

Critical inquiry and knowledge translation: exploring compatibilities and tensions

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Abstract

Knowledge translation has been widely taken up as an innovative process to facilitate the uptake of research-derived knowledge into health care services. Drawing on a recent research project, we engage in a philosophic examination of how knowledge translation might serve as vehicle for the transfer of critically oriented knowledge regarding social justice, health inequities, and cultural safety into clinical practice. Through an explication of what might be considered disparate traditions (those of critical inquiry and knowledge translation), we identify compatibilities and discrepancies both within the critical tradition, and between critical inquiry and knowledge translation. The ontological and epistemological origins of the knowledge to be translated carry implications for the synthesis and translation phases of knowledge translation. In our case, the studies we synthesized were informed by various critical perspectives and hence we needed to reconcile differences that exist within the critical tradition. A review of the history of critical inquiry served to articulate the nature of these differences while identifying common purposes around which to strategically coalesce. Other challenges arise when knowledge translation and critical inquiry are brought together. Critique is one of the hallmark methods of critical inquiry and, yet, the engagement required for knowledge translation between researchers and health care administrators, practitioners, and other stakeholders makes an antagonistic stance of critique problematic. While knowledge translation offers expanded views of evidence and the complex processes of knowledge exchange, we have been alerted to the continual pull toward epistemologies and methods reminiscent of the positivist paradigm by their instrumental views of knowledge and assumptions of objectivity and political neutrality. These types of tensions have been productive for us as a research team in prompting a critical reconceptualization of knowledge translation.

Keywords

critical inquiry; knowledge translation; postcolonial feminism; critique; theoretical pluralism; social justice

Introduction

Knowledge translation (KT), and the closely related knowledge exchange, knowledge transfer, knowledge mobilization, and knowledge brokering, has taken hold in a movement for improved uptake of research-derived knowledge in the health services. Undoubtedly, the aim of KT to ground practice, whether planning health service delivery systems, ascertaining the most effective treatment for diseases, or guiding health professionals in decision-making at the point of care, in the best available evidence is fundamental to health care services today. However, approaches to KT are still being developed, and the mechanisms whereby KT best occurs are not entirely clear, particularly when the nature of the knowledge to be translated and the contexts for knowledge uptake vary. There is also beginning exploration of the implications of the philosophic and theoretical grounding of the research knowledge that is being translated.

The purpose of this paper is to engage in a philosophic discussion of the implications of bringing together what could be considered two distinct paradigms or approaches to knowledge; the emerging knowledge translation movement and the genre of critical inquiry. Specifically, we articulate the compatibilities among various critical perspectives, and examine how these might be taken forward, drawing on a KT project that used the concept of cultural safety to prompt critical reflection on critically oriented knowledge from our collective programmes of research (Anderson *et al.*, 2008; Browne *et al.*, 2009). Our KT project was designed to synthesize and apply knowledge from several research studies informed by critical theories, including studies of help-seeking, health care access, and hospitalization experiences of patients from various backgrounds, involving people who have immigrated to Canada and Aboriginal peoples (Anderson *et al.*, 2008). The project team aimed to pilot selected KT strategies that would best serve as vehicles for the uptake of this critical knowledge. The objectives of the KT project were to:

1. Build on established partnerships between researchers and health professionals to co-create knowledge and incorporate that knowledge into practice.
2. Synthesize research findings from several studies that contribute to knowledge focused on the social circumstances of patients' lives that impact on transitions; and, engage health professionals in dialogue about how this knowledge can facilitate smooth patient transitions between hospital and home.
3. Co-create opportunities for health professionals to critically reflect on their assumptions about patients and the impact of these assumptions on patient care.
4. Evaluate the impact and effectiveness of this process of KT on the smooth transition of patients from hospital to home.

One of the unique features of this project, compared with other KT projects, was its theoretical framing informed primarily by postcolonial feminism, and the fact that the knowledge being translated was developed using critical inquiry, representing various theoretical perspectives. That most of the studies serving as the source of the knowledge were qualitative in nature added to the distinctiveness.

The paper begins with an historical overview of the development of what we refer to as the 'critical paradigm'. Postcolonial feminism is situated within this genealogy. Team members have relied upon various critical perspectives within this paradigm for the studies that comprised the knowledge to be translated. In the process of synthesizing knowledge from these studies the team realized the necessity of examining in more depth the ontological and epistemological differences among various theoretical perspectives within the critical paradigm, and we present this next. With this representation of critical perspectives, and their distinctness, we then review some of the epistemological and ontological assumptions underlying current approaches to KT. We ask the question whether knowledge translation might serve as vehicle for the uptake or transfer of critically oriented knowledge into clinical practice. We discuss compatibilities and differences between critical inquiry and knowledge translation, as well as possible limitations of both, as made visible through this exercise. The paper concludes with several recommendations for critical knowledge translation.

Critical inquiry

This KT project was informed by critical perspectives. Because the project focused on cultural safety in the context of providing care to diverse populations, a postcolonial feminist theoretical framing was primarily relied upon for its attention to themes of race, racialization, and associated intersectional oppressions. Doing so carried ramifications for the KT process. Positioned within the critical paradigm, post-colonial feminist theory shares certain features with other critical perspectives but also holds some key distinctive features, a point to which we return shortly. These distinctions and convergences, elucidated in the following brief genealogy of critical traditions, ultimately carry implications for our pursuant reconceptualizations of knowledge translation.

A brief genealogy of critical perspectives

The term 'critical theory' was coined in 1937 by Horkheimer to reflect the Marxist-oriented research at the Institute of Social Research founded in Frankfurt, Germany in 1923 (subsequently referred to as the Frankfurt School). Horkheimer, with other colleagues including Adorno and Marcuse, developed critical theory as grounded in social theory and political economy (informed largely by Marxist theory) to carry out systematic critique of existing society, and ally itself with efforts to produce alternatives to capitalism (Kellner, 2005). Habermas, a student of Adorno and Horkheimer, produced a rich body of work that began in a Western Marxist stance and eventually developed into a philosophy of communicative action and critical social theory (Kellner, 2005).

From these predominantly Marxist roots, cultural studies branched off in various forms in the 1960s with French intellectuals such as Sartre, Baudrillard, and Lyotard pursuing what became known as post-modernism, and Derrida and Foucault engaging in the development

of post-structuralism (Barker, 2000). During this time, anticolonialists, notably Frantz Fanon, Albert Memmi, and Aime Cesaire, were denouncing European colonialism with analyses of the role of class, race, national culture and violence in the struggle for national liberation, and in retrospect, can be seen to have begun the postcolonial movement. In her overview of the development of postcolonial theorizing, Parry (2004) notes that foremost postcolonial scholar Edward Said both acknowledged the contributions of post-structuralist theory, Western Marxism, and Anglo-American criticism, and observes that within these theories there is indifference to colonialism as constitutive of metropolitan society and culture. In particular, Said called attention to their failure to recognize the work of anticolonialist critics such as Cesaire and Fanon. This then became the departing point for postcolonial theory. Said's *Orientalism*, published in 1978, showed how deeply certain visions of Asiatic societies were woven into canonical European literature. Colonization was no longer seen only as enacted in exotic places, but as central to the very existence and identity of European culture (Cooper, 2005). Taking inspiration from Said's work, postcolonial studies began in the late 1970s and early 1980s in what was then called 'colonial discourses analysis' (Parry, 2004).

In the early 1980s, colonial discourse analysis coincided with the institutionalization of an extensive platform of research initiatives, including gender, feminist, African American, 'ethnic', and gay/queer studies. Together these initiatives examined how dominant systems of knowledge had affected the discursive regulation and institutional oppression of subordinated communities and marginalized cultural traditions (Parry, 2004). From early roots in Marxist analyses, then, the diverse family of critical theories has developed in many ways, and is now understood to be concerned 'with issues of power, and justice and the ways that the economy, matters of race, class and gender, ideologies, discourses, education, religion and other social institutions, and cultural dynamics interact to construct a social system' (Kincheloe & McLaren, 2000, p. 281). Key to our discussion here is the shared historical materialist-realist ontology (Guba & Lincoln, 2005) of these critical perspectives that views reality as shaped by social, political, cultural, economic, ethnic, and gender values crystallized over time. Such an ontology makes linkages between the everyday experience of individuals with broader social structures, based on the assumption that the real world makes a material difference in terms of race, class, gender, and other such social categories. Within this stance, the basic critical analytic process is one of scrutinizing taken-for-granted assumptions and relationships by asking how they actually relate to wider oppressive structures and how these structures legitimate and conceal their oppressive mechanisms (Harvey, cited in Labonte *et al.*, 2005).

The development of postcolonial theories can be understood as sharing some early common roots and concerns with other theories in the critical paradigm, but developing a clearly distinct body of scholarship based on critiques of the, by then, established field. Broadly, postcolonial theories are concerned with the legacy and ongoing effects of colonialism. From the groundwork laid by Fanon and other anticolonialists, Said's *Orientalism* (1978) was followed by what is referred to as a 'linguistic turn' that saw Spivak (1988) and Bhabha (e.g. *The Location of Culture*, 1994) leading in discursive analyses (influenced by Derrida and Foucault's deconstruction and post-structural methods). Following from Said's *Orientalism* and the provocative question raised by Spivak, 'Can the subaltern speak?', a

fundamental distinguishing element of postcolonial theories is their commitment to giving voice to subjugated and indigenous knowledges, especially non-Western voices. Parry (2004) observes that within postcolonial critique 'discourse' has since been privileged as the model of social practice with the consequence of a remarkable 'incuriosity about enabling socio-economic and political institutions' (p. 68), particularly where postcolonialism has found its home in English, Literary Studies, and Cultural Studies university departments. While attention to and critique of dominant discourses and ideologies and their effects is essential, it is insufficient to the cause of redressing pervasive social inequities.

Such concerns, and the widespread inattention to gender analyses in postcolonial theorizing, matched by a lack of race as an analytic category in feminism, led concerned Black feminist scholars such as Patricia Hill Collins, Rose Brewer, and bell hooks to draw attention to how women of Colour are typically positioned in society and how race, class, and gender operate in tandem in what are multiple, shifting sites of oppression. Building on these works, postcolonial feminists [also referred to as 'feminist postcolonialism' (Lewis & Mills, 2003)] are now relying on intersectional analyses that begin with the assumption that one cannot understand the experiences of 'women' or 'Blacks', or 'migrants' or the 'poor' in isolation from all of the multiple social classifications or identities each individual carries, the privilege or disadvantage associated with these identities, and that these social identities are indivisible from each other (Yuval-Davies, 2006).

In summary, central to postcolonial feminist theory as taken up by several team members are the examination of the root causes of racialized, classed and gendered inequities; critical analyses of people's historical and ongoing experiences of colonialism and neocolonialism; deliberate decentring of dominant culture in order that the perspectives of those who have been marginalized become starting points for knowledge development; and examination of how key concepts such as race, racialization, and culture are constructed with particular effects (Anderson, 2002; Reimer-Kirkham & Anderson, 2002). These features of postcolonial feminist theorizing, especially the focus on disrupting the history of race-based thinking and racializing processes, and the concern with the structural inequities perpetuated by historical and current political, economic and social conditions (Browne *et al.*, 2005; Anderson *et al.*, 2007), offer considerable analytic currency in the area of social justice and health inequities (Reimer-Kirkham & Browne, 2006).

Theoretical pluralism and knowledge synthesis

Members of the research team have also drawn on a range of critical perspectives other than postcolonial feminist theory (e.g. feminist theory, post-structuralism, critical race theory) and various theorists (e.g. Bourdieu, Foucault, Ricouer) to enhance scholarship. A question that engaged the team, particularly in the early phases when we were synthesizing findings from our various studies, was 'how would we work together, given our work was informed by various theories?' Ultimately, what drew the team together was a commitment to research for social justice and equity, an ideal shared by the range of critical perspectives upon which team members drew (see Reimer-Kirkham & Browne, 2006; and Browne & Tarlier, 2008 for discussion of critical conceptions of social justice). Cultural safety, a concept that several of us had been working with in various ways and to which our team was committed to using,

served as the vehicle to operationalize social justice for the KT project (See Browne *et al.*, 2009). Yet, while the team shared these core commitments, during the project (including conceptualization of the project, implementation activities, and analytic processes) we encountered tensions regarding the degree to which we were able to stay focused on, or 'true', to the direction provided by the critical framing of the project.

As the project progressed, distinctions between the different theories that informed the various sources of the knowledge for translation came to the attention of the team. These various theoretical traditions influenced what ideas were brought to the foreground. For example, the extent to which gender, race or class were the primary unit of analysis varied. Some of our work drew explicit attention to the corporate context of health care and the impact on nurses' work (e.g. Varcoe & Rodney, 2001); other work emphasized the racialization of nurses' practice environments (e.g. Varcoe, 2001; Reimer-Kirkham, 2003); and yet other work focused on the racializing and culturalist discourses that (often inadvertently) influence health care providers' knowledge and practices (Varcoe, 2001, 2009; Browne, 2005, 2007). Our individual social locations also entered in, and as the project progressed, we became more reflexive regarding our individual social positions, and how these might lend to privileging particular analyses.

In earlier work by several members of the research team (Anderson *et al.*, 2007) examining connections between Bourdieu and postcolonial feminist scholarship, the suggestion was made that 'examining the points of connection between critical theoretical perspectives might further the construction of reflexive and transformative knowledge, to move us forward in addressing past injustices and continuing inequities in health and health-care' (p. 179). The argument was made for a pragmatism that accommodates theoretical pluralism for the sake of explanatory capacity and praxis while, at the same time, cautioning against 'marrying' or merging theories without critically questioning the epistemological and methodological disjunctures between theories. In this KT project, to bring together knowledge for social justice from variously informed critical inquiry studies meant the team needed to continually take note of any such disjunctures.

An important difference between theories within the critical paradigm has to do with the ontology of the subject in regard to the extent to which being and knowing, ontology and epistemology are differentiated. Philosophers from various strands of feminism and hermeneutics argue for seeing knower and knowledge as inseparable (e.g. Harding, 1991; Ricoeur, 1991). Related is the ontological tension concerning the nature of power. Fenwick (2004) notes that tensions remain unresolved between those arguing for a materialist understanding of power informed by Marxist roots (i.e. power existing in and enacted through structures) and others committed to more discursive analyses of circulating cultural power, drawing on post-structural conceptions of the micropolitics of power. The matter of agency, and particularly how independent from social context the individual is understood to be, follows from how one conceives of power. Although all of the critical perspectives brought to this project hold to the importance of contextual analyses, there are variations in emphasis, reflecting a central problematic in social theory today; the tensions between particularities (the 'local') and universals (the 'global'), agency and structure. To what extent do individuals influence structures, and to what extent are they shaped by structures?

Whereas some scholars in the critical paradigm might tend toward an interpretive stance that focuses on the lived reality of individuals (as in the case of critical phenomenology), other analyses function predominantly at macro levels with observations of how privileges and oppressions are structured. For our work together on this project this meant that we grappled with various views of agency. For example, there was some variance in the extent to which some of the team saw nurses' agency in the practice setting as constrained by the wider context (i.e. the contexts of health care and the social world more generally). Moreover, those team members who drew extensively on feminist theory tended to focus more closely on the experiences of the nurses, while those who relied primarily on postcolonial theorizing were more attuned to racialization in health care services.

Another disjuncture of note here is that of whether critical theory functions as a master narrative originating with Western intellectual elites, or whether it begins from the standpoint of subjugated knowledges, outside of Western tradition and Enlightenment thinking. As we have argued elsewhere (Anderson *et al.*, 2007), 'postcolonial feminist theorizing begins with the subaltern, gendered voice, with the specific intent of interrupting the "master" narratives' (p. 185). Thus, as Anderson (2002) has explained:

post-colonial and Black feminist perspectives cannot be extensions of critical perspectives developed within Euro-American traditions. Through dialogue, however, there is the potential to reframe dominant discourses and to create a perspective on knowledge development that reflects multiple social locations. But this is not possible until the voices that have been marginalized are recognized and treated as legitimate in the social production of knowledge. (p. 18)

Embedded then in this difference between knowledge derived from master narratives compared with subjugated knowledges is the epistemological and methodological distinction between deductive theorizing and that of the postcolonial feminist practice of starting with voice and everyday life experiences of those who bear the burden of colonizing histories, impoverishment, and ill health (Anderson *et al.*, 2007). Our challenge became how to bring marginalized voices into the forefront of health care discourses.

Given this theoretical pluralism within the critical paradigm, and our research team more specifically, we engaged in a process of identifying compatibilities between critical perspectives. Based on our shared commitment, grounded in the critical paradigm, to social justice and addressing health inequities, we centred this process on the concomitant knowledge required to enact this commitment, and the framing of this knowledge in relation to cultural safety for the purposes of translation.

The nature of knowledge produced by critical inquiry

The nature of knowledge produced by critical inquiry is socially organized, meaning it is contextual, perspectival, political, and historical. Knowledge is partial, representing particular realities, while simultaneously organized by the social context, meaning that broader social forces such as economics, gender, history, and politics shape knowledge. Knowledge produced within the critical paradigm is done so with a deep awareness of its social organization, and thus tends toward certain types of knowledge. The research projects drawn on as the source of the knowledge translated in this project elucidated themes such as

health inequities, unequal access to health care services, the marginalizing practices of racialization, and assumptions underpinning societal discourses brought to health care provider–recipient encounters (Anderson *et al.*, 2008). This knowledge was characterized by at least four key features: how oppression is understood, how culture is defined, the importance of social determinants of health, and the continuities between social and health care inequities.

As made clear by postcolonial feminist scholars, we stress the importance of understanding oppression not as an ‘us’ and ‘them’ phenomenon (Collins, 1990; Anderson, 2002), but rather as shifting systems of privilege and disadvantage, where a person can be simultaneously advantaged and disadvantaged. However, we understand the shifting locations of privilege and oppression as falling along axes of power represented by intersecting social categorizations such as gender, race, and class (Yuval-Davies, 2006).

The synthesized knowledge formulated by our team was also founded on critical perspectives of culture itself, viewing culture not as static, neutral, or reified, but as a power-laden social construction inscribed with racialized images and assumptions (Anderson *et al.*, 1991; Reimer-Kirkham *et al.*, 2002; Lynam *et al.*, 2007). Postcolonial feminist scholarship departs from what has become ‘the common mode of exploring “difference” (i.e. a culturalist focus on culture as a relatively static set of beliefs, values, norms, and practices attached to a discrete group sharing a common ethnic background by pointing to the politics of *race*, particularly in sustaining colonizing relationships’ (Reimer-Kirkham & Anderson, 2002, p. 3) (see also Browne *et al.*, 2009).

Our scholarship invariably sheds light on the broader context of health care services, and the social distribution of health and illness given our scrutiny of the effects of operations of power across macrostructural and micropolitical levels. While we argue for access to appropriate, efficient, and effective health care services, health care in and of itself is not a major predictor of health status. Social and economic determinants of health, also referred to as the ‘social gradient of health’ (Marmot, 2006, p. 2), mean that other factors such as poverty, nurturing childhood environments, housing, employment, social support, clean water, and food (factors that are shaped along the axes of gender, race, migration experiences, age, ability and so on) are as important or more important to health status. These social determinants are typically beyond the sphere of influence for health care professionals and arguably are also outside the domain of health policy, depending on how health ministries’ mandates and policy jurisdictions are aligned. Moreover, Labonte *et al.* (2005) assert: ‘One cannot talk meaningfully about the social determinants of health – nor begin to impact on them – without recognizing that they reflect underlying social processes’ (p. 8). These underlying social processes, so determinative of health status, include capitalist, neoliberal and neocolonial ideologies and practices that serve as the roots of poverty, under-housing, inadequate access to services, and so forth. These root causes and their outcomes are central to the interests of critical inquiry. Thus, we understand health inequities as contiguous with and partially constituted by wider social inequities. The same dynamics that sustain wider social inequities also shape health care services, inequities in access to health care, and health care encounters.

Thus the knowledge generated by critical inquiry and brought together for the purposes of this KT project represents a type of knowledge distinct from the types of knowledge (such as clinical or health care administration knowledge) typically relied upon in health care contexts. Yet, our assumption in undertaking this project was that critically oriented knowledge is crucial for the effective, efficient, and equitable delivery of health services. The question we took up in this project was how such knowledge could be integrated into clinical practice settings, alongside and complementary to other health care knowledges. Could knowledge translation, as it is currently conceptualized, serve as a mechanism for the uptake of such critical knowledge into health care practice? We turn now to a discussion of some of the philosophical assumptions that underlie current KT discourses.

Knowledge translation

Knowledge translation, as a movement, has seen remarkable uptake in a short period of time, with national organizations around the world endorsing knowledge translation (although specific terminology, interpretation, and implementation vary to some extent) as core to the research enterprise. Where differentiation is made between KT and related processes such as diffusion and dissemination, KT is generally understood as a much broader concept that places a significant emphasis on the implementation of research-derived evidence within a complex system of exchange among stakeholders. A recent study (Tetroe *et al.*, 2008) to determine the knowledge translation policy, expectations, and activities of health research funding agencies internationally found that while the specific terminologies and strategies may vary, KT is being increasingly recognized as an important area of research internationally and the research funders are seen as taking increasing (though variable) roles in KT. In the UK, promoting and strengthening translational research has been a key priority for the Medical Research Council, which describes translational research as ‘the process of the bidirectional transfer of knowledge between basic work (in the laboratory and elsewhere) with that of the person, in health or disease’ (MRC, 2007, p. 3). Research partnerships such as those between researchers and health care organizations have also been recognized as one of the key strategies for KT by the Agency for Healthcare Research and Quality in the United States. Like the UK and US, over recent years the national funders of health research in Australia (National Health and Medical Research Council) and in New Zealand (Health Research Council) have emphasized knowledge translation through funding and support of research that addresses knowledge gaps and through promoting partnerships between research organizations, government agencies, individual researchers and consumer groups to assist in building research capacity and to enhance the translation of research into policy and practice (NHMRC, 2000; HRC, 2007; MRC, 2007).

In Canada, KT has gained considerable momentum since the Canadian Institutes of Health Research (CIHR), Canada’s national medical and health research funding agency, brought it to the forefront of its national research agenda in 2000. Motivated by the observation that despite large monetary investments by funding agencies such as CIHR into research, research findings were not being implemented into clinical practice, and patients were as a result not receiving the best possible care, Canada’s national health research funding agency set out a strategic knowledge translation plan (Graham *et al.*, 2006). The Canadian Institutes of Health Research defines KT as:

a dynamic and iterative process that includes synthesis, dissemination, exchange and ethically sound application of knowledge to improve the health of Canadians, provide more effective health services and products and strengthen the health care system. This process takes place within a complex system of interactions between researchers and knowledge users which may vary in intensity, complexity and level of engagement depending on the nature of the research and the findings as well as the needs of the particular knowledge user. (cited in Graham & Tetroe, 2009, p. 46)

Thus, knowledge translation is generally understood as consisting of two concepts, knowledge creation and action (Graham *et al.*, 2006), and all the phases encompassed by and between these two concepts.

Notably, evidence within the knowledge translation movement is expanded beyond what is typified by views of evidence within evidence-based practice discourses. Knowledge translation discourses operate in similar fields as those of evidence-based practice (EBP) and evidence-based medicine (EBM); however, conflation of the two movements should be resisted. The knowledge translation movement is more recent and perhaps so because despite decades of EBM the gap between knowledge and action persisted (Graham *et al.*, 2006). Emerging in the 1980s, EBM (which served as the basis for other evidence-based movements) attempted to offer a new approach to clinical problem solving for medical practitioners that involved the preparation, maintenance, and dissemination of systematic reviews in all fields of health care (French, 2002; Orsini, 2007). Sackett *et al.*'s (1996) definition of evidence-based medicine has served as template for the majority of subsequent EBP definitions: 'Evidence-based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients' (p. 71). The adoption of EBM as a guiding principle inevitably privileged disciplines that could produce 'hard' or concrete facts derived from accepted (or taken-for granted) positivist assumptions about the nature of knowledge (Orsini, 2007).

With the broadened understanding of evidence beyond what typifies EBP, the knowledge translation movement has been described as a 'cultural shift in professional practice' (Rycroft-Malone, 2005, p. 170) with some commentators (e.g. Hedges, 2007) drawing on the Kuhnian notion of a paradigm shift to communicate the extent of this cultural shift. In our reading of the KT literature, some of the most noteworthy cultural shifts represented by the movement include:

1. a shift to acknowledge the complexity of knowledge translation as other than a linear rational process;
2. a shift in how evidence is viewed, from preference for context-stripped evidence to the integration of context-sensitive knowledge; with a recognition of the diverse ways of generating knowledge that counts as legitimate evidence;
3. an acknowledgement of the contributions of non-instrumental uses of knowledge;
4. a shift from silos of practice and research to university – community/clinical partnerships and exchange;

5. a shift in the responsibilities of the researcher, from detached scientist to involved collaborator, negotiator and communicator of knowledge; and
6. knowledge translation as occurring at many levels, aimed not only at health care practitioners but actively involving policy and decision-makers.

The KT paradigm shift as summarized by Dickinson (2004) is that of viewing knowledge as a product to knowledge as a process. How knowledge is viewed carries significant implications for how translation is envisioned and ultimately evaluated. An emphasis, for example, on evaluating the ‘success’ of KT on the basis of behavioural and practice changes (i.e. ‘did people change their behaviours?’) could be understood as reminiscent of the knowledge as instrumental stance, rather than knowledge as processual, and also reflective of the ongoing tension between practice and academic discourses.

Knowledge translation and critical inquiry: compatibilities and dilemmas

With these substantive shifts represented by the knowledge translation movement, there was considerable appeal to us, as a group of researchers drawing on critical perspectives, to engage with the leading edges of knowledge translation. We anticipated that these conceptions of the nature of evidence, the acknowledgement of context-sensitive knowledge, and multi-level engagement with practitioners, decision-makers, and organizations would lend themselves to the uptake of critical knowledge. The pilot project prompted us to contemplate how to best conceptualize and implement KT in order to realize the benefits a postcolonial feminist framing offers; those of giving voice to subjugated knowledges, promoting reflexivity, linking agency and structure, and challenging racializing discourses and practices. The focus of this last section is to examine in more detail the implications of bringing together knowledge translation and critical inquiry. While compatibilities exist between the two traditions, certain dilemmas arise when bringing them together. We conclude by proposing features of knowledge translation generated by critical inquiry that in its very processes of implementation also reflects tenets of critical inquiry.

Critiques of KT through a critical lens

Examining KT through the lens of critical inquiry further elucidates certain limitations already identified in the literature. Concerns of a fundamental ontological nature have been raised in regards to how KT and EBP movements translate theory into practice. Doane and Varcoe (2008) draw attention to how singular emphases on knowledge apart from the knower overlook the interrelationship of meaning, interpretation, subjectivity, and context. Drawing on Ricoeur’s insights, they contend that understanding, including interpretation and translation, are not simply modes of knowing, but are ways of being and ways of relating; action is fundamentally ontological. With such an understanding, the focus shifts to a ‘*way-of-being*’ in which the interconnection of theory, evidence and practice is lived’ (Doane & Varcoe, 2008, p. 289).

The assumption that knowledge can be packaged and translated as a neutral, discrete entity is increasingly being cited as a problematic underpinning of the knowledge-to-action movements (Lambert, 2006; Reimer-Kirkham *et al.*, 2007; Kitson, 2008). Poole (2008) points to the oversight of extant KT literature that infers researcher as ‘expert’ translating

knowledge without accounting for the complicated relations of power shaping any exchange. A parallel concern regarding the acontextual tendencies of KT has to do with how complexities of clinical practice (the messiness of the everyday) are typically not considered (Reimer-Kirkham *et al.*, 2007; Doane & Varcoe, 2008). Similarly, Genuis and Genuis (2006) critique reductionist views of health and illness in KT literature and practices that tend to overlook the social conditions that determine health. From a postcolonial feminist perspective, these concerns extend to name narrow interpretations of evidence that marginalize certain types of knowledge. By relying primarily on knowledge generated through randomized controlled trials that typically do not involve non-English speaking patients, do not account for the social context of people's lives, and historically have not included representation from women, incomplete non-representative knowledge is applied (Reimer-Kirkham *et al.*, 2007). The convincing body of evidence concerning the social determinants of health is difficult to translate into health service delivery through KT approaches (Kemmer, 2006; Reimer-Kirkham *et al.*, 2007).

Related concerns have addressed the specific methods of knowledge translation, noting, among other concerns, a bias toward individualistic interventions (as opposed to organizational or system-oriented interventions) (Lambert, 2006; Poole, 2008). The emerging nature of KT as a 'new' field is facing continual pull back toward entrenched views regarding evidence and established methods of EBP. In our situation, relying on 'credible messenger', 'action plans', and 'just in time teaching' (Lavis *et al.*, 2003) as KT strategies proved problematic at the level of basic paradigmatic disagreement (Anderson *et al.*, 2008). This prompted our investigative team to reflect carefully on the assumptions that we brought in relation to the need for particular KT strategies at the outset of this study.

These critiques of KT, amplified through a critical lens, suggest areas for future development. Lambert (2006) recommends the future trajectories of KT as responding to structural influences and contextual dimensions. Remembering our earlier observation of the 'paradigm shift' represented by KT, we are cautious to not discount the possibilities of KT for the translation of critical knowledges, despite these critiques. The challenge, we suggest, is to be aware of the continual pull toward using KT methods more akin to traditional EBP and reminiscent of the positivist paradigm by their instrumental views of knowledge and assumptions of objectivity and political neutrality. By bringing KT and critical inquiry (CI) together, we have also come to appreciate anew the need for ongoing reflexivity about how we work within the critical paradigm.

KT dilemmas related to the nature of critical inquiry

Bringing KT and CI together raises another set of dilemmas stemming from the nature of CI itself, what Fenwick (2004) characterizes as the challenge of moving from a theory of CI to the practice of CI. The very strengths of CI (critique and the critical questioning of taken-for-granted assumptions and identifying how the operations of power through social structures shape the everyday, along with postcolonial feminism's commitment to foreground marginalized voices) can also be the source of considerable angst among researchers, and between researchers and other stakeholders (e.g. participants, clinical and administrative partners) when critical researchers attempt to move beyond the walls of the

academy. These dilemmas have to do with the role (and method) of critique and the adequacy of certain critical conceptualizations (Fenwick, 2004).

Anyone relying on CI in the enterprise of KT is inevitably faced with questions regarding the role of critique. Critique is a hallmark of scholarship within the critical paradigm, and is not synonymous with criticism. By critique we mean examining the conditions and assumptions upon which something exists (in our case, health, social justice and health inequities, and health care services) and, following deconstruction, envisioning a renewed or reconstructed way. The method of critique is also reflexive, marked by tentativeness or openness, given that critique, as knowledge, is always partial and put forth from a particular social location (Heyting & Winch, 2004). The call for knowledge translation as engagement between researchers and practice, a call that aligns with postcolonial feminist values of giving voice, reciprocity, and partnerships within research relations, can paradoxically result in a bind for the researcher between the purposes of critique and partnership. Indeed, Fenwick (2004) notes that some critical theorists argue that emancipatory practice ‘within capitalist institutions is completely untenable and that what emerges would always be a domesticated shadow of critical struggles against oppression, exploitation and inequity’ (p. 200). From such a position, some critical academics disengage, resorting to a type of intellectual elitism, rather than risking dilution of critical messages. However, in order to accomplish KT, an antagonistic or confrontational stance on the part of the researcher is equally untenable. Is it possible to ‘stay true’ to the tenets of CI and communicate the knowledges derived from CI while at the same time seeking engagement? Mendez (2008) writing from the perspective of an ‘activist scholar’ suggests a ‘strategic duality’ in which the researcher uses her position within the academy to contribute to social justice struggles by working to place alternate voices and ways of knowing at the centre (p. 138). Mendez names several resources from feminist thought for the balancing of this strategic positioning, including a process-oriented view of social change and transformation, a reconceptualization of power as multidimensional and intersectional, and an ongoing feminist critique of conventional academic epistemologies.

Employing a more reflexive stance regarding academic epistemologies, one might question the adequacy of some critical conceptualizations (Fenwick, 2004). To what extent do they construct certain groups within health care organizations as wielding power, as though unified, over other groups, also fixed, who suffer under domination and oppression? It would not be accurate to portray health care decision-makers and managers as a homogeneous block of ‘oppressors’, given the intersectional, sometimes ambiguous, variations produced by gender, race, class, and other systems of social classification. Similarly, Nelson (1997) has pointed out that while nursing often is positioned as ‘oppressed’, doing so oversimplifies nursing and overlooks the complexities of advantage and disadvantage within nursing. Positioning health care providers as oppressors and patients from racialized backgrounds as oppressed also suggests oversimplifying complex social relations and processes (Tang & Browne, 2008). Likewise, when taking critique to a broader social level, for example, analysing the role of neoliberal ideology in perpetuating social injustices and health inequities, we must find ways to account for shifting and contradictory discourses that remain incomplete, at least to some extent. For example, in the Canadian context, calls for equity compete continuously with more oppressive rhetoric, as noted in Henry and Tator’s

(2006) observation of Canada's democratic racism. Moreover, reflexivity is required on the part of the critical researcher to avoid taking on a self-selected role of zealot. Researchers cannot offer critique from neutral stances that position them as somehow apart from the everyday workings of power. The act of using critique to name that which needs to be 'transformed' is itself an expression of power/privilege. In the companion paper (Browne *et al.*, 2009), we attempt to reflect critically on the KT process and, in particular, on the assumptions we have brought to it.

Our experience in this pilot project has been that bringing together CI with KT (as with other domains of practice) is not easy. There are profound, though not incommensurable or insurmountable, differences between the knowledge translation and critical paradigms. We concur therefore with Fenwick's (2004) observation that 'without further theorizing of fundamental contradictions [of critical studies and practice] and their political play in workplace organizations, little may be gained except perhaps further disillusionment and duplicity' (p. 200). Likewise, we echo the call for enriched theories of knowledge translation (Rycroft-Malone, 2005; Estabrooks *et al.*, 2006). Toward these ends of contributing to the theorizing of both critical theory and knowledge translation, our efforts in this paper have been to articulate the compatibilities between various critical perspectives, and to subsequently examine how these might be taken forward in a knowledge translation project aimed at promoting cultural safety in practice.

Concluding comments: toward a critical conception and implementation of knowledge translation

This paper has presented both opportunities and challenges that arise when KT and CI are brought together. The tensions we experienced during this project have been productive in prompting us to examine the underpinning assumptions of the two movements, and have thereby opened the door to consider how to move toward more critical conceptions of knowledge translation while also thinking through the implications of integrating critical perspectives into health care services. In the spirit of CI, with the acknowledgement of the partial nature of knowledge, we offer our insights here as a beginning conversation. We are left with questions as to whether these various perspectives (both within CI and between KT and CI) can be integrated given the epistemological and ontological differences among them.

Critical inquiry's essential features of critique, reflexivity, and action (or, deconstruction and reconstruction) are marked by tentativeness, openness, and focus on process, and therefore do not fit easily with the KT methods of 'packaging' knowledge for practice. Researchers within the critical paradigm engaging in KT may experience pressure to be concrete and specific, while the knowledge derived from critical inquiry typically calls for broad based changes. This disjuncture is exemplified by postcolonial feminism's injunction to disrupt histories of race-based discourses and practices, an 'end' that may be accomplished to some extent by KT efforts, but that ultimately represents a social problem not amenable to 'easy fixes' and that will extend into the foreseeable future. The CI focus thus is one of process as much as outcome. A related tension to be worked out when bringing CI and KT together stems from how CI seeks to balance agency and structure. While KT activities can (and

ought to) be targeted at level of individual nurses, organizational and structural contexts must be brought into view. The challenge is that of considering both limits and possibilities for individual and collective agency without invoking the paralysis of privileging structural constraints, nor falling into the short-sightedness of overlooking structural constraints.

Our exploration of the genealogy of critical inquiry has highlighted distinctions and commonalities between various critical approaches. Some uncertainties remain for us regarding theoretical pluralism and how to reconcile some of the fundamental differences between critical perspectives when bringing them together in a KT effort aimed at promoting cultural safety, equity, and social justice. While embracing the shared concern for social justice and equity held by various critical perspectives, we raise some caution regarding the possibility of pushing race analyses to the margins when the European voice, represented by many critical perspectives, continues to be privileged. In such cases, theoretical pluralism can result in incomplete analyses; intersectional analyses of how health inequities and social injustice result from simultaneous oppressions are needed.

We continue to engage with questions such as: How might critical conceptions of knowledge translation facilitate the uptake of social justice, equity, and cultural safety? How does the context of health care shape the uptake of critical discourses? At a practical level, what knowledge translation strategies facilitate the uptake of critical knowledges? And how do we, as researchers and practitioners, enact our power and resistances keeping the goals of social justice and equity in view? In the companion paper (Browne *et al.*, 2009), we further develop our analyses of some aspects of these questions.

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