Résumé

Repenser les notions d'émancipation et d'autonomie en recherche-action : Leçons apprises dans trois petits hôpitaux en région rurale

Martha L. P. MacLeod et Lela V. Zimmer

La recherche-action a pour principal but d'aboutir à des changements sociaux qui auront été portés, dans une large mesure, par les participants et les participantes au projet. Elle repose sur deux grandes hypothèses. D'abord, le fait de prendre part à la démarche de recherche inciterait les participants à devenir des acteurs informés au sein de leur environnement personnel, professionnel ou social, leur procurant par le fait même un sentiment de pouvoir et d'autonomie. Ensuite, les enseignements et le sentiment d'émancipation découlant de cette participation seraient porteurs d'action. La validité de ces hypothèses a été remise en cause au cours d'un projet de recherche-action de type interprétatif mené dans trois petits hôpitaux situés en région rurale au nord de la Colombie-Britannique, au Canada. L'analyse des problèmes survenus au cours du projet met en lumière les rapports interdépendants entre vie professionnelle et vie sociale chez les infirmières. Ce constat oblige à repenser les moyens par lesquels les infirmières évoluant dans ce milieu peuvent parvenir à un certain degré d'autonomie et d'émancipation.

Mots clés : recherche-action, région rurale, infirmières, Canada

Rethinking Emancipation and Empowerment in Action Research: Lessons from Small Rural Hospitals

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A primary goal of action research is social change that is driven largely by the research participants. A major assumption is that through the research process, participants are enabled to take knowledgeable action in their personal, work, or community environments, and that through this action they experience empowerment. Another is that action becomes possible as a result of enlightenment and emancipation through participation in the research. These assumptions were called into question during the course of an interpretive action research study conducted with nurses employed in 3 small rural hospitals in northern British Columbia, Canada. Examination of the issues that emerged during the study illuminates the ways in which nurses' professional and community lives are intertwined. This interconnection provoked a re-examination of how empowerment and emancipation can be realized by nurses in small rural hospitals.

Keywords: action research, rural, nursing practice, Canada

Introduction

Action research in its various iterations is increasingly being used in the development of nursing practice and community health initiatives (Binnie & Titchen, 1999; Royal Society of Canada, 1995; Stringer & Genat, 2004; Wuest & Merritt-Gray, 1997). It has been described as a family of research methodologies that pursue action and research outcomes simultaneously (Dick, 1999), as research that involves participants as partners at one or more of its stages, and as research that contributes to both practical and theoretical developments. One of its precepts is that action and change occur during the research process, with action generally undertaken by the participants, facilitated by those whose role is primarily that of researcher (Stringer & Genat). Through active participation in research on issues that lead to personal, organizational, practice, and/or community change, there is an understanding that action research is emancipatory in nature.

Undertaking action research is rarely straightforward (Meyer, 1993; Reason, 1994; Reason & Bradbury, 2001; Wuest & Merritt-Gray, 1997). The very fact of joint action by researchers and participants through iterative and reflexive processes lends unpredictability to the endeavour

(Binnie & Titchen, 1999; Wuest & Merritt-Gray). Accounts of various types of action research illuminate issues and problems in its use in health-care settings (e.g., Binnie & Titchen; Hagey, 1997; Williamson & Prosser, 2002; Wuest & Merritt-Gray). With few exceptions (e.g., Wuest & Merritt-Gray), these accounts refer to practices within urban settings; issues encountered in doing action research in small rural health facilities remain largely unexamined. With the continuing need for researchers to engage effectively and respectfully in ways that advance health care in rural and remote communities (Lyons & Gardner, 2001), it is important that issues in conducting action research with rural and remote nurses be better understood.

This paper examines the assumptions of emancipation and empowerment in action research in the context of rural nursing practice. The reflection arises from an action research study undertaken with nurses in small rural hospitals concerning their nursing practice and the development of strategies in caring for increasingly diverse patient populations (MacLeod, 1998, 1999). In the course of the study, the nurses said that the researchers had captured their experiences and the nature of their practice accurately and well. They consciously and knowingly declined to take substantive action themselves to change their practice settings, but at the same time asked the researchers to take their story forward to policy-makers and decision-makers in order to effect change. Their decision caused us to re-examine the assumptions underlying action research, particularly their implications in the context of small rural facilities.

Action Research and Its Assumptions

Action research has evolved from and within several different disciplines, for several different purposes; hence various forms have different ontological, epistemological, and disciplinary commitments. All forms of action research, however, encompass systematic inquiry, reflection, learning, and action. All have a goal of social change, be it at a local or a systemic level, driven, to a greater or lesser extent, by the research participants. Explicit attention is paid to power relations within the research endeavour and to the realities of the participants. There is an inherent ethical commitment to improvement and change that is enlightening or emancipatory and may be empowering.

Although usage varies within action research literature, the term *enlighten* generally means to free from prejudice or constrained ways of thinking and acting; *emancipation* refers to actions or reflections that free participants from restraint or oppression, especially social or political restraint; and *empower,* as defined in *The Canadian Oxford Dictionary,* means to "provide with the means, opportunity, etc. necessary for inde-

pendence, self–assertion, etc." (Barber, 1998). The ways in which these assumptions of enlightenment, emancipation, empowerment, and action leading to change are borne out in practice vary amongst the different approaches to action research.

Hart and Bond (1996) argue that awareness of the different types of action research helps researchers to maintain a consistent focus within an action research process. Although Hart and Bond themselves, Holter and Schwartz–Barcott (1993), and McKernan (1991) offer typologies of action research, these are discrete categorizations with limited focus. Hart and Bond acknowledge the dynamic context of action research, developing their typology specifically for practitioners in health and social care. In these typologies, emancipation and empowerment are allocated to a discrete category (Holter & Schwartz–Barcott; McKernan) or towards the end of a continuum (Hart & Bond). Selener's (1997) typology provides a different perspective, one in which the assumptions of emancipation and empowerment can be seen in each of the categories. Selener's delineation arises specifically from the historical and contextual origins of the different approaches.

Selener (1997) suggests that action research has arisen in four iterations: community development, organizations, education (which has broadened to professional practice in several social service and health fields), and participatory research with farmers:

1. Participatory research in community development. In this tradition, concepts of critical thinking, critical consciousness, "conscientization," and empowerment are central, and explicit attention is given to overcoming oppression as a means of shifting social, political, and economic structural power relations (Fals Borda, 1992; Freire, 1970; Maguire, 1987). While social change is directed at a long–term shifting of power relations in community and societal structures, it is accomplished in the short term through practical problem–posing and problem–solving activities at the local level. There is explicit collective attention to overcoming oppression, with a view to liberation and emancipation (Hall, 1984). Importantly, the focus of attention is the collective, with emancipation being more societal than personal in nature.

2. Action research in organizations. The disciplines of social psychology (Lewin, 1946), organizational sociology (e.g., Whyte, 1991), and organizational development (e.g., Argyris & Schön, 1996; Schön, 1983; Stringer, 1999; Stringer & Genat, 2004) have developed action research as a tool for organizational change and development in a variety of management and social– and health–service settings. This form of action research aims to achieve simultaneous problem–

solving, participant learning, and scientific-knowledge generation. Concepts of developmental change, reflection, experiential learning, and organizational learning are inherent in this form of action research, which seeks to make social systems and organizations more effective and efficient through humanistic and consensus-oriented approaches. The ways in which organizational forms and actions can oppress ways of thinking and engaging in change are attended to (e.g., Argyris & Schön), with a view to enhancing individuals' and work groups' awareness of actions or their theories-in-use, in order to humanize and emancipate the organization, its programs, and its workplace environments. The goal is an enlightened organization.

3. Action research in professional practice. Selener (1997) delineates action research in professional practice as a movement originating in the field of education, which has become a broader movement of action research in professional practice. The central assumption is that practitioners will engage in more effective practices if they are actively involved in activities that require them to become researchers and change agents in their own work environments. Central concepts are collaborative inquiry, dialogue, and critical reflection leading to action. While there are some in this movement (e.g., Carr & Kemmis, 1986) who draw on critical social theory and count individual and collective emancipation among the goals, there are others (e.g., Heron, 1985, 1996; Reason, 1994) who focus more on the development among individual practitioners of the "skills of reflective practice" and the development of individual awareness (Centre for Action Research in Professional Practice, 2004). The goal is for professionals to better do what they do by undergoing a form of personal emancipation. Although collaborative inquiry and cooperative action are hallmarks of this approach, the focus is on individual reflection and action rather than directly on the collective. The goal is personal empowerment.

4. Participatory technology development. Selener (1997) suggests that participatory research with farmers is an alternative to the traditional, top-down transfer of technology in agriculture. In this form of action research, collaboration between scientists and farmers occurs in the generation, testing, and evaluation of technologies for improved farming practices. Enlightenment is described in terms of learning about new ways to achieve goals, and empowerment in terms of the knowledgeable adoption of technology.

Underlying all these forms of action research are assumptions about the nature of individual and/or collective agency that will result in empowerment and/or emancipation. There is an assumption that if done

well, the research will enable participants to become aware of constraints on their action, and, through enlightenment, see new possibilities for "being" or for action. It is further assumed that once possibilities are seen and understood, and participants are sufficiently empowered, they can and will find ways of taking knowledgeable action to change their personal, work, or community practices. Individuals or groups will seek to better their individual lives, their workplaces, or their communities, and in so doing become emancipated. These assumptions were not borne out as expected in our study with nurses in small rural hospitals.

Research With Nurses in Small Rural Hospitals

The Hospitals and Their Communities

The study was carried out in hospitals in three resource-based towns in northern British Columbia, Canada, each with a population of less than 5,000 and located more than 2 hours by road from an urban centre (du Plessis, Beshiri, Bollman, & Clemenson, 2002). At the time of the study, each 12- to 16-bed hospital had two nurses on each shift. On any one shift, there could be a baby born, one or more motor vehicle accidents, and patients coming in for minor emergencies or as outpatients for treatments such as with bronchodilators or antibiotics. The acute-care inpatient population was similarly varied, from patients receiving psychiatric crisis response care to patients receiving palliative care, not to mention the extended-care residents for whom the hospital was home. The nurses were required to competently care for a wide variety of patients who, in urban facilities, would be receiving care from specialized teams of nurses and other health-care professionals.

The Study

This interpretive action research study drew largely on a research approach developed to examine the nature of everyday practice in nursing (MacLeod, 1996), coupled with approaches to action research with practitioners (e.g., Carr & Kemmis, 1986). The directors of nursing at the three hospitals identified the focus of the research and invited the first author to undertake the study with them, with the enthusiastic support of the general-duty nurses, in order to address three questions: *What does it mean to care for diverse patient populations? What facilitates and hinders nurses' developing expertise in the care of increasingly diverse patient populations? What strategies are likely to be effective in increasing the flexibility and responsiveness of nurses' practice in very small hospitals?*

Following ethical approval from the University of Northern British Columbia Research Ethics Committee, the study was undertaken in five stages: (1) interviewing and shadowing 24 of the 60 registered and

licensed practical nurses working in the three hospitals; (2) undertaking a hermeneutic interpretation with transcribed interviews and field notes and developing preliminary themes; (3) confirming, changing, and extending the themes with individual nurses and the directors of nursing; (4) developing the constitutive pattern "we're it" and the action plan at a 2-day meeting with participating general-duty nurses; and (5) implementing the action plan. The methods are described in detail in MacLeod (1998).

During stage 4, nine participating registered nurses, three from each hospital, discussed the preliminary themes and issues and identified the central pattern of their work. They settled upon the phrase "we're it" to depict their experience of being nurses in these small rural hospitals. Themes centred around the demands of handling complex situations with little backup and few resources, the impact of distance on their practice and learning, and the centrality to their practice of being in and of a small community (see MacLeod, 1998). The nurses identified ways in which their practice and the development of their expertise were facilitated or hindered. Then they looked at where they might focus any actions.

Issues in Practice: Areas for Action Strategies?

The nurses identified four factors that helped or hindered the development of their practice: teamwork, decision supports, education, and administrative and clinical support. Although they identified actions that they and their colleagues could take to partially address these issues, they noted how the issues were largely organizational and structural in character.
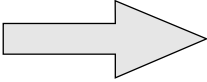
Teamwork. In these small hospitals, the two nurses who made up each shift were the only personnel in the facility between 5 p.m. and 8 a.m. The ways in which the two nurses worked as a team, and in conjunction with the physicians, significantly affected the quality of care they could give and the ways in which their own abilities could be mobilized. The nurses spoke of situations that went well because they were paired on the shift with a nurse whose expertise complemented their own, so they were able to pool their knowledge and skills. At other times — for example, when very junior nurses were paired — they felt their collective lack of knowledge hindered the quality of care they could give. They had no one readily at hand to help fill in their knowledge gaps. While the directors of nursing did what they could to staff the hospital with well-matched pairs, the collective-agreement terms governing work rotations and the small pool of nurses limited what they could achieve.

Communication was a central issue in nurses' working relationships with physicians. Although many nurses discussed situations of working smoothly as a team with physicians, they also described many situations characterized by a lack of respect and support for the nurses' knowledge, skills, and practice. The nurses identified many possible reasons for difficulties with physicians, including differences in education and experience; high turnover of physicians and/or nurses, leading to difficulties in knowing and trusting each others' judgements; differing expectations amongst physicians; and differences in the status of nurses and physicians within the community.

Decision supports. At the time of the study, there were few practice guidelines available to the nurses. For example, there was wide variation within and among the hospitals as to how independently nurses could initiate minor treatment. There were few decision supports promoting consistency in the primary-care activities that made up much of the nursing practice in the emergency room. The nurses spoke of "that frenzy of no consistency here…" and of orienting new nurses — "this is how I do it, when you work with so and so they're going to be doing it differently, so pick and choose what you like to do and go fly at it." The variability of practice created conflicts among nurses, and between physicians and nurses. In order to create supports for the more independent practice that the nurses were required to assume, particularly when physicians were not readily available, professional practice changes were needed. For example, in order to adequately support the daily practices of treating minor conditions and dispensing small amounts of pain medications at night in communities without a pharmacy, changes were needed in hospital, regional, and professional association policies, as well as in provincial regulations.

Education. While the nurses thought that relevant basic education was critical, as was accessible continuing education in such topics as advanced cardiac life support and neonatal resuscitation, education itself was not as large an issue as anticipated. Nurses did talk about the need to have "knowledge in their fingertips," and how difficult that was to achieve in rural facilities. They said they would like more education, including opportunities to travel to regional and provincial centres. Far more important for them, however, were workplace supports for using their knowledge and incorporating it into the fabric of their practice. The nurses talked about learning new approaches to patient care through reading, courses, meetings, or workshops, or from locum physicians. They spoke of many instances where they had identified a problem in practice, and where, by themselves or with a small group, investigated it and attempted to make changes (see MacLeod, 1998). The directors of

Table 1 *Taking Action?*

Thoughts when planning research	We expected that the research would	We found that
Issues and problems are not known but likely can be addressed by focusing on: • nurses' practice issues • education • local, fixable systems	• illuminate practice and experience • raise awareness	• most significant issues were systemic and organizational • actions to change systems would be risky for nurses
	• engage nurses in action • begin to resolve/address issues • result in better practice and empowered nurses	• nurses decided to stay at the level of illumination, opting to raise awareness more broadly • nurses did not take direct action • researchers took action at nurses' request

nursing usually applauded these efforts, but for a variety of reasons were seldom able to put in place the structural and organizational supports needed to maintain the innovations.

Administrative and clinical support. The directors of nursing said how difficult it was to achieve economies of scale in small facilities, including achieving appropriate levels of local management and leadership. During the study and shortly afterwards, all three hospitals underwent leadership changes as part of a new regional structure. The strongest call from nurses in the study was for on-site clinical leadership by a person, working directly with nurses and sanctioned by both the organization and the nurses, to provide continuity and coordination of care, as well as to facilitate practice standards. They asked for "somebody to back us up one way or the other," to make sure that clinical decisions were enacted consistently and to hold staff accountable for implementing agreed-upon practice changes.

Taking Action: Changing Practice?

Initially, the directors of nursing and the researchers had expected that the action would come in the form of initiating new practices, protocols, or educational endeavours within the workplace itself. We held this assumption on the basis of initial discussions and support for the project by the hospital boards, the hospital administration, and the nurses themselves. It was expected that the research, by illuminating everyday nursing practice, would help to empower the nurses to engage in specific actions within their workplaces. The focus of action changed when the nurses identified the priority to be enhanced organizational and structural supports — areas in which they had no immediate or direct influence (Table 1).

The research illuminated previously hidden or taken-for-granted aspects of everyday practice. The nurses said they also gained new insight into their practice. They were enlightened about their work and their work situation. As one nurse said, "You're seeing yourself in a mirror by looking at it, so then all of a sudden you might have more [ways to act]."

Despite their new awareness, the nurses declined to focus their efforts on ward-based actions. Among the nine nurses who engaged in the planning session were informal leaders from each of the hospitals, who said they had repeatedly tried to implement change but, without the required structural supports at the hospital and regional levels, the changes were always transient and limited. Importantly, the nurses said that they were not inclined to continue to work on "band aid" solutions of implementing local actions when they saw that, over time, these had not changed the continuing issues in their worklives: "It hasn't been fixed in 16 years of working." At the same time, the nurses took some small actions

as a direct result of the research. For example, the nurses in one facility returned to their hospital following the group discussion and were able to coherently name their need for clinical leadership to their administrator. In moving from one facility to another, the first author shared information about money- and time-saving autoclaving practices in one hospital that were subsequently investigated and implemented by individual nurses in another. The nurses found coming together for conversation during the planning meeting to be helpful for sharing ideas and making new professional connections. Nevertheless, they declined to generate and systematically test any action strategies that might improve the flexibility and responsiveness of care, something they had outlined as a research goal.

The nurses stated that in order for change to happen, others needed to understand their practice. Much of their work continued to be taken for granted and unrecognized in their communities and organizations. Changes were needed at the organizational and structural level, including the education of decision-makers about the nurses' everyday world of work: "First of all we have to educate the administrator into what the nurse does. But there has to be some structural basis… The weakest linkage is organization, clinical leadership policies… [We need] to identify how we see ourselves as nurses, because they probably don't see us that well."

The nurses instructed the researchers to tell their story to the hospital boards (now the regional board), to the local communities, to the ministry of health, and to the broader professional community. As one nurse said, "Somebody coming in and talking to administration may make them see us from a different point of view, because we can't get them to see us." They wanted the researchers to present the findings to their employers, communities, and planners. As a result, the researchers engaged in discussions with managers and policy-makers across northern British Columbia and throughout the province. The findings were included in provincial health human resource planning and regional nursing strategic planning, and formed the impetus for a national study of the nature of rural and remote nursing practice (MacLeod, Kulig, Stewart, Pitblado, & Knock, 2004).

Despite the fact that they gained awareness about their practice through the research, the nurses in these small hospitals did not believe that changes they might initiate would be successful over the long term. Some had tried for years to make changes that were not sustained. They felt that the problems were deep-seated, requiring systemic and organizational action, and that it would not be prudent for them to act. Although the nurses became enlightened, it cannot be said that they became emancipated or empowered: direct action by the nurses was not forthcoming.

Revisiting Assumptions

Although making change in organizations always carries a degree of personal and professional risk, we became aware during the course of this research that system-directed actions in small hospitals can be particularly risky. The literature on action research in organizations and professional practice tends to treat action as non-problematic — as something that, with sufficient enlightenment, persistence, and the right approach, is possible (Reason, 1994, 1998; Stringer & Genat, 2004). In our study we did not find this to be the case.

Action

The personal nature of small communities permeates the everyday actions and practices of the nurses; it is sometimes enabling and sometimes constraining. In small communities, nurses know and are known by community members. This provides them with a unique understanding that enables them to tailor their practices to the people who arrive for care — to give what they name as "more personal care." At the same time, it can cause difficulties in professional and working relationships. As one director of nursing said, "There's no way you can speak to people and not be personal in a small community or a small hospital."

Nurses in small communities not only face co-workers or patients at work, but they face them as neighbours as well. In one small community in the study area, some residents wished to change garbage pick-up policy. Many community members signed a petition, which they presented to the village council. The garbage collector, who was also a member of the community, went to several of those who signed the petition asking why they were not happy with his work. Even though the petition was about policy, not performance, the garbage collector personalized the issue. At least one of the people he had contacted feared that the garbage collector would "hold it against her that she signed that petition," and that his feelings would last for years.

While such personal accountability is positive, it can also inhibit action. This is also the case in small hospitals, when one nurse hesitates to speak to another about her performance because her husband is the first nurse's boss: "There's all kinds of issues about families, about somebody's daughter who is engaged to somebody else's son, or married to somebody's cousin." In a small community, actions in one area of life frequently impact directly on another. Even though positive community collective action and organizational change take place in these small communities, the nurses are very careful about where and when they rock the boat. They have more to lose than their jobs.

Enlightenment

By telling their stories and having their practice reflected back to them in words that resonated but were beyond their own, the nurses gained a new appreciation of their work, were able to better articulate their practice, and gained insight into what helped or hindered it. It was at this point of newly seeing the organizational and structural constraints to their practice that the nurses declined to take local action. They told the researchers that we had heard them correctly and had accurately reflected the realities of their everyday work in our interpretations and reports. Through our "getting it right," the nurses came to see the researchers as trusted allies. The nurses asked us, as credible outsiders, to take their story forward to policy-makers and decision-makers, to seek broader change. Through the researchers, the nurses felt their voices could be heard. We did not face the same risks as the nurses and their directors of nursing, risks that come with being integrally involved in small communities and small health-care organizations.

Emancipation

Underlying the implementation of personal, organizational, and social change in action research is the understanding that people individually or collectively are oppressed. Hospitals have long been seen as bureaucratic environments in which nurses' practices are constrained or oppressed in some ways. Small hospitals are no exception. In these small hospitals, the nurses' responsibility, authority, and autonomy frequently were neither in congruence nor supported. As a result, the nurses experienced an onerous burden of responsibility in their everyday work (MacLeod, 1999). They spoke of many frustrating situations, where they had to act without sufficient policy or practice backup because there were no other options if patients were to receive care. The nurses were well aware of the oppressiveness within their own work situation, but it would be difficult to describe them as oppressed people overall. In their own towns, they were leaders of community health initiatives as well as leaders in school and sports activities. As nurses, they were well respected for their knowledge and skills. Even within their own facilities, the nurses were able to find ways to be creative in their practice and improve the care for their patients, at least on their own shifts. They were frustrated in trying to make more systemic or lasting change within the hospital. The nurses may have been oppressed — but only in a portion of their lives.

Empowerment

In deciding whether to engage in action, the nurses said they had to consider more than just taking on another project. Because of the character

of change needed, they were faced with making choices about their worklives and their lives as community members. In the hospitals at the time, persistent difficulties with leadership and organizational structure meant that the nurses' burden of responsibility was not acknowledged or relieved by supports needed for nursing authority and autonomous practice. Fostering empowerment in this context was difficult for both nurses and their nursing managers. Unlike large urban settings, where hospital work and community life are clearly separate, in small communities the two are intertwined. The gains for the nurses needed to be considerable in order to outweigh the risks of some actions. The nurses could have a lot to lose as neighbours and as community members if they were to take the kind of actions needed to make systemic and organizational change.

Action Research in Small Hospitals: Fulfilling an Emancipatory Intent

Perhaps the most important lesson that we learned about action research during this study is the effect of the small community context on how we might fulfil an emancipatory intent. In order to achieve empowerment and social change that is emancipatory, the focus of action and the ability of the participants to take that action must be congruent. If the barrier to improving nursing care and engaging in more responsive practice within a supportive environment is individual nurses' lack of knowledge, then the agency for action may more appropriately rest with the individual, or the team. However, if the barrier is organizational or structural, such as the lack of clinical leadership in facilitating practice that integrates that knowledge, then agency needs to rest elsewhere. Action on the part of the organization, the administration, or the board, or a collective action to change inherent power relations, is called for. In small communities, actions in work environments cannot be understood in isolation. Just as the hospital is in and of the community, so are the nurses. Actions that may be prudent for nurses to take in a larger organization or community may not be so in a small community. For changes to successfully occur within rural and remote health-care organizations, they need to be in keeping with the ways that change is possible within their communities.

When nurses engage in examining their taken-for-granted practices and the relational nature of their ongoing work, there is an opportunity to see new possibilities. In action research with professionals, the goal of increased awareness and enhanced personal learning is sometimes seen as a sufficient outcome, with the assumption that changed practice will follow increased awareness (e.g., Carson & Sumara, 1997). In working with health-care professionals in small communities, it is incumbent

upon researchers to ensure that their expectations and willingness to act remain in concert with the kind of agency required in that situation. Researchers may find themselves with different-from-anticipated roles to play. One such role may be to develop "spaces for conversation and dialogue" (Smits, 1997, p. 293), both at the local level and beyond — spaces that will enable actions that are inherently and ultimately empowering for rural nurses and their practice.

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