

Research as care: Practice-based knowledge translation as transformative learning through video-reflexive ethnography

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Abstract

Collaborative approaches to knowledge translation seek to make research useful and applicable, by centring the perspectives and concerns of healthcare actors (rather than researchers) in problem formulation and solving. Such research thus involves multiple actors, in interaction with pre-existing ecologies of knowledge and expertise.

Although collaboration is emphasised, conflict, dissonance, and other tensions, may arise from the multiplicity of perspectives and power dynamics involved. Our article examines knowledge translation in this space, as both empirical focus and research methodology. Drawing from practice theory and critical pedagogy, we describe knowledge translation as a situated and social process of transformative learning, enabled by reflexive dialogue about practice, and supported by care. With examples from five studies across two countries, we show that practice-based knowledge translation can be mediated by researchers, using video-reflexive ethnography. We describe the importance (and features) of practices of care in these studies, that created psychological safety for transformative learning. We argue that attempts to transform and improve healthcare must account for sustained and reciprocal care, both for, and between, those made vulnerable in the process, and that knowledge translation can, and should, be a process of capacity strengthening, with care as a core principle and practice.

Keywords: care; knowledge translation; video-reflexive ethnography; transformative learning; psychological safety; reflexivity

Introduction

There have long been concerns about gaps between ‘what we know’ and ‘what we do’ (Bacchi, 2008), articulated across multiple philosophical and research traditions (Davies, Powell, & Nutley, 2016; Greenhalgh and Wieringa, 2011). In healthcare, the concern is commonly expressed as poor uptake of clinical evidence to improve clinical care (Dadich and Doloswala, 2018). Amidst a panoply of related terms (including knowledge transfer, exchange, mobilisation, implementation, dissemination, and diffusion), knowledge translation in this article is understood as ‘turning knowledge into action and encompass[ing] the processes of both knowledge creation and knowledge application’ (Graham et al., 2006, p. 22).

In this broad and diverse field, we are aligned with the growing push for collaborative approaches to improve the quality, applicability, and impact of knowledge (Coen, 2021). Collaborative approaches have their own plethora of related terms, including ‘Mode 2’, co-creation, co-production, co-design, and participatory action research (Greenhalgh, Jackson, Shaw, & Janamian, 2016). These approaches generally seek to be more socially accountable, centring the diverse perspectives, priorities, and concerns of participants (rather than researchers) in problem formulation and solving (Gibbons et al., 1994). Research thus becomes a dialogic and reflexive process among multiple actors, in interaction with pre-existing ecologies of knowledge and expertise (Nowotny, Scott, & Gibbons, 2003).

Our article examines knowledge translation in this dynamic space – of multiple knowledges in interaction, where the boundaries between knowledge production and use, and distinctions between researchers and participants, are blurred. We draw on practice theory, which treats knowing as interwoven with doing, such that knowledge is not something that resides in someone’s head, books, or journal articles, but is constituted through practice; and participation in practice, in turn, is how knowledge is changed or perpetuated (Gherardi,

2008). Knowledge translation, therefore, becomes a situated and ongoing practical accomplishment of actors, functioning within the healthcare system (Salter and Kothari, 2016).

A practice-based study of knowledge translation attends to socio-material interactions, *in-situ*, to see the ‘fine details of how people use the resources available to them to accomplish intelligent actions, and how they give those actions sense and meaning’ (Gherardi, 2012, p. 2). For example, Gabbay and le May (2004) showed how primary care clinicians make everyday decisions – rarely by consulting clinical guidelines, but rather, by using ‘mindlines’ or socially-constituted knowledge, which is informally and iteratively negotiated with patients and colleagues across multiple contexts. To know, therefore, is ‘to be capable of participating with the requisite competence in the complex web of relationships among people, material artifacts, and activities’ (Gherardi, 2008, p. 517).

From a practice-based perspective, there have also been calls for ‘engaged scholarship’ from researchers, to create spaces for collaborative learning with healthcare practitioners that harness these ‘social’ processes of knowledge translation (Salter and Kothari, 2016). Here, learning is facilitated through comparison with the perspectives of other co-participants in a practice (Gherardi and Nicolini, 2002). This reflects transformative learning (Mezirow, 2003), which emphasises intersubjective learning by reflecting on experiences and assessing frames of reference through dialogue, partly through assuming another’s perspective. Practice-based collaborative research thus offers opportunities and resources for intersubjective learning by creating opportunities for people to reflexively examine their own ways of knowing-in-practice, in dialogue with others.

The conduct of such research, however, is not straightforward. Gherardi and Nicolini (2002, p. 420) remind us that ‘comparing among different perspectives does not necessarily involve the merging of diversity into some sort of synthesis’. Although collaboration is

emphasised, conflict and dissonance can arise from differences in power, interests, and perspectives (Oliver, Kothari, & Mays, 2019), requiring careful conflict management and facilitation (Greenhalgh, et al., 2016). Transformative learning can involve emotional discomfort, including feelings of loss and disorientation, when taken-for-granted perspectives are challenged (Kwon, Han, & Nicolaides, 2020).

In this article, we describe how potential moments of tension, dissonance, or emotional discomfort are navigated in studies adopting a practice-based research methodology, video-reflexive ethnography (VRE), to facilitate transformative learning in healthcare. VRE researchers collaborate with participants to: co-create video-footage of everyday practices of interest (V); view the footage together during reflexive sessions to elicit multiple interpretations and perspective through discussion (R); and (re)frame understandings of participants' practices and experiences (E) (Iedema et al., 2019).

VRE is used to facilitate transformative learning by collaborating with participants to examine 'the accomplishment of everyday practices' (Iedema, et al., 2019, p. 13), and eliciting multiple perspectives on those practices through reflexive dialogue. This process, however, requires relational and emotional labour to offset the 'costs' of collaboration and transformation (Oliver, et al., 2019). Therefore, in VRE, care is treated as a core methodological principle (alongside exnovation, collaboration and reflexivity) (Iedema, et al., 2019). Care is central and necessary to VRE, given that participants are asked to place themselves in vulnerable positions – their behaviours are recorded and viewed for scrutiny by themselves and others, and their perspectives are potentially found to be in conflict or dissonance with others (Iedema, et al., 2019). Care for the researcher is also relevant, given that their actions and perspectives are available for participants' ongoing scrutiny (Carroll, 2009).

In this article, we attend to care as an empirical topic, but primarily as a methodological orientation. Here we acknowledge long traditions of sociological scholarship, including feminist, postcolonial, and science and technology studies that have delved into care – its sustaining and protective aspects, as well as its ‘dark sides’ (implicating inequalities, tensions, dependencies, and ambivalences) (Alacovska, 2020; Coopmans and McNamara, 2020; Puig de la Bellacasa, 2017). We also acknowledge the leadership of Indigenous scholars and their practices of community engagement in research, which centre relationality and relationships, and are committed to capacity strengthening in reciprocal and reflexive ways (Williams and Marlin, 2022).

Care, in VRE, is described as an ongoing process of researcher reflexivity (Collier and Wyer, 2016) and open communication with research collaborators. It involves: careful attention to differences in hierarchy and power; researcher transparency; and ameliorating likely sources of anxiety (Iedema, et al., 2019). This can be facilitated from the very start of VRE by ‘deep hanging out’ (Geertz, 1998) to build trust between researchers and participants and develop researcher understanding of the context. Other strategies include: making time to discuss ethical concerns with participants; iteratively requesting consent to show video-clips that feature participants; taking care to balance power dynamics among participants invited to reflexive sessions; and acknowledging the courage of participants who have agreed to be shown in video-clips (Iedema, et al., 2019).

These acts of care promote psychological safety – an influential concept in organisational studies, referring to a shared belief that the context is safe for interpersonal risk-taking (Edmondson, 2019). Psychological safety is essential for open reflexive discussion and team learning in organisations (Edmondson, 2019), and the self-reflexivity and critical dialogue that transformative learning requires (Kwon, et al., 2020). In this article,

we apply our practice-based perspective to consider how psychological safety is produced through practices of care to enable transformative learning in VRE.

Towards this aim, we describe the collaborative process by which this article was developed and outline the VRE studies from which our examples are drawn. Then, using vignettes, we describe how VRE facilitates transformative learning, and how this learning is enabled by attention to, and acts of care. Our central argument is that knowledge creation and use are ongoing accomplishments that should be examined at the micro-level of everyday healthcare practices. For research to productively intervene in these situated practices of knowledge translation, collaboration is necessary, and attention to care (as a practice) is required to participate in and sustain these interactions.

Methods

This article was initiated at a meeting of the International Association of Video Reflexive Ethnographers, during a discussion about care as a methodological principle. A subset of members (the authors, from Australia, the Netherlands and the United States) met regularly online to develop arguments relating to care, knowledge translation, and transformative learning in VRE. We shared de-identified transcript excerpts and reflexive writing from five of our studies (see Table 1). Concurrently, we shared literature from our (overlapping) areas of expertise: sociology, medical education, science and technology studies, health communication, organisational studies, translational science, and psychology.

[Insert Table 1 here]

The process of analysing our data and shaping our theoretical framework was an iterative and collaborative process of ‘thinking with theory’. Using a process of ‘plugging in’, we trialled applying different theories to our data and reflexive writing, from critical pedagogy (c.f. Mezirow, 2003) and organisational studies (c.f. Davies, et al., 2016) to build a

coherent argument out of the assemblage (Jackson and Mazzei, 2012). We used structured questions to guide our review of data and to draft vignettes; and took turns drafting and editing this manuscript, with SH primarily responsible for the coherence of the argument.

As in VRE, the process of developing this article sought a ‘plurality of discourses’ and legitimated their co-existence. Coming from different academic backgrounds, we were reflexive about our own practices of knowledge translation. For instance, we actively made space for uncertainty, discontinuities, and incoherence in discussions, as much as we worked to achieve negotiated meanings and a coherent narrative (Gherardi and Nicolini, 2002). Our meetings were recorded, to allow us to revisit prior discussions. Our work on shared documents were likewise tracked and recorded through version control, allowing all changes, and commentary to be re-traced.

Akin to our central argument, enacting care for one another through curiosity, respect and humility (Edmondson, 2019) was central to the psychological safety of the team. This was exemplified through the time and space given to: express uncertainty; consider every suggestion offered; and to co-create and test understandings of theories and data.

Ethics statement

All studies described were approved by the relevant human research ethics committees. All participants provided informed consent.

Findings

Here, we draw on examples from our VRE studies (Table 1) to describe how VRE fosters transformative learning through collaborative and critical reflexive scrutiny of everyday healthcare practices. This can be disorienting and emotionally complex, requiring practices of care to foster psychological safety.

We present our ‘data’ in five vignettes, written either as reflexive accounts from the researcher’s viewpoint or as third-person accounts of research events, illustrating three features of care identified in our analysis. First, care is not only planned by researchers, but is also necessarily enacted in response. This is characteristic of the fluid engagement of VRE researchers and the unpredictability of how VRE unfolds in complex healthcare settings (see vignettes 1 to 4). Second, care is not the sole responsibility of the researcher, but is enacted reciprocally, between participants and researchers, ‘in the moment’ during fieldwork and reflexive sessions (see vignettes 1 to 5). Just as care is reciprocal, so too are opportunities for transformative learning in VRE, where both researchers and participants find themselves challenging their own assumptions and coming to new realisations (see vignettes 2 to 4). Third, care is central to healthcare and this alignment of values might reflect the compatibility (and therefore impact) of research methodologies undergirded by an ethos of care (see vignettes 3 to 5). Although discussed separately here, in practice, and in our vignettes, these three features are intertwined.

Transformative learning enabled through responsive and reciprocal care

In VRE, reflexive sessions are designed to facilitate multiple perspectives on everyday practices shown in the video-clips to challenge, change, and transform how collaborators (both researchers and participants) understand their own and others’ ways of knowing-in-practice. Collaborators see, hear, and experience other perspectives on taken-for-granted practices, which might mean having their (or others’) behaviours challenged. Suggestions of wrongdoing are discomfiting and can threaten the psychological safety of those whose behaviours are scrutinised. In vignettes one and two, we see how this is handled by participants during reflexive discussions.

Vignette One

In this study on communication in intensive care, participants from multiple professions and across the hierarchy in one intensive care unit were involved, giving participants the opportunity to ‘see’ and discuss how different roles contributed to the safe and efficient functioning of the unit.

‘It was great to hear what everyone else is seeing [in the footage].’ (Nurse manager)

Video-footage of activity in areas like the central workstations highlighted the volume of information communicated at any one time and the ongoing challenge of keeping up with information without being distracted from important tasks. In intensive care, information needs to be communicated in a timely manner to respond to rapid changes in patient acuity. However, interruptions can also lead to mistakes and lapses. In the following exchanges, we see different perspectives raised on this issue, beginning with a senior doctor complaining of being interrupted during radiology rounds at the central workstation:

Consultant1: [During radiology rounds] we’re trying to concentrate on [the x-rays] and exchange information... and there’s constant noise and interruption.

Dietician: We go, ‘Aha! All the doctors in one place how convenient for myself to catch them’ [laughs cheerfully].

[...]

Consultant1: [And yet] I think lots of people are finely tuned to hear... I find it hard to concentrate on x-rays if I know there’s a team talking about a patient of mine nearby.

Nurse 1: Anything that gets you that little bit of advantage, a step ahead, allows you to prepare just that little bit of time in advance.

These exchanges show colleagues recognising that distractions were both problematic and useful. Later in the same session, other participants took care to justify colleagues' actions as reasonable, to protect them from criticism and negative judgement:

Nurse 2: [In one clip, Consultant 2 was] sitting at the desk - he was trying to read notes and he got disturbed about five or six times from different people.

Nurse 3: [Maybe some of] the people that interrupted him were nurses that were [interrupting because] what was explained at the bedside wasn't clear enough so they're having to go back again.

Physiotherapist: And maybe [there was] a change in the patient and they need to know [what to do].

Nurse 2: Yeah.

In vignette one, collaborators raised the problem (drawing on what is seen in the video footage) that doctors were constantly interrupted by colleagues, disrupting their concentration. In response, a dietician cheerfully acknowledged her role in causing interruptions (while justifying it by convenience). That she volunteered this perspective, accompanied with laughter, suggested that she felt psychologically safe in that discussion. The consultant and nurse then implicated themselves (and others), admitting they sometimes benefitted from the distractions. Later, another example of an interruption, framed as

problematic, was reframed as necessary for patient safety, demonstrating empathy for colleagues and understanding. In this session, participants co-constructed multiple frames of reference on interruptions – these countered suggestions of wrongdoing, leading to different realisations about the complexity of communication in the unit.

Vignette Two

As a nurse, I understand healthcare and as a researcher who uses VRE, I am not a distanced observer of hospital life. Rather, I consider myself to also be a research participant. I learnt a lot about myself when watching footage with patients. For example, James, a patient, and I watched footage of a healthcare worker drawing a blood sample from him. Our purpose was to consider the infection transmission risks posed. However, the very first observation that James noticed was me, in the background, contaminating research materials, which eventually left the room with me. He calls me out on it:

James: So, what I seen with you was with your notebook – and you'd already been touching [contaminated] things...

Me: My notebook. So, what I've had to do is try to go and clean that when I went out.

James: Oh, okay. So, any success? [Said jovially]

Me: Well, the trouble with that notebook is, and I'm going to get rid of it because it's not the right kind of notebook to have in this environment, because it's not easily cleanable. So, I'm going to get a board, like a plastic one that can be more easily wiped down... But this is a problem for me as a researcher

doing this and not wanting to spread things around to other people. So... great point.

This interaction shows the care that James afforded me while drawing attention to my unsafe practice. At first, I became defensive and grappled to position myself as the ‘expert’: a nurse and an IPC researcher. James did not backdown or let me assume that position; yet he also took great care in his challenge to allow me to save face. James used a jovial tone to keep the moment light, yet focused. I did not quite surrender my defensiveness, but I explored what I needed to do in future. By listening to James as an expert (after all, he spent weeks in isolation due to his healthcare-acquired drug resistant infection), I gained a different perspective on IPC and how to change my research practices when working in infectious rooms.

In vignette two, a patient observed the researcher potentially contaminating research materials. The patient shared his observation with humour, demonstrating empathy and care for the researcher’s awkward position. It could also suggest his sense of psychological safety, that he felt able to challenge the researcher’s actions. Here, it was the researcher whose understanding of her own practices was transformed through critical self-reflexivity, prompted by the interaction, as well as her reframing and recognition of the patient’s expertise.

In other situations, moments of tension in VRE arose from *in-situ* interactions during fieldwork, because healthcare work and interactions are often emotionally challenging. We see examples of this in vignettes three and four.

Vignette Three

During this study, researchers were struck by the rich reflexive sessions where clinicians explored, with great sensitivity, some challenging moments in the recordings. These responses sensitised us to the importance of supporting trainees who are in emotional distress. A moment was captured on video, showing a supervisor (a senior doctor) caring for a trainee when he noticed the trainee struggling:

‘That was my first shift... I’m a very anxious person; I was having a really hard time adjusting to starting work... and I was having panic attacks, like full-blown. I’m standing in the middle of [the resuscitation area] just like clearly not okay, almost in tears, and then [the supervisor’s] like, “Are you okay?” I’m like, “No”.’ (Trainee)

The supervisor then created a safe environment by taking the trainee to a quiet part of the department, reassuring the trainee that it was normal to feel this way. When the video-clip was shared with a group of the trainee’s peers and a different senior doctor during a reflexive session, the senior doctor acknowledged the trainee’s bravery and the trainees openly shared their own rarely discussed experiences of navigating emotions, including the difficulty of sharing emotions with senior colleagues:

‘It was really lovely that she allowed you to record that.’
(Senior doctor)

‘Within medicine, it’s like, don’t pretend you’re... human and actually have emotions; whatever you do, keep it together. But

that's just the vibe that I've got from people; maybe I'm wrong.' (Trainee)

After watching the video-clip, the senior doctor realised their role in enabling that communication, and the importance of care:

'I think the psychological safety that's created, in just that 30-second clip that you've shown me, is a lifetime of impact, that really warms my heart... You can tell them till you're blue in the face that they're not expected to be a robot. But it counts for nothing if we aren't embodying that ourselves and that once they hit the floor, we're not enabling them to do any of those things.' (Senior doctor)

Through reflexive dialogue about this one important and intense moment, both trainees and senior doctors generated different ways of attending to, and communicating emotions, as part of workplace learning and supervision.

In vignette three, a video-clip of a senior doctor caring for a medical trainee elicited reflexive discussion on the hitherto sidelined topic of talking about emotions in medical work and training. In watching this exemplary moment of care together, trainees felt safe to share their experiences, and a senior doctor realised their role in enabling communication about emotions with junior colleagues. Perspectives on what constituted acceptable discourse during medical training were expanded, in this discussion, to include the emotional impact of medical practice.

Vignette Four

Given that both of my parents died some 18 months before this study, I found a need to (figuratively) tread cautiously for its duration. The hospital was

where my father died, and where my mother was diagnosed with an aggressive cancer. Shadowing the palliative care clinicians, I learnt how they established rapport with patients and family members, how they broke bad news and managed difficult conversations, how they negotiated organisational politics, and how they advanced particular agendas, sometimes their own.

In preparation for each patient visit, a clinician I shadowed would typically describe the patient's situation, as we accessed elevators, climbed stairs, and traversed corridors. As we grew closer to the ward, I felt a sense of déjà vu. Yet given that the wards and corridors looked and felt very similar (if not the same), I was unsure why. Then, as we approached the patient's room, I froze. This was the same room that my father had died in. The feeling was surreal. The room had not changed – it still contained the bedside drawers that my mother stocked with my food that we hoped my father would consume, the chair that had become my bed, and the window that I looked out of, hoping for a better outcome. Even the patient who currently occupied the room was reminiscent of my father, who was also an older man whose primary language was not English. And, like my father, this patient looked frail as his weary family members watched with concern and did what they could to make him comfortable.

Realising my unease, the clinician took a moment to quietly ask if I was okay. Keen to ensure that I did not hinder their clinical work, I sheepishly smiled and softly explained why I was somewhat taken aback. They kindly asked whether I would prefer to forgo this patient visit – but given her compassion, I felt comfortable in taking the plunge by entering this room. After we left the patient's room, the clinician warmly asked how I was. I noticed that their pace

was not as hurried as it was before the patient visit – perhaps this was to afford us greater opportunity to debrief. Then, maybe as a sign of compassion, they shared their own experience of loss – the death of a family member.

In vignette four, the moment of tension occurs during ethnographic observation, with a bereaved researcher, suddenly reminded of her grief during fieldwork. Here, the frames of reference of ‘researcher’ and ‘family member’, and ‘clinician’ and ‘research participant’, were productively blurred. The clinician’s attentiveness and compassion enabled the researcher to feel safe to continue fieldwork and develop insights into her research question – how palliative care clinicians enact family-centred care, having experienced this, herself. VRE enabled this learning, firstly by foregrounding the expertise, and co-engagement of both researchers and clinicians in learning; and secondly, by fostering rapport and compassionate relationships to form, through the researcher’s embeddedness in the context over a period of time. This ‘orientation to others’ (James, 2015, p. 1) drives reciprocity and ethical engagement, without which it would be difficult to enact, examine, and comprehend care.

In our final example, vignette five, we see how preparations to care for and welcome participants during reflexive sessions, mirrored similar practices in the maternity unit. Through reflexive discussions, parents and maternity care professionals reframed acts of hospitality (offering hot drinks and cookies) from taken-for-granted practices to being recognised and re-valued as important acts of care

Vignette Five

In a study on collaboration and communication in maternity care, (expectant) parents and healthcare professionals were involved. Conscious of soliciting the professionals and (expectant) parents’ comfort and ease, the researchers transformed the clinical settings for the reflexive sessions by dimming lights, bringing in teapots and cups from their homes, arranging tables and chairs in a

circle, having healthcare professionals attend in their own clothes (not uniforms), and by using first names only.

In one session, participating professionals and (expectant) parents shifted in their thinking about the importance of having access to tea, coffee, and cookies in waiting rooms and hospital pantries. At first, they noted these ‘frivolous’ details were ‘nice and all’, especially for parents, but not worth serious attention. However, further reflection generated a re-evaluation of these offerings. They not only redefined the availability of tea, coffee, and cookies as necessary to create a homely atmosphere that made them feel welcome, but also added a temporal dimension. These attributes of a nice atmosphere elongated the felt care time. It enabled parents to feel cared for when their appointment had not even begun yet, stretching care beyond the border of scheduled appointments. One medical assistant gave an example of how she suggested to some parents that they have a cup of coffee in the hospital restaurant because their appointment was delayed, as she had no facilities to offer them a beverage. Given the parents’ contributions to the reflexive sessions, she now realised how this suggestion to have the parents temporarily leave the waiting room functioned as more than just a filler of otherwise unused time; it made those parents feel seen and cared for. The offering of coffee provided the parents with an activity to fill waiting time. It also provided the medical assistant an opportunity to show the parents she cared. With this awareness of the important role of coffee, tea, and cookies, came an awareness of the value of everyday interactions as an aspect of maternity care.

As with vignettes three and four, vignette five demonstrates how healthcare research is necessarily *research about care*. When examining healthcare practices at this level of detail, participating competently in healthcare as a healthcare professional or patient is not only about knowing information in the objective sense of scientific evidence; it is also about knowing how to care. Likewise, participating competently in research that seeks to transform healthcare practices requires researchers (and collaborators) to know how to care and be receptive to care.

Discussion

Previously, care has been described in VRE literature through the actions, attention and reflexivity of *researchers*, towards participant safety (Collier and Wyer, 2016; Iedema, et al., 2019). Our findings support and expand this description of care, by showing how care can be planned, but is primarily responsive in action, given the unexpected interactions and reactions that can occur in healthcare, and during VRE. Further, we describe how care in VRE is reciprocal – with participants as well as researchers demonstrating sensitivity and attention to the wellbeing of one another. The acts of care observed between participants in our vignettes were not surprising, reflecting how organisational theorists like Edmondson (2019) describe psychological safety ‘at work’, enabling learning in ordinary circumstances and during VRE. What is less often described is how participants also care for researchers.

One implication for these findings, is that participants who are research collaborators share ‘ownership’ of the research (Novotny and Gagnon, 2018), and this may also include a share in responsibilities. We do not refer here to the kinds of research responsibilities formalised in research protocols, consent forms, or inter-organisational agreements. Using a practice-based lens, we find that care, like knowledge translation, is also an ongoing, relational accomplishment, situated in (and inextricable from) the socio-material interactions and contexts in which it is enacted. For instance, we presented our ‘data’ in vignettes, partly

because the acts of care we described were not all verbal, but also experienced as tones of voice, changes in pace, and atmosphere. This reflects how care is about being ‘*touched* rather than observing from a distance’ (de la Bellacasa, 2017, p. 93, original italics). While we would not go so far as to argue that participants *should* care for researchers or how they should do so, we draw attention to it and invite others to join us in considering the implications for knowledge translation in healthcare. In this, we are informed by researchers who collaborate with vulnerable (or rather, structurally underserved) communities, and argue for collaboration to improve knowledge translation and health service reform through care for human rights as well as social and epistemic justice (Bellingham et al., 2021; Novotny and Gagnon, 2018; Williams and Marlin, 2022). In the field of climate science, Coen (2021, p. 51) argues for usable science as that which serves the needs of those vulnerable to climate change, as ‘a form of care: care for data and its analysis, and care for people and their relationships’.

In a similar vein, our paper also contributes empirical support for a practice-based perspective on knowledge translation, as a process of social learning that involves critical reflexive dialogue between practitioners, wherein they (re)examine and (re)negotiate personal and shared theories of practice (Salter and Kothari, 2016). Critical perspectives in the past have warned that the term ‘translation’ is a constraint to more complex understandings of the links between knowledge and practice (Davies et al., 2008; Greenhalgh & Wieringa, 2011). However, we retain it as useful, given that it is a common term of reference (albeit one among many) for a broad range of endeavours that include efforts to acknowledge non-linearity and complexity in knowledge creation and use (Davies et al., 2016). In a sense, we take a different critical approach to knowledge translation, treating it as a ‘matter of concern’ by offering participants arenas to assemble and examine together what makes knowledge translation possible (Latour, 2004). In other words, VRE researchers do not treat knowledge

translation only as an empirical topic – tracing how it is accomplished in practice by (healthcare) actors; but also, facilitating its accomplishment as a collaborative and interventionist research methodology.

In some ways, VRE represents ‘knowledge intermediation’ (Davies et al., 2008), designed to facilitate the interaction of multiple knowledges in practice. The term is popular in the organisational development and learning literature. It emphasises the role of intermediaries in facilitating corporate innovation, bringing together actors, such as researchers, practitioners, and policymakers (Powell et al., 2017). For VRE researchers, the emphasis is not so much on innovation, but rather, exnovation (Iedema et al., 2013), which is a form of innovation *from within* – this emphasises the inherent reflexive and transformational capabilities of (healthcare) actors. The researcher role in VRE is not to provide expert knowledge that might be integrated into practice; but rather, to provide a collaborative learning ‘space’ (Salter & Kothari, 2016) where local actors feel safe to surface and articulate their own knowledges-in-use, to compare, question, and reconsider them, and to alter their practices, accordingly.

In doing so, VRE aims not only to create instances of learning, but also, to strengthen local actors’ capabilities to learn, collectively. This is described as an outcome of transformative learning processes, by which learners experience ‘a deep shift in perspective toward a more open, permeable, and justifiable way of seeing themselves and the world around them’ (Cranton & Wright, 2008, p. 34). Learners also become more ‘emotionally *able* to change’ (Mezirow, 2003, p. 58, emphasis added). VRE thus describes how researchers, as mediators, can impact on knowledge translation in practice, strengthening participants’ (and their own) capabilities for reflexivity, and future transformative learning (Carroll & Mesman, 2018). These reflexive capabilities require a kind of ‘passivity competence’, meaning the

ability and willingness to first observe and listen instead of acting immediately (Iedema et al., 2013).

It is worth remembering that the aim of knowledge translation is to improve practice, and, as Davidoff (2002, p. 623) noted, ‘shame is the universal dark side of improvement’. This is because improvement requires practitioners to recognise their current practice as inadequate or worse still, unsafe. However, if this vulnerability is treated with care, as we have shown in VRE, it can become a productive (or generative) state of being, creating an affective engagement with learning that transforms learning (Collier and Wyer, 2016). In healthcare, this is important, given that care for others (and being cared for) is at the heart of healthcare work and experiences (Kuhn and Le Plastrier, 2022), and yet we continue to grapple with unacceptable levels of unsafe care (Schiff and Shojania, 2022).

We described, in our findings, how participants cared for one another and for researchers during fieldwork and reflexive sessions in ways that mirrored how they usually care for colleagues, patients and family members, by using humour, showing empathy and hospitality. VRE has been described as a process of exnovation – eliciting and strengthening the inherent creativity, resourcefulness, and transformational capabilities of healthcare actors as experts in their own domains of practice (Iedema, et al., 2013). Our findings suggest that we should also recognise (and celebrate) participants’ abilities and expertise in care, as a core skill in enabling transformational learning and improvement in practice.

Conclusion

In this article, we demonstrated what knowledge translation, done collaboratively and sustained by care, looks like in practice. Using examples from five VRE studies, we described accounts of transformative learning that were enabled by care. In this, researchers and participants experienced and enacted learning and care, attuned to one another and willing to be vulnerable in each other’s company. Care enables and sustains interactions that

build trust and community in the difficult (and sensitive) work of understanding what different people ‘know’ and what that means for how we do healthcare differently.

Healthcare is beset by myriad challenges exacerbated by the pandemic, including a workforce that is burnt-out and exhausted (Schiff and Shojanian, 2022). We suggest that any attempt to transform and improve healthcare practices cannot be successful unless it involves, from the start, genuine collaboration with those who are impacted by these changes. In this context, it may be fruitful to reimagine (and account for) knowledge translation as a practice of capacity strengthening, that is undergirded, not by scientific expertise or implementation frameworks, but rather, by care.

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The authors report there are no competing interests to declare.

Data availability statement

The data are not available, due to ethical restrictions regarding the privacy of research participants

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