

McNiff, Jean, Edvardsen, Odd and Steinholt, Margit (2018) 'Impact', educational influence and the practice of shared expertise. *Educational Action Research*, 26 (5). pp. 803-819.

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<https://doi.org/10.1080/09650792.2018.1426469>

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The Practice of Shared Expertise

Jean McNiff, Odd Edvardsen and Margit Steinholt

Introduction

The main aim of this paper (about how we understand 'impact' in relation to the principles and practices of different traditions in action research in health and wellbeing) is to contribute to a growing body of literature that places local practitioners at the centre of enquiries and practices in health and development work; a secondary, embedded aim is to challenge systems of thought that see progress as moving towards a designated end point (a traditionalist view that informs orthodox forms of social science research) rather than as what people do as they create themselves in company with others (a pragmatic, contingency approach as found in action research). While the focus in the paper is on promoting health and wellbeing in international contexts, the ideas may be relevant for all development work, including the professional education of practitioners across the professions. We argue that patients' and participants' local knowledge is core to any understanding or practice of healthcare or development and that all should be actively involved in promoting independence, not just tackling disease (Crisp 2010, vii). We agree with Chambers (1993), Crisp (2010) and Chilisa (2012) that combining the local, insider knowledge of patients, participants and villagers with the expert outsider knowledge of doctors, nurses and development workers can provide a powerful resource for communities' accelerated development. We also argue that the success of programmes depends largely on the extent to which local insiders themselves take, or are allowed to take control of their practices: in our view, all participants, regardless of role or positioning, should be seen as actors who are entitled to come together on an equal footing to discuss and decide how they should live their lives. This view informed the research project outlined below.

We agree with definitions such as that by Hefce (2016), that practices should demonstrate 'an effect on, change or benefit to the economy, society, culture, public policy or services, health, the environment or quality of life, beyond academia' (<http://www.hefce.ac.uk/rsrch/REFimpact>): demonstrating 'impact' therefore becomes about evaluating the quality of those practices intended to influence processes of change and the practices that become their effects. We also argue that all practices, not only those in academia, should aim to do the same: in our view, showing a willingness to consider and demonstrate the effect of a practice for other people communicates an ethical commitment to the future. Peat (1995, 7) comments that the traditions of the Iroquois people stipulate that 'in arriving at a decision they consider its implications right down to the seventh generation that comes after them.' Perhaps we would all do well to do the same. And adopting this view also suggests that practices should be seen as contingent, situated in wider cultural, historical, political and social discourses, and should be interrogated in relation to whose interests they potentially serve. This means, therefore, locating the notion 'impact' within a lifeworld focus of dynamically evolving practices.

However, this view of the exercise of emancipatory potentials has implications for the field, mainly because it flies in the face of currently orthodox corporate and higher education international development health practices (Easterly 2006); here is where the values of techno-rationality and self-service feel most at home. Easterly also (2013) speaks of 'the tyranny of experts', the idea that only 'official' knowers are qualified to think and act in

relation to others' practices and that only they are qualified to evaluate insiders' practices (see also Herr and Anderson 2005). It also poses a challenge to the current epistemological hegemony that maintains that:

- there is 'one right way' of doing things;
- the production of new knowledge can take place only 'in relation to a prior citational world and an imagined world of specialised professional readers' (Appadurai 2000, 10);
- 'results' may be demonstrated through a rational positivist form that aims to establish causal relationships and celebrates the randomised controlled trial of experimental methods and predictable, measurable outcomes (see also Thomson 2015, 309).

These were, in fact, the methods most familiar to the medical and clinical professionals involved in the action research project told here. This project, initiated in 1999, involved us three authors working collaboratively and at different times across the years with other European professionals and with local trauma surgeons, nurses and midwives. We three authors are: a Norwegian clinical nurse located in a Norwegian university setting, a founder-member of the project in 1999; a Norwegian obstetrician-gynaecologist affiliated with a rural Norwegian hospital, involved in the project since 2005; and a UK university-based education professional, working in UK and international settings and involved since 2013. The aim for this phase of the project, now located in post-conflict Cambodia, was to contribute to the development of new social and professional structures and practices that would contribute to a more sustainable future for all. The data for this paper are drawn specifically from work conducted since 2005 in Cambodia.

Conceptual frameworks

We draw specifically on two concepts from the literatures to help frame our ideas: these are, first, Alasdair MacIntyre's (1981) distinction between the concept of a practice and the role of institutions; second, Hannah Arendt's (1958) theory of action.

Alasdair MacIntyre's (1981) distinction between the concept of a practice and the role of institutions

We do not entirely agree with MacIntyre's concept of a practice: in our view, 'practices' are what we do intentionally as thoughtful practitioners, different from unreflective 'actions' such as tripping over. However, we do find useful the distinction MacIntyre draws between practices and institutions. A practice, he says (MacIntyre 1981), may be understood as:

... any coherent and complex form of socially established cooperative human activity through which goods internal to that form of activity are realised in the course of trying to achieve those standards of excellence which are appropriate to, and partially definitive of, that form of activity ... (p. 187).

MacIntyre also makes a distinction between the nature and purposes of practices and institutions. Institutions, he says:

... are characteristically and necessarily concerned with what I have called external goods. They are involved in acquiring money, power and status as rewards. Nor could they do otherwise if they are to sustain not only themselves, but also the practices of which they are the bearers. (p. 194)

Further, we suggest, such institutional activities, especially those in corporate settings, may be seen as symptomatic of what Habermas (1972) calls 'systems' rather than of the everyday lifeworld practices of practitioners (de Certeau 1984), with considerable consequences for all concerned. These lifeworld practices are the contexts most relevant to Hannah Arendt's (1958) theory of action.

Hannah Arendt's (1958) theory of action

Arendt argues for the idea of action as the highest pinnacle of human potential. Such realisation, she says, is grounded in the recognition of two main existential conditions for human living: that of natality, the capacity to bring something new into the world, and plurality, the idea that humans live in webs of time-space relationships. It is understood that any action unleashes a chain of reactions whose effects are unpredictable and uncontrollable. This idea is found also in Polanyi (1978/1951), who, according to Warner (1978, xi) says that actions and their effects take the form of 'spontaneous orders ... that result from the interplay of individuals mutually adjusting their actions to the actions of others'; or, in the more recent language of complexity science, where they become complex adaptive systems with the capacity for self-organisation and internal order (see also Lewin 1993; Waldrop 1992). For Arendt, this capacity for self-organisation becomes a context for power: power arises from the mutual promises and agreements achieved by individuals acting together and reciprocally with a common purpose (Hayden 2014, 16): it is contrary to violence, when power is concentrated in the hands of some, often minorities, who seek to control the actions of others. Adopting these views, however, implies the need for self-determination, through which persons can realise and reveal themselves as unique persons; they are also able to judge what might be appropriate action within the traditions of a particular context. The idea of praxis is thus embedded within a philosophy of action informed by a logic of freedom (Polanyi 1978/1951).

Towards a contextualised reading of 'impact' (and 'health' and 'wellbeing')

So, in light of these two frameworks, we suggest that, to appreciate the implications of 'impact' (and also 'health' and 'wellbeing'), we need to interrogate the practices involved, specifically in relation to what counts as quality in those practices. We also introduce the idea of 'exercising influence' (see Said 1997) as possibly providing a more powerful and appropriate metaphor than 'impact'. Said says (p. 15) that the notion 'influence' is vitally important, given that the very concept of originality is derived from it. Quoting from the poet Valéry (1972, 15), he writes:

We say that an author is original when we cannot trace the hidden transformations that others underwent in his mind; we mean to say that the dependence of what he does on what others have done is excessively complex and irregular.
... [consequently] [t]here are ... works of which the relations with earlier productions is so intricate that we become confused and attribute them to the direct intervention of the gods. (Valéry 1972, 15, in Said 1997, 15: italics in original)

'Influence' then appears relevant to the process where one person learns from another, though the lines between them often become blurred and sometimes invisible through their repeated historical and cultural transformations. Rather than the metaphor of 'impact', the

metaphor of 'influence' possibly better communicates the gradual evolutionary processes involved in achieving quality in practices, however 'quality' is construed, as explained shortly.

Interrogating quality in practices

However, a problematic emerges: drawing on MacIntyre's (1981) distinction above between practices and institutions, we suggest that what counts as quality in practices and how this is achieved needs to be seen in relation to different parties' interests: 'the public, politicians and patients are almost all conditioned by history to think about health and healthcare in particular ways,' says Crisp (2010, 54). Not to make the link between understandings of health and wellbeing and human interests may lead to confusion: for example, while the quality outcomes of medical and clinical nursing practices (i.e. treating and managing illness and helping people get well) may be seen as the main aims and internal goods of immediate medical and clinical nursing, those same outcomes may also be seen simply as linked benefits in relation to achieving the wider aims and internal goods of development work (i.e. securing the independence and freedom of those usually positioned as beneficiaries). In this case, it may be argued, as in Crisp (2010), Sen (1999) and Marmot (2016), health and wellbeing come to stand as desirable conditions for achieving the necessary conditions of independence and freedom that enable all participants to take control of and live their lives in ways they choose to value. However, others may see those outcomes as interdependent: a person may experience a sense of wellbeing only when they are free: a colonised life in any form may not be healthy for either colonised or coloniser (Memmi 1974).

We suggest that typologies such as those by Habermas (1972) can help resolve potential confusion. Habermas proposes three knowledge-constitutive interests, which he calls the 'technical', the 'practical' and the 'emancipatory' (see also Carr and Kemmis 1986): these may be linked with a traditional Aristotelian view of the intellectual virtues of *techne*, *episteme* and *phronesis* (Dunne 1993; Eikeland 2008). A technical interest tends to produce instrumental forms of knowledge, a practical interest produces practical understanding and actions, and an emancipatory interest encourages thoughtful reflection on those practices within an understanding of their wider social, cultural, historical and economic contexts. The question 'Cui bono?' needs to be born in mind, says Crisp (2010): who benefits? 'Often someone does, other than the patient.' (p. 165) On this interpretation, corporations may well foreground technical interests: health would be seen as a primary good in relation to the production of highly functional operatives; clinical medics and nurses may foreground practical interests, given their main aim of restoring injured and sick people to full health as quickly as possible; while international development agencies may foreground emancipatory interests on the basis that full health is often less important than independence (as in Figure 1 below). Consequently, what counts as 'health' and 'wellbeing' would be different according to those different agents' interests.

<Place Figure 1 somewhere here>

This, we suggest, reinforces a view that the meanings of concepts such as 'impact' and 'quality' should be seen not as neutral or decontextualised but always as contingent on individuals' and collectives' interests, and especially whether those interests are institutionally or community oriented. It also has implications for the assumptions of orthodox evaluation practices, where an external evaluator (an 'upper' in Chambers' 1993 language) evaluates the practices of local practitioners ('lowers' for Chambers),

communicating the experience of a one-way street rather than of interrelated, multidirectional and dynamic practices and their effects. This is different from a contextualised view that sees all parties in the interaction as both implementers of practices (those positioned as actors) and 'recipients' of their effects (those positioned as acted upon). Therefore, in contexts both of health and development, while 'donors' and 'beneficiaries' may be differently positioned, all should recognise the benefits of learning that can arise from the exchange of knowledge and social interaction.

This idea of linking knowledge and interests also suggests that practitioners whose main interest is the acquisition of technical knowledge can come to see it as part of a transformational process towards intellectual and practical independence. Similarly, Noffke (2009, 21), speaking about action research across its varied forms, asks whether action research should be seen a 'a set of commitments (a methodology in Harding's (1987) sense of the term), rather than a set of techniques for research (a method)'. While appreciating that 'the various forms of action research vary, they share an epistemology that sees knowledge as essentially connected with practice' (p. 21). However, achieving this understanding can be difficult, and involves, in our view, developing what Aristotle termed *phronesis*, commonly translated as 'practical wisdom', an understanding of both what should be done and how to do it, the means and ends of practices (Crisp 2010, 145): this becomes integral to achieving *praxis*, that is, a morally-committed practice (Kinsella and Pitman 2012). It also becomes integral to achieving quality of life for all according to their life goals. This in itself signals a shift from systems to real-life everyday practices.

Establishing quality

So how to test the validity of knowledge claims to have influenced the learning of others and ourselves so that they and we learn to exercise *phronesis* for achieving independence and self-determination? How to communicate the effects over time of one person's or group of persons' thinking and action for the current and future wellbeing of other persons and themselves? And to introduce the aspect of articulating purpose, why is the research undertaken and whose interests does it serve?

Consequently, specifically in relation to a contextualised reading of evaluating quality, we suggest that, while socially-oriented practices should and do have an effect, a primary focus should be on whether that effect has been beneficial both for the 'recipients' in whose interests a development project is undertaken and for providers who learn from and with those they are supporting. Contrary to much health and general and international development work where criteria for judging effects are usually set in relation to the interests of policy makers, providers, donors and project managers, thus positioning them as owners of the processes and practices of healthcare (Chambers 1993; Crisp 2010; Easterly 2006), we argue that local people, the 'recipients', should be involved in setting the criteria for judging the quality of a project in terms of its effects for their lives. Providers and managers should listen to 'recipients', as set out in *Time to Listen* (Anderson et al. 2012: available online at <http://cdacollaborative.org>) and be open to their own learning from the process and from participants' insights as these become refined through the dialogue: the effect/impact changes direction back to those who initiate it, and then back again, setting a reciprocal process in train. This view is also commensurable with the *telos* of collaborative action research as a powerful means for establishing social hope (Rorty 1999). While

circumstances may be unsatisfactory, they can be changed; but this requires all participants in an interchange to negotiate evaluations of their own and one another's practices, and for evaluation criteria to work in the interests of all.

These ideas have implications, including a shift of power in decisions about who is entitled to speak and make judgements in evaluation practices: who, in Arendt's (1958) terms, can be an actor capable of making judgements about practices. They also imply a shift in theoretical perspective, from seeing evaluation in only abstract terms to seeing it as a dynamic process of individual and collective inquiry into practices.

Demonstrating and communicating effect in lifeworld practices

A contextualised reading, then, suggests that all actions conducted in the social domain have 'effects' or consequences. Nor should the practice that leads to the effect be seen as a 'cause': multiple factors, including the action, may have been involved, some often far removed from the immediate context. We opt therefore for McNiff's (2016: 144) view, that effects may be seen in and through:

- personal/collective learning, which leads to –
- personal/collective actions, which leads to –
- other people's learning, which leads to –
- other people's actions, which leads to –
- new personal/collective learning ... and so on.

<PLACE FIGURE 2 SOMEWHERE HERE>

Figure 2 shows that these are not separate sets of activities but a meshwork (Ingold 2011) of mutually reciprocal and self- and other-influencing interrelationships. Further, actions and their effects transform over time, as part of the dynamic reality in which they are embedded: existing experiences and insights transform into new experiences and patterns, burgeoning with potential for ongoing transformation for different constituencies. New questions then arise in relation to whose interests the learning serves and which new discourses and practices might be generated. The data below aim to show these processes in action.

Mapping the research context

To provide a context for these ideas and for the data produced, here is a brief outline of the ongoing research project in Cambodia. More extended descriptions appear in McNiff (2017) and McNiff, et al. (in preparation).

In 1999, a small, loosely-knit group of Norwegian higher education-based healthcare practitioners from different fields founded a formal organisation called The Tromsø [Land]Mine Victim Resource Center (TMC). Their aim was initially to provide health care to the most vulnerable people caught in war and conflict zones, often in rural settings, and to help the 'recipients' or 'beneficiaries' of the work to develop the capacity for determining their own futures.

The project has always taken the transformational form of action research, with a shifting focus in different settings, initially on prehospital treatment for war and landmine victims,

and gradually focusing on personal and professional education through establishing a Village University in every setting the group worked in.

The TMC always saw their work as action research,' says Odd Edvardsen in a 2011 interview. 'The methodology and epistemology has always been developmental. When we started out we anticipated that the work would develop and we took action accordingly ... When research becomes everyday practice, as in rural villages, then this is what research is all about. It's about developing good attitudes to research and life in general.' This point became a central focus of the end-of-project conference in 2014, when eight Cambodian doctors and midwives presented their work.

All teaching was done in local villages and all medical training was adapted to the context of the region. The project has been successful: data gathered systematically by the team showed that the death rate from landmine injuries dropped from 40% before the team's intervention to <10% in both Northern Iraq and Cambodia (see Husum et al. 2000; Edvardsen 2006). A later focus on reducing the maternal mortality rate (MMR) through developing a network of midwives, including Traditional Birth Attendants produced data to show a reduction in the MMR by >85%. Perinatal death rate was also reduced by >80% (Huoy et al. 2017).

The team also introduced a three-year research training programme in Cambodia for 16 Village University participants, leading to the significant intellectual and personal development of providers and participants alike: former enemies from the Khmer Rouge time came to interact both professionally and personally; female participants transformed from the traditional submissive role of Khmer women into fearless individuals fighting for their own and their patients' right to equal and fair treatment.

It was always an expectation that participants on all training programmes would 'pass on' their subject, research and pedagogical knowledge to local and rural communities, commensurable with Hefce's definition above of 'impact' and with Arendt's ideas of the exercise of natality and the realisation of plurality. The consequent growth of knowledge was at the heart of demonstrating the project's quality in terms of its effect in people's lives, a main feature of which was an acknowledgement of the power of locals' knowledge and capacity for solving their own practical dilemmas.

In 2016 a formal action research course was developed with a view to developing practice-based research capacity and publishing in scholarly journals (the Norwegians were already publishing in medical and midwifery journals: for example, Husum et al. 2003). While participants had already produced scientific papers about their medical and clinical work during the 3-year programme, now they could embed those papers in their everyday work practices and put a public language and form to them. Significantly all participants saw action research as a form of self-evaluation to track their learning and actions, and assess whether they had 'passed on' their knowledge and thereby benefited local communities.

However, as noted above, this kind of local self-evaluation by indigenous peoples is contrary to orthodox corporate and higher education international development health practices (Easterly 2006), which tend to be located more within the technical interests of achieving wealth and power, sustained by established forms of technical-rational research. How, then, to combat the hegemony to achieve inclusion; how to achieve a view of 'globalization from

below' (Appadurai 2000), or to achieve Arendt's (1958) view that all should be seen as actors in the interests of a more equitable and pluralistic society?

We support the idea that the production of rigorous research accounts can go some way towards establishing social hope through the celebration of practitioners' everyday knowledge. Therefore, in our own effort to produce a rigorous account, we explain how we have (1) identified specific values as criteria and standards of judgement in the articulation of knowledge claims, and (2) produced authenticated evidence to test the validity of those claims (McNiff 2013). And, considering Hefce's criteria above about demonstrating an 'effect' on or benefit to the quality of life in a context outside our immediate sphere of influence, we produce evidence to show the following:

- that learning from the project influenced the generation of new learnings and actions for different parties (discussed in our 'Data and evidence' section).
- That learning from the project has implications for wider domains (discussed in our 'Significance' section).

Data and evidence

The task now is to produce evidence from our data archive, including tape recorded interviews with providers and participants, participants' scientific papers, personal accounts, records and written reports and video-recordings to show that the aims of the project in relation to the interactions communicated in Figure 2 were realised: that is, how learning from the project influenced the generation of new learnings and actions for different parties. These outcomes also showed the transformation of our values-as-criteria into living practices.

We produce data from four situations to show how the project aims transformed from a focus on technical and practical interests to an emancipatory interest (the theoretical context for passing on the knowledge): these are:

- reducing the maternal mortality rate: this initiative began with a specific practical health focus and transformed into improving the quality of life for mothers, babies and families through supporting the growth of their self-reliance;
- developing research-based medical knowledge for organisational development; this shows how improved medical knowledge can enhance organisational and social wellbeing;
- achieving gender equality: this shows how health and social matters are intimately linked, with implications for social interdependence;
- developing self-sufficiency for amputees: this shows the realisation of linking health with independence and freedom

Reducing the maternal mortality rate

In a project evaluation report, Norwegian Margit Steinholt (obstetrician-gynaecologist) speaks about reducing the Maternal Mortality Rate through collaborative working:

From 2004 to 2005 other European colleagues, qualified Cambodian midwives and I rolled out training in basic obstetrical care for almost 500 lay health workers, from 266 villages in remote areas. We also conducted antenatal classes for women of

reproductive age, in order to encourage women to give birth at health centres rather than at home. However, after two years still very few women opted for the health centre.

The midwives, now research-competent from our training course, interviewed local midwives and traditional birth attendants (TBAs) to find out why this was the case (see Siv et al. n.d). Interview data collected from expectant mothers revealed:

- ‘It is too expensive to give birth at the health centre; I cannot afford the travel.’
- ‘The health centre provides no accommodation for expectant mothers or relatives.’

The problem of insufficient beds and non-availability of accommodation were therefore identified as major obstacles, given that most rural Cambodians live in extreme poverty.

This personal and collective learning led to Margit’s and local midwives taking action:

We therefore facilitated the building of eight waiting houses in the most remote health centres. These are simple buildings with free accommodation for 4–6 women and their companions, with basic facilities and access to a professional midwife on call. The women provide for their own daily needs.

Their actions led to new learning (as per Figure 2):

Just by strengthening the infrastructure with these eight small buildings, successful deliveries increased at all health centres by 50–100%. In 2014, approximately 1000 women had a safer delivery. Their newborns also got a better start in life because mother and baby could be more closely monitored and the baby could receive the first doses of essential vaccines prior to the family’s departure for their village.

Further data from a scholarly paper by qualified midwives Siv et al. (2014) shows the effect of passing on the knowledge:

Our informants [local TBAs] said that the waiting houses make it more convenient to use public health services, and that they personally use these services more because of the waiting houses. ... Many report an improvement in social relationships and trust between local people and health centre staff. We conclude that both rural people and health staff see waiting houses as a valuable service to the rural poor in Cambodia and likely to contribute to a reduction in maternal and perinatal mortality rates (Siv et al. 2014: 1).

This cycle of learning → reflection → action → re-reflection → new action → re-re-reflection → n represents a typical transformational action reflection-cycle, as in, for example, Argyris and Schön (1978). Such cycles may also be understood as transformative learning (Brookfield 2009), which involves ‘what could be termed personality changes, or changes in the organisation of the self, and is characterised by simultaneous restructuring of a whole cluster of schemes and patterns ...’ (Illeris 2009, 14).

Developing research-based capacity in medicine

A senior surgeon says in interview:

I was on a mobile team at the frontline combat zone for three years, along the Cambodian-Thailand border. We had a lot of casualties, about 60% from landmine injuries, the rest from bullets and other weapons. I performed more surgery on the front line than in hospital. ... there was a lack of everything: lack of medicine, lack of transportation. Some died of complications including post-operative wound infection.

Speaking of his learning from the research training course, he says:

The course helped me learn how to stop or reduce post-operative wound infection. I now have that knowledge.

And he passed the knowledge on ...

During the research and afterwards, I also spread the knowledge around the hospital. I will use this knowledge and share it with young physicians who can learn to do the same. Without the course it would be just like during the war. I would not have this knowledge; I would not know what to do.

Achieving gender equality

A qualified midwife comments on the inequalities between male doctors and female midwives:

During the course we learned to negotiate our positions with doctors. Some high status and highly paid doctors learned to position themselves as equal with midwives. This is different from normal Cambodia culture where people with higher status don't want to talk with lower status people. In this programme Dr Hans [Husum] (course provider and a co-founder of TMC) said, 'We don't want to see arrogant people: we want to see equality, friendly', as he demonstrates through his own practices. The experience has led doctors here to rethink their relationship with other course participants, including midwives and nurses. They invited each other to their homes, ate together, even went to the bar and dancing together. I was not with them but I know they went to the bar together.

Margit Steinholt also reports:

We, the European outsiders, did not initially understand the nature of the conflict between local doctors and midwives. In hindsight, we perceived it as a conflict of professions and genders and a conflict of wealth and class, since most Cambodian doctors are more affluent men while rural midwives are poorer and frequently from ethnic minorities. Initially my Norwegian male colleagues also appeared not to be aware of the problem. It was, however, immediately clear to me because the Cambodian male doctors showed less respect for me whenever I conducted training by myself. However, now that the problem had been surfaced it could be dealt with.

Developing self-sufficiency for amputees

Footage be found in the videotape 'Getting out of the mud' (available at [url](#)) of an initiative to provide amputees with prosthetics made from locally-resourced materials such as plastic water pipes. The video shows amputees making custom-made prosthetics for other amputees, with a much better fit than those prosthetics available from official health

organisations. Also, obtaining such prosthetics involved travelling to big cities, prohibitive in terms of cost for most local people who would also have to leave their farms to travel. The video shows an amputee, delighted with his new prosthetic, saying, 'Look! I can walk! I can kick!' Such is the effect of passing on the knowledge.

Significance of the research

We believe that the project data potentially have significance for four overlapping domains (our selection here is down to limited space: there are many more domains). We organise the four domains as the personal, the professional, the political and the theoretical.

The personal

A significant feature of the project was the realisation of Arendt's (1958) view that all should be seen as agents, capable of thinking and thereby exercising their natality, and for the development of collective power through negotiated discussion. It has also shown the realisation of Appadurai's (1996, 167) idea of 'the right to research'. Research, he says, is a 'specialised name for a generalised capacity ... to make disciplined inquiries into those things we need to know but do not know yet. All human beings are, in this sense, researchers.'

Yet achieving this state involves for many a change in personal and professional identity, from 'practitioners', 'doctors' and 'midwives' to competent and capable practitioner-researchers. This transformation was experienced by most participants, especially the women. However, such transformation has implications, from seeing oneself in terms of a safe, often stereotypical role or position to that of an involved participant in a wider conversation about the transformational potentials of learning for social action.

The professional

In 1993 and 1995 respectively, Chambers and Schön spoke of the need for a 'new professionalism' that emphasises the need for dialogue and for participatory forms of working grounded in respect for the other's capacity for action. Their view is that current conceptualisations of development are stuck in what they see as an old paradigm view of professionalism and research that reinforces the exclusivity of research as a specialist field and of researchers as mainly academic professionals. A key feature of Schön's contribution is the need for a new epistemology of practice, a way of knowing and being that sees everything in emergence and interrelated (see also Bergson 1998/1911; Hoyle 1983). This view links with those of Polanyi (1958) and Arendt (1958) about pluralism as a condition for democratic participation. In the Cambodian narratives, the mainly European professionals positioned themselves not as 'official experts' so much as learners, though with practical and theoretical expertise in the field; as did local people who, also with practical and theoretical expertise of their own war-torn and mine-ridden fields, had learned to celebrate their capacity for enhancing their professionalism. As a community of enquiry (Elkeland 2006), all were positioned as learning with and from one another in order to generate new knowledge that would benefit all.

The political

There is enormous significance in the shift from seeing the management and delivery of international development programmes as the property of 'professionals' who self-identify as

solely knowledgeable about what needs to be done, to a collective effort that involves local participants as knowledgeable about their practices and contexts and able to contribute to negotiated discussions about the imagination and management of futures. It also vindicates Schulte's view that 'Social reality – as constructed by the researcher – is more than meets the eye; along with social ties, it is the sense-making processes that are of importance here'; and of Hall's (1993, 276) notion that such sense-making processes can lead actors towards new forms of thinking. This paper contains data that shows this process in action: participants have actively re-framed their identities and practices in relation to others. However, according to Noffke (2009, 17), these ideas about the value of 'local knowledge production for civic purposes [is] not always seen as part of educational action research work [although it is] very common in the forms of action research that have developed in health, human services and the social sciences.' Nor does this account fit with the mainstream of those forms, with their assumptions that 'official' researchers do research with participants. In the research that informed the writing of this paper, the assumption was that all do research together: all learn and pass on their learning for the production of collective knowledge with the aim of achieving social hope.

The theoretical

Easterly (2006) proposes that people in different contexts have different motives. One context is institutions: these tend to contain 'planners', those who assume that they know what should be known, and adopt research methodologies to prove their points. He cites lawyer and journalist Jean-Claude Shanda Tonme's objection to many aid agencies: 'they still believe us to be like children that they must save' with their 'willingness to propose solutions on our behalf' (p. 23). Workplaces and villages, on the other hand, contain 'searchers', those who are looking for solutions to complex problems and dilemmas: they accept responsibility for their actions, find out what is in demand, adapt to local conditions and find out what the reality is at the bottom (p. 5), a view supported by Calderisi (2006) who says that a foreigner does not understand village life unless they have spent a night in a village. The idea of 'searchers' presupposes adopting an action research attitude, which is about finding the best way forward within often intractable dilemmas. An action research perspective begins with an assumption that things do not need to be as they are: they can be changed, beginning with a critical interrogation of the current situation and the development of new perceptions of social reality. This view is appropriate for the world's poor and for patients, who wish to have a say in the nature and development of their futures. 'The world's poor do not have to wait passively for the West to save them (and they are not so waiting)', says Easterly (2006, 23). The world's amputees are not waiting for prosthetics to be delivered or for maternal mortality rates to reduce: they have found new solutions, working collaboratively with foreign helpers, who have also learned from them. The Norwegian group were open to the need to switch focus from saving lives and limbs to helping others learn how to do so for themselves. The Village University was about passing on the knowledge about how to pass on the knowledge: the action research course was about helping surgeons, midwives and nurses see the power of investigating personal practices with a view to helping others to do the same. In *The History Boys* (Bennett and Hytner 2006, 107) the disreputable teacher Douglas Hector whispers from the sidelines, 'That's the game I wanted you to learn. Pass it on.'

Some implications

These ideas have significant implications for all practitioners, whether positioned as local insiders and outsider experts in health and international development settings or as qualified supervisors and unqualified trainees in clinical nursing contexts, especially in relation to reimagining their professional identities and responsibilities. This can be enormously difficult for all parties, especially in relation to how identities tend to be formed through prevailing discourses. Many workplace practitioners may enjoy grumbling about managers, the 'them' often portrayed as villains; and institutionally-oriented teachers are heard to say, 'I have taught it to them: why haven't they learned it?'. To a certain extent, this attitude is often justified. Yet, if the aim is to develop healthy cultures of independent, responsible agents who are able to do research and be seen as exercising their natality within pluralistic contexts (Arendt 1958), all practitioners, regardless of setting or status need to stop hiding in the language of 'them and us' and see 'all of us' as complicit in those same systems of power.

Making these kinds of changes can be hard, with potential penalties, especially for the rich and powerful who may consequently never wish to change. But for those who do, the process has to begin with a recognition that, whatever systems of discourses and practices we buy into, those systems work at two levels. The 'Level 1' of systems requires accepting normative assumptions that there is one 'right' way of thinking, the one promoted by the established epistemological traditions of the community. The 'Level 2' of systems requires accepting that normative assumptions are themselves to be accepted as normative. Perhaps systems-level change means appreciating that once this level is reached it may already be too late: the point of no return may already have been passed. Once one has fully bought into the deeper Level 2 system they may no longer see what others may see as an unsatisfactory situation: they ask, 'What is all the fuss about? That's the culture: that's the way things are' (see also Milosz 1953). To see things anew then becomes a case of performing mental acrobatics, where one interrogates mental constructs along with one's own motives for holding them, surely one of the most difficult things possible: stepping outside discourses to critique them while using the same form of discourses to do so.

Yet perhaps this is what it takes, which also involves an appreciation that change can take time. This is a core understanding of action research: the need to produce appropriate data to test the validity of knowledge claims that an initiative has demonstrated the potential for long-lasting influence ('impact' in popular discourses). This extends Lather's (1986) idea of catalytic validity in that the catalyst themselves change: they recognise that they cannot step outside the reality they are investigating and are part of the dynamic lifeworld that moves everyone along in its flow. They change along with everything else.

Change on this view is not an add-on, an interruption: it is part of the natural order, part of the natural process of new beginnings (Said 1997). Perhaps the trick is to try to develop and realise new visions of social reality where people work collectively to develop those new beginnings in company with others who are trying to do the same. And perhaps it may be wise to take Pressfield's (2011) advice – to start before you are ready: given that each moment represents a new beginning, perhaps here and now is as good a place as any.

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