

Nursing Practice  
**Discussion**  
**Research nursing**

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The nursing profession needs to regain control of the research agenda, otherwise it risks becoming subordinated to the interests of academic institutions

# Reclaiming nursing as a research-based profession

RESEARCH CHALLENGES: PART 2 OF 2

## In this article...

- › Why nursing should be in control of its knowledge base
- › Experiential know-how versus academic knowledge
- › Building partnerships between practitioners and researchers

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**Abstract** Rolfe G (2016) Research challenges part 2: Reclaiming nursing as a research-led profession. *Nursing Times*; online issue 13: 1-3.

In part 1 of this two-part series, I questioned the usefulness of nursing research as it is currently conducted. In part 2 I delve deeper into the complex relationship between research and practice, demonstrating how the research agenda is increasingly being set by academic institutions without due regard to the expertise of practitioners. I will argue that the nursing profession needs to regain its influence over three key agendas: research excellence, evidence-based practice and nursing expertise. I also suggest ways to rethink practice and research for the benefit of all involved.

Nursing has long prided itself on being a research-based profession; one in which practitioners identify gaps in knowledge and researchers strive to fill them. In a previous article (Rolfe, 2016), I argued it is in danger of becoming research-led. I could go further and contend that a profession which no longer controls its own knowledge base may not deserve the title of 'profession', and it may be more accurate to say that nursing has become little more than an occupation. In their eagerness to escape from being doctors' handmaidens, nurses have put themselves in danger of being led by university-based academic research instead.

However, it is not too late. Nursing can

regain control of its own knowledge base. To do so, it must be in a position to decide for itself what counts as nursing knowledge, how that knowledge is produced, how its value is assessed and, most importantly, what the relationship between knowledge and practice should be. In this article, I argue that nurses need to regain influence over three key agendas: excellence, evidence and expertise.

### The excellence agenda

'Excellence' has become a widely used – and somewhat abused – term in recent years, not only in nursing but in all walks of life. We are told that we should all aspire to excellence in whatever we do, but – as we might suspect from the fact that the term has been applied to everything, from driving a van to making a bar of chocolate – excellence has no meaning in itself and can adopt any meaning attributed to it.

Readings warns of the slipperiness of the word (Readings, 1996), using the example of a university in the USA that had awarded its estates department 'excellence in parking'; it transpired this was for the department's success in restricting parking on the campus, not making it easier. Readings' point is that whoever controls the 'excellence agenda' has the power to define what excellence means according to their own interest in the matter.

In the UK, the term 'research excellence' has been co-opted by the higher education sector and defined in terms of the Research Excellence Framework (REF), the assessment exercise through which universities are awarded status and funding. For academic researchers to be recognised as excellent by their universities, they must score highly in the REF, which entails

## 5 discussion points

**1** To reassert itself as a profession, nursing needs to regain influence over the excellence, evidence and expertise agendas

**2** In nursing research, excellence is defined according to academic standards, not usefulness for practice

**3** The original intention of evidence-based practice was to empower practitioners, but this has not been achieved

**4** The intuitive understanding of experienced practitioners is disregarded in favour of theoretical knowledge

**5** Practitioners, academics and managers need to reunite practice and research in ways that benefit both the nursing profession, patients and universities

# Nursing Practice

## Discussion

obtaining grants and publishing in academic journals cited by other academics (Rolfe, 2016). Whereas nursing research used to be judged on its relevance to practitioners and its benefits to patients, its excellence is now assessed by metrics largely unrelated to nursing practice.

### The evidence agenda

The rise of evidence-based practice over the past two decades has contributed to a shift in control over knowledge generation towards the academic community. Evidence-based practice follows a hierarchy of evidence that favours randomised controlled trials and quasi-experiments over qualitative research, and qualitative research over professional experience and expertise.

A number of hierarchies have been published over the years, most being strikingly similar. I chose the one shown in Table 1 (Evans, 2003), because it is intended primarily for nursing and offers separate hierarchies for evaluating the effectiveness, appropriateness and feasibility of healthcare interventions. As we can see, systematic reviews and randomised controlled trails (RCTs) are considered 'excellent' forms of evidence regardless of what is being evaluated, and expert opinion is consistently ranked 'poor' alongside 'studies of poor methodological quality'. To me, it seems extraordinary that any profession would support an approach to practice which denigrates its most experienced practitioners in this way.

From this hierarchy and other similar ones, it is clear that decisions regarding the strength of evidence depend on an academic judgement about the validity of the research methods, rather than a clinical judgement on the usefulness of the findings for practice. The most credible evidence derives from large, complex and expensive RCTs, which require resources and technical expertise usually only found in universities. Furthermore, it is difficult to escape the conclusion that the expert opinion of nurses is not to be trusted.

The original vision of evidence-based practice was that every practitioner should individually assess the quality of the evidence for themselves (EBMWG, 1992). However, it soon became apparent that it was not practical to teach all nurses the necessary research evaluation skills; and in any case, few had the time and resources to track down and read the evidence for every clinical decision they had to make. As a consequence, the term 'evidence-based practice' is now usually associated with care pathways, clinical guidelines and

**TABLE 1 A HIERARCHY OF EVIDENCE**

	Effectiveness	Appropriateness	Feasibility
<b>Excellent</b>	<ul style="list-style-type: none"> <li>● Systematic reviews</li> <li>● Multicentre studies</li> </ul>	<ul style="list-style-type: none"> <li>● Systematic reviews</li> <li>● Multicentre studies</li> </ul>	<ul style="list-style-type: none"> <li>● Systematic reviews</li> <li>● Multicentre studies</li> </ul>
<b>Good</b>	<ul style="list-style-type: none"> <li>● RCTs</li> <li>● Observational studies</li> </ul>	<ul style="list-style-type: none"> <li>● RCTs</li> <li>● Observational studies</li> <li>● Interpretive studies</li> </ul>	<ul style="list-style-type: none"> <li>● RCTs</li> <li>● Observational studies</li> <li>● Interpretive studies</li> </ul>
<b>Fair</b>	<ul style="list-style-type: none"> <li>● Uncontrolled trials with dramatic results</li> <li>● Before and after studies</li> <li>● Non-randomised controlled trials</li> </ul>	<ul style="list-style-type: none"> <li>● Descriptive studies</li> <li>● Focus groups</li> </ul>	<ul style="list-style-type: none"> <li>● Descriptive studies</li> <li>● Action research</li> <li>● Before and after studies</li> <li>● Focus groups</li> </ul>
<b>Poor</b>	<ul style="list-style-type: none"> <li>● Descriptive studies</li> <li>● Case studies</li> <li>● Expert opinion</li> <li>● Studies of poor methodological quality</li> </ul>	<ul style="list-style-type: none"> <li>● Expert opinion</li> <li>● Case studies</li> <li>● Studies of poor methodological quality</li> </ul>	<ul style="list-style-type: none"> <li>● Expert opinion</li> <li>● Case studies</li> <li>● Studies of poor methodological quality</li> </ul>

Adapted from Evans, 2003

other recommendations. Even if most guidelines stress that individual clinical judgement should be exercised, it is clear that the expert opinion of nurses is considered to be poor evidence. Whereas the intention of evidence-based practice was originally to empower practitioners to make and justify their own clinical decisions, it now arguably disempowers them by reducing practice to a mere rule-following procedure.

### The expertise agenda

Benner (1984) defined expertise in terms of autonomous decision-making – of knowing the right thing to do based on years of experience. In contrast, novice practitioners follow evidence-based guidelines and practise 'by the book'. Benner claimed expert knowledge is intuitive and hard to put into words, and therefore difficult to document and pass on to others. Experienced nurses cannot tell novices how to practise; they can only show them.

This view of expertise favours the apprenticeship model of education, where students learn by working alongside experts. When nurse education moved into the higher education sector in the 1990s, greater emphasis began to be placed on classroom teaching of theory and empirical research, and the relationship between knowledge and practice was gradually reversed. As a result, experiential knowledge became devalued. Nowadays, academic success is based mostly on well-referenced essays and written

examinations. While nurses still need to pass practice-based assessments, degree classification depends primarily on what Benner called theoretical 'knowing that', as opposed to practical 'knowing how'.

The concept of the expert has shifted from Benner's experienced practitioner who 'just knows' the right thing to do, to the academic who knows how to evaluate research outcomes and apply them to practice. Today it is not uncommon for academics who have not practiced nursing for many years to claim expertise based on having conducted research or written a systematic review on a particular topic. Practising nurses have been demoted from experts in their own right, who make clinical decisions based on their own intuitive understanding, to novices who follow pre-determined procedures.

### Regaining ownership

If nursing is to re-establish itself as an autonomous profession, it needs to regain ownership of the excellence, evidence and expertise agendas. Nurse academics are key to this project, since they straddle both worlds. However, as I have previously argued (Rolfe, 2016), they are often confronted with a choice between acting in the best interests of their university and following their professional code of conduct, which instructs them to 'put the interests of people using or needing nursing or mid-wifery services first' (Nursing and Mid-wifery Council, 2015).

The best – and perhaps only – way to

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Academics and practitioners must help nurses explore and articulate their knowledge

resolve this dilemma is for practitioners and academics to form a partnership and narrow the gap between their conflicting interests. This entails the nursing profession helping academics meet the demands placed upon them by their employers in ways that are more creative and in greater accord with the values of nursing.

### Excellence

The first task of this new partnership is to redefine what excellence in nursing research means. The nursing profession as a whole, from students and junior staff nurses to clinical directors and chief nursing officers, must emphasise to university heads of department, vice chancellors and REF panels the importance of the clinical impact of research. First, we must make the case that research should be judged according to the good it does, rather than the methodology it employs or the journal in which it is published. Second, we must demonstrate new ways of being excellent; for example, through action research, practice development and other small-scale local interventions that have a direct impact on nursing practice and patient care. Third, and most importantly, nurses must involve themselves in these new practices as equal partners.

### Evidence

The evidence agenda is currently controlled by academic institutions with a vested interest in ensuring that RCTs and other experimental methods remain at the top of the hierarchy. Rather than having professional researchers make decisions about how to decide on the best evidence for practice, the nursing profession should be taking back control of this agenda. While few would deny that practice based

on 'best evidence' is a good thing, a model that considers practitioners' expert opinions to be the lowest form of evidence devalues professional practice. At the very least, academics and practitioners should campaign together to 'flatten' the hierarchy. A better idea would be to get rid of it altogether. Rather than judge clinical interventions according to a predetermined hierarchy of research methodologies, we need to develop new criteria by which practitioners can apply their experience and expertise to evaluate the impact of nursing interventions directly on practice.

### Expertise

The expertise agenda is of particular importance, because it is not only research expertise that is at stake. Experience is devalued partly because it is difficult to articulate, so those practitioners and academics with a strong grounding in theoretical and research-based knowledge are held up as experts, particularly if they can also communicate their knowledge articulately. Once the profession concedes that expertise is characterised by theoretical 'knowing that' rather than experiential 'know-how', we might well end up with experts in nursing who are not even nurses. Academics and practitioners must work together for the good of the profession, in order to find ways of helping nurses to explore, articulate and disseminate their experiential knowledge; for example, through reflection in and on action, through clinical supervision and through writing for publication.

### Conclusion

The relationship between research and practice is multifactorial. In nursing, it is

further complicated by the fact that researchers and practitioners answer to employers who often have different goals. Many nurse academics find themselves torn between doing what is best for their university careers and what is right for the profession of nursing. I think the balance has tipped too far in favour of the university. If nursing is to survive as a research-based profession in the true meaning of the term, practitioners, academics and managers will need to reunite practice and research in ways that benefit the nursing profession as well as meeting the expectations of universities. **NT**

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