

## Editorial

### **Nursing research: A success story or what next?**

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I believe it is fair to say, in light of the remarkable worldwide development, that nursing research is here to stay. The number of nursing journals has greatly increased and just a glance at the list of contributors and their affiliations indicates that the scale of nursing research is growing throughout the world. This development is encouraging and imparts hope that nursing care will become increasingly evidence based to the benefit of the health of people everywhere.

However, there are also indications that too much of the research is not designed to justify the results being implemented in clinical practice, not yet (1-3). Much research in general, not only in nursing, is too fragmented and too weak regarding design, sample and methods to be able to produce results that should be taken up by clinical practice. Being an optimist I would say, yes, there are problems and evidently there is also the capacity and ability to move on. Thus now is the time to reflect on what we are doing, how we are doing it and what change in direction is needed to increase the impact nursing research should have on clinical practice and people's health.

In this editorial I would like to share with you some of the challenges which, in my view, we need to reflect on and perhaps what can be done to strengthen our research and moving forward. The challenges I would like to address concern the kind of research questions we raise and in particular the implicit assumptions that lie behind those questions. A further challenge, in my opinion, is how we regard knowledge and knowledge building in relation to research, i.e. how we understand the process of

producing evidence based knowledge, addressing discovery, evaluation and implementation. The third challenge is related to the first and is connected with our closeness to practice and, perhaps even more, how we can integrate research in practice, which is related to how we position ourselves as researchers. I am fully aware that there are many barriers and hurdles to overcome but that should not stop us striving to enable the next generation of nurse researchers to go even further than their predecessors.

#### **Assumptions behind our research questions**

The field of nursing research is extremely broad, I would say as broad as the research field of medicine itself. Thus the opportunities in terms of research questions are vast. The research problems can range from basic questions inspired by philosophy, ethics or existing theories to questions arising from clinical problems/questions and any nurse knows that the area of clinical or public nursing covers just about everything. Thus there are plenty of research questions to be raised but how to do it may need some reflection. The way we approach the question is permeated with our personal and/or professional value system, whether or not we are aware of it. This value system stems from our culture, the current values in our society and specifically our training to become nurses. It is essential to reflect on our implicit assumptions about what it is to be a human being and what we as nurses endorse in the patient's progress towards health, a transition to new living conditions or approaching death and dying. There are

various approaches to encounters with patients and their families, and cultural variation; some of them are perhaps outdated and others prevalent. For instance a paternalistic approach (Lynöe, Engström, Löfmark, 2009) has dominated the role and practice of health care, and thus also the research questions and how they were addressed (4). Some years ago I participated in a group tasked with systematically collecting and presenting available knowledge about the doctor-patient relationship. My job was to analyse research related to the impact on patients following the doctor's prescription. It was interesting to discover that the earliest studies on the subject investigated patient characteristics in order to understand why the patient did not comply with the doctor's instructions. Later on the research was based on the assumption that there was something wrong with the message; i.e. the communication itself was the problem and the ensuing research explored the doctor's way of communicating. In other words, the doctor was doing something wrong. The most recent research was influenced by the assumption that the prescription was not negotiated with the patient in such a way that the patient became part of the decision process and influenced the final decision, with the aim of ensuring that the prescription was optimal and fitted the patient's life situation (5). The assumptions behind the research questions are also revealed in the terms used, the most common being compliance. The term indicates the asymmetry in the situation and the expectation that patients will follow prescriptions consequently, more recent research attempts to avoid the term preferring to talk about the decision process. Thus a move from a paternalistic view of patients and their families to a more humanistic view can be discerned. A humanist perspective affirms the notion of human freedom and progress and individuals as knowledgeable and responsible for their development (see International Humanist and Ethical Union [www.IHEU.org](http://www.IHEU.org) ).

It also views people as capable and in charge of their current and future life. There is a delicate balance between a humanist approach and what I would call a maternal approach. This latter grew out of the idea that women possess certain characteristics, warmth, caring, tenderness and openness towards others. It may well be true that women in general have a more developed maternal instinct than men but maternalism should not necessarily mark the nurse-patient relationship (6). Too maternal an approach may take away the individual's responsibility and hinder rather than heal. There is a difference between "being the good mother" and being empathetic in an encounter with another person (7). I am not sure that this is a problem in clinical practice, but from time to time I get the impression that the assumptions currently imbuing some research are inspired by maternalism. Concepts such as person-centered care may sometimes evoke this impression. It may be conveyed by the way in which the research problem is stated, the design chosen, the concepts used and particularly by what is written in the section about clinical implications, where there is often a failure to recognize the role and limitations of the healthcare system. However, other assumptions not approached critically may stem from healthcare policies. For instance the powerful focus on researching how to increase care at home for elderly people is not perhaps in the interest of a frail, older person. The assumption seems to be that it is best for older people to remain in their own homes, based on the fact that, when asked, older people in general state that they want to stay in their home *as long as it is possible*. The meaning of 'as long as it is possible' is not clarified. Basing our research on this assumption risks us, as researchers, becoming a weapon in the healthcare providers' struggle to reduce costs, rather than finding what is best for the older person.

Both of these assumptions are spread throughout the world in research and also in clinical practice despite the weakness of the conceptualization, the specification and the evidence base.

### **Knowledge building in a continuous process**

Another problem I have come across over the years is related to how we construct knowledge for practice and when our research is able to deliver knowledge for practice. Knowledge that is ready to be implemented in practice needs to be scientifically proved, the outcome needs to be maximized and inflict no harm on patients or staff; it has to be cost-effective regarding use of resources, usually costing the same or less and have a better outcome than nature simply taking its course. I like the idea that knowledge building is a continuous process, either focusing on *discovering* aspects of a certain phenomenon or *evaluating*, focusing on establishing the effect of a certain intervention and thereby clarifying whether it should be implemented in practice and finally *implementing* the new knowledge in practice once the effect is established. Studies need to employ designs that are best suited to responding to questions related to either discovery evaluation or implementation. Otherwise there is a risk that conclusions are drawn that cannot be drawn because of the design used, for instance descriptive designs cannot respond to effect (1). The process of developing robust knowledge for practice may well move back and forth using different designs before knowledge can be established, and the phase of discovery is essential for building a relevant theory suggesting how a certain phenomenon can be manipulated to achieve a better outcome than merely letting nature take its course or continuing with what is already in place. Testing a theory or intervention however requires a design that can respond to questions related to effect/effectiveness. In order to achieve this much broader and deeper knowledge of a phenomenon and to be able to intervene to achieve a better outcome my view is that we

need to work in research programs rather than in single isolated projects. Working in a research program means addressing a broader problem from different angles, using different designs and methods and persisting until we arrive at a tentative theory about how the phenomenon operates and test the theory/idea in an experimental design, hence testing an idea of how to intervene to improve the outcome of a nursing intervention. One example of a phenomenon suitable for a research program to look into is the social network and how it can be used to improve health and recovery. There is extensive research showing a strong relationship between social network and health and recovery. It is also well known that a strong social network is characterized by the person having a higher education, a good financial situation and several supportive relationships. Thus it is probably a strong health/recovery factor. However the next step to take, based on current knowledge, is to formulate a tentative theory about how it works, for whom and when etc., and in particular we need a theory concerning how to intervene, test the theory/idea in an intervention in health care so as to use this strong natural resource to improve outcome of this resource. Another example of an area where a solid research program is perhaps needed is that of fatigue. It is well known that fatigue accompanies several severe diseases: cancer, heart conditions, neurological diseases, inflammatory diseases etc. The impression from some of the research in this field is that we work in silos, fatigue in cancer, fatigue in Parkinson's disease etc., perhaps overlooking common mechanisms. Most surprising, however, is the prevailing assumption that interventions should focus on the person's thinking, which may lead to overlooking an interaction between body and mind (1). Nurses have a sound training in biomedicine that is possibly not really visible in our research. Several attempts have been made to review nursing research to reveal whether publications in nursing journals indicate ongoing research programs and

most of all whether the research is moving from discovery towards interventions that can inform practice (2, 3). The study by Mantzoukas (8) showed that 37% of the studies published over a ten-year period in the ten nursing journals with the greatest impact were qualitative and 39% were descriptive, quantitative and mainly cross-sectional, thus representing the first phase of knowledge, that of discovery. Only 13% were intervention studies and thus representing evaluation. In short this means that 76% of the papers could not provide evidence for how to intervene to improve practice i.e. they could not provide evidence-based knowledge. Setting up intervention studies is challenging and not something one can jump into at the drop of a hat. What is needed is solid knowledge, proper acceptance and integration in practice and, consequently, being part of a research program, a continuous process of knowledge building. The concept of complex interventions in health research in a way portrays this process (9).

### **Integrating research in practice**

Increased integration of research into clinical practice or public health surveillance is an opportunity which, to my knowledge, is neither explored nor sufficiently used in nursing research. It is common in medical research to build up databases/registers for specific diseases, such as cancer, or regarding the health and social situation of the entire population. These databases are an invaluable resource for research and if a country uses personal registration numbers one database can be combined with one or more other databases. This type of infrastructure makes research more cost-effective. My view is that we as nurse researchers could contribute by either working to integrate data essential for nursing care and research into those already existing or by creating additional databases. Working towards combining biomedical and nursing variables can be helpful in furthering the understanding of the interaction between "body and mind". For instance a large data base on women contracting and being treated

for breast cancer (Sweden Cancerome Analysis Network – Breast. [www.scan.bmc.lu.se](http://www.scan.bmc.lu.se)) now has a sub-database exploring the relationship between biomolecular variables and psychological resilience, quality of life, social network and trust in health care/treatment (10). This is thus an attempt to broaden and make use of the biomedical data already collected by integrating nursing and psychological research.

Another approach is to build up specific databases for aspects related to nursing care. An impressive and sophisticated example of this is the research program "Translating research in elder care" (TREC) ([www.trecresearch.ca](http://www.trecresearch.ca)) run by Professor Carole Estabrooks, University of Alberta, Canada. This database covers an area that is not perhaps at the center of medical research, but is certainly at the center of nursing care and research. In addition it is of great interest for most societies for several reasons including quality of care for the older generation, costs and working conditions for those involved. The purpose of TREC, as I understand it, is to advance knowledge translation. This is done by working from several angles, one being creating an infrastructure by collecting data on residents and staff longitudinally, down to micro-level and covering a fair number of Canadian nursing homes. Another part is developing and applying methods suited to the purpose, in particular methods to assess quality of care and staff job satisfaction. Through using these standardized methods in the data base effects of interventions can be studied more efficiently. This highly developed infrastructure and its use to improve care and working conditions in elder care is run in close collaboration with stakeholders, providers and staff. TREC is integrated in practice i.e. it is not only about collaborating but about integration in practice and at all levels of management. Perhaps one key to further developing nursing research is to improve our infrastructure either in collaboration with medicine or independently, depending on the area.

Another way to advance nursing research is to be closely related to, or rather integrated into, practice thereby enabling nurse researchers to pick up the most important research questions or introduce important research questions. This can for instance be done through joint appointments, academy and clinical practice.

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