From the editor

WHO BENEFITS?

"We only do clinical research here," the professor exclaimed proudly to the nurse interviewing for a faculty position. "What does that mean?" asked the prospective faculty member. "The subjects must be patients," explained the professor.

Does this exchange sound familiar? Naive? Absurd? My response to each possibility is "Yes." I am aware that the tides of popularity in nursing research have shifted away from that which was "about nurses and nursing" toward that which is about people who receive nursing care. However, in our well-intended fervor to become grounded in a scientific foundation for the practice of nursing, we have shifted ever-so-subtly into a sphere where the benefits can be easily misplaced.

In the "clinical" setting, or in settings where nursing is practiced, there continue to be many parties, or stakeholders, interested in what happens. Because of nursing's recent history of being influenced, sometimes controlled, by outside interests, our research activities are likewise influenced and often controlled. To proceed in many of these settings, nurses are required to compromise the method, the design, the conceptualization, and even the authorship of their best research. In some instances, nurses who do their own research are only allowed to do so if they first "do" someone else's research to justify their position.

Rather than blame our foresisters for failure to pursue direct client-oriented research in prior decades, or our contemporary colleagues for doing someone else's research, we need to recognize the real constraints of the social and political environments in which nursing research might have been and is conceived and conducted. Nurses of the 1940s and 1950s may have wished at times to focus their research on questions directly related to those who received nursing care, but the constraints around doing so cannot be ignored. To be involved in such research during these and intervening decades, nurses have often been required to have physician sponsorship, supervision, primary authorship, or coauthorship. As difficult as it is to face, some of the most important research activity of nurses (such as that on maternal–infant attachment) indeed has never been attributed to the nurses who actually did the research; rather, it is attributed to physicians and others who held interests vested in their own careers, funding opportunities, or fame.

I believe that classifications and priorities along lines of content, researcher characteristics, or participant characteristics have not served and still do not serve well as parameters around which to focus nursing's research priorities, energies and resources. These parameters leave us vulnerable to exploitation, lacking clarity in our own interests. These parameters also inevitably set aside meaningful nursing research questions that are disregarded as unimportant, and that go unasked and therefore unanswered. For example, if we shun research in which nurses themselves are the participants, we consider as low priority such questions as those concerning moral conflicts of nurses, the meaning of support that makes it possible for nurses to do their work, or the processes by which clinical judgments are made. The benefits of exploring these questions relate not only to nurses, how nursing is taught, and how it is practiced, but ultimately to those who receive nursing care.

If we form research priorities according to the types of benefits we seek for ourselves, for those we serve, and for the health care system at large, I believe we will move toward research priorities informed by clarity of intent and purpose.

—Peggy L. Chinn, RN, PhD, FAAN
Editor