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A teaching model for health professionals learning reflective practice

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Abstract

The aim of this work was to use the theory and concepts of critical reflection in the development of a teaching model to enhance the learning approach to reflective practice for health professionals. The results of this initial stage of a larger project have identified the key challenges for health professionals learning about reflective practice. From the literature a model for teaching critical reflection was conceptualized. It begins with an exploration of self and values, moves students through a dialogue with peers, and explores the social and historical contexts of practice. Conclusions drawn from this work show that despite the agenda in healthcare to bridge the theory-practice gap, when focusing on critical reflection students struggle with professional, legal and ethical issues much more than they do with empirical ones. Our work has aimed to design a course of study that facilitates students' development in critical reflection in order to promote their empowerment and capacity for change. We believe that reflective practice that is aimed at empowering individuals within their own practice has the potential to engage the learner, as well as provide improved health outcomes.

Keywords: Reflective practice; critical reflection; learning model; health professionals.

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1. Introduction

Our aim was to develop a reflective practice teaching model, designed to empower health professionals to improve health outcomes and be agents for social change.

We recognised that health care delivery begins with an awareness and understanding of self. Our goal was to contextualise that self with practice, facilitating the development of healthcare practitioners who are global in outlook, concerned with health disparities, access, equity and diversity.

Our focus was specifically on developing critical reflection. This incorporates the levels of technical and practical reflection as articulated by Shiel and Jones (2003), and extends practitioners through a consideration of the moral, ethical and socio- historical contexts of their practice (Gardner 2009, Hickson 2011). Our approach also draws on ways of knowing and practice development techniques to develop participatory and appreciative action and reflection (Finlay 2002, Ghaye 2007, Dewing 2010,) as a framework for the development of health professional education. Our aim was to enable students and practitioners to ask critical questions of themselves and their practice, and to address the significant issues being encountered in their practice.

2. Reflective Practice in Healthcare

Reflective practice has a long history in nurse and health professional education. Emerging from the work of renowned educationalist, John Dewey, reflection was originally posited as an "active, persistent, and careful consideration of any belief or supposed form of knowledge in the light of the grounds that support it, and the further conclusions to which it tends" (Dewey, 1910). This is reflection as experience: the ability to think critically about one's own choices and actions, and to understand the broader contexts within which these choices were made (Fook and Gardner 2007).

For Dewey, people learnt not just by thinking but by doing: by thinking about what they were doing and why they were doing it that way. Reflection therefore was part of the process of "doing something overtly to bring about the anticipated result and thereby testing the hypothesis" (Dewey, 1916). Later, Donald Schön expanded on this way of thinking to develop his idea of reflection-in-action, as the process by which professionals make decisions in the process of their work. In this conception there is a continual interplay of thought and action, and the ability to be more than reactive in real time, which exemplified the truly reflective practitioner (Schön, 1987).

Rolfe argues that the way in which reflective practice has come to be understood and utilised in the health sciences, in nursing in particular, is now far removed from this original conception (Rolfe, 2014). Although healthcare professionals are now required to 'reflect' as part of their registration and professional development, for example through the Nursing Competency Assessment Schedule and the Australian Nursing and Midwifery Board (Levett-Jones et al 2013), this has become a fairly toothless exercise which practitioners utilise once a year, rather than in their everyday practice. Rolfe laments this turn of events, arguing that reflection should be the means of "radical critique based on the premise that knowledge generated by practitioners reflecting on their own experiences is of at least equal value to knowledge derived by academics from empirical research" (Rolfe, 2002).

In many cases, as Rolfe indicates, reflective practice had historically been developed by health educators who believed in the primacy of 'evidence based practice' and knowledge based on academic research. In this scenario, reflections were focused on negative clinical events and the purpose was to identify 'researchable questions'. This was problematic for a number of reasons: firstly it placed a burden of learning in one subject that required students to move very quickly and superficially through self-reflection to identify 'research questions' to actually conducting and writing academic literature reviews. Secondly, this approach placed a burden on the teaching staff that were required to teach both research and reflective skills within the same course. At the University of Wollongong, with the opening of a separate research skills subject in the postgraduate program, the focus was able to be shifted towards developing meaningful and lasting skills of critical reflection.

3. Teaching Model for Reflective Practice

A review of the literature around the reflective practice for health professionals (Schön 1983, 1987; Mezirow 1990; Edwards et al 2002; Fook & Gardner 2007; Johns 2009, Rolfe 2014; Nelson 2012) was undertaken to inform the development of a model for teaching health professional undertaking core reflective practice subjects in a post graduate course. This review of theories and concepts of reflective practice led to the development of a three-stage teaching model, which was used as the framework for the revision of subject outcomes, learning activities and assessments.

The model focuses on the exploration of 'wicked problems' and the ethics of person centred care (McCormack & McCance 2010) and was used to articulate new learning outcomes and teaching and learning materials. New assessments were then aligned with the intended learning outcomes, the University's new transformation agenda principles and an Australian Qualifications Framework (AQF) audit, which stressed the need for a focus on 'real world' problems and 'technology enriched' learning in order to provide meaningful experiences across a range of learning delivery methods.
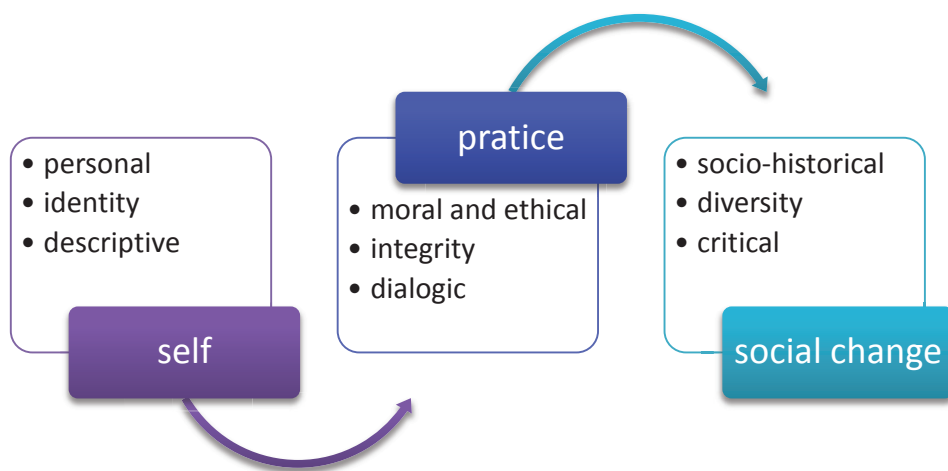

Fig. 1. Reflective practice teaching model (2015).

This model is designed to move students through three levels of reflection, recognizing that this is not always a linear or instant process and that reflective practice is in fact a cycle, within itself and over time.

The first level starts with an exploration of the self, and is based on the practitioner identifying their own values and recognizing the role of themselves and their personalities in health care events. The reflection at this level may be descriptive and inward looking. It is often this level that students find most accessible and easy to 'write' as they focus on their own thoughts, feelings and actions. It is important to allow this stage to occur as it is only through understanding the self first that students are able to understand others. This level of reflection was supported by teaching and learning activities that drew on practice development techniques such as vales clarification exercises which encouraged students to honestly examine all of their beliefs and attitudes and decide which ones they felt were appropriate to bring into the workplace. At the same time, students were given examples of simple models of reflection to encourage them to start describing events or issues that they felt they would need to explore. Reflective journaling was encouraged as a way of beginning this process, but journals did not need to be shared with others at this point in the process.

As students' progress to the next level they take the insights gained from an examination of self and enter into a dialogue with external factors immediate to their work place, and in relation to their practice. The aim is to relate the self to peers and other factors affecting health care practice such as policy and procedures, health guidelines, and the ethical and legal considerations within which health care is provided. This progression was facilitated by learning

activities which asked students to share their reflections with peers to identify and discuss similarities and differences. This stage of the model was supported by an assessment task which used the 'fundamental patterns' in Carper's ways of knowing as a reflective tool, and students were asked to consider factors both internal to their system of beliefs and external to their culture and workplace.

The third level asks practitioners to consider factors beyond the immediate health care system, but within which both them and their practice is formed and bounded. This level is highly critical in that it requires practitioners to ask why and how things have become the way they are, and to consider the socio-historical context of their practice. The aim here is to remind health care practitioners that they can be agents of social change in their patient's lives and beyond, and that the narratives that underpin beliefs and attitudes towards health are socially and historically constructed. The learning materials for this stage of the process included readings from sociology, critical theory and history which all used interdisciplinary approaches to analyse and critique health care practices and systems. Of particular use in this stage was the work of nurse historians Julie Fairman and Patricia D'Antonio, which draws overt links between historical decisions and contemporary policy (Fairman & D'Antonio 2013). This demonstrated to students that all health systems and care practices are the result of past politics, an analysis which was extended through an examination of contemporary media. Students were asked to explore a particular health care issue from the point of view of contemporary news media, analyzing the language and focus to expose particular biases and politics. This served to remind students that the general population, their patients, carry different meanings and attitudes towards health 'evidence'. To be effective person centred practitioners, students needed to be cognizant of the many ways in which people inform themselves about health issues, and to be aware of the power of the media in both the past and present to frame the ways in which health is popularly understood. The aim of this stage of the model is to remind students that all human practices have a history, and that by exploring that history students are encouraged to examine the often 'taken-for-granted' nature of assumptions inherent to contemporary approaches to health care.

3.1. Application of the reflective practice model

To move forward from the inherited subject design, we needed an overarching theoretical approach that set out what we were doing and why we were doing it differently. This also required developing the relevant concepts, tools and technology to enable students to move away from techno-rational, competency check-list approaches to reflection, in order to create true critical thinkers and enable reflection IN action. However, we recognized that this was a learned approach, that we could not expect novices to display high-level clinical reasoning in the same way that expert practitioners do (Schön 1987, Finlay 2002). Within this framework students were encouraged to develop their own portfolio of critical reflection, drawing on theories and concepts of reflection and different ways of knowing; incorporating technology, media, and social and historical contexts. Our vision of the reflective practitioner was the movement towards a particular way of being in the world: the engaged, empowered and emancipated self.

To facilitate the implementation of this model, subject outcomes, learning activities and assessments were all aligned to one or more levels of reflection. Subject learning outcomes were rewritten so that on completion of the subject students would be able to:

- Appreciate concepts, theories and models of reflection, specifically on practice
- Articulate a critical awareness of self as a health professional in the context of a variety of patterns of knowledge such as the personal, empirical, aesthetic and ethical
- Apply a selection of approaches and tools in order to critically analyse and reflect on practice
- Identify the local and global historical contexts of specific health care practices.

Assessment tasks were then constructively aligned with the learning outcomes (Biggs & Tang, 2011) and overtly scaffolded through the learning modules to facilitate learning oriented assessment (Carless, Joughin, & Liu, 2006). The two new assessments were a Reflective Report and a Reflective Portfolio. In the report, students were asked to provide a written reflection using Carper's "Ways of Knowing" (Carper 1978) as a reflective template to locate the

personal, empirical, ethical and aesthetic elements of their practice, focusing on one particular event. The aim here was for students to practice the descriptive and to begin the dialogic analysis of their practice.

The reflective portfolio contained five elements and was designed to be submitted via Mahara (an e-portfolio software program) that was integrated with Moodle, the university's learning platform. The portfolio required students to 'represent' themselves as creatively as possible (self/personal); undertake a reflection using the Rolfe model (dialogic); and then analyse a media article about their identified practice event (socio-historical). They were required to bring these elements together through an evaluative component that asked students to consider themselves as agents of social change, and submit the necessary references.

The learning materials were redesigned to suit a modular approach for delivery through Moodle. Modules were designed to relate specifically to each phase of the model, and to draw specifically on the subject learning outcomes. Modules related to phase one of the model (descriptive reflection) were:

- A Framework for Reflection – introducing the model and concepts of critical reflection
- Ways of Knowing – an introduction to Carper's personal, aesthetic, empirical and ethical ways of knowing and how to use this as a template for reflection
- You and your values – introducing students to values clarification exercises

Modules related to phase two of the model asked students to begin a dialogue with their peers and their workplaces and introduced more complicated theories and models of reflection. These modules included:

- Practicing reflection – introducing students to theory and models of reflection, particularly the work of Gary Rolfe and Christopher Johns
- Building reflective portfolios – introducing students to tools for practicing reflection including journaling and the development of creative portfolios both offline and using Mahara

The final modules of the subject asked students to engage with theory and readings outside the usual bounds of clinical literature in order to develop critical thinking about the context of their practice. Students engaged with critical social theory, the concept of social determinants of health, bioethics, person centred care, and contemporary media, as well as the field of nursing history scholarship (Fairman & D'Antonio 2013). This learning was synthesised in the following modules:

- Socio-historical contexts of health care – introducing students to the use of history for understanding health care policy and encouraging an analysis of popular media to understand the ways in which health behaviours and attitudes are formed.
- Evaluation: becoming a reflexive practitioner.

Students enrolled in the subject in either a blended delivery or fully distance instance, and all students had the option to attend intensive study sessions totally 18 hours across the 13 week sessions augmented with an online delivery through the Moodle learning platform. Each weekly activity face to face and online was explicitly linked to each of the levels of reflection, with initial sessions focused on 'values clarification' (focus on the self); followed by sessions focused on developing communities of practice (dialogue with peers) and finishing with sessions focused on the socio-historical contexts of practice (identifying issues and work solutions).

4. Conclusion

We particularly wanted to encourage reflection as 'a way of being', not just a one off task. It is only in this way that we felt that reflective practice could reach its potential to be a 'radical technology' (Nelson, 2012), capable of creating health care practitioners that were able to provide person centred care, and act as agents of social change, placing health and wellness in its broader social context. We underpinned our approach with well known theory and methods of reflection which recognised the unique issues of health professionals as adult learners (Mezirow 1990,

Dewing 2010). We felt that this required more innovative and creative ways of practicing reflection and wanted to explore options for online portfolios as a means of learning and assessment (Ghaye, 2007; Ross, 2011; Shiel & Jones, 2003).

We introduced concepts of practice development and person centred care, because these are theories and frameworks that include ways of learning specific to health care. Both practice development and the person-centred nursing framework begin with the an examination of the self, focusing on values clarification, but take students beyond this static and sometimes overwhelming stage, by focusing on transformation of both the self and cultures of practice (Mezirow 1990, McCormack & McCance 2010, McCormack, Manley & Titchen 2013), By empowering students to recognize their own attitudes and beliefs and equipping them with tools for self-management, we were aiming to produce emancipated practitioners whose individual practice was seen as the first step towards cultural change.

This also enabled a deep analysis of ethical issues in health practice, because student reflections often revealed deep discomfort at their own, or other people's practice within health systems that were based on risk management, rather than on patient centred, compassionate care. The person-centred nursing framework in particular provided tools and concepts that students could relate to when faced with ethical dilemmas in their practice and in their workplaces. Most students were strongly committed to providing compassionate, person-centred care, and the model was aimed to validate and reinforce this approach.

In discussion with staff teaching in the subject we felt that students struggled with the way we conceptualized reflection initially, as they may have been used to more 'model' or 'tool' based approaches. Health students encounter little theory or philosophy in their undergraduate degrees and by introducing the more concrete notion of 'social and historical contexts of your practice' led to discussions about politics and health care funding, and most students had plenty to say on this topic.

Similarly, staff felt that students were uncomfortable with a subject that focused on the idea of the self, and on values clarification, but that this uncomfortability actually justified our focus in this area. There is a tendency in the health sciences to fall back on 'evidence' as the basis of practice, but this can lead to negative health outcomes when health professionals become judgmental and believe they are 'right' and the patient must be 'compliant'. This was a consistent theme in student reflections which we sought to challenge particularly through the first assessment which asked students to equally consider the personal, ethical, aesthetic and empiric aspects of their practice. The next phase in this work is to formally evaluate the subject revisions using a pre/post-test impact of the teaching model on the student experience of learning reflective practice.

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