

Should Only Nurses Do Nursing Research?

Authors: Jane Koziol-McLain, PhD, RN, CEN, John S. Drummond, RN, DipN, Cert Ed. MEd (Hons), PhD, and M. Katherine Maeve, RN, PhD, Auckland, New Zealand, Dundee, Scotland, and Columbia, SC

Section Editor: Mary D. Gunnels, PhD, MS, RN, CEN

John S. Drummond is Senior Lecturer in Nurse Education, School of Nursing and Midwifery, University of Dundee, Dundee, Scotland. M. Katherine Maeve is Research Associate Professor, Center for Nursing Research, University of South Carolina, Columbia, SC.

For reprints, write: John S. Drummond, RN, DipN, Cert Ed. MEd (Hons), PhD, School of Nursing and Midwifery, University of Dundee, 11 Airlie Place, Dundee, Scotland, United Kingdom DD1 4HJ; E-mail: j.s.drummond@dundee.ac.uk.

J Emerg Nurs 2002;28:362-4.

Copyright © 2002 by the Emergency Nurses Association.

0099-1767/2002 \$35.00 + 0 18/9/124247

doi:10.1067/men.2002.124247

*(Research: careful investigation or study especially of a scholarly or scientific nature [from French, *rechercher*, “to search closely”])*

In this column, Jane Koziol-McLain, PhD, RN, CEN, formerly a postdoctoral fellow at Johns Hopkins University School of Nursing and section editor of this Journal's Research Column, and currently Associate Professor, School of Nursing and Midwifery, and co-director of the Interdisciplinary Trauma Research Unit, Auckland University of Technology, Auckland, New Zealand (E-mail: Jane.Koziol-McLain@aut.ac.nz), posed a question to 2 nursing leaders: “Should only nurses do nursing research?”

When reading research about nursing practice we generally look to see whether nurses were involved as investigators in the study—but must nurses be involved? The debate is important for nurses who participate in research as investigators, participants, and users of research-generated knowledge. As is often the case in such debates, what is valuable here is not so much the question or its answer, but rather the fact that the question acts as a catalyst for many useful nuggets of thoughtfulness and insight. The discussion that follows will not settle the debate, but we hope it will move it forward.

John S. Drummond, RN, DipN, Cert Ed. MEd (Hons), PhD

Focusing on the word “should” and its imperative status, I think the answer would have to be no. Let me explain. Doubtless, there will be many occasions when it would be more appropriate for a nurse to be doing or at least leading a particular piece of nursing research, just as there will be many occasions when, if a research project into nuclear

physics was not being done or led by a nuclear physicist, then this would appear rather odd—with the result that the analysis and conclusions may not be much respected, and may even be seriously flawed or unproductive for those who might otherwise use the findings.

This argument seems clear enough. However, returning to the word “should,” I doubt that this argument would always universally hold. This is to say that there are times when the “should” may be difficult to justify. For example, a lot of useful research into pressure sores has been done by structural engineers. All research into nursing, medicine, or disease is not done by practicing clinicians.

Put in simple terms, the blunt answer to the question is no. Of course, it will depend on what the research question is, how we define the key terms in the debate, etc. That seems modest enough. However, there are 3 underlying and related issues that also may be worthy of consideration.

1. The first issue is that nursing is not, at least yet, a purely research-driven profession. It may be an almost research-aware profession; it may even be an increasingly research-based profession, but, as a series or network of knowledge-practices, it is not yet a research-driven profession. What do I mean by this? Basically, and in the present times, a research-driven profession is one where the notion of knowledge-practice in the absence of research is simply inconceivable. Nuclear physics is one example. However, the notion of nursing knowledge-practice in the absence of nursing research remains conceivable. Nursing is such a polymorphous concept and activity that perhaps this will always remain, if incrementally less the case, then at least partly the case. There is no shame in that, but it leads to my second point.
2. Nursing (although the style and strategic purpose has changed) still remains a predominantly top-down profession, which is to say, a profession managed by managers. Managers, by and large, manage a workforce or an organization (including continuing professional development), but they do not manage nursing knowledge-practice in its substantive sense. What, however, they do manage is the resource required for nurses to be able to gain expertise in and carry out nursing research into nursing knowledge-practice. Everyone knows that this resource is pathetically insufficient (which is not

always the fault of the managers). For example, in Scotland there is a medical research council but no nursing research council. As a consequence, nursing is vulnerable to policies and strategies decided elsewhere. This leads to my third and final point.

3. Coming back to the original question, the intent of the use of the word “should” could be: are there occasions when non-nurses are carrying out nursing research (or research into nursing) when, really, it might be better for the profession if nurses were doing or leading that particular research? The answer to this particular interpretation of the original question would be a definite yes. It will be a long haul, and the outcome is not guaranteed, but I think we are getting there.

M. Katherine Maeve, RN, PhD

I would like to focus my remarks to specifically address the idea of physicians researching nurses. The idea of persons outside the discipline of nursing conducting research about nursing is not new. Various sociologists have looked at nursing from a variety of positions and given us valuable insights. Sociologist Susan Reverby's now classic work *Ordered to Care*, and ethnographer Annette Street's work *Inside Nursing* have both demonstrated important contributions to nursing. Drs Reverby and Street each approached nurses and the discipline of nursing with regard and respect.

What is remarkable about both of these researchers/authors is that they never had immediate power and/or control *over* nurses. The same cannot be argued about physicians. Physician-generated research about nurses and/or nursing practice, then, must be critically examined.

Although the control of physicians over all matters of sick care and health care has waned somewhat in recent years, their expectation of that control remains largely unchanged. Nurses continue to take “orders” from physicians, as opposed to nurses “collaborating in prescribed therapy.”

When physicians approach research with nurses and our practice, there must be an acknowledgment of their position of authority, privilege, and power over nurses. This cannot help but have an impact on the development of their research foci, methods, and analyses. Indeed, this very

premise is much discussed in graduate nursing education. Nurses, too, must acknowledge our own power imbalances with other nurses and with our patients.

The research of 2 physicians evidence the differences in approaches and outcomes. Dr David Asch published a widely discussed study on the role of critical care nurses in euthanasia and assisted suicide. This study was reported on every major television network on the nightly news and in every major newspaper in the United States, and it also rated quite a lengthy discussion on National Public Radio. Unfortunately, Asch characterized nurses (and ultimately not just critical care nurses) as women out of control who were cavalierly killing patients whom they believed should no longer live. The shockingly amateurish methodologic flaws aside, this research was clearly not approached in a manner that valued nursing or validated our particular expertise in the care of the dying. Although many of us entered into the debate around the study, our voice was only made available through the vehicles of nursing communication. We were not interviewed on the nightly news. Many of us concluded at the time that this study contributed a “physician’s” interpretation of nursing experience—one that was clearly inaccurate and inadequate.

Another physician approached his research from a completely different vantage point. Dr David Olds has conducted nearly 20 years of research about nursing interventions with young teen mothers having their first child. These young families had the benefit of long years of monthly visits with professional nurses. The families subsequently experienced fewer incidents of abuse, neglect, and health care crises. Because of the longitudinal nature of the study, Dr Olds also has been able to demonstrate that both mothers and children in his study were also less likely to engage in criminal activities and less likely to become involved in the criminal justice system than their counterparts living in the same neighborhoods and with the same economic constraints.

Interestingly, when Dr Olds presented these findings at a plenary session to the American Society of Criminology meeting in 1999 held in Toronto, Canada, conference participants questioned the notion that nurses would, over time, be committed to such a boring project. “What would keep them interested?” and “How could he be sure they were really well educated enough to handle this sort of

task?” they asked. (As a nurse committed to public/community health and an attendee at this conference, I cringed at the idea that a room full of doctorally prepared professionals [mostly criminologists/sociologists] would need to ask such questions about nurses.)

To my great delight and relief, Dr Olds informed the audience that this was *exactly* the type of work at which nurses excelled. Professional nurses, he informed the audience, were unique in their ability to assess, evaluate, problem solve, appropriately refer, and “care” for individuals and families, and ultimately communities. To the question of education, Dr Olds pointed out that during one phase of the study, they attempted to use nonlicensed but trained persons to provide care as prescribed within the protocol. The results, he indicated, were far inferior to the types of results he achieved with registered professional nurses. Importantly, he had the quantitative data to support his claims. Although Dr Olds’ research has been widely reported in professional journals, to my knowledge, it has yet to make the evening news.

Thus, as I consider the question of whether others, specifically physicians, can conduct nursing research, my answer is a cautious “yes.” What we must demand is a kind of research commensurability between disciplines. Nurses, too, must abide by the same rules when (and if) nurses research physicians or the members of any other discipline and/or their practice. First, we must recognize relative positions of privilege and power between us and those we research. Second, we must recognize and acknowledge the “validity” of each other’s experience(s). Third, we must recognize and respect the particular expertise of the other. Thus, as did Drs Reverby, Street, and Olds, we will have earned our place at the table.

Contributions for this column are welcomed and encouraged. Submissions should be sent to:

Mary D. Gunnels, PhD, MS, RN, CEN

Department of Emergency Medicine, Oregon Health & Science University, Mail Code: CR 114, 3181 W Sam Jackson Park Rd, Portland, OR 97201-3098

503 494-1614 • gunnelms@ohsu.edu