

IDENTIFYING AND MANAGING POTENTIAL DILEMMAS FOR NURSE/RESEARCHERS: CONFLICTS BETWEEN THE ROLE OF NURSE AND RESEARCHER

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ABSTRACT

Parahoo (2006) advises that researchers who are nurses must always ensure that the efforts involved in research, particularly recruiting participants, does not over-ride the patient's needs, wishes and rights. Bearing this statement in mind, some of the ethical issues which occur when the researcher is also a nurse or clinician may be particularly significant when considering the principles of non-maleficence (*Beauchamp and Childress, 2009*). Rigid application of the principle may cause tensions (*Johnson, 2004*), particularly in the data collection phase where practice observed or patient 'needs' may precipitate a dilemma between the primary role of researcher, the professional role of nurse (*Jack, 2008; Bell and Nutt, 2003*) and, rarely referred to in the literature, the personal 'moral compass' of the individual carrying out the research. This discourse will examine and explore some of these issues including power, intervention dilemma and coercion and propose some ways to address these.

ETHICAL PRINCIPLES

The declaration of Helsinki (*WMA, 2000*) provides a set of principles to guide medical (and nursing) research. These have been further refined by the Royal College of Nursing for their own research guidelines specific to nursing which sets out those areas which are important to ensure research is carried out appropriately and responsibly (*RCN, 2009*). This is not a discussion document, nor does it consider some of the issues which occupy the academic nursing press. Whilst the document emphasises a need for research which needs to be good quality, impact positively to inform practice and improve care for patients, it also stresses the importance of the duty of care which nurses have to their patients. Equally, the ethical principles described by *Beauchamp and Childress (2009)* may be usefully considered in relation to some of the issues encountered within nursing research, although not always straightforward to transfer into practice.

Feminist ethics has a strong emphasis on care, and care is central to the work of nursing in the way it is enacted within the clinical environment, particularly in the relationships developed with vulnerable patients such as trust, empathy and reciprocity (*Liaschenko and Peter, 2003*). *Bowden (2000 cited in Tschudin 2003)* comments on the predicament of nursing within a highly politicised, technical and hierarchical institution where the fundamental concept and meaning of care may

become 'an ideology or even a technology'. Clearly nursing is complex, technological and demanding; yet as a profession the position of nursing in comparison to other professions is ambiguous (*Yam, 2004*). Equally, within research, the scientific approach of the controlled trial may be perceived as superior to 'softer' research methodologies (*Onwuegbuzie and Leech, 2005; Carson and Fariburn, 2002*), although there is an increasing acceptance of the value of qualitative research in its own right and also to enhance the 'scientific methods' (*Onwuegbuzie and Leech, 2005; Thomas et al, 2004*). Perhaps this perception of nursing research may create additional tensions for the nurse/researcher if, as an aspiring profession, nursing embraces a more rigid 'scientific' approach.

POWER AND THE RESEARCHER

Foucault (1977, cited by Henderson, 1994) describes the clinical 'gaze' that subordinates the body of the person or patient under the scrutiny of the medical practitioner. This is most evident in clinical environments such as Intensive Care Units (*Henderson, 1994*). The power imbalance lies between the knowledge and expertise held by the healthcare professional and the personal self-knowledge held by the patient, where the professional knowledge has perceived greater 'value'. However, this does not help to develop a 'meaningful'

relationship between nurse and patient (Henderson, 1994) and when the nurse is a researcher there may not be this desired rapport. One solution might be to interview or observe interactions with participants who are unknown to the researcher. However, the next dilemma would be whether ethically one has to declare one's background. Veracity, or truth-telling is important to the relationship with participants but may affect the objectivity and validity of the data (Johnson, 2004), yet any omission or attempt to deny information to the patient in a study would be compromise respect for autonomy (Beauchamp and Childress, 2009). Defining substandard practice – observed or patient-reported

The overwhelming ethical principle applied to care and research is non-maleficence; that is to do no harm, either by act or by omission (Beauchamp & Childress, 2009). Some would claim that the principle is basically flawed in the respect that some nursing interventions could be perceived as harmful. Giving an injection or enema is usually uncomfortable and not without risk, although the intention is to confer benefit (Johnson, 2004). Protecting those who participate in research from harm is a fundamental tenet of the principle of non-maleficence. Whilst most psychological research, compared to medical research is unlikely to cause any physical harm, there is potential for emotional harm (Ford, 2006). Where the researcher is observing a healthcare practitioner interacting with a patient the potential for harm may be less easy to define, for example, if a doctor gives incorrect advice; there is an omission of procedure for example failing to check the blood pressure of a known hypertensive patient; or colluding with a patient by agreeing that a high glucose level is acceptable. Challenging such practice is certainly uncomfortable and may impact on the willingness of the practitioner to continue to participate in any research project.

Two levels of substandard practice might occur. One which is unlikely to compromise safety but which may compromise the validity of the intervention is the approach or consultation style of the healthcare professional which could be regarded as prescriptive and non person/patient centred. For example, a nurse who focuses on a computer template for disease management to dictate the subjects discussed in a consultation rather than follow the patient's agenda. The second is substandard care which may impact on the patient's health – this may be judged at various levels of immediate threat to health and potential long-term threat to health. According to Bell and Nutt (2003), research

ethics are embedded in the nurses' code of professional conduct yet to maintain patient safety, confidentiality and report adverse events may compromise the requirement for confidentiality within the research process. Outside of health and social care this may be regarded as alien to the strict scientific principles of *research ethics*.

MANAGING THE ROLE OF NURSE AND RESEARCHER

Consequently, Bell and Nutt (2003) advise of the complexity of managing 'ethically' when the researcher has additional roles such as healthcare professional or academic, proposing that a reflexive approach may support the notion of 'self-regulation' to help address this. However, self-regulation may require a degree of transparency and monitoring to ensure that the practitioner/researcher/academic is really practicing ethically at all times – perhaps within a formal system of supervision such as with an academic supervisor. The authors comment on some tensions that may exist in the interpretation and language of ethical issues depending on the organisation or professional perspectives (Bell and Nutt, 2003) and, similarly, this analysis will take a broad view of ethical issues in order to satisfy each dimension.

A fundamental but perhaps neglected consideration before embarking on research is to consider how the role of researcher and practitioner will be managed in the research environment, particularly where data is being collected in a clinical setting involving patients and practitioners. Indeed the researchers epistemological/methodological position may have some impact on how this may be interpreted (Jack, 2008). Whilst qualitative approaches may appear to interact more with the subject and the data, encouraging reflexivity, the discourse for empirical research stresses 'detachment' from the phenomena being investigated in order to minimise influence and bias (Jack, 2008). Whilst the latter approach may be perceived as more 'scientific' it could lead to a real dilemma with regard to intervention if a person was subject to potential harm such as observed poor practice, poor conduct or an adverse effect in a drug trial. If the participant was asking the nurse/researcher questions about their condition or some detail about their care 'the nurse' may feel a professional or personal obligation to address this whereas the nurse as researcher might perceive this as contaminating the data and introducing bias (Polgar and Thomas, 2008) which may cause a dilemma. One possible way to address this is to agree

to set aside some time after data collection to discuss personal health issues with the participant/patient or, with prior consent, to agree to refer them to another healthcare professional.

Furthermore, it is difficult for a researcher with insider knowledge (such as a specialist diabetes nurse) to neither interact with the interviewee nor the data (Simmons, 2007), whilst remaining 'detached' in the role of researcher and the likelihood is that as someone with specialist knowledge the professional status of the researcher would be revealed at some stage during data collection. Perhaps controversially, Haigh *et al* (2005) reported that patients in a hospital study appeared to use the 'power' of the researcher to meet their own ends. This included emotional and experience contextualisation though clarifying information received in the context of their 'usual' care; sponsorship whereby the patient uses the researcher to express concerns about their care or progress to care givers; in a 'mascot' role (Adams, 1999) where being researched confers a status to the participant (patient); or by what the patients perceived as a social relationship, created on an equal basis, as a 'friend' sharing information or reflecting on their hospitalisation but not with the expectation of the researcher taking any caring action on their behalf. Whilst Haigh and colleagues (2005) mention 'attachment' in the context of those experiencing stress seeking 'wise care givers' they do not comment on the potential tensions which might occur for those involved in research who also have a professional caring role. Attachment involves a more intense relationship as the patient becomes increasingly dependent on one healthcare professional and is less willing to be self-caring (Gillibrand *et al*, 2001; Altschuler, 1997). The reason for this omission by Haigh and colleagues (2005) may be that the study used a research assistant to collect data rather than someone who could be identified as a healthcare professional.

THE DILEMMA OF INTERVENTION

Citing a study by Jones (1975) where a nurse is observed giving a nasogastric feed using boiling water, Johnson (2004) debates at what level (if at all) the nurse-researcher should intervene if some harm is going to occur to the patient – what he calls 'intervention dilemma'. Furthermore, there may be potential issues of concern in the research environment. Bell & Nutt (2003) describe the dilemma of seeing a sexually explicit painting in the home of a foster carer whilst carrying out a research interview. At the time the researcher did not inquire about this but after much deliberation, particularly as this

might impact on the care of vulnerable children, adhered to her social work professional code and informed local social services. A researcher without this professional background may disregard the significance of this whereas the practitioner involved believed that, whilst she may have compromised her position with regard to 'confidentiality' within a research ethics framework, was following the principles within 'self-regulation' and a key tenet within this is to 'act responsibly' (Bell and Nutt, 2003). Personally and professionally, one could argue that the imperative to detach oneself from the participant in the interests of objectivity should never over-ride intervening in the event of any actual or potential risk to the participant (Rumbold, 1999).

Despite Johnson (2004) proposing that nursing research is pre-occupied with ethical issues at the expense of more freedom to research certain subject areas or use particular methodologies, professional practice, in which our research is embedded, too often (and too late) recognises its mistakes with hindsight. It should not take a researcher to identify and publicise this. What this may mean from the perspective of 'scientific rigour' is that nurses are likely to intervene if there is perceived harm for participants. In a (small) study of twelve nurse researchers by Wilkes and Beale (2005), given four participant 'risk' scenarios, most of those interviewed would take appropriate action to prevent harm to the patient at the time. Whilst Wilkes and Beale (2005) commented on 'blurring of boundaries' between the nurse and researcher role, the respondents felt this was in fact a key characteristic of nurse researchers and that developing clear guidance for the conduct of nurses researching in clinical environments was problematic but could include protocols for interventions, regular mentorship and 'education' (although the latter is not defined, but presumably in research ethics and methodologies).

CONSTRAINTS OF ETHICS

Some practices are clearly unacceptable and not to act is perhaps indefensible, however, Johnson (2004) is critical of the 'debilitating' culture of ethics in nursing which he criticises as losing sight of actual harms and benefits for patients taking part in research. Discussing some classic studies and listing the deceptions which researchers used to obtain data, Johnson (2004) argues that there may be some instances where data obtained covertly may be defensible but, if this is to test whether practice or professional behaviours are appropriate, then there are more transparent methods of achieving

this. Action research is one such example and change in practice or behaviour is more likely as participants have more investment in the research. Exploring how the principles of biomedical ethics (*Beauchamp and Childress, 2006*) may be applied *Johnson (2004)* argues that these are not to be interpreted rigidly and indeed some may be ambiguous, e.g. non-maleficence, where many nursing interventions in fact cause pain, although the intent is to improve the patients health. The point being that research ethics comes under more scrutiny, whilst usually unlikely to 'do harm' whereas everyday care where risk is far greater to the patient, is not so rigorously scrutinised. *Slowther and Parker (2007)*, suggest that because of the nebulous nature of ethical problems it is difficult to evaluate or measure outcomes from ethics committees although many of the principles of good practice, such as consent to treatment, have probably resulted from the work of clinical ethics committees.

CONCLUSION

This discussion has attempted to identify some of the potential conflicts and dilemmas for the nurse-

researcher. *Jack (2008)* provides a useful framework to encourage reflection and 'reflexivity', essential to explore the dimensions of the nurse/researcher – participant relationship and to consider how the research approach, researcher's previous experience, profession and any interventions, impact on the quality of the interview and data collection. Most authors appear to agree that it is difficult for nurses to become detached as researchers from the caring role of nurse and ultimate responsibility for the well-being of patients. This may range from intervening where there may be potential harm to patients/participants to revealing their professional status despite this impinging on the value of the data collected. Perhaps, as a consequence, a qualitative research paradigm might be more appropriate, where the researcher often acknowledges interaction with the data. However, one could also argue, that the nature of many quantitative studies fosters detachment from the data and methodologies that are rigorously tested before formal data collection, potentially anticipating some of the issues discussed. Before embarking on any research it would seem imperative to examine potential likely issues and plan for how these might be managed. MJN

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