Illustrating the ethical dimensions of action research

Graham Williamson and Sue Prosser discuss the ethical dimensions of action research, informed by their experiences of participation in an action research project in the workplace.

Key words: action research, lecturer practitioners, ethics in research, research methodology

Introduction

Lecturer practitioner (LP) roles are no longer new in the United Kingdom (UK), having been established initially in the 1980s to overcome the theory/practice gap in nursing (Lathlean 1992). Teachers were seen as being far removed from practice, while practitioners did not know about the theoretical elements that might inform their work (Cave 1994). This perceived situation was widely regarded as a ‘problematic, even embarrassing sign of failure within education, practice and research’ in nursing, which it was essential to rectify (Rafferty et al 1996). Furthermore, as Lathlean (1992) discusses, a long history of ‘ideological differences between school and service’ meant that students were ill-prepared for the reality of work after qualification.

The current political climate and policy context are favourable for higher education institutions and trusts seeking to strengthen the links between service and education (Fairbrother 2000, Waters 1999). There are explicit calls from government to expand the number of LPs in order to support pre-registration students. For example, the Department of Health (1999) calls for a strengthening of pre-registration education and training, with better teacher support a priority.

However, there are several problems with the role. Although introduced to bridge the theory-practice gap (Hewison and Wildman 1996), some LPs do not see this as their primary role (Lathlean 1992, McCrea et al 1998), or do not actually work with pre-registration students (Fairbrother...
2000). There are varying definitions and conceptualisations of the role (Elcock 1998), and this is reflected in a lack of clear job descriptions for role occupants (Woodrow 1994). Authors also discuss role conflicts resulting from conflicting demands from ‘service’ and ‘education’, resulting in overload for post-holders (Hollingworth 1997). There are also conflicting expectations of staff development for role occupants, a lack of career structure, and a lack of personal and professional support for role holders (Fairbrother and Ford 1997).

Preliminary work at our institution found that LPs were described as ‘adding value’ to education provision by students, managers, and the LPs themselves, and that they gained a great deal from their roles both personally and professionally. However, their key concerns were an absence of role clarity (particularly in the initial months of employment), absence of effective joint review/appraisal (because university, NHS trust managers and LPs themselves frequently did not meet together to review the roles), and absence of formal support (Williamson and Webb 2000, 2001).

In order to develop aspects of LPs’ work roles and their employment position, establish formal support for post-holders, and facilitate joint appraisal and effective induction to the role, we established an action research (AR) project, entitled ‘Developing Lecturer Practitioner Roles Using Action Research’.

We will begin by outlining the key features of an AR approach, and then discuss how the political and ethical aspects of participation in AR are potentially problematic for those working in their own organisations. These observations are illustrated with personal reflections made as a result of participation in the project.

*Action Research approaches*
For Waterman et al (2001) action research is: ‘a period of inquiry that describes, interprets and explains social situations while executing a change intervention aimed at improvement and involvement. It is problem-focused, context-specific and future-oriented.’ AR is a critical social activity, relying on participation and collaborative working to generate change and new knowledge. One of the benefits of such an
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approach is the emphasis on using experiential knowledge to inform an agenda of change in aspects of practice, and this is particularly valuable when practitioners are marginalised in some manner (Winter and Munn-Giddings 2001).

A ‘spiral’ framework is utilised, and although this may vary between projects, there is typically a planning phase, an action phase, an evaluation phase, and a reflective phase, where the newly-changed practices can be further investigated and the spiral re-visited (see Figure 1). The spiral should not be rigidly adhered to, but should be flexibly applied, allowing researchers to move seamlessly between phases, and it should have an emphasis on critical personal reflection (Winter and Munn-Giddings 2001).

figure 1: Typical action research ‘spiral’ framework

Developed from the pioneering work of Kurt Lewin (1946, 1966), AR has been used by workers seeking to develop practices in their own organisations. It has also been utilised by external facilitators in industrial settings (Weiskopf and Laske 1996), and by nurses working to develop elements of patient/client experiences of health and illness (Koch et al.
AR is democratic and participatory, with the aim of developing a more just or more satisfying situation for the stakeholders (Greenwood and Levin 1998).

In nursing, ‘the over-arching aim of action research has been to improve professional practice and raise standards of service provision’ (Morton-Cooper, 2000). Although AR is more strongly associated with changing nursing practice (Nolan and Grant 1993), it is also discussed as a vehicle for generating new knowledge grounded in the reality of nursing practice (Walters and East 2001, Waterman et al 1995).

However, if AR has potential for changing practice and generating new knowledge, it can also be politically and ethically problematic. A feature of AR is that participants require a close and collaborative working relationship, but this is very different from other research approaches. In both qualitative and quantitative research, the emphasis is on data collection ‘in the field’, with ‘research subjects’, and the analysis and interpretation of findings by ‘expert’ researchers. While some qualitative researchers, most notably feminists (McKie 1996, Oakley 1981) and focus-group practitioners (Kitzinger and Barbour 1999) acknowledge their proximity to those they are studying, and seek to make data collection more democratic, there are still degrees of separation and boundaries in these approaches between researchers and subjects. These are much less pronounced in AR because the researcher is a part of the situation as well as being a student of it.

In AR, then, there is greater ‘exposure’ than in other research approaches. This can have particular consequences for those working in their own organisations, but these are rarely discussed in the nursing literature (Coghlan and Brannick 2001). We argue that AR is politically different from other research approaches, and that there are ethical dimensions inherent in the methodology, factors that raise three important ethical questions for action researchers.

The political dimensions of AR
For Coghlan and Brannick (2001), AR is explicitly political for those working in their own organisations. Although ‘insiders’ have advantages over external facilitators because of their privileged access to documents
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and personnel, their AR work is imbedded in the organisation’s microclimate of personalities and relationships. This can create a role duality (Coghlan 2001) where AR researchers’ ‘work’ lives conflict with their ‘research’ lives.

Power and control issues in organisations also mean that the judgements researchers make in diagnosing issues may not be welcomed by superiors, as they question organisational and individual practices, norms and beliefs. Action researchers seek to generate useful information to inform decision making and foster choice, but this information is intensely political because it is focused on change (Coghlan 2001), and AR researchers must actively manage the politics of the organisations in which they work.

Some nursing studies consider the ‘insider/outsider’ debate, but generally give only a limited picture of the issues, as they are written by ‘friendly outsiders’ rather than permanent members of the team (Coghlan and Casey 2001), rarely discussing issues of power and control in organisations. For example, Titchen and Binnie’s (1993a, 1993b) work is concerned with enhancing data collection and analysis in their project relationship. Webb (1989) discusses relationships in one practice setting. Koch et al (2002) note their success in a ‘bottom-up’ approach in several AR projects with various client groups, saying that managerial support is important, but give no further detail. Thus AR studies in nursing frequently underplay political concerns relating to organisational life inherent in AR methodology, the extent of political dissonance experienced, and the career concerns there may be for AR workers (Coghlan and Brannick 2001, Williamson and Prosser 2002a). These concerns strongly influence the ethical dimensions of AR.

The ethical dimensions of AR
AR is frequently discussed as an ‘ethical’ activity in itself. Stringer (1999) discusses ethical issues in AR as relating to the worth or value of the project: AR is conceptualised as an inherently moral undertaking because it engages individuals in a dialogue with other members of their community to improve some aspect of community living or work practice. Thus, for Stringer, the underlying ethical principles involved in
AR concern the expression of human values between participants. This is discussed as similar to standpoint epistemology, emphasising how a meaningful understanding of a situation can be constructed only by starting with the experience of individuals and groups themselves.

However, Stringer’s (1999) view neglects other ethical dimensions of AR. Williams (1995) notes the ethical confusion surrounding the potentially conflicting roles for nurses in AR, saying that the multiple roles of the ‘insider’ action researcher mean that a participant disclosing sensitive information may not be clear to whom information is being disclosed – the researcher, the colleague or the friend – as each role exists simultaneously in one person. This type of dilemma is arguably unavoidable when researchers work in their own organisations, whether with patients or other members of staff, and contributes to AR as a stressful activity in which nurses are likely to need significant personal support (Webb et al 1998).

There are further ethical dimensions arising from involvement in AR. In research, ‘subjects’ are commonly ethically protected by researchers undertaking not to do them harm, to maintain their confidentiality and anonymity, and to ensure informed consent, honesty, and their right to withdraw (Coghlan and Brannick 2001, Winter and Munn-Giddings 2001). While AR takes place within this framework, there are several areas in which AR is ethically much less clear, and these require clarification at the outset of the project, and negotiation throughout, in a manner which other research approaches are less likely to require. We illustrate these areas with details of our own AR project.

Firstly, given the political nature of action research, it is very difficult to guarantee confidentiality and anonymity. Others in the organisation will know who participated, and although data collection and analysis can be made confidential and anonymous, completely disguising data in finished reports may be difficult (Lathlean 1996, Morton 1998, Webb et al 1998). For example, in our study, as SP noted in her reflective diary, it was obvious to others in the organisation who participated in the study because the numbers of LPs employed was relatively small. Often meetings and focus groups consisted of eight people, and this meant that although GRW guaranteed to make sure that the names and other
identifying details were removed from transcripts and analyses, this small group was easily identifiable to their peers. In addition, SP reported feeling personally very strongly identified with the work.

Secondly, as AR is a journey and evolves through participation, reflection and purposeful action (Hope 1998), so ‘informed consent’ is a more difficult concept than in other research approaches, where studies are likely to be conceptually more developed and planned. If neither researchers or participants know where the journey will take them in advance, they cannot fully know to what they are consenting when they agree to participate (Meyer 1993). In Lathlean’s (1996) AR work with trainee ward sisters, for example, participants might have been protected in data collection, but they could not refuse to be observed at work: they had consented to ongoing involvement by taking up their ‘trainee’ posts, and withdrawal or sabotage might have severe consequences for their careers. For Meyer (1993), continued co-operation in AR is frequently forced, and this contradicts the ethos of willing collaboration. There may be opposition among members of a ward team, but this may be suppressed by the general consensus.

For example, in our study, SP reflected in her personal diary that even though she was asked to give verbal consent to participate, nobody involved initially had a realistic understanding about what they were consenting to; the nature of AR meant that the project goals were unclear at the outset. Thus proximity and participation may be seen as simultaneously offering strength in terms of changing and developing practice, but offer ethical weaknesses.

In AR, this sort of dilemma is doubly serious because of participants’ potential lack of anonymity and confidentiality, meaning, lastly, that the protection of subjects from harm can be also problematic: for example, in our study GRW wrote in a reflective diary account: ‘I really didn’t like the way in which speakers might be identified from the issues I mentioned [at a meeting], and it put me in quite a quandary. I could be breaking confidences by discussing these issues publicly (although I really didn’t name any names and only referred to issues quite broadly, I’m quite sure people knew exactly what and whom I was talking about). If there was
any comeback for individual LPs, this would break up the trust that I need to be able to function in this capacity, and would be a disaster because then no-one would want to disclose any information in the focus groups that I need to do to generate evaluative data and suggestions for the future.’

Again, such dilemmas are central in AR, and their resolution is likely to be a central issue in AR studies if those involved are willing to participate voluntarily, rather than as a result of coercion.

Possible solutions
Several solutions to the ethical dilemmas we have identified are possible: the establishment of ethical codes in AR, ‘transparency’ and external scrutiny, and the issue of ‘ownership’ of the project work and findings.

I argue elsewhere that although ethical codes may appear desirable in AR, this approach is unlikely to be effective, as practical and philosophical problems in the construction of such codes apply to AR just as they do elsewhere (Williamson 2001, Williamson and Prosser 2002b), as if fixed, external rules were established, these could not take into account the variety of situations researchers may experience, and so could not adequately guide action. More useful than establishing ethical codes is the concept of professional morality in nursing (Williamson 2001), and the idea of transparency through external scrutiny.

So, it is necessary to rely on nurse researchers’ sense of professional morality when they are working ‘in the field’ in AR work, and to establish structures for research governance. In our study, important transparency was established in the form of a steering group, to which GRW was required to describe and discuss the development of the project, in addition to the usual research degree supervision. There was also a degree of scrutiny established in the form of other meetings and public fora, for examples with senior nurses from local NHS trusts. Materials were also constantly accessible to participants and managers on a website. So, issues concerning the conduct, development and findings of the study were discussed openly. While this might offer ethical threats in the sense that these fora are potential sites for breaching confidentiality, as discussed above, it also ensures that participants are protected from ‘manipulation’ by a researcher, who also receives senior guidance on the conduct of the study.
Lastly, the issue of ‘ownership’ is important in AR studies: in fully collaborative projects, researchers and participants have equal responsibility for findings, and therefore the political and organisational consequences. But, in reality there are usually ‘lead’ researcher/facilitator(s) (Winter and Munn-Giddings 2001); the ward-manager seeking to change practice, or a university academic developing aspects of clinical or organisational practice. Where ‘insiders’ take a lead role, it is possibly easier to negotiate and secure ‘ownership’ of findings, because researchers and participants are likely to be in closer contact. Where the researchers are ‘outsiders’ or external facilitators who may ‘project manage’ the AR work before moving on, they must be clear that participants accept and verify the report so that responsibility is shared. So, formal procedures are required for participants to evaluate findings before work is more widely disseminated within the organisation and the academic community. Such procedures are already common in qualitative research, in the form of ‘participant feedback’, which ensures that the researcher has adequately understood what was meant by the participants. This ‘member checking’ (Kreuger 1994), or ‘member validation’ (Bloor et al 2001) allows participants to comment on, rather than amend, the researchers’ preliminary interpretations. Such procedures are frequently not acknowledged in reports of AR, as the assumption is that close collaboration and participation alone ensure joint ownership of findings. In our study, the preliminary work was discussed at two ‘feedback events’, and following small group work, policies were formulated and piloted, and their impact assessed in a focus group.

Yet, if, as Coghlan and Brannick (2001) argue, action researchers are key change agents, they have a duty to protect their co-researchers. They must therefore be willing to take special professional and personal responsibility for obvious harm, and for the interpretation discussed in published work, and might legitimately ‘shelter’ less powerful or more vulnerable participants if required (Kelly 1989, Williamson and Prosser 2002a).

**Conclusion**

Using AR to change practice and generate new knowledge involves practitioners in difficult political and ethical dilemmas, which are made
more complex than in other research approaches by the researchers’ relationships with participants. AR is currently growing in popularity in health care and nursing (Waterman et al 2001), and so it would appear that many more nurses and other health care professionals will participate in AR projects. We suggest that potential action researchers and participants attempt to clarify by discussion and negotiation how these political and ethical questions are to be addressed in their work before they begin, and re-visit these ideas during the course of their projects. In this respect, AR requires constant and sensitive dialogue between those involved, rather than the establishment of formal ethical codes, which are not likely to be helpful (Williamson 2001, Williamson and Prosser 2002b) as this is a feature of its methodology. We would also recommend that there is the maximum ‘transparency’ and external scrutiny in the project management of such work, and that participants working in their own organisations are clear about issues of ownership of the written products of their work.

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