

Research partnerships: collaborative action research in nursing

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This methodological paper discusses and critiques the 'insider' and 'outsider' models of action research described in the nursing literature. It highlights tensions and problems with these models and demonstrates how the models developed by the authors — the 'double-act' and 'collaborative group' partnerships — overcome these difficulties. The success of this approach suggests that such partnerships of nurse practitioners and a researcher should be considered when practitioners want to introduce innovation and facilitate change in practice and generate and test theory which is relevant to practice. The paper is presented in the form of a commentary, interspersed with reflective conversations in which the authors illustrate and reflect upon their attempts to make the methodology described a reality.

BACKGROUND

We are engaged in a 4-year action research study of the development of patient-centred nursing in the acute medical unit at the John Radcliffe Hospital, Oxford. Early in 1989, Alison Binnie was appointed, as a senior sister in the unit, to lead the innovation. She successfully approached the Institute of Nursing in Oxford, to propose the setting up of a collaborative study. Angie Titchen, an educationist and researcher with a physiotherapy background, was appointed by the Institute in May 1989 as the project researcher. We quickly established that we shared the same values and philosophies of health care and personal and professional development, that is, a strong belief in patient-centred care and learner-centred development. We then devised the complementary roles of 'actor', in the form of a change agent/facilitator role, and 'researcher', both within a collaborative partnership. Alison was mainly an 'actor', whilst Angie was mainly 'researcher'. Over time, we developed and refined our complementary way

of working, fine-tuning our relationship within our practice and our research, becoming what we now see as an effective 'double-act' (Titchen & Binnie 1992a).

The project, entitled 'Patient-Centred Nursing in Practice', was designed to help the nurses on two study wards to move gradually from traditional to patient-centred nursing, using the work organization method of primary nursing. The major focus of the study is the unravelling of the complex organizational, personal and professional changes required for such a practice shift. The aim is to provide UK nurses with a 'map' of the processes involved and point to the kinds of strategy that are likely to be effective in achieving change.

Primary nursing

Primary nursing is a system which devolves to a staff nurse the authority to manage the nursing care of a small group of patients from admission to discharge. Continuity of care allows nurses to practise in patient and family-centred ways, through the development of close therapeutic

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relationships Humanistic values underpin these relationships and care is given in an individualized and holistic way This style of nursing is a major departure from traditional practice which is governed by standardized routines and procedures and where authority for key decisions about patient care rests with the sister

Before the project began, the medical wards had a rather poor image within the hospital Nursing there was seen as a heavy, unglamorous work, often boring, and organized in a traditional way The staff turnover was rapid and there was little evidence of staff development or innovation in practice We therefore developed several different, but interconnected strategies (Titchen & Binnie 1992b) for

- 1 introducing innovation and facilitating change,
- 2 helping practitioners research their own practice,
- 3 facilitating professional learning and reflective practice,
- 4 democratizing health care through the emancipation of nurses from the traditional nursing hierarchy and the role of doctor's handmaiden,
- 5 generating and testing theory

Although these strategies are generally seen as quite separate, we saw them as connected or unified in various ways For example, we felt that if we could help the nurses and sisters to research their own practice and innovations, and thereby generate and test theory, they would inevitably develop personally and professionally, as they learned to think critically, analytically and reflectively We anticipated that a bottom-up change strategy would help nurses to empower themselves and raise their self-esteem The creation of new roles and a new work organizational design would also mean that nurses would have to learn to think and act in new ways — thus organizational change could lead to personal and professional learning Moreover, researching or reflecting upon their own practice would help nurses to articulate their unique contribution to health care and might, therefore, help nurses to enter into more collegiate relationships with doctors because their own roles were clearer We found support for the notion that action research unifies quite distinct activities in the educational field (Elliott 1991)

Our goals and strategies were ambitious and we needed to adopt a model of research which would help us to achieve them

MODELS OF ACTION RESEARCH

We identified two models of action research in the nursing literature, 'insider' and 'outsider' models, where the

researcher role is not built on the traditional notion of the researcher as impartial observer We developed two further models, in this study, based on partnerships between practitioners and a researcher who also had an 'actor' role We call these partnerships the 'double-act' and the 'collaborative group' models of action research

'Insider'

The 'insider' model combines the roles of actor (clinical leader with authority for initiating and managing change), change agent and researcher The integration of authority in the setting with the research role would appear to be advantageous, but there are difficulties within this model Where the actor/change agent is the researcher, the commitment to the action has potential implications for the objectivity of the study and for the willingness of participants to disclose information fully (Lathlean 1989)

However, all action researchers, whichever model they adopt, carefully consider the issue of reflexivity, that is, action researchers are part of the social scene they are studying (Hammersley & Atkinson 1983) They do not ignore their part in the situation, but take into account, for example, the effect of their roles, relationships, values, prior interpretations of the phenomena they are studying

The other potential difficulty in this model is the great personal cost it involves, and the accompanying risk of burnout Nevertheless, this complex 'insider' model has been very successfully achieved in nursing by Pearson (1985), FitzGerald (1989) and Batehup (1991)

'Outsider'

In the second model, the action researcher is someone from outside the setting — an 'outsider' with no authority in the situation — who has a diagnostic function and who feeds back observations to the participants, but who does not initiate or carry out the change The action researcher supports the change agent(s) who belong(s) to the setting (Lathlean & Farnish 1984, Smith 1986, Hunt 1987, Webb 1989, Wilson-Barnett *et al* 1990, Armitage *et al* 1991, Meyer 1991) The rationale of this model is that if the 'outsider' implemented change, there would be a real danger that the innovation would not be owned by the participants This could then result in a reversion to the old ways when the 'outsider' leaves the situation

From a review of the nursing literature and from discussions with fellow action researchers, we conclude that there may be tensions between the researcher and the actors in the 'outsider' model

- 1 There may be differences in the ways the practitioner and the researcher attempt to reduce uncertainty. This tension is explored elsewhere (Titchen & Binnie 1992c).
- 2 The 'outsider' researcher may be engaging in a study of a particular change and then the participants may head off in a new direction. The researcher and the participants may have very different ideas of what they consider important to study. This tension may be at its greatest when the 'outsider' is taking a higher degree, and is interested in a particular area of study.
- 3 If the researcher meets resistance to proposed changes or where change has been agreed and then the participants do not implement the changes, the researcher, with no legitimate authority in the situation, may only have limited power to influence what is happening.

Less successful

An analysis of the nursing studies, in terms of whether the desired change was achieved or not, suggests that the 'outsider' model appears to be less successful than the 'insider' model. The three 'insider' studies were all successful in that they achieved the intended changes, whilst only three of the seven 'outsider' studies were successful in this sense. We suggest that because authority is vested in the researcher, the 'insider' model overcomes some of the possible tensions of the 'outsider' model. We suggest, from our analysis and from our own experience, that many factors, in addition to the tensions already noted, could have contributed to the lack of success of the 'outsider' studies.

The time period of the study is critical. Major change in practice is often slow and it takes time to sort out roles and change peoples' attitudes. For some of the nursing studies, the time period was a year or less. In our opinion, this time scale is not long enough to overcome role problems and resistance to change.

The attitude of the participants will be influenced by who initiates the study and whether they are involved from the beginning. They are more likely to 'own' the project if they initiate it themselves or, where a manager or 'outsider' initiates it, if they are immediately involved in the agenda setting with an equal share of the power base. The participants' attitudes to the work and to the 'outsider' will also be shaped by whether they feel the need to change.

In Smith's (1986) and Meyer's (1991) studies, the participants perceived the role of the 'outsider' as the person who would lead/carry out the change, despite

the action researchers' vigorous attempts to help the participants to determine and undertake the changes themselves.

The person who suggests possible solutions to the problems may also be a key factor. Hunt's (1987) suggestions were not taken up (for structural reasons), despite the problem being owned by the participants.

Elliott (1991) suggests that the function of an 'outsider' is a subordinate one — to support and facilitate reflective practice without damaging the unity of its constituent parts — as opposed to imposing on practitioners a hegemony of specialist expertise. He argues that action research integrates practice, practice development, research and philosophical reflection into a unified concept of a reflective professional practice. This unified concept has power implications, inasmuch as it negates a rigid division of labour into hierarchical activities. Elliott (1991) gives the example of the higher status of the 'outsider' academic researcher and the lower status of the 'insider' practitioner. He believes that a unified professional practice empowers 'insiders'. Our interpretation of Elliott's argument is that the 'outsider' helps the 'insiders' to achieve an integration of practice and research activities. This conception of the 'outsider' function underpins our 'double-act' model which we believe is new in the nursing field.

'Double-act'

We developed the complementary roles of 'actor', in the form of a change agent/facilitator role, and 'researcher', both within a collaborative relationship. Alison, holding an 'insider' role, was mainly an 'actor'. Angie, mainly a 'researcher' employed by the Institute of Nursing, with an honorary contract at the hospital, occupied an 'insider'/'outsider' role.

Change agent/facilitator role

The change process was very complex because changes were required at various levels in the organization, as well as changes in the philosophy and concepts of nursing care and caring. This complexity was mirrored in Alison's innovative role working as a change agent, with authority at three levels in the organization: as senior sister on her own wards, where she was facilitating the development of the staff nurses; as nursing practice facilitator in the medical unit, where she was helping the other sisters to develop their wards; and as the nursing representative on the clinical management team, where she established collegiate relationships with medical staff to foster a climate conducive to the growth of patient-centred care.

Angie adopted a facilitator role in staff nurse support groups, workshops, meetings, professional development sessions, as well as in the informal situations which arose when she was on the ward as a participant observer. Her role was to support and sustain the growth of a reflective professional culture in the move away from traditional values and norms.

Researcher role

Planning the research was a collaborative activity. We made joint decisions on the research methods and the data to be collected. Angie was responsible for developing the data collection guidelines and collecting the data.

We analysed and interpreted the findings together in an impressionistic or first-order analysis to help us to move the action on. Retrospectively, we carried out a second-order analysis, a more systematic and rigorous analysis and theorization to illuminate the change process for others.

Every fortnight, we held a recorded reflective conversation which enabled the impressionistic analysis of data, interpretation and evaluation which led to planning or revising the action and the data collection methods.

Joint action researchers

Both 'actor' and 'researcher' roles were sometimes carried out simultaneously, for example, when Angie was feeding back data to a nurse for validation and interpretation or asking probing questions in an interview, the nurse reflected upon her practice and went further in her thinking. Alison was also collecting data on the effects of our actions, as she helped nurses to learn from their everyday work with patients.

CLARIFICATION AND NEGOTIATION OF ROLES

Warned by the writings of Brown & McIntyre (1981), we attempted to avoid the unsatisfactory effects of confused action researcher roles, by investing time and energy in the clarification and negotiation of our complex roles and relationships. We viewed ourselves, to a large extent, as having 'one mind', even where we were carrying out action plans independently, because we had initially explored the issues and problems and tested ideas with each other before devising the action plan.

We propose that our 'double-act' model combines the best of the 'insider' and 'outsider' models and counteracts some of the problems and tensions inherent in these

models. One of the advantages of the 'insider' model is that authority for the change is vested in the action researcher. Within our partnership, authority in the clinical setting was held by Alison (although Angie had equal authority in the research).

The disadvantage of the 'insider' model — the danger of burnout — is overcome by the 'double-act'. First, it allows the 'insider' to remain in the field, leading, managing and collecting data on the change, while the 'outsider' withdraws from the field for reading, planning, data analysis and writing. Secondly, it provides support for the 'insider' in the change process. The 'outsider' gives moral, psychological, emotional and intellectual support and helps to carry out some of the action.

The advantage of the 'outsider' model is that an inside change agent has support. Our 'double-act' provides that support and reduces the three tensions, already described, between researchers and practitioners in the 'outsider' model.

In relation to the first tension, our model brought together the different ways that practitioners and researchers try to reduce uncertainty. The scope of this paper prevents us from discussing the complex process of this bringing together, but it is reported elsewhere (Titchen & Binne 1992c).

In relation to the second tension, we did not have the problem of the practitioners changing the direction of the study, because it was the practitioners who were setting the main agenda for change, rather than the researcher.

The third tension, where the researcher, with no legitimate authority in the situation, meets resistance to change, falls away in the 'double-act' because the practitioner in the partnership has legitimate authority. Possession of this authority is the one principle of the model that cannot be compromised.

Pitfalls

Nevertheless, the 'double-act' model has inherent pitfalls.

I found that whilst undoubtedly immensely valuable and productive, the partnership does have some inherent difficulties. Firstly, I have found a problem managing my time in such a way as to give the research enough attention. The demands of managing major change, in a busy, large department, can be almost overwhelming, particularly in the early stages, and the demands of people involved and problems that occur tend to be urgent. Thus, at times, I have had to let the stream of papers that Angie sends pile up on my desk, ignored, and I become anxious that I am not using the data that we are generating.

(Alison)

Through discussion in our reflective conversations, we devised a way of organizing Alison's clinical involvement in the ward into discrete monthly blocks. This arrangement helped her to overcome the problem, because she knew that she would have a less stressed period, between each block, when she could catch up with the research. The monthly block system worked well for Angie as well, as it gave her an opportunity for time away from the ward for data analysis and interpretation.

I sometimes experience feelings of guilt as a result of apparent imbalance within the partnership. I feel that the guilt comes from the remnants within myself of nursing's traditional undervaluing of practice. Because the dominant part of my role is managing the practice change, I do not generate as much paper as Angie and I sometimes feel that I am not working hard enough or contributing as much to the research as Angie, because I do not do as much reading and writing. I have to keep reminding myself that managing the action is just as important a part of the project as collecting data about it.

(Alison)

On the other hand, when I observe the enormous pressure that Alison is working under, I feel guilty when I withdraw to the office. I try to allay this guilt by being supportive and helping Alison to 'off load' her problems and tensions.

(Angie)

Unfortunately, this strategy contributed to another source of guilt for Alison, because her stories tended to dominate our conversations.

My stories come from the action on the wards and Angie often goes away and writes them up as valuable data. Although the telling of the stories is therapeutic for me, I feel guilty that Angie has less time for telling her own stories and so, perhaps has less support from the partnership.

(Alison)

But whenever I feel the need to talk through problems and concerns, I find that Alison is an attentive listener, and she often gives me brief, but quality, time when she is in the midst of looking after patients.

(Angie)

We managed the potential tensions which could arise from this imbalance within the partnership by openly acknowledging from time to time that they existed and were inevitable consequences of the different emphases within the roles. Angie established other effective sources of support, for example, within the Institute of Nursing,

from a self-help postgraduate researchers' group and from her own research supervisor in the university.

Initially I experienced considerable difficulty in the analysis and interpretation of data. I had had previous experience of qualitative data analysis, nevertheless, I felt considerable anxiety over making sense of it, first of all, in dealing with the sheer quantity of data (so whilst Alison was feeling guilty about not producing as much paper as I was, I was feeling overwhelmed by producing so much!). Secondly, I wanted to avoid resorting to a quantitative analysis of qualitative data, i.e. a content analysis, but I was very unsure about how to develop themes and patterns inductively from the data. It was in the exploration of complex methodological issues that I particularly needed help and support outside our partnership.

(Angie)

Ethical issues

Our close relationship has also raised some ethical issues.

The eager and spontaneous story-telling that occurs whenever we meet has sometimes raised ethical concerns. Because we work so closely together and because Angie is so interested in every detail and nuance of ward life, I find it easy to blurt out stories which contain personal information about staff, without stopping to consider the status of the stories, that is, are they data for the research or the private sharing of an experience with a colleague—confidante?

(Alison)

Recognizing the difference and the potential hazards of confusing personal confidences with legitimate data, we both agreed that any story, or any other information about the wards or staff, should remain entirely confidential until we had formally acknowledged that it may be disclosed elsewhere or recorded as project data.

The very closeness which contributed to the success of our working relationship did have its dangers.

We work so closely together, in terms of our approach to development and handling the data that we are very 'in tune' with each other. We have learned to use this closeness and intuition in a very powerful way. To others, we are sometimes perceived as almost acting as a shared consciousness, so that even if we are working independently we seem to be working within that one consciousness. Although that is true to a large extent, we feel that we do have different perspectives — we know where one ends and the other begins. We are aware that our closeness brings the dangers of being too 'cozy', i.e. being uncritical, unquestioning of the other's thinking and behaviour or 'me being seen to be on the senior sister's side', i.e. appearing to others to be constantly 'in league' with each other. We think that we have avoided these dangers by

constantly monitoring ourselves and by having a third party who regularly challenges our thinking and behaviour. In the writing up of the data analysis and theorization, I have taken care not to talk about Alison's actions in preferential terms or to make excuses for her when her strategies were ineffective. When we are both on the ward and at social gatherings, we take care not to sit together or to be seen talking together in corners.

(Angie)

I think that the ward staff see Angie as someone who brings things up, issues which need addressing which are sometimes uncomfortable for me or for them. They see Angie as helping them to address these issues, not as someone who protects me.

(Alison)

Throughout the project, we collected data on the effects of our partnership within the study, and on how we influenced each other (Titchen & Binnie 1992a). We did this, not only to address the issue of reflexivity, but also to explore the 'double-act' model as a potential model for change in nursing. Through a process of description, hypothesis generation and testing, we plan to develop a set of guiding principles for such a partnership.

COLLABORATIVE GROUP MODEL

Our collaborative group model differs from the group model prescribed by Carr & Kemmis (1986) and Kemmis & McTaggart (1988). They promote the notion of a group of practitioners working together, as co-action researchers, to question the relationship between the actual and the possible and to embark on a 'critical project' or 'struggle for reform'. The struggle is seen as working towards the democratization of education through the development of a critical theory of education by a group of co-action researchers. We were not aiming to develop a critical theory of nursing, because we did not think that the nurses were at a stage where this kind of commitment and level of work was conceivable. Moreover, we were not convinced that the development of a critical theory would necessarily lead to reform. There appears to be no evidence in the educational literature to suggest that it does.

We facilitated, therefore, the creation of collaborating groups of reflective practitioners, change agents and researchers, rather than groups of co-action researchers. We collaborated with different groups: the sisters in the medical unit, and staff nurses in the unit and on Alison's wards. To varying extents, in the nursing literature, both 'insider' and 'outsider' action researchers were collaborating with participants, but the characteristic which distinguishes our 'collaborative group' model is that

we were operating, within the groups, in our 'double-act' roles.

Ward sisters

The structure for enabling the involvement of the ward sisters in the study was the medical ward sisters' meeting. One of Alison's first actions when she took up her post was the setting up of this group. Identification of issues, problems, decision-making, action planning and evaluation of the action took place at these bi-monthly meetings in the sisters' homes.

In the early days, we helped the sisters to talk about their work and wards, and to share developments, problems and ideas in an attempt to raise their self-esteem and make them feel valued. Angie often acted as a group facilitator, using various group processes to help them to examine their current roles and their context from historical, social and political perspectives.

It took about 2 years for the group to become firmly established and cohesive and to begin to collaborate in a mature and confident way with the project work.

The group initiated an action research cycle which investigated the changing role of the sister. Here, they became change agents themselves. They identified the problem of others not understanding or wanting to accept their new role of sister in the primary nursing system and the conflict and frustration that this lack of understanding or acceptance created. They worked systematically in groups to clarify their roles, thus beginning to examine the relationship between the actual and the possible, to articulate what they had to offer to the health care team.

(Alison)

The Multi-Disciplinary Working Cycle, which focused on working relationships with the health care team, in particular with doctors, was also strongly advocated by the sisters. They took part in the detailed planning of the data collection, proposing the research questions and suggesting the data collection methods.

(Angie)

Alison worked in partnership with the sister of the other ward in her unit to establish patient-centred nursing. However, we did not invite the sister, at the beginning, to be on the project team, because we perceived her as not having experience as a researcher and as seeing herself in that way, too. We made a major mistake here. When problems arose later in the work, we realized that it was essential to have, on the team, the person in authority in the other setting where we hoped to facilitate change.

We discussed our mistake with her and she agreed that she would have felt reluctant to be on the team because of her lack of research knowledge and experience. We realize now that we should have recognized, ourselves, and made explicit to her, that she had a legitimate and important place in the team, if not as a researcher, as a key change agent in the unit we were studying.

By the time we were familiar with the action research literature which discusses issues of empowerment and democratization, the sister was firmly entrenched in the mind-set of 'Alison's and Angie's project', and her talk and behaviour made it clear that she saw herself as being studied by Angie and helped by Alison.

(Angie)

However, we have made some amends and she is on the project team and has agreed to write up her experiences of the change process and to help us with the validation process.

(Alison)

Staff nurses

The majority of staff nurses in Alison's ward adopted the roles of collaborating informant and reflective practitioner, identifying and exploring problems and issues, planning, carrying out and evaluating actions and attempting to theorize their own situations. We saw many occasions where nurses were empowered by engaging in the action research process in these ways.

Two staff nurses were very actively involved in a specific cycle of the research which focused on patient assessment and care planning. These two staff nurses moved from being reflective practitioners—helping to develop new ideas, and then to use and evaluate them in the assessment of patients and care planning—to being collaborative researchers carrying out an observational study to establish nurses' views on orthodox assessments and care planning and their views on the innovation.

These two staff nurses and I devised an experiential learning programme to help them to develop and refine the research skills of observation and questioning.

(Angie)

Other staff nurses in the medical unit who attended Angie's support group became reflective practitioners who were using the action research process. As a group, they identified problems with their practice, explored possible explanations and solutions for the problem, before devising action plans to carry out on their own wards. Later, they fed back their findings and interpretations to the

group and they helped each other to reflect upon and evaluate their actions and draw up a revised action plan.

The major problem with this initiative was maintaining continuity which was difficult with shift patterns and with nurses who were unused to having the freedom to organize their own work time. Nevertheless, the group was beneficial to a few committed nurses.

As these examples illustrate, we found that, once a climate and specific opportunities had been created, it was possible for nurses to collaborate in the research in different ways and at different levels. We also learned that people only became involved when they were ready and that it required sustained investment in individuals to help them to reach a point where they were ready to move from being reflective practitioners to becoming researchers of their own practice. These individuals needed help to refine their existing research skills and to develop new ones, to enable rigorous, systematic data collection.

These various experiences, that is, research experiences not available in everyday nursing life, provided insights and skills which contributed to the growth of confidence and maturity, already beginning to transform the nurses' working relationships with health professional and medical colleagues and their control over their work.

The only problem we experienced with the 'collaborative group' model was that it took a long time to establish. However, this situation seems inevitable because the introduction of a major innovation appears to be a slow process.

CONCLUSION

We have presented two models of action research not described in the nursing literature—the 'double-act' and 'collaborative group' models—placing them in the context of the 'insider' and 'outsider' models used by other action researchers in nursing. We conclude, from our experience, that our models combine the best of the 'insider' and 'outsider' models and overcome their associated problems, although not being without problems of their own.

We, therefore, recommend that nurses planning to use action research as a strategy for implementing major innovations (Titchen & Binnie 1992b) or generating and testing theory (Titchen & Binnie 1992c) consider the advantages that the 'double-act' and 'collaborative group' models offer.

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References

- Armitage P, Champney-Smith J & Andrews K (1991) Primary nursing and the role of the nurse preceptor in changing long-term mental health care: an evaluation *Journal of Advanced Nursing* **16**(4), 413–422
- Batehup L (1991) Personal Reflections Action Research Workshop, Department of Nursing, King's College, London, 18 April
- Brown S & McIntyre D (1981) An action research approach to innovation in centralized educational systems *European Journal of Science Education* **3**(3), 243–258
- Carr W & Kemmis S (1986) *Becoming Critical Education, Knowledge and Action Research* Falmer Press, Lewes, East Sussex
- Elliott J (1991) *Action Research for Educational Change* Open University Press, Buckingham
- FitzGerald M (1989) Lecturer–Practitioner Action–Researcher Unpublished Master of Nursing Dissertation University of Wales, Cardiff
- Hammersley M & Atkinson P (1983) *Ethnography Principles in Practice* Tavistock Publications, London
- Hunt M (1987) The process of translating research findings into nursing practice *Journal of Advanced Nursing* **12**, 101–110
- Kemmis S & McTaggart R (eds) (1988) *The Action Research Planner* Deakin University Press, Victoria, Australia
- Lathlean J (1989) Action Research for Nursing Unpublished paper Oxford University Department of Educational Studies, Oxford
- Lathlean J & Farnish S (1984) *The Ward Sister Training Project: An Evaluation of a Training Scheme* Nursing Education Research Unit, Department of Nursing Studies, Kings College, London
- Meyer J (1991) Personal Reflections Action Research Workshop, Department of Nursing, King's College, London, 18 April
- Pearson A (1985) The effects of introducing new norms in a nursing unit and an analysis of the process of change Unpublished doctoral thesis Goldsmith's College, Department of Social Science and Administration, University of London, London
- Smith G (1986) Resistance to change in geriatric care *International Journal of Nursing Studies* **23**(1), 61–70
- Titchen A & Binnie A (1992a) *A Double Act: Co-Action Researcher Roles in an Acute Hospital Setting* Institute of Nursing, Oxford
- Titchen A & Binnie A (1992b) *A Unified Action Research Strategy in Nursing* Institute of Nursing, Oxford
- Titchen A & Binnie A (1992c) *Action Research: A Strategy for Generating and Testing Theory* Institute of Nursing, Oxford
- Webb C (1989) Action research philosophy, methods and personal experiences *Journal of Advanced Nursing* **14**, 403–410
- Wilson-Barnett J, Corner J & De Carle B (1990) Integrating nursing research and practice — the role of the researcher as teacher *Journal of Advanced Nursing* **15**, 621–625

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