Toward a nursing practice research method

This article promotes a structure for nursing research in which the primary feature is the nurse researcher-as-clinician in a collaborative relationship with the client-as-subject. Elements of a theoretical rationale for blending the roles of clinician and researcher in an essentially qualitative methodology are developed. A nursing practice research method is conceptualized not as merely a technical activity with a focus on narrative data, but also as an explicit recognition of research as practice with an emphasis on intersubjectivity and dialogue in the research process as constitutive of reality. Research and knowledge development are thus envisioned as taking place from within the nursing situation and contingent on the quality of the nurse–client relationship. The nurse and client are recognized as the authors of the nursing-research situation in which meanings of health experiences are explored and chosen, and opportunities for enhanced quality of life are presented to both. Nurse and client each lend a unique perspective in the shared nursing-research situation. Regardless of the facticities of the client's medical status, both nurse and client have the potential for positive growth and change when these unique perspectives of nurse and client are joined. The proposed nursing practice research methodology capitalizes on these features of the practice situation, and thus, speaks directly to the concerns of the clinician. Key words: clinical method, clinical research, collaborative research, nursing method, nursing research, qualitative research

Carolyn Oiler Boyd, EdD, RN
Associate Professor
College of Nursing
Villanova University
Villanova, Pennsylvania

FOR MANY NURSES, the appeal of qualitative research methodologies resides in the philosophical fit of the qualitative paradigm with the values and beliefs that have long characterized nursing practice. The gaps between theory and research on the one hand, and nursing practice on the other, resist closure in part because of the misalignment between positivist approaches to research and nursing situations as they are lived through by practicing nurses. The hearty emergence of qualitative research in nursing can be attributed to the desire to develop knowledge in the discipline in accord with the practice that such knowledge serves. In view of the enviable position of nurses to study a wide variety of human experiences (or human responses), research methods that disrupt that position and distance nurses from the focus of their concerns are unfortunate. For at least some nurses, research study might proceed from within the nursing situation, but such an approach requires new study designs that open

Adv Nurs Sci 1993;16(2):9–25

nursing experience to the scrutiny of research. Even qualitative designs must be reconsidered with new data-collection strategies and a revised sense of what constitutes research data.

Lefort reports that there is a growing recognition that statistical significance testing is not always meaningful from a clinical point of view as manifest in under-use of research findings in practice settings and the turn toward clinical efficacy and subjective indicators of health.[1] In a critical review of approaches to assessment of clinical significance, Lefort concludes that a social validation orientation seems to be most appropriate in nursing research.

> This approach is based on the premise that for change to be clinically significant, it must make an obvious qualitative difference in people's lives, and should lead to noticeable improvement in their everyday functioning and sense of well-being .... The social validation approach is the only method to acknowledge unreservedly that clinical significance is ultimately a matter of values, and therefore, what is meaningful or important will depend, in part, on who is asked.[1(p61)]

Social validation is a technique of evaluating clinical significance by asking those who may be in the best position to make such a judgment, that is, clients, significant others, clinicians, and society. Each source of judgment obviously is subject to its own set of criteria, stemming from a particular set of values. Although Lefort takes the position that clinical significance is best defined by clients and families, she emphasizes the importance of context, which suggests the need to be more inclusive in evaluating the significance of the effect of interventions. The caregivers' perspective in particular warrants inclusion; when the caregiver is a nurse, this perspective pointedly incorporates understandings about the differences that changes make to his or her clients and families. For nursing, the judgment of clinical significance is a function of a careful attending to the client in his or her world, but may also include other considerations, such as ease of implementation in the caregiving situation. There is, in other words, the opportunity to arrive at judgments of clinical significance based on the wealth of data ordinarily available to the perceptive, responsive, reflective nurse.

As Lefort notes, qualitative research approaches are the means by which to address questions of clinical significance. As more and more nurse researchers turn toward combined quantitative and qualitative research approaches, we might expect a thorough and integrated discussion of research findings that provide more insight about the clinical outcomes of various interventions. This turn toward qualitative research, in this case as supplementary, represents a change in nursing science, that is, a growing accommodation of multiple research paradigms for developing nursing knowledge. In this proposal for a nursing practice research approach, the vision of nursing practice is both humanistic and scientific. Profoundly influenced by Paterson and Zderad[2] and the qualitative research paradigm, the proposal establishes a rationale and a commentary on possible interpretations in practice-research strategies. The key feature is recognition and use of research as practice. Nurse researchers, then, must be clinicians with a primary commitment to practice. But they must also want intellectual intensity/density and the satisfaction of doing those things that extend the influence of their work beyond the clients under their direct care; that

is, they must be clinicians who want to be a part of knowledge development in nursing.

BEYOND RESEARCH CONTROL

Researching nursing from within nursing practice would (1) recognize clinical data as research data, (2) focus on the clinician as a voice for her clients and for other nurses under her supervision or mentorship, and (3) capitalize on those aspects of clinical work that coincide with aspects of research work. Such a research model does not sound so radical as to warrant protest, but the legacy of the dominant tradition in research does set up obstacles that have made obscure the knowledge developed through practice. To illustrate this unfortunate turn in the discipline's quest to develop a body of knowledge and to attain status as a profession, one need only to recall the effort in research to control what is called subject reactivity. Collins and colleagues reported on the effects of research participation on the variables in their study of family caregivers of elderly relatives in the home.[3] In this study, five interviews were conducted during a 12-month period to collect data about patient and caregiver characteristics, caregiver involvement, informal and formal support, financial aspects of caregiving, caregiver mental and physical health, and reactions to providing care. In the last interview, subjects were asked to respond to three open-ended questions about the effects of study participation: how study participation had influenced their thoughts or feelings about being a caregiver, the way they provided care to their relatives, and changes they had made in their lives during the past year as a result of participation.

Of the 226 subjects who completed the open-ended questions, 117 (52%) identified at least one effect of study participation. Many respondents identified more than one effect, resulting in a total of 188 identified effects of study participation. Four categories of effects were identified: subjects' appraisals of their caregiving situation, coping responses that involved modifications in the problem-solving strategies used by caregivers as they provided care to their elderly relatives, controlling the meaning of the caregiving situations, and the coping resource of self-esteem. Table 1 lists these categories by percentage of total responses with illustrative responses from participants in each category of effect.

The researcher's speculations on the way subjects were influenced, from a clinical point of view, provide a common sense insight. They suggest that subjects had the opportunity through their participation in the interviews to examine their experience relative to that of other caregivers.

> What family caregivers experienced as participants in our study, but failed to experience in their social network or formal contacts with the health care system, was an opportunity to: (a) examine their experience as a caregiver in depth, (b) anticipate what the future might hold for them, and (c) compare their personal experience to the experience of other families providing care to elderly members.[3(p253)]

As clinicians, it comes as no surprise that attending to others' situations in an interested and nonjudgmental way that commu-

Research reactivity is not only inevitable, but also a potential asset in the research enterprise.

Table 1. Effects of study participation on participants

Category of effect	Reported effects (%)	Illustrative response
Changes in appraisal of their care-giving situations	42%	Participation in this study has brought me an up-front awareness of my attitudes and has had an influence on how I have thought about the various issues confronting me.
Changes in coping: problem-solving strategies	34%	I accept more help from family and friends.
Changes in controlling meaning of care-giving situation	13%	Some of the questions made me aware of problems other caregivers face and I might be confronted with. I realize how fortunate I am at the moment.
Changes in coping: self-esteem	11%	I now feel as if I'm doing a really good job and have realized how much I actually do.

Source: Collins C, Given B, Berry D. Longitudinal studies as intervention. *Nurs Res.* 1989;38(4):251–253.

nicates the importance of not only their situations but also their perceptions of those situations makes a difference in their lives. Research reactivity is not only inevitable but also a potential asset in the research enterprise.

Berg and Smith note that the use of self as instrument in research establishes a responsibility to the researched as well as to science. Further, efforts to isolate the researcher from the research process

> [P]laces severe limitations on what we can learn about social systems precisely because the method itself denies what we already know: that human beings studying human beings are inevitably influenced in complex ways by a variety of social and psychological forces.[4(p13)]

Thus, their approach to social science method features the beliefs that (1) both the nature and quality of findings are a function of the relationship between the researcher and the researched, (2) this relationship must therefore undergo intense methodological scrutiny, and (3) research methodology must address the whole research process, inclusive of that relationship.[4] Such a methodology is characterized by

1. Direct involvement with the researched.
2. Commitment to self-scrutiny by the researcher.
3. Willingness to change theory or method in response to the unfolding research process.
4. Preference for depth over breadth in the research.
5. Engagement of the researched as participant in the research.[4]

What we already know about people is used to generate new understanding in the same way that the clinician uses extant knowledge to assess a given client's unique circumstances. As in clinical practice, the new knowledge that is gained is directly connected to the quality of the relationship between the researcher and the researched. The features of clinical process in nursing thus bear potential for a nursing practice research methodology. Although the exami-

nation of this potential might include application of research process to a nursing practice situation, the emphasis is on research as practice.

THE NEXUS OF NURSING PRACTICE AND RESEARCH

Paterson and Zderad protested nursing's embrace of a research paradigm that objectifies patients to subjects, decontextualizes the nursing situation by focusing on the measurable, and converts the nurse clinician to an uninvolved observer.[2] For them, research methods that aim to disclose aspects of the nursing situation cannot destroy it in the process. The concern for maintaining context in research has grown to produce a rich literature on qualitative research methods and studies of nursing phenomena that use those methods. From the qualitative research paradigm, a number of features supportive of researching one's own practice can be extracted. Rather than being an extraneous variable to control, patient reactivity is an expected and unavoidable occurrence, as is researcher involvement with the researched.[5-8]

As the Collins, Given, and Berry study[3] pointed out, being a subject in research project changes things for the subject. Doing research is intervention, bearing considerable promise for nursing studies. Lather states that when research is interpreted as praxis, the experience of participants in the research process is cocreative of realities, and hence, of theories.[6] There must be a reciprocity between researcher and researched, a reciprocity that permits use of theory to illuminate lived experience with an explicitly recognized agenda for change. In contrast, when we use existing theory to frame research activities such that data are shaped to fit the framework, we inherently support the status quo. The interaction between researcher and researched must be directed toward using the research process to help participants change their situations in desired, chosen directions.[6] Newman has indicated that for nursing, research as praxis in developing a method to study expanding consciousness requires a theoretical orientation toward health as an evolving pattern of consciousness, an orientation that pointedly strives to grasp the interconnectedness of the entire living system, and a reliance on the interpersonal processes of negotiation, reciprocity, and empowerment.

> The elements of the research method . . . are: (a) establishing the mutuality of the process of inquiry, (b) focusing on the most meaningful persons and events in the interviewee's life, (c) organizing the data in narrative form and displaying it as sequential patterns over time, and (d) sharing the interviewer's perception of the pattern with the interviewee and seeking revision or confirmation. Inherent in this process is the insight interviewees gain into their own pattern and the concomitant illumination of their action possibilities.[7(pp40,41)]

Research as praxis, then, rejects the myth of value-free social science and adopts the feature of an explicit interest in forwarding beliefs about the world we *want* to live in.[6] The goal is to use research consciously to help research participants understand and change their situations, just as the goal in nursing care is to help patients understand and change their health situations. The overriding value of self-determination is apparent in both. In research as praxis, a commitment to critiquing the status quo in order to create a more suitable situation for the researched characterizes the methodology.

The focus on the nexus of nursing philosophy with all elements of nursing activities is, in effect, a concern for a welded relationship between practice and research. Nursing's beliefs, values, concerns, and clinical practice commitments provide the a priori framework for research as praxis, and research participants change through their participation in research guided by such a framework by virtue of the coincidence of the research framework with the framework for clinical nursing practice.

Paterson and Zderad, in a seminal work that predated nursing's readiness on a large scale for exploratory ventures in qualitative research approaches, claim that "nurses know there are events in their commonplace worlds that scream for human interpretation, understanding, and attestation."[2(p57)] They take the position that nursing socialization into a valuing of attention to "all the things that influence the response and comfort of those for whom you care" is in direct opposition to the research dictum to "select out, isolate, focus down on a single question, limit your variables, establish a protocol of operation, control for reliability and validity, tunnel your vision, and safeguard objectivity."[2(p58)] In other words, we strive to comprehend the whole largely through relating parts to the whole, and the dominant paradigm in research "jams" this orientation. The research methodology that they propose for nursing aims to unscramble this mixed message and to enable clinicians to pursue answers to questions most relevant to them; that is, questions concerning "the nature and meaning of the nursing act and how the event of nursing is lived, experienced, and responded to by the participants."[2(p58)] Table 2 summarizes an interpretation of their vision for a nursing methodology that corresponds to nursing process, thus highlighting the nexus between practice and research.

Paterson and Zderad's emphases are clinical in nature. Preparation of the nurse to know involves an openness and self-awareness that is similarly stressed in Berg and Smith's premise that the research relationship has both emotional and intellectual consequences for both the researcher and the researched. Research becomes clinical, they state, when the researcher is unable or unwilling to remove himself or herself from involvement from the researched,[4] a stance that is generally associated with intensive clinical nursing practice. The commitment to self-scrutiny and to a willingness to change theory and/or method as the research process unfolds is essential in research that presents the researcher–researched relationship as central to the process. This commitment is equally essential in conceptualization of the nursing situation for the purpose of helping the individual client in a particular situation and the purpose of theorizing about a type of nursing situation in the development of nursing knowledge. Data collected from within the nursing situation include intuitive insights and empathic awarenesses that are scientifically analyzed in the full context of all data available to the clinician, inclusive of others' perspectives of the situation (lab data, for example), relevant theory and research, and such descriptions of others' experiential knowledge that might be accessible. The terms "primary" and "secondary" data are introduced to distinguish between the clinician-researcher's direct observations and those learned from others. Scientific synthesis is the process of locating other related or similar situations (from past experience and the literature) in

Table 2. Paterson and Zderad's nursing method aligned with nursing process

Preparation for knowing	Knowing intuitively	Knowing scientifically	Synthesis and abstraction
Ongoing development of nurse as person and professional Introductory data ordinarily received prior to initial contact with client: • gender, age, race • medical dx and Rx • setting of care	Primary data obtained from participation with the client in the nursing situation: • what the client says • what nurse observes about the client • what nurse observes about self in the nurse–client relationship	Secondary data obtained in relation to the client's situation: • information from chart and other caregivers • relevant theory and research	Compare and contrast with past experience and with other sources of information about similar situations (theory and research, clinical anecdotes) Definition of the client's needs for nursing care and development of plans to meet those needs: interpretation, judgment, and action in the particular case Accommodation of similarities and across cases: interpretation, judgment, and recommended action in the expanded sense • expanded clinical competence for the clinician • expanded clinical knowledge for the nursing discipline

Source: Paterson J, Zderad I. *Humanistic Nursing.* New York, NY: Wiley; 1976.

order to compare and contrast the data with other known realities. This is an interpretive activity performed to sort and classify the data thematically. The final abstraction is a theorizing activity to account for the relatedness of this particular nursing situation to, and its variations from, other knowledge. Nursing knowledge is thus expanded, and the researcher as clinician is transformed in perspective.[2]

If we recognize that our research will change life for those who participate in it, that change can be incorporated into the design, guiding decisions about such factors as the aims of the research, obtaining consent, giving participants appropriate control over the research process, openly sharing findings, and seeking validation with participants. The parallels between research process and nursing process must be preserved in order to preserve the integrity of the nursing situation and to produce knowledge about it. An overview of major parallels between research and practice is summarized in Table 3 and discussed subsequently.

The parallel between nursing research questions and clinical nursing questions

Consistent with the framework for nursing assessment in practice, the researcher's attention to the client's situation is both humanistic and scientific. Concretely, this

Table 3. Clinical and research activities serving common purposes

Purposes	Clinical activities	Research I	Research II	Research III
Establish boundaries of nurse–client relationship	Introductory data Rapport Contract	Formulate research question Rapport Consent		
Perform nursing assessment, honoring reciprocity and context	Primary and secondary, subjective and objective data collection	Primary and secondary, subjective and objective data collection	Formulate research question Consent	
	Nursing diagnosis	Supplementary data collection	Supplementary data-collection option	
		Monitoring of process	Monitoring of process	
Intervene, honoring self-determination	Collaborative planning and implementation	Monitoring of process	Monitoring of process	Formulate research question
			Supplementary data-collection option	Consent Monitoring of process
Evaluation	Monitoring client responses to care	Monitoring of responses to care	Monitoring of responses to care	Supplementary data collection
		Validation of findings with client–participant	Supplementary data-collection option	Monitoring of responses to care
			Validation of findings with client–participant	Validation of findings with client–participant

means that the nurse's intention to intervene in ways that promote the client's well-being and quality of life directly influences the inclusiveness of the question and its explicit valuing of the client's perspective as central in the caring and researching processes. In the care of a chronically ill patient, for example, the nurse usually begins with general knowledge of the patient (for example, gender, age, ethnic identity), of the illness and treatment, and of the setting for care that serves as a broad assessment framework. The care process is initiated by assessing how the patient and his or her significant others regard the life that they share and how things go for them in the ordinary day-to-day experiencing of that life within the focusing context of this assessment framework. As difficult as it is to grasp and to respond to family-unit experiences as a whole, the expert clinician nevertheless strives to do just that, and intervenes with a caring awareness of the integrity of the whole. Simply attending to the perspectives and experiences of significant others in itself often produces positive outcomes for the patient and his or her family. The power of assessment is commonly recognized by clinicians.

For nurses with a strong family orientation, the rationale for this orientation goes beyond the benefits of allowing family members to ventilate and obtain relief from feelings of isolation to include securing a database that informs intervention with the family as a unit. The emphasis for both clinician and researcher, then, is on questions about how patients and their families experience their health status inclusive of treatment and relationships with health care providers in the broad contexts of the health care delivery system and the society in which that system is created and maintained. A research agenda may be established at the onset of the nurse–patient relationship (I), in the course of assessment (II), or when planned clinical intervention is initiated or evaluated (III). Qualitative research approaches are particularly well suited in spirit and in the strategies that they employ to adopt the clinician's questions as they arise in the nursing situation. Such questions include, but are not limited to, the patient's and family's perspectives. The nursing situation, although philosophically and theoretically oriented to those perspectives, requires other sources of information in order to proceed beyond assessment/understanding to intervention/change.

The parallel between data generation in research and therapeutic caring process

In nursing practice, the nursing situation refers to the nurse–client relationship and the broad context in which that relationship is lived through, inclusive of the institution/unit/community/societal milieus. These nursing situations provide the occasion for coming to know clients and to intervene through relationship with them. This position is not ignorant of the realities of a highly technological health care industry. On the contrary, such realities figure prominently in the nursing situation, and the nurse's expertise with technology is presumed. However, the nursing orientation, the chosen beliefs, values, and intentions direct nursing care to the patient's experience with the health care technology that bears on his or her experience. This orientation, particularly in the care of patients in treatment involving health care technology, is

expressed in the focus on patients' modes of adaptation to ventilators, dialysis machines, and so on.[9]

The nursing situation is particularly thick with awarenesses of a variety of perspectives, and the nurse's ordering of these perspectives and the expression of his or her sensibilities through the nurse–client relationship can in many cases incorporate the research purpose of knowledge development. Myers and Haase, in a presentation of guidelines for integrating quantitative and qualitative approaches, conceptualize nursing practice as grounded in several "levels of reality . . . [which] exist within the whole and are interactive . . . ."[10(p299)] Other nurse scholars have similarly presented nursing practice (variously labeled) as inclusive of multiple data sources from multiple perspectives or modes of awareness in what we have come to know as a holistic orientation in nursing.[11–14] There appears to be a waning interest in explications of models for nursing practice in general, and in the focus on the nurse–patient relationship in particular. This proposal for a nursing practice research method, however, renews this interest with its recognition of the nurse–patient relationship as the modality and context of care.

> Testing [theoretically based models of nursing care] requires adaptations based on the context in which care is given, usually a nurse–client relationship. In many instances, the relationship is the treatment, not merely an adjunct or something to be held constant. Typically, there are multiple components of caring that occur over an extended period of time and on multiple occasions. Thus one cannot ignore the caregiver's involvement.[15(p779)]

Although not usually explicit, arguments for combining quantitative and qualitative research approaches also may (deliberately or inadvertently) be drawing from the nursing practice model in which the integration of perspectives in the nursing situation is commonplace.[16] Reconsideration of the centrality of the nurse–patient relationship in practice and the importance of that relationship in research is the primary point for deliberation in this proposal.

Increasingly, health care providers are recognizing that life quality and personal growth are elements of health and intersubjective in nature.

Increasingly, health care providers are recognizing that life quality and personal growth are elements of health and intersubjective in nature. The concept of therapeutic reciprocity addresses this idea nicely. Marck explains that therapeutic reciprocity refers to mutual exchange characterized by the outcomes of

1. Shared meanings about the client's experience that enhance mutual understanding and instruct the nurse and client's approach to the situation.
2. Shared control of and responsibility for the outcomes of the relationship.
3. Trust in the ability of both nurse and patient to relate effectively in the help-seeking situation and in each other as fellow human beings.
4. Enhanced ability to cope more effectively with the help-seeking situation, and the probability of positive outcomes for both nurse and patient.[17]

In Marck's discussion of the concept, she outlines a number of observable features of therapeutic reciprocity that are readily iden-

tifiable in nursing practice: reciprocal accommodation of personal space, mutual disclosure, shared humor, shared perceptions of concerns, shared understandings of health messages taught and received, shared use of intuition, and shared language.[17] To the extent that these outcomes and features of therapeutic reciprocity coincide with the knowledge that guides a nurse's practice, ideal conditions for doing qualitative research are in place.

Qualitative research is promoted customarily in terms of its philosophical juxtaposition with nursing practice. However, to the extent that the qualitative paradigm represents a committed turn toward a humanistic, holistic model in nursing, nursing practice itself may undergo modification to accommodate the beliefs and value orientation of the model, thereby closing the gap between practice and research approaches even further. Readers are referred to Young's discussion of clinician self-disclosure[18] and to Moch's proposal for a nursing concept of health[19] for two examples of this kind of alignment of the model with practice. Clinician involvement in the nursing situation, then, has a parallel with researcher involvement in the research situation, with implications for the relevance of the nurse's subjective data in a nursing practice research method.

The parallel between research data analysis and clinical judgment

Paterson and Zderad recognized that data analysis in both clinical and research practices involves shifts in perspectives between the subjective and objective, taking into account not only the patient's report of his experience, but also other knowledge about the situation.[2] These include objective/scientific knowledge concerning what is understood about the disease or injury, its treatment, the institutional, familial, and societal stressors associated with treatment and/or long-term management of sequelae of the disease or injury, and so on, and the subjective/intuitive knowledge that becomes available to the nurse by virtue of his or her presence and participation with the patient and family in a health care episode(s). The nurse is not solely objective or subjective, but adopts both perspectives in the course of sense-making, otherwise known as assessment, nursing diagnosis, and continuous monitoring requisite in nursing care. For a discussion of how one researcher used her subjective data, generated and recorded during the research process, in analysis of her findings, readers are referred to Drew's study of patients' positive and negative encounters with caregivers.[20] Gadow has also provided a description of how the nurse uses a variety of perspectives in collaboration with the patient to arrive at an understanding of the patient in his or her circumstance in a unified way. The patient alone can provide the perspective of the lived experience of suffering, for example. The nurse introduces the scientific perspectives of pain and its management, which can be used supplementarily to interpret the patient's circumstances and to come to decisions about how to change them.[11] It goes without saying that understanding the patient's lived experience is an inadequate understanding for nursing care, but it is also true that in nursing we have chosen to concern ourselves with the patient's lived experience and to join forces with the patient to change it. Understanding the patient's experience is therefore primary in the nursing situation and in research about that situation.

The parallel between experiential practice knowledge and theoretical research knowledge

When a nursing situation is concluded, the implications of that experience are housed in the nurse's repertoire of experiential knowledge. As Paterson and Zderad[2] and Benner[21] have described, the nurse compares and contrasts this experience with other similar ones to produce an increasingly complex, rich, and grounded base of knowledge in caring for patients in similar circumstances. The process is one of a kind of synthesis in which differences in similar realities do not compete with or negate one another. Rather, it is a dialectical process that encourages illumination of one reality by the others to arrive at an expanded view.[2]

For the researcher, when findings are analyzed, there is a formal effort to relate those findings to extant nursing knowledge and a commitment to communicating what has been learned in this case to the nursing community. Changed understandings of phenomena occur as thinking becomes increasingly inclusive, moving beyond variations and contradictions of multiple nursing situations and interpretations of those situations. The aim is conceptualization that is "meaningful to the many or to all."[2(p81)]

THE GOOD LIFE OF RESEARCHING ONE'S CLINICAL PRACTICE

Certainly, doing research adds a number of dimensions to the nursing situation. The intent to theorize about one's practice experiences requires a commitment to reflection and scrutiny that goes beyond the intellectual involvement in clinical practice. In return, the clinician-researcher is offered the satisfaction of being a voice for patients, their experiences, and the contribution of nursing care in their lives. The reciprocity between clinical and research processes means that they inform each other, producing superior insights about interventions or how to help people change things as well as about what patients live through in various health circumstances.

Admittedly, there are many unanswered questions about how to proceed simultaneously with a clinical and research agenda. Among these, there are questions of the ethics involved. Obtaining informed consent in a formal way is off-putting for some people, recalling a sense of being used without any personal gain. Researching one's own nursing, however, merely acknowledges the reality of the nurse's gain in experiential knowledge from each care situation. The commitment to do research simply extends this gain to a larger audience. The research and the care are both geared toward ferreting out patient meanings/perceptions that enable nurse and patient to construct new meanings that make desired actions and consequences possible. In this view, nursing is a mutual search for meaning and action; adding a research agenda to one's nursing work merely provides for the communication of what is learned so that other nurses, other patients may profit from it. For some patients, the opportunity to tell their stories and the prospect of having an influence on health care delivery are ample motivation to consent to participate in research. These considerations need attention in thinking through the ethical imperatives in a nursing practice research methodology with the aim of avoiding unnecessary obstacles to obtaining patients' consent to participate in the research agendas for their nurse caregivers.[22]

Thus far, the benefits of researching nursing from the inside out as a clinician have been largely implied rather than explicit. First, there is an economy to accomplishing two purposes simultaneously; second, mutual respect is introduced into the research process by claiming the researched's needs as sacrosanct and the nurse's entitlements to personal growth as legitimate; and third, the limitations of quantitative research methods are resolved: the kinds of data relevant to the nursing process are included rather than controlled, research data collection is incorporated into the process of nursing care rather than being imposed on the patient regardless of his or her interest in or need for disclosure in a prescribed format, and findings bear immediate relevance to clinical practice. For the discipline, the experiential knowledge of clinicians is not lost; the unique access of nurses to data and knowledge is exploited in a most positive way. Happily, the skills required in qualitative research are routinely practiced, particularly by those nurses who practice holistically with a primary focus on patients' experiences; doing research in thus much more continuous with the inclinations and competencies of nurses, and need not deplete our ranks of clinical expertise.

FORMS AND STRATEGIES OF PRACTICE AS RESEARCH

Qualitative approaches to research with their attendant philosophical framework are especially sympathetic to the idea of researching one's own practice. In general, these research approaches share the features of

1. multiple sources of data collected over a relatively long period,
2. high researcher involvement as participant observer,
3. the role of the researched as collaborator in the research process,
4. a relationship between researcher and researched characterized by dialogue, negotiation, validation, and reciprocity, and
5. a mutual search for meanings in the shared researcher–researched situation.

Many of the interpersonal skills foundational to nursing practice are central to qualitative research approaches: for example, establishing rapport, facilitating disclosure, seeking to understand the patient's perspectives and perceptions, and the collaborating and negotiating that are instrumental to the helping process with patients. A turn toward practice as a research arena capitalizes on these natural features of the nursing situation, extending them to establish a research focus; to select a research design; to map out types of data needed, sources, and strategies for generating the data; and to reflect on and interpret data as they are collected.

Establishing a research focus

The first extension concerns formulation of a research focus. This requires conceptualization of some aspect of the nursing situation, as, for example, in the following research questions:

- What is enabling/disabling for patients' adherence to medication Rx?
- What are the effects of X nursing intervention on patients' ability to recognize symptoms and monitor their own health?
- How does participation in group therapy influence recidivism?

- What is the nature of patients' experiences of loneliness (or hope, or grief, or rage)?

The general idea is to recognize what there is to learn about the nature of being human, the nature of nursing processes in the nursing situation, and to select from among the many possibilities based on not only the potential benefit to nursing, but also the potential benefit to the patient.

Selecting a research design

The next extension concerns decisions about design. A number of possibilities come to mind.

Case studies

Made famous by psychoanalysts, this design has served medicine and psychology well. A kind of groundwork was established through case studies as a precursor for other types of research in those fields. In nursing, we might pursue this design in order to establish the grounding needed for knowledge development in the field. Benner's work in explicating the knowledge embedded in clinical practice is an example of this.[21] Two concerns must be addressed methodologically: first, there is the question of rigor needed to make case study scholarly rather than mere anecdote; and second, there is the question of extracting knowledge directly through one's own clinical involvement or vicariously, through study of others' clinical work.

Research teams

Research teams can be used to advantage in at least two ways. First, independent case studies with the same research focus (eg, testing a nursing intervention) can be merged after data collection in order to compare and contrast cases, identify recurring themes, and relate findings to the literature and to theory underlying the intervention. Second, a research problem can be broken down into constituent parts. Each researcher on the team might then work on one part with perhaps the same sample, or each researcher might work with his or her own sample.

Action research

A case-study approach using both quantitative and qualitative data, action research is particularly useful in dealing with institution-wide or unit-wide research foci such as experimentation with a new approach for managing sexual acting-out or an investigation into incidents leading to the use of cuff restraints. It too can be adopted in a research team approach. The idea is to use research to answer real clinical problems.

Ethnographies

These are useful to explore cultural aspects of nursing situations, and could be used, for example, to reveal the taken-for-granted culture of a nursing unit, or to provide insight into transcultural experiences of recent immigrants or the subcultural experiences of minorities. Multisite ethnographies might be especially useful, enabling the nurse researcher to study from within his or her own practice setting with his or her own patients as well as to study the phenomenon of interest in a more traditional researcher role in other settings with both nurses and patients as research participants.

Phenomenologies

This research approach is especially well suited to interests in such aspects of nursing situations as the transitions from home to

hospital to home when there are recurring acute episodes in chronic illness, or the distress of terminating the helping relationship. In the nursing research that is categorized or labeled as phenomenological, it is unusual to be able to discern a high level of researcher involvement, yet this general feature of the variety of qualitative approaches is a primary feature in phenomenology.

Ex post facto designs

Ex post facto designs, by their very nature, allow the clinical situation under study to unfold naturally, introducing observation retrospectively and when the study is initiated. In view of these design features, ex post facto research is of value in ways that go unrecognized from the perspective of the positivist paradigm.

Critical social theory

The idea of research as praxis is adopted from critical theory that has been presented to nursing especially well in Allen's presentation of its central tenets as they might inform nursing research. The point of departure in such research is recognition of power imbalances such as in male–female or black–white relationships in society, and the goal "is to make people aware of the constraints under which they may be consciously or unconsciously operating" in what Allen refers to as a "radical notion of 'informed consent.'"[5(pp61,62)]

Clinical research data

The types of data relevant to most studies of nursing situations coincide with the data needed to assess patient status at any given time. Process recordings supported by taped interviews might be introduced as a means of conserving clinician recording time. Subjective data—the clinician's thoughts, feelings, reactions—are equally relevant for the leads they often provide and require provisions for their documentation such as clinical journals. Intervention strategies such as reviewing a family album with a patient, attending a concert together, assigning the patient to a photography project, or soliciting a patient's responses to works of art might be introduced for the potential they have for disclosing patient subjectivity. Depending on the research focus, other kinds of nursing data might be relevant. Nursing flow sheets that record dietary intake or vital signs might be entered as research data, for example. In making decisions about what kind of data to generate and how, the patient's therapeutic needs take precedence; there is no ethical dilemma for the nurse who observes this therapeutic imperative.

Nursing flow sheets that record dietary intake or vital signs might be entered as research data.

The processes of data collection and data analysis are simultaneous, protecting the patient and nurse from the uncomfortable position in traditional research of identifying a need and having one's hands tied by the research requirements. Research conducted by the clinician does mean that the situation being studied will not remain stable during the study period. The clinician will intervene; the research itself intervenes. In this sense, this kind of clinical research always involves study of intervention even though the research focus may be to describe or to explain some aspect of the patient's experience such as coping with hospitalization.

Process consent is the mechanism used in qualitative studies to provide participants with mutual control over the joint project. The patient's initial consent to share with others the learning that takes place in the nursing-research situation seems appropriate to formalize and would be required by human rights committees and institutional review boards. However, this initial consent should not be construed as absolute or final. Initial agreements concerning what the patient will share, when, and how are tentative at best; often, what transpires in the nursing situation cannot be predicted in any certain way. The therapeutic process unfolds over time, and so does the research process. For this reason, consent too must be renegotiated again and again.

• • •

Practically speaking, nursing practice research requires a commitment not only in valuing the potential of practice to forward knowledge development, but also in time and effort aside from the clinical situation to perform the rigorous work of analyzing and synthesizing the clinical experience. Nurses who take on this task must adopt a research attitude of searching for understanding of their patients in the highest sense of "knowing one's patient"[23] and serving as spokesperson for a target population concerning some aspect of their health experiences. Having an explicit value orientation about the world as it *should* be is a strategic element of the research just as it is for the care process. The unit of analysis is the nursing situation in which the type and quality of data obtained are determined. In this way, the context of data is maintained in order to draw meaningful comments derived from the nursing situation. Throughout the research process, the therapeutic imperatives are sacrosanct, preserving the framework for practice at all times. The concept of therapeutic reciprocity provides an apt framework for such research in a profound respect for research participants' rights to self-determination and an explicit recognition that human experience is intersubjective in nature. A high degree of researcher involvement and a reciprocal relationship with the researched are prescribed in order to produce understanding and change. The incentive for participants in research is that generally people profit from contribution. The patient has the opportunity of experiencing himself or herself as having something of value to offer others; extending that something is its own reward. For the nurse, clinical activity and research activity should be personal expressions that produce personal satisfaction as well as benefit to others. Nurse researchers who have been a step or more removed from clinical involvement may find that doing nursing practice research is renewing for them.

Many details remain to be worked out. The idea of a nursing practice research methodology may be adopted in whole or in part in applications to selected research interests or needs. Questions of scientific rigor need to be addressed, as do issues of informed consent and effective ways of communicating findings of studies of nursing situations.[24] Above all, the possibilities opened by a combined clinician–researcher role need to be contemplated. Chinn notes that the important questions to ask of research innovations are

What limits does this stretch for nursing?
How can I stretch my own preconceived limits?
What possibilities might this approach create?

How could this approach move beyond what I now understand?
What new doors does this open?[25(pvi)]

To a large extent, answers to these questions will emerge from efforts to explicate the knowledge generated through one's clinical practice and submitting it to colleagues' scrutiny.

REFERENCES

1. Lefort S. The statistical versus clinical significance debate. *Image J Nurs Sch.* 1993;25(1):57–62.
2. Paterson J, Zderad L. *Humanistic Nursing.* New York, NY: Wiley; 1976.
3. Collins C, Given B, Berry D. Longitudinal studies as intervention. *Nurs Res.* 1989;38(4):251–253.
4. Berg D, Smith K. *The Self in Social Inquiry: Researching Methods.* Newbury Park, Calif: Sage; 1988.
5. Allen D. Nursing research and social control: alternative models of science that emphasize understanding and emancipation. *Image J Nurs Sch* 1985; 17(2):58–64.
6. Lather P. Research as praxis. *Harv Educ Rev.* 1986;56(3):257–277.
7. Newman M. Newman's theory of health. *Nurs Sci Q.* 1990;3(1):37–41.
8. Oiler Boyd C. Emerging nursing methodologies: clarifying the issues. *Nurs Sci Q.* 1990;3(1):16–19.
9. Zwolski K. Professional nursing in a technical system. *Image J Nurs Sch.* 1989;21(4):238–242.
10. Myers S, Haase J. Guidelines for integration of quantitative and qualitative approaches. *Nurs Res.* 1989;38(5):299–301.
11. Gadow S. Existential advocacy: philosophical foundation of nursing. Presented to the Four State Consortium on Nursing and the Humanities at its Phase I Conference, *Nursing and the Humanities: A Public Dialogue*; 1977; Farmington, Conn.
12. Orlando I. *The Dynamic Nurse–Patient Relationship.* New York, NY: Putman; 1961.
13. Ujhely G. *Determinants of the Nurse–Patient Relationship.* New York, NY: Springer; 1968.
14. Wiedenbach E. *Clinical Nursing: A Helping Art.* New York, NY: Springer; 1964.
15. Woods N. Testing theoretically based nursing care: necessary modifications of the clinical trial. *West J Nurs Res.* 1990;12(6):777–782.
16. Oiler Boyd C. Combining qualitative and quantitative approaches. In: Munhall P, Oiler Boyd C, eds. *Nursing Research: A Qualitative Perspective*, 2nd ed. New York, NY: National League for Nursing; 1993.
17. Marck P. Therapeutic reciprocity: a caring phenomenon. *ANS.* 1990;13(1):49–59.
18. Young J. Rationale for clinician self-disclosure and research agenda. *Image J Nurs Sch.* 1988;20(4):196–199.
19. Moch S. Health within illness: conceptual evolution and practice possibilities. *ANS.* 1989;11(4):23–31.
20. Drew N. The interviewer's experience as data in phenomenological research. *West J Nurs Res.* 1989;11(4):431–439.
21. Benner P. Uncovering the knowledge embedded in clinical practice. *Image J Nurs Sch.* 1983;15(2):21–34.
22. Noble M, Oberst M. Written informed consent: closing the door to clinical research. *Nurs Outlook.* 1985;33(6):292–295.
23. Jenny J, Logan J. Knowing the patient: one aspect of clinical knowledge. *Image J Nurs Sch.* 1992;24(4):254–258.
24. Boykin A, Schoenhofer S. Story as link between nursing practice, ontology, epistemology. *Image J Nurs Sch.* 1991;23(4):245–248.
25. Chinn P. Research innovations: a contradiction of terms? *ANS.* 1990;12(3):vi.