

DILEMMAS OF ETHICS AND VALIDITY IN QUALITATIVE NURSING RESEARCH

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Nurses engaged in qualitative research are faced with role and relationship dilemmas that have a significant bearing on the ethics of their encounters with patients in the research context and on the validity of the research findings. The dilemmas to be addressed, those of informed consent, influence, immersion into the data and intervention within the research context, are not new. However, experience has taught the authors that additional consideration is required in order to manage the research process in ways compatible with the dual considerations of responsibility to participants and responsibility for systematic, scientific inquiry.

Qualitative and quantitative paradigms of nursing research reflect orientations to research problems and research processes that are philosophically distinct. Quantitative approaches originate from empirical principles concerning the necessity for explaining behaviour through rigorous and objective measurement of that which is amenable to reliable and valid quantification. In contrast, qualitative approaches seek to explain behaviour not through measurement, but through systematically entering into the context that would explain the beliefs, thoughts, and intentions underlying the behaviour (Bernheimer, 1986).

While research guided by either paradigm may involve data collection by the interview method, the role of the researcher in conducting the interview is specifically determined by the philosophical perspective inherent in the research paradigm. Distinctions within this role appear in the selection of data sources, the structure of the interview, the relationship that is formed between researcher and informant and the conduct of the research throughout the research process. Because of the expectation that the roles of nurse and researcher can and should be both distinct and separate, the nature of the role

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required of a qualitative researcher presents some peculiar dilemmas for the nurse who is using such an approach to explore clinical questions.

The professional orientation of nursing plays a role in shaping the nature and process of the qualitative inquiry. In several important ways, the act of gathering relevant, individualized data and subjecting it to an established set of analytic processes for the purpose of formulating defensible conclusions is indistinguishable from the essence of nursing action. It has been said, in fact, that the nurse behaves as an implicit social scientist in order to account for competent nursing action.

Just like scientists constructing theories, nurses observe patient behaviour (signs and symptoms), impose structure on their observations through conceptualization and categorization, formulate and test implicit theories about health and illness and the nature of patients and use hypotheses generated from these personal theories to guide observation and action (Kasch, 1986, p.228).

The cognitive processes of qualitative analysis, and the interactional context of qualitative data gathering are similar to those of nursing practice. As such, distinctions between the roles of nurse and researcher are easily blurred. Further, as Styles (1982) explains, the obligation to attend to clinical concerns is something of a "moral imperative" for nurses. Thus it is unlikely that qualitative nurse researchers can completely shed the trappings of their clinical role. While early efforts to explain the difficulties qualitative researchers experience with divesting themselves of the role of nurse attributed the problem to neophyte nurse researchers who were insufficiently comfortable adopting a research role (Byerly, 1969; Davis, 1968), it seems more fruitful to recognize that the problem reflects an inherent dilemma for all nurse researchers involved in qualitative studies of clinical nursing phenomena (Field & Morse, 1985). It is our belief that, by virtue of being a nurse, the qualitative researcher faces unique issues associated with informed consent, influence, immersion into the data and intervention within the research context. These four aspects of the research process illustrate the dilemmas we confront when we attempt to combine the ideologically distinct roles of nurse and researcher.

Informed Consent

Informed consent has long been recognized as a problematic issue in qualitative research (Archbold, 1986; Byerly, 1969; Wax, 1977). Of concern is the reality that the nature of qualitative inquiry precludes prior knowledge of precisely what will occur in the context of the research encounter (Cassell, 1980). Further, because detailed explanations of what the researcher expects to find would contravene the underlying assumptions and shape the data con-

struction, they are not expected in qualitative research designs. Traditionally, the expectation has been that consent is a product of on-going negotiation throughout the period of data gathering (Wax, 1977). Because data collection and analysis occur simultaneously, consent implied at one stage of the fieldwork cannot be assumed once the original intent of the researcher has been revised or refined (Byerly, 1969).

Qualitative nurse researchers share this concern with other researchers; however, their status as nurses further complicates the inherent problem. While the social status of nursing affords nurse researchers some advantages in terms of access to and credibility in certain types of fieldwork situations (Olesen & Whittaker, 1967), it also poses some disadvantages in terms of the social role that participants expect of a nurse in the research context (Wilson, 1985b). The social image of nursing is that of dedication and altruism, an image that is cherished and cultivated within the profession. While other professional groups may share comparably powerful social images, ours is distinguished by the fact that the attributes are interpreted as belonging in the context of personal qualities rather than skills. As Kim (1983) states,

... most of what nurses do is not significantly different from what ordinary people do in their everyday lives. What is different is not the acts themselves, but when, how and why they are carried out. In nursing, the same acts take on special meanings in their enactment (p.12).

While nurses may be able to isolate and enumerate some of the fine distinctions between the actions required in clinical and research roles, it behooves us to recognize that the lay public is much less aware of these subtle differences, and therefore likely to confuse the roles. Thus, informed consent may be further compromised by participants' assumptions about the research encounter based on expectations of the researcher as nurse.

Some authorities suggest that the dilemma be addressed by emphasizing at every opportunity the research aspect of the role (May, 1979). While this may be of some benefit in assuring on-going consent, it raises the likelihood that data are influenced by the researcher's focus upon role. How informants might respond to repeated assertions about one's professional role is unknown. Further, if informants are to be expected to consider the researcher as a non-nurse, it is doubtful that such assertions would prove successful.

Another approach to the dilemma addresses the specificity of consent as the central issue. From this perspective, when informants' responses to an interviewer are incongruent with the research context, the interviewer must recognize that consent to participate in research has been theoretically withdrawn (Field & Morse, 1985). If this perspective were taken seriously, the qualitative nurse researcher would have to distinguish between responses

that implied informant role and those that implied patient role. However, such distinctions would be impossible in most instances, because it is only in the extreme cases that we can be certain informants perceive us in the role we try to portray.

The authors perceive that informed consent is problematic at best and perhaps even impossible in the context of qualitative nursing research; therefore it is our opinion that the obligation of the nurse researcher is to account for and acknowledge the expectations inherent in the roles of both nurse and researcher. The assumption of informed consent must be treated with caution, and, as such, the ethical obligations of the professional nurse must be recognized as operating within the clinical research situation.

Influence

The issue of influence requires close examination in every qualitative research project. In contrast to quantitative designs which aim to control for all possible avenues of influence upon the data, qualitative researchers accept the premise that there is "no way to study a thing without changing it" (Sandelowski, 1986, p.34). As Knaack (1984) points out, by merely attending to selected aspects of an experience or seeking clarification of a perception, the researcher often triggers shifts in the meaning an informant assigns to the phenomenon under study. In recognition of this issue, qualitative researchers have addressed the role of researcher bias in both construction and interpretation of data. Concern about researcher bias in relation to data construction will be addressed here in terms of influence, while bias in relation to data interpretation will be addressed in terms of the issue of immersion. Bias occurring through researcher influence on the construction of data is viewed not as a limitation, but as an inherent component of the data, that must be accounted for in the process of data analysis and in the reporting of findings (Byerly, 1969). The researcher is viewed as the instrument of inquiry, thus the qualities of that instrument must be known. This knowledge is perceived as an asset to the research process in that it explains the findings in the context of the relationship that was the basis for data gathering.

Beyond individual assumptions and biases, the nurse involved in qualitative research brings to the endeavor the assumptions and biases of the profession. Styles (1982) believes that socialization and enculturation into the profession of nursing are sufficiently powerful to make "the sense of self and sense of vocation ... inseparable, inextricably bound together" (p.107). She maintains that the sense of mission, awareness of the social sanction for that mission and certainty about the nature and importance of the work are characteristic of nurses' socialization. Kim (1983) contends that, because of this professional enculturation, nurse researchers bring a unique perspective to the study of any research problem, and that this perspective can be differentiated

from the perspective of any other discipline using similar methods to study a similar issue.

Nurses who do qualitative research, therefore, have an obligation to account for the influence of their professional perspective upon the process and outcome of their research. It has been recognized, for example, that nurses have an advantage in obtaining certain species of data that might not be available to non-nurses (Chenitz, 1986). The nurse researcher expects to have access to private or personal information, and rightly assumes that informants will offer it more readily than they would to non-nurses. Informants appreciate that the business of nursing requires involvement in the most intimate of bodily functions and human experiences, thus are disinclined to protect the nurse researcher from the detail and specificity they expect nursing knowledge to require (Byerly, 1969).

Influence upon data occurs not only in relation to the species of data that are available to the nurse researcher, but also in relation to the process of obtaining that data. Fieldworkers and qualitative researchers of all disciplines recognize the necessity for developing trusting relationships with informants in order to generate data that are accurate and true. The context of all nursing practice is the development of just such trusting relationships; as a result, nurses have well developed skills in this aspect of the research relationship. Moreover, nurses have developed the capacity to manipulate those very skills toward the goals of their professional practice. They use their relationships with patients not only to facilitate data gathering, but also as tools for interpersonal influence (Kasch, 1986). Because of this, accepted practice as to appropriate roles for social scientists engaged in fieldwork cannot be adopted without condition. While supportive responses might be essential to encourage the sharing of private information (Swanson, 1986) and interdependency might be productive in equalizing the balance of power (Wax, 1977), nurses are trained to use these skills toward more goal-directed functions such as comforting, teaching, or reassuring (Kasch, 1986). By virtue of training received in the constructively manipulative aspects of these interactional behaviours, the nurse is at special risk for influencing the data source during the data gathering process.

It is essential to recognize that our efforts to build rapport, foster trust and engage the informant in introspection are made easier by our knowledge of and expertise in the nurse-patient relationship. We can no more abandon these special skills than we can deny our nursing perspective. However, in acknowledging that our communications skills are powerful tools, we are required to take responsibility for the ethical implications of the relationships we develop. Data are being influenced, but, even more importantly, people are being influenced. Therefore, rather than claiming that there is no known risk to the informant because talking is a neutral activity, we must acknowl-

edge that even the process of reflecting upon an experience under the guidance of a skilled interviewer can have a powerful impact on the informant's view of the event (Archbold, 1986). Thus, the already thorny issue of informed consent takes on added significance as a dilemma in qualitative nursing research.

Immersion

Quantitative and qualitative research are often distinguished by their variant concerns with objectivity and subjectivity. While qualitative research implies a preference for subjectivity, its techniques of disciplined inquiry are as thorough and objective as those of quantitative research (Bernheimer, 1986). The tension between subjectivity, which is essential for data collection, and objectivity, which is essential for data analysis, is apparent in the concern qualitative researchers have for the issue of immersion.

The literature on fieldwork contains abundant advice on how to immerse oneself in the data in order to gain access to the processes or perspectives being studied. It further provides caution as to the problems inherent in over-immersion, or "going native" (Evaneshko, 1985). A measure of objectivity is essential for the analysis of data, which occurs concurrently with data collection; with this in mind, some researchers advocate periods of immersion interspersed with periods of withdrawal from the data (Byerly, 1969; Glaser & Strauss, 1966). The assumptions underlying the concern for immersion are that objectivity is the foundation for valid data, while bias related to data interpretation is a product of subjectivity.

All qualitative methods require direct, subjective involvement with the subject of inquiry as an essential part of the research process (Wilson, 1985a). Clearly, the intimacy that occurs in the relationship between researcher and informant promotes both the telling and the judging of truth (Leininger, 1985; van Binsbergen, 1979). However, total immersion can cause the informants' way of thinking to be adopted by the researcher, producing confusion and the loss of critical faculties necessary for analysis (Hutchinson, 1985; Sanday, 1979). Without critical analysis, the researcher is at risk of misinterpreting data, special pleading, premature analysis or inability to make sense of the data (Duffy, 1985; Glaser & Strauss, 1966; Sandelowski, 1986).

When the qualitative researcher is a nurse and the focus of study is a clinical one, there is an added dimension to the more general subjectivity-objectivity dilemma. As Kim (1983) states, nursing scientists do not enjoy the same privilege of objective distance that other scientists rely upon. She maintains that while nurses may strive for detachment in their scientific inquiries, they must continually balance this attitude with one of advocacy

for client well-being. The focus of nursing is the experience of the human person, and clinical research serves as an indepth exploration into that experience; thus the nurse researcher is at once the observer and the recipient of the knowledge gained through observation. It does no more good to insist that a researcher ignore her nursing imperative than it would to tell a nurse to cease systematic inquiry. Inherent in the qualitative nurse researcher role is the fact that neither stance can be shed and neither perspective can be even temporarily abandoned. Thus nurses engaged in qualitative research have an investment in confronting the dilemma of tension between opposing perspectives, and finding strategies to strive toward a sort of equilibrium. Rather than trying to protect ourselves against the dangers of over- or under-immersion, our sights should be set on ways to judge and account for the quality of our immersion in the dual roles of qualitative researcher and nurse. At very least, the practice of accounting for our efforts toward balancing the tensions associated with immersion should be reflected in our research reports and in our guidance for beginning nurse researchers.

Intervention

Perhaps the most problematic repercussion to result from the contamination of nurse and researcher roles is the reality that our research relationships foster expectations that we will intervene no matter how vehemently we try to protest that we are not acting in a clinical role. Chenitz (1986) argues that as long as we claim the identity of "nurse" researchers we imply a promise to intervene. The frequency with which the issue of intervention is addressed in the qualitative nursing research literature supports her claim that this is a particularly pressing problem for nurses in research.

In the traditional participant-observer fieldwork role, it was recognized that intimacy between informants and investigators increased the richness and validity of the data obtained (Gold, 1958; Pearsall, 1965). Toward this end, various tactics were sanctioned to foster intimacy, including such acts as doing favors for potential informants (Douglas, 1976). Nurse investigators have correctly identified the reality that such acts on their part toward potential or actual informants would heighten role confusion and reduce the likelihood of effective informed consent.

While it is true that all social scientists conducting qualitative research can encounter situations in which intervention seems imperative, it must be recognised that the nurse faces unique challenges to both ethics and validity that are distinct from those of other researchers. Unlike the quantitative research situation, in which the rules governing interference are explicit and precise, the qualitative researcher must consider the implications of each instance of influence upon the data that are generated. Thus when the qualitative investigator encounters a situation in which intervention is

needed, the guiding principle is the ethic of respect for the personal autonomy of the individual (Cassell, 1980). Social scientists view this ethic as being of particular import when the investigation of a group of people is undertaken for the express purpose of improving their lot or improving their quality of life (Schensul & Schensul, 1978).

What distinguishes this general societal obligation from the specific obligation of the nurse in clinical research is the entirely different relationship nursing has to the knowledge and skills necessary to effect an intervention (Davis, 1968). As Styles (1982) has argued, there is a form of moral obligation on the part of one who has acquired nursing knowledge and skills. The essential humanism that is part of the social role of "nurse" cannot be disregarded merely to expedite the research process. As Byerly (1969) explains, nurse researchers feel obliged at times to make "nursing judgements," and recognize that if not for the self-imposed restrictions arising from their research, they would intervene and bring about change.

Current theorists addressing the problem faced by qualitative nurse researchers tackle the dilemma in two ways. The first reflects strategies to avoid intervening and therefore contaminating data. Some of the suggestions offered include conscientiously remaining on the margin of the group under study (Davis, 1968), withholding intervention until the end of data collection (Archbold, 1986; Field & Morse, 1985; Swanson, 1986) or deliberately communicating the transition between roles when intervention is inevitable (Swanson, 1986). Included in the discussion of strategy by all of these theorists, though, is the recognition that no guidelines will serve all eventualities. Field and Morse (1985), for example, make the argument that intervention may be essential. They maintain that refusing to become involved in order to maintain access to informants or preserve the validity of the data is indefensible. They further note that failure to intervene in certain circumstances would reflect valuing of research above the quality of life.

The second way of tackling the dilemma reflects awareness that intervention is in fact an obligation for the nurse researcher at times. Archbold (1986) and Davis (1986) believe that the issue should be addressed from the stance that nurse researchers can and will intervene from time to time because ethical obligations to the informants take precedence over the interests of the researcher. Because of this, they suggest that attention be directed to the methods by which this phenomenon can be addressed in the process of conducting research. Davis (1986) believes that it is essential to account for any intervention in the course of data analysis. She argues that the researcher must be alert to instances when intervention has occurred, the reasons for its occurrence and the implications of its occurrence for the informants and the data constructed. Archbold (1986) raises the further issue of obligation for clinical follow-up that might be necessary because of intervention. Clearly

her perspective is that the moral obligation of a professional nurse goes beyond what is essential for the immediate well-being of the informant. She acknowledges, however, that there exists little guidance as to how "contaminated" data should be properly treated in order to improve validity of the findings. It is our contention that the expectation for intervention is a natural occurrence when nurse researchers investigate clinical concerns with informants who have the potential to be the client of nursing. Thus, obligation for the qualitative nurse researcher is again one of accounting for the particular influence of intervention on data construction and the research relationship.

Implications for Nursing Research

The issues we have raised are those that have provoked much thought and consideration in our own research. We have come to believe that concern about adhering to the rigors of scientific methodology has led to an artificial separation of the roles of nurse and researcher, which has exacerbated existing conflicts in the qualitative research endeavor. As an alternative approach, we argue that each role stimulates the other and that, in fact, these roles are so closely intertwined as to be inextricably linked. We believe that efforts to clarify the distinctions between the roles will only serve to complicate the dilemmas faced by nurses in qualitative research. From our perspective, the task should properly be one not of differentiation but rather of deliberate fusion. While clinical nursing can be defined as including an inherent aspect of systematic inquiry, so can clinical nursing research be understood to include some components of professional nursing practice.

One such component, the commitment to on-going assessment, is a useful means by which to address the dilemmas of informed consent and intervention in qualitative clinical nursing studies. We have argued that informed consent may be impossible in the truest sense. However, if the ethical principles underlying the intent of informed consent are of value, then efforts to produce the closest approximation to informed consent are required. Given that involvement in the research process itself will alter the nature of informed consent, our obligation must be to on-going assessment of commitment to continue in the informant role. The circumstance in which informed consent may be most severely jeopardized is the event of intervention on the part of the researcher. Whether such intervention constitutes a major or minor shift to the role of "clinician," it nevertheless upsets the critical balance sufficiently to oblige the researcher to reassess the existence of consent, and, if it exists, the foundation for that consent.

One general strategy that has served us well in our efforts to address dilemmas of ethics and validity is the formalized and systematic use of colleagues in the context of a research team or in the capacity of project

advisors. Teams of peers can address the issues of ethics and validity in a number of ways. First, freedom to immerse in subjective data can be greater if a trusted team member can be relied upon to carry the banner of objectivity. Designated perspectives within the research team allow the team to capitalize upon the subjectivity-objectivity tension in order to attain new depth of meaning without sacrificing validity. Ethical considerations related to informed consent, influence and intervention can be addressed as part of the on-going data gathering process if team members monitor each other's field notes and transcriptions. Correspondingly, project advisors or consultants could be most effectively employed if actually involved in monitoring the process of research in a similar manner. In this way, a broader perspective of the data becomes possible and analysis gains depth and credibility.

The net result of these strategies is to clarify the interaction between the process and product of the research endeavor. In order to account for this interaction in such a way that informs other researchers and assists interpretation of the data, it would seem essential to give a detailed description of the research process, including critical examination of issues associated with informed consent, influence, immersion and intervention, in the written research report.

The issues we have discussed are sufficiently critical to demand the serious consideration of all qualitative nursing research theorists. We believe that a body of theory addressing qualitative nursing research issues must evolve, and must continue to reflect the peculiarities that our profession brings to our interpretation of these methods of inquiry. Careful reflection, meticulous reporting and vigorous debate must be hallmarks of the process we use and are seen to use as qualitative nursing research evolves into a distinct and potent form of knowledge development.

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RÉSUMÉ

La relation dans le contexte de la recherche qualitative des soins infirmiers: Dilemme de morale et de validité

Ce papier adresse le dilemme qui se pose lors d'une recherche qualitative axée sur l'expérience de clients de soins infirmiers. La discussion porte sur quatre secteurs d'intérêt identifiés comme suit: le consentement avisé, l'influence, l'immersion et l'intervention. Les auteurs soutiennent que lorsque le processus de recherche dépend d'une relation intime entre le chercheur, qui est également infirmier/ère, et l'informateur, qui est également passible de recevoir des soins infirmiers, certaines des suppositions inhérentes à la méthodologie de recherche qualitative sont mises en question. L'interaction unique entre les soins infirmiers et les rôles de la recherche qualitative est perçue comme exigeant une considération sérieuse de la part de tous les chercheurs du secteur de la recherche qualitative des soins infirmiers.