Role conflict: appropriateness of a nurse researcher’s actions in the clinical field

This study aimed to judge the appropriateness of a particular nurse researcher’s actions in a vignette from the clinical field, and to explore frameworks used to determine the appropriateness of actions. Twelve experienced nurse researchers were interviewed by telephone. They were given four vignettes of actual research situations and asked to comment and explain their judgement on the appropriateness of the nurse researcher’s actions. The findings confirmed blurring of boundaries between professional and research roles for nurses. Nurses appear to use a mixture of frameworks, including scientific/rigour method, ethics, nursing competencies and their own personal-moral values. Frameworks need to be discussed and debated so that neophyte researchers are well prepared before they enter the field to conduct research.

Introduction

Nurse researchers need to question their and others’ expectations of whether they should always remain ‘the researcher’ when conducting clinical research, or should sometimes act as a nurse (Field 1991, Namei et al 1993). We have documented nurse researchers’ stories of being placed in a situation where they...
had to consider moving from a researcher role to a nurse role when collecting data in the clinical area (Beale and Wilkes 2001). We found that nurse researchers often moved into the nurse role. Their decisions were based on the evaluation of rightness coming from their individual personal values rather than that proposed by the nursing profession, ethicists or research methodologists. This paper reports an extension of the research, in which we asked experienced nurse researchers to analyse the appropriateness of the researcher’s actions in stories from the original study and provide a rationale for their judgement.

**Literature review**


A number of papers debate the benefits and pitfalls of nurse researchers entering the therapeutic role when conducting clinical research (Chenitz 1986, Swanson 1986, Cartwright and Limandri 1997). A synthesis of these papers implies that nurse researchers work in varying degrees within four decision-making frameworks:

- the scientific/rigour approach of the research
- the research ethical framework of the study
- their own personal-moral values
- professional competencies of registered nurses.

Nurses need to maintain a rigorous approach to the research process, regardless of whether they are conducting research in a qualitative or quantitative paradigm (Schneider et al 2003). Rigour is established within the quantitative paradigm by the validity, reliability and objectivity of the research process (Lincoln and Guba 1985). With qualitative research, the rigour is in the credibility, dependability and conformability of its processes (Lincoln and Guba 1985, Beck 1993, Sandelowski 1993, Morse et al 2002). In the Australian context, this is elaborated in the joint NHMRC/AVCC Statement and Guidelines.
on Research Practice (1997) which affirms: ‘the scientific integrity of research is governed by research questions that contribute to knowledge, are committed to the pursuit and protection of truth, research methods appropriate to the discipline and honesty’ (NHMRC 1999).

Because of these scientific/rigour principles some authors advise that, unless the situation is life threatening, the nurse researcher should only intervene clinically at the end of the encounter (Swanson 1986, Cartwright and Limandri 1997). The researcher and nurse roles must always be separate, they contend, unless a patient is in a state of anxiety or his or her life is threatened (Field and Morse 1985, Chenitz 1986).

The ethical framework of research on human subjects should be governed by the principles of beneficence, respect for person and justice (Beauchamp and Childress 1994). ‘Beneficence’ is doing good for others (Gillon 1992). It requires the provision of benefits (including the prevention and removal of harm as well as the promotion of welfare) and the balancing of benefits and harms (Beauchamp and Childress 1989).

‘Respect for person’ is complex. It means that individuals should be treated as autonomous agents, and that persons with diminished autonomy are entitled to protection. Respect includes honouring the inherent dignity and the rights of persons and committing not to use a person as a means to an end (NHMRC 1999).

‘Justice’ addresses the issue of who ought to receive the benefit of research and bear its burden. It can become a matter for concern when groups are used frequently in research because of convenience, or where public funds are used for research.

The ethical conduct of research in Australia is governed by the NHMRC guidelines, which emphasise that ethical inadequacies of research proposals are as significant as scientific ones (NHMRC 1999). Some nurse researchers suggest that the balance of ethical principles is often difficult to achieve, particularly when conducting research in the clinical arena.

Nurse researchers’ roles in using the ethical framework for decision making have been evaluated by a number of nurse authors (Behi 1995, Holloway and Wheeler 1995, Merrell and Williams 1995, Cerinus 2001). Some suggest it is a balancing act that can cause the nurse researcher to question his
or her actions (Behi 1995, Merrell and Williams 1995), but ultimately it is the individual’s decision that will determine the outcome for the research and its participants.

Nurses bring their own personal-moral values and beliefs to ethical decision-making in the clinical arena, in ethics committees and in research (Marks-Marar 1994, Wilkes and White 1995, Cerinus 2001, Sinfield 2001, Wilkes 2001). We found this to be the case in our last study (Beale and Wilkes 2001).

Professional standards of practice also influence nurses when conducting research. In Australia, the relevant items are the Australian Nursing Council (ANC) national nursing competency standards (ANC Inc 2000). Those of particular interest for nurses conducting research are that a nurse:

- functions in accordance with legislation and common law affecting nursing practice
- protects the rights of individual and groups in relation to health care
- accepts accountability and responsibility for own action within nursing practice (including research)
- values research in contributing to developments in nursing and improved standards of care
- contributes to the maintenance of an environment that promotes safety, security and personal integrity of persons and groups (ANC Inc 2000).

The aim of the study reported here was to determine how experienced nurse researchers:

- judge the appropriateness of the actions taken by a particular nurse researcher described in a scenario from the clinical field
- rationalise their decision about the appropriateness of the researcher’s actions in the scenario.

**Method**

We conducted a qualitative study using telephone interviews to explore experienced nurse researchers’ views on the appropriateness of nurses’ actions when conducting clinical research. The research was conducted within the constructivist paradigm, where theories construct our own meaning of reality, which may be common with or different from others (Lincoln and Guba 1985). This reality can
be understood to some extent by exploring phenomena in the natural setting, but cannot be used to determine cause and effect.

Sample
Prior research had established that a select number of nurses in Australia had a significant research publication record (Wilkes et al 2002). Using contact details published in research articles, 58 nurse researchers in Australia were contacted by e-mail with an attached information sheet outlining the research project and consent form. They were asked to return the signed consent by fax or post if they wished to be part of the study interview.

Data collection
Respondents to the email were faxed four vignettes of actual scenarios from the research field. Details of the vignettes are provided in the ‘Results’ section (below). Arrangements were then made to conduct the telephone interview at a time convenient to the researcher and participant. Participants were asked if they thought the nurse researcher had acted appropriately in each scenario, and to explain the reasons for their judgement. Other prompts were used to investigate their perceptions of the judgement made.

Data analysis
Transcribed interviews were read and re-read to allow the researchers to be intensively immersed in the data (Lofland and Lofland 1995). They then coded and content-analysed the interviews. Initially, free coding was done, after which the codes were collapsed into the four decision-making frameworks (see above) which were cross-checked by the researchers. Responses were counted and tabulated for each scenario.

Participants’ responses in relation to the four scenarios were also sorted according to:

- whether the participant considered the actions of the nurse researcher in each scenario to be appropriate
- what framework of decision making the participant used to determine appropriateness of the nurse researcher’s actions (scientific/ rigour, ethical, personal-moral or professional standards) (ANC Inc 2000).
Ethical considerations

The University of Western Sydney Human Ethics Review Committee approved the project. Informed consent was obtained from all volunteers. The identity of the participants was only known to the researchers. No identifying names or characteristics have been used in any publications. Data have been managed according to NHMRC guidelines (1999).

Results

Twelve experienced nurse researchers contacted us and became the participants for the study. They came from four states: Victoria, Queensland, South Australia and New South Wales. Ten participants were female, eight were doctorally qualified and four had a Master’s degree. Seven were in academic positions and five had management/clinical positions, with four being full-time researchers.

Research experience ranged from five to 17 years, with a mean of 10 years. Six participants had experience in qualitative and quantitative methodology, four quantitative only, and two qualitative only. The research contexts in which they worked varied considerably, encompassing areas as diverse as forensic psychiatry, acute care and women’s health.

Table 1 summarises the categories that emerged during data analysis. These categories will be described for each scenario in turn.
Scenario 1
A nurse who was performing research in the community described a situation that occurred when she arrived at a house to interview a woman and could not raise her. She described her actions at interview... then the community nurse came and we organised to enter the house and found the woman on the floor having had a stroke. We organised an ambulance etc.

This scenario reports a life-threatening episode. All of the participants agreed that the action of the researcher was appropriate. They judged the appropriateness of the researcher’s actions from the ANC nursing competency standards perspective, in that the nurses needed to function in accordance with legislation and common law and accept accountability and responsibility for their own nursing practice. Most participants emphasised the fact the researchers were primarily health professionals. One participant stated: ‘She has a professional obligation whether or not she is a researcher ... you are first and foremost a healthcare professional’, and another: ‘when we do research, we still have a duty of care about participants.’

When judging the ethics of the situation, the participants saw beneficence as doing no harm and doing good to the woman primarily from a care perspective. The issue of weighing the benefit of the research against harm did not arise in the scenario. Because of the seriousness of the situation, no scientific/rigour framework or obvious personal-moral valuing of decision making was used.

Scenario 2
One informant acted clearly as an advocate during a research project investigating the health knowledge and status of young detainees in custody. She described an interaction with a detainee about how stressed he felt being locked up: He could not mentally stand confinement any longer and confided in me his plans to escape. At this point I became distressed. I felt the participant needed to have immediate psychological assistance and that he had trusted me, almost appealing to me to help him...

After discussing my concern with the other researchers in the team, who understood the dilemma, I decided to tell the nurse in the centre that in my professional opinion, I felt this person should see a psychologist immediately ... I am left wondering what was the eventual outcome for this person. I still reflect on my feelings of despair.
All but three of the participants felt that the researcher acted appropriately on the grounds of beneficence. One said: ‘I suppose she acted in the person’s best interest…’, and another: ‘she knew there was potential harm and she just didn’t do her research and leave … she actually took it further, acting as the interviewee’s advocate.’ It was interesting that a number of participants referred to the detainee as ‘the patient’, which reinforces the nursing element of the scenario.

Participants considered appropriate the ANC nursing competency standards of accepting accountability and responsibility for own actions within nursing practice and contributing to the maintenance of an environment that promotes safety, security and personal integrity of persons and groups.

While some participants referred to the legal implications of not reporting the detainee, one felt that the researcher might be taking on a custodial role as well as a researcher role. Another suggested the researcher should remember that he or she might not be qualified to help the detainee in the situation. One participant who felt the researcher acted inappropriately stated: ‘I see that as a researcher … you’ve gone there as a researcher, not as a clinical practitioner.’ Another discussed the dilemma and unclear boundaries of the researcher’s role: ‘…it gets really grey and really difficult to define what the clear responsibilities are in this case.’

While participants believed the researcher acted appropriately, some felt concern over confidentiality and consent issues, both from the scientific/rigour protocol perspective and the ethical perspective of respect for persons. The dilemma of balancing respect for persons and avoiding harm is highlighted by one participant’s response: ‘I am not prepared to let a patient suffer massive harm because I happen to be wearing my researcher’s hat’, while another said: ‘if you believe the informant’s being threatened then you have to decide what level of risk is served by breaking confidentiality.’

Five participants believed that a response should be planned for ‘worst-case scenarios’. As one emphasised: ‘you must set up your protocol.’ Another stated: ‘…You need to have thought ahead of time about what you are going to do … In the information sheet, if there is any information that comes forth… you would ask the person for permission to reveal that information or pass that information along or to refer them for further assistance as appropriate.’

From the scientific/rigour and ethical framework perspective, the partici-
pants clearly stated that the researcher should have prepared for eventualities by having clear information and consent protocols in place, and should have discussed these with the youths before any research intervention.

Scenario 3
One informant whose clinical and research interests were mental health spoke generally about her approach to interviewing and conducting research. She related the following:

I wondered if what I was doing as a researcher was any different to my usual role of listening empathetically and trying to make meaning out of what was being said ... I decided that research interviews were therapeutic and allowed the participants to tell their stories ... So I felt comfortable in combining the roles and ultimately being able to be empathic towards these people and use my skill that I had developed as a nurse and as a clinician and being with people therapeutically, to actually bring this to the research role...

Ten participants agreed with the premise that research interviews were therapeutic. This emphasises their personal-moral valuing of the research activity, rather than any other framework. As suggested by one and confirmed by others, interview participants often say to the interviewer: ‘a lot of people say [the interview] is healing … no one had spoken to them before about their problems and no one had talked to them before and they thanked me for doing this.’

The one participant who did not see this conflict in the intent of the interview felt that at all times, she was a nurse. She acted primarily in this mode and from a personal-moral valuing framework: ‘I have a big circle that encompasses my nursing... I think totally within this circle and my research is within this circle ... just like every other aspect of my life.’

Contrary to the above, all but one felt that the intent of the interview should be research, not therapy, and that the researcher should not attempt to do both (as implied in the scenario): ‘I don’t think that you should go in there with that as a co-objective of doing the research’, and: ‘that may be a by-product.’ They felt it was important not to cross boundaries between the research and therapy roles: ‘as long as listening is the only intervention’, and: ‘it’s a pretty fine line ... being very clear ... where your boundaries lie.’
Participants were making a judgement in these deliberations from the scientific/rigour framework perspective.

Upholding the scientific/rigour imperative in research, one of the participants (who did not think the researcher acted appropriately) stated: ‘She’s lost the plot. She may feel comfortable and all of those things but I think she’s really not seeing what research is about in this type of setting. I don’t think you can do it and be totally objective.’ The other participant who disagreed with the action of the researcher cited the delineation of the two roles of nurse and researcher from the scientific/rigour approach perspective: ‘I think that if you are going in there as a researcher, then that is your principle role ... they are two different roles.’

All of the participants agreed that because of the life-threatening nature of the incident, the researcher had acted appropriately within the ethical framework of beneficence and from the ANC nursing competency standards perspective of accepting accountability and responsibility for own action.

Five participants, however, qualified their answers, claiming that she should have summoned professional help as she was not in the NICU as a nurse. From the ANC nursing competency standards perspective, she was not functioning in accordance with legislative and common law affecting nursing practice: ‘It’s a difficult one ... Legally what she should have done was ring the buzzer three times and summoned whoever was supposed to be caring for the neonates.’
Most participants felt from a personal-moral valuing perspective that the situation was complicated by the fact that the researcher was gathering data in an area in which she had previously worked. They contended that staff perceive the situation as: ‘you are a familiar face ... they don’t switch their thinking to believe that you are there as a researcher and not a clinical nurse and people have forgotten about the boundaries.’ One participant felt this situation could have been prevented. She emphasised: ‘she should have made it clear in the first place ...”I am not here as a nurse doing this, I am not here to care for these patients, you cannot leave me here while you disappear.”

Participants also used the scientific/rigour and ethical frameworks in justifying their judgement of appropriateness of the researcher’s actions. As one participant stated, from a scientific/rigour method and the ethical perspective of beneficence, the researcher should have set the research agenda with the staff beforehand: ‘What a terrible dilemma, why does anyone let themselves get into these situations?’ and: ‘I think in this situation she allowed herself to be too familiar to the area in which she used to work and therefore she stepped outside her role as researcher.’

**Discussion**

The study has exposed a lack of role clarity in conducting research when you are a professional such as a nurse. The blurring of boundaries between the researcher and professional roles was exposed and suggested as a necessary characteristic by experienced nurse researchers in the study. These ideas are congruent with writers such as Bamberger and Schon (1991), Gardner (1996) and Schutz (1994), who emphasised the need for nurses to be close to research participants to elucidate rich data, even if that means assuming a nursing role.

Table 1 shows that developing a clear model of how to conduct clinical research in nursing is difficult. Each situation brings with it different possibilities and problems for the nurse researcher to consider. Participants used a number of frameworks to consider the appropriateness of the researcher’s actions when conflict between the role of nurse and researcher occurred in conducting research in the clinical field. Most used predominantly a nurse-competency model and, in some cases, did not consider scientific/rigour or ethical issues. In previous research, the personal values and beliefs of the researcher (the experi-
enced nurse researcher in this study) influenced their judgements.

Nurses appear to have difficulty considering the scientific/rigour approach to research, as defined by LoBiondo-Wood and Haber (1994), when in the field. Complications arise when the suggestion that nurses should only intervene at the end of an encounter is made (Swanson 1986, Cartwright and Limandri 1997), implying that it is only the timing that is in question. In fact, assessing the severity of the situation the nurse faces will also come into play, complicated by consideration of factors such as the influence of professional competencies. It is easy to see why nurse researchers are sometimes confused about selecting the ‘right’ course of action.

One of the most common ways to address difficult situations suggested by participants in this study was to be prepared with well-delineated research protocols to cover extenuating circumstances. This may not always be possible, but nurse researchers in all the scenarios should have had more mentoring and education.

Conclusion
The study highlights deficiencies in education, which are often hidden because of the emphasis placed on scientific/rigour and ethical frameworks used in teaching research method courses. Standards of nursing practice, such as the ANC competencies, and personal-moral values are not often addressed in such courses. There must be more avenues for debate, sharing and analysis of the research experiences of experienced and neophyte researchers.

While education programmes in research usually highlight the issue of informed consent, reasons and methodologies for renegotiating the conditions of consent, such as confidentiality during research projects, need to be included (Munhall 1988, Ramos 1989, Cerinus 2001).

This study was limited in the number of participants, but has provided significant data to be considered not only by educators, but also by nurses conducting research in the clinical arena.
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References


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