FROM THE EDITOR – Dr Jackie Jones RN PhD

PROFESSIONAL PARTNERS IN RESEARCH AND WRITING? THE ABYSS BETWEEN THE 'DOERS' AND 'THINKERS' OF RESEARCH.

As we move to our final edition of *AJAN* for the year 2006 it is timely to reflect how research leadership and nurses' roles therein are progressing within the clinical domain. After all, evidence based practice is firmly established in the quality and safety rhetoric of major teaching and non teaching patient care environments.

Professor Gardner in her guest editorial identifies the need for nurses to work more collaboratively as researchers and as clinicians to *'establish truly collaborative research programs involving teams that include basic researchers, clinicians and clinical researchers who are all working on different points of a trajectory strategically and holistically designed to develop, translate, test and evaluate theoretically based nursing interventions' (p.8)*. This is a tremendous ideal and yet trying to make this work in practice, particularly for clinicians who look for results immediately to enhance patient outcomes, presents a far greater challenge than trying to change perceptions of research validity for nursing evolution. A key issue is understanding that, what we espouse versus what we experience in trying to make such research partnerships work, can be significantly divergent.

It may be increasingly important in the future to explore the rhetoric of putting nurses with others to do research and acknowledging and defining what that role means organisationally and professionally. Ask a clinician what research is and compare this to a research 'trained' clinician and you may be surprised by a very different response. An example of research rhetoric is the role of the research nurse who collects data for a clinical team and yet is not involved in any conceptual or analytical role related to the research per se. For all intents and purposes these research nurses are considered to be researchers by some. Other nurses do undertake a more extensive role within the research endeavour and yet may find themselves excluded from being known as part of the research team therefore diluting nursing research capacity in the process.

Undertaking research within a university setting is replete with academic language, academic expectations for scholarship and rigour, and a common groundswell of research 'trained' individuals who have PhD qualifications. Access to the clinical field for research is a valuable and often sought after commodity in the performance driven environment of research funding. Clinical research thinking at the other end of the spectrum, one could argue, seems to focus more on the outcomes, the results per se, rather than the research process. Furthermore there is a paucity of appropriately research 'qualified' clinical staff and as such this can directly contribute to the hindrance of research scholarship. Ultimately developing a 'blind leading the blind' culture where the norm is not knowing what it is 'we' don't know about research rigour and quality.

The complexity of ethical conduct and who owns what in the clinical domain involving patients means research rigour and ethical process is at risk of being clouded by a longstanding medical or professional ownership dimension. Is what is usually a given in terms of access to a patient and indeed their body acceptable and ethical in research terms? As nurses become part of the research endeavour they also become part of the standards that govern research and consequently must increasingly act as advocate for patient participants from within research.

One must question whether nurses in trying to participate as professional partners in research are on a level playing field within the current research environment. Research monies are often awarded in the clinical context to experienced medical researchers thus making it hard for nurses to gain isolated funding or gain experience sufficient to win research monies. We know from contemporary ideas that health care team effectiveness has the potential to enhance or hinder patient/client outcomes. The following questions therefore arise. 'Are teams really fully functioning teams? Do research team members have the necessary knowledge and expertise to participate in and or lead research? If they are clinical leaders are they adequate research leaders? To what degree does the professional and clinical status of an individual influence the degree to which such leaders are held in high regard as researchers? Who are the gatekeepers and therefore providers of safety nets for patients on the receiving end of research.

If a person is a great clinician, skilled in a particular field or procedure does that make the doctor, nurse or allied health professional a great researcher? If they are leaders within the clinical environment what of the role of research experts brought in to help guide the research development and rigor? Are these expert partners truly considered professional partners in research or merely the instruments through which others do research? What also of the role of nurses who are told they are doing research and yet may be the collectors of data for others only.

Collaborative research and research partnerships require the development and acknowledgement of specific skills. It is fair to say that in the main all is not ideal in the collaborative research environment. The research environment of the university is at times, it may

seem, at odds with the research environment within the clinical field. The rigors and expectations of quality in one versus the power, availability of patients and measure of accountability in another provide further challenges for nurses. How does a nurse, for example, actively participate in a research team with research knowledge and expertise yet no clinical power?

It is imperative that nurses know their rights and how to support the rights of others including research participants and fellow nurses or colleagues doing research. A solid place to start is to be aware of and engage in the positions and debates offered by the *Australian Code for the Responsible Conduct of Research* (ACRCR) (2006) jointly authored by the Australian Research Council, the Australian Vice Chancellor's Committee and the National Health and Medical Research Council. These peak research voices, through this joint code, highlight that 'good research conduct arises from a research culture of respect for the truth and for those involved in the research process' (p.11). The code goes on to argue that 'the right to authorship is not tied to either position or profession and does not depend on whether the contribution was paid or voluntary' (ACRCR 2006, p.29). Authorship requires substantial scholarly contribution and as such no person who qualifies as an author may be included or excluded as an author without their permission in writing (p.29). Strategies such as early conversations, full team meetings, joint allocation and development of all written work, shadowing on ethics committees and succession planning for professional partnerships in research can build effective research teams. Mentoring novice researchers in research conduct, research writing, and strategic communication can help develop nurses as professional partners.

We at *AJAN* encourage papers from across the spectrum of novice to expert researcher and across the complex to simple or more basic research trajectory. In addition peer reviewers contribute to the ongoing development of ideas and research ideals through writing, feedback and critique for authors. In this edition research papers reflect the variety of differences between and across contexts such as mental health and general nursing; clinical educators or preceptors bridging the gaps between theory and practice; palliative care in acute settings; and the prevalence of health behaviours such as smoking of health professionals.

The first paper presents a small qualitative study by Sharrock et al that describes the subjective experience of nurses in providing surgical and medical care for patients experiencing mental health problems. Using grounded theory, findings indicated that the nurses were striving for competence in the provision of mental health care and supported the notion that general nurses lack confidence when caring for patients with mental health problems in medical-surgical settings. These authors also make note of the discrepancy between the holistic framework encouraged at undergraduate level and what is experienced in practice.

In the second paper Mcallister and Moyle argue that clinical educators in Australian health settings whilst performing a crucial role in facilitating effective learning for students of nursing are undervalued and under-supported. They motivate students to make links between theory and practice; moving students safely from the known to the unknown; developing clinical skills and reflective practice.

Parish and colleagues present research findings from a retrospective analysis using multiple methods such as case note auditing and interviews of key staff to determine the quality of end of life support provided to an opportunistic sample of patients who died in acute care wards of a 250 bed teaching hospital. They argue that patients who are receiving end of life care in an acute hospital may not experience support which fully reflects appropriate palliative care management.

Gaynor et al systematically reviewed the published scientific literature for studies quantifying or examining factors associated with the attrition of undergraduate nursing students in pre-registration programs and the retention of graduate nurses in the workforce. Gaynor and colleagues argue there is an identified need to systematically track undergraduates and new graduates to quantify and understand attrition, retention and workforce choices within the nursing profession and begin to build a rigorous evidence-base.

In recognising the cultural diversity evident in Australia and therefore in our health care settings, our next paper by Smith reports on a study that used a self-report questionnaire adapted from previous investigations and sent to a complete cross-section of 1162 nurses from a large teaching hospital in southern Japan. The study raises questions regarding specific interventions to address the cultural and social motivations for tobacco usage among Japanese nurses.

Charleston and Happell examine the preceptorship relationship between students' and mental health nurses' in the mental health setting. The range of settings included: adult acute; rehabilitation; and community teams. Dealing with the uncertainty of, and reconciling differences between, the general and mental health environments emerged as a strong theme from the research. The next two research papers reflect our growing international nursing audience and similarity of practice. Khowaja reports on a study using a transurethral resection of prostate (TURP) clinical pathway intervention in Pakistan; whilst Movahedi et al from Iran report on the effects of local refrigeration prior to venipuncture on pain related responses in school age children.

In our scholarly paper Elsom et al focuses discussion on the potential implications for the developing nurse practitioner role on the existing clinical nurse specialist

role. In a context of a lack of clarity Elsom et al argue that the roles of clinical nurse specialist and nurse practitioner may be complementary but fulfil different functions. These authors suggest that in relation to mental health in particular it is important that both roles be maintained and implemented in response to consumer and health service needs.

REFERENCES

AVCC/NHMRC/ARC 2006 Australian Code for the Responsible Conduct of Research (ACRCR) available:
http://www.nhmrc.gov.au/funding/policy/code.htm.