says, "only those who remain linked to clinical practice are likely to study problems in nursing practice and develop theories of practice".²

References

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