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Effective learning in health care professional education

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Summary of Thesis

The argument of this thesis is that the link between learner motives and effective learning can only be understood in the context of the influences from and on the learning organisation. This work is an exercise in applied social science utilising a multi-method participative action research approach. An outline and assessment of a series of planned interventions in educational delivery to groups of trainee health care professionals (nurses, midwives and radiographers) is provided. The argument put forward is that effective learning for these health care professional groups is dependent upon a particular combination of student motivation, staff perceptions and attitudes and other features of the structure of the organisation within which the learning takes place. Effective interventions into improving learner motivation and, thereby, learner effectiveness, must also incorporate interventions into educator motivations and into the organisational context within which learner and educator progress together. From within the writer's role of an active participant developer and researcher, traditional concepts of learning style and motivation are rejected in favour of the analysis and modification both of motivational narratives and of the organisational context of learning. Although drawing primarily upon research with nursing students and nurse lecturers it is argued that these principles of effective learning apply to all health care professionals. The thesis adds to knowledge by advocating and describing the development of the technique of the vision workshop; by developing and applying the concept of the caring learning organisation; and by the introduction of a narrative approach to motivation applied to the learning process. The thesis concludes with specific recommendations for educational and organisational development in the training of health care professionals.

Chapter 1 Introduction and Background

Introduction

This thesis represents the coming together of several strands of intellectual and professional interest and concern. It draws upon a longstanding interest in the concept of motivation, and upon a concern to apply this interest to individual and organisational change and development in the sphere of professional education. It is based upon my experience, observations, research and practice as a Lecturer in Sociology within the School of Nursing and Midwifery Studies (SNMS), in the Faculty of Health Studies, University of Wales, Bangor (UWB). Methodologically it is predominantly qualitative, action-oriented and participative in the sense that much of what is accomplished here has depended upon principles of collaborative enquiry and deliberate attempts to apply emergent findings to the ongoing work of the School. As such it is a mix of descriptive, analytic and prescriptive work. The success of the collaborative elements of the work and its application has depended upon the willingness and commitment of valued colleagues to contribute to and learn from the research outcomes and, when possible, to implement them in the form of changes in curriculum development, course delivery and organisational structure.

There are evidently ethical considerations when conducting research in a clearly identifiable organisational setting. Throughout recognition has been accorded to my colleagues and collaborators, but wherever possible contributions have been anonymised to protect confidentiality or generic role titles have been employed. In some places specific individuals may be capable of identification with some effort or by their role title. Such individuals have been contacted and their permission given to make the comments as written.

As with all participative action research it is impossible to say when it is complete. It may never be complete and such is the nature of reflective professional practice. What I hope to have accomplished with this work is change for the better based on systematic inquiry and the production of sound evidence. Throughout higher education (HE) there is a continuing recognition of and willingness to confront

change and to discover and implement evidence-based "best practice". This thesis confronts some central issues and presents a useable set of procedures for how this might be accomplished.

Outline of thesis

The rest of Chapter 1 summarises the background to the research. It discusses my personal engagement with the problems of curriculum development, research and teaching after over twenty years of working with mature students with mixed vocational aspirations. The contrast in the Faculty of Health Studies, more particularly within SNMS, represents a narrowing of vocational aspirations - toward nursing and midwifery - but with the same range of mixed ability and some degree of mixed age groups to which I had been previously accustomed. The thesis is a test of my experiences and professional attempts to confront such problems of educational delivery in light of a wide range of ability and experience amongst students and in the face of the constraints of educational organisation.

This work is not, strictly, a longitudinal study. It is rather a series of studies which took place over a seven year period and which are linked to the theme of how to improve the learning environment. Given its unconventional structure it might help to explain my writing strategy. Each reported intervention can be seen as a case study that relates to this central theme. The studies were, in fact, originally "actions" that related to my own work within SNMS. Each of these actions resulted in internal organisational documents, most of which were disseminated to all academic staff, responses were sought (either written or in meetings), incorporated into proposals and subsequent decisions and actions then taken for curriculum, teaching and learning and organisational development. (This is why I describe the work as participative action research: myself and colleagues participated in the processes under investigation, changes were made as a consequence of the work, and ideas and concepts related to effective learning were tested and developed.)

Throughout the thesis when predominantly collaborative work is being reported I write in the first person plural, when I am the primary "researcher" I write in the first

person singular, and when reporting the work of others I write, conventionally, in the third person. In between each chapter there is a "reflective" commentary printed in italics which was written subsequent to the completion of the thesis drawing upon diary notes and recollections of my experience of the reported interventions and events surrounding them. These exercises in reflective practice are intended to personify the research and provide the human "thread", a narrative which links the different stages in the project.

Appropriate dissemination outlets were sought for each of the studies, so that much of the thesis has already been published. Parts of the published work were re-written for the purpose of this thesis with each chapter containing information from one or more publications. Each chapter starts with an introductory section which pre-figures the content of the chapter and shows links to the preceding sections of the thesis. The conclusion to each chapter draws out the salient points from the chapter and indicates the future direction of the argument to the thesis. The final chapter acts as an overall conclusion, drawing upon my views based on experience of higher education, upon other writers' observations, and, together with comments and evaluations from the other participants to this research, makes recommendations intended to guide not only SNMS but other organisations in similar situations.

Chapter 2 sets the broader scene for this thesis by discussing change within the health services, parallel and related changes within the education of all professional health carers and, specifically, changes that took place in the study setting for the period 1993 to 1999. The impetus to this is not just service change, but what is seen as essential educational development. The issues and problems and suggested reforms are discussed in general before indicating how they have specifically affected SNMS. The emergence of the strategic plan for curriculum and staff development and the instituting of a research culture will be outlined.

Against a background of general theories about adult learning and about effectiveness in learning Chapter 3 looks at the nature of learning going on in nurse education and other comparative spheres of health professional education. What sorts of learning is being engaged in and what makes some of it more effective than others? Chapter 4 continues to review the question of effective learning through the examination of

interventions based on the production and delivery of a course in study skills and research into students' learning styles, which has had a profound influence in research on educational change, particularly in the education of nurses. The value of a "learning styles" approach is tested in application to some student cohorts within SNMS.

After what amounts to a trial and considered critique of the learning styles approach, Chapter 5 picks up on earlier work of mine to suggest the value of focusing upon learner motivation. Reductionist psychological approaches to motivation are rejected in favour of a more holistic sociological approach in which a study of the "motivational narrative" is advocated. This concept is introduced and tested with other student cohorts in SNMS.

Chapter 6 puts these ideas about effective learning and motivational narratives into the context of the organisation within which the learning takes place. The key question here is how possible it is to learn particular kinds of content (that is, "caring") if that content is not a vehicle for the pedagogy or andragogy employed. How does one teach caring if the teaching is not done in a caring manner? Similarly, how can students learn to cope with change in the workplace if they are located in an organisation which does not appear to know how to learn and how to change itself?

In conclusion, Chapter 7 discusses the implications of these findings and reviews some of the theoretical and methodological issues arising out of this work. Applications and recommendations for further research and practice in making health care education more effective are then considered. The Appendices contain information on the dissemination of the separate elements of this thesis, a chronology of key events and a copy of the questionnaire used for the learning styles research.

Background

The suitability of this work to extending my previous research became evident from initial impressions about the nature of my contractual role. I was appointed as one of two "specialist lecturers" in sociology to the SNMS in the newly established Faculty

of Health Studies formed from formerly independent schools of nursing and midwifery and from a separate school of radiography education. SNMS subdivided into divisions for pre-registration, post-registration education and for research. My formal location was in the Research Division with a brief which was indicated by the Deputy Director of Nursing Studies and in original application details to include: curriculum design and development; course delivery; research activity and development; and staff development.

In teaching sociology to nursing students and as an experienced adult educationist I became concerned about initially negative evaluations of sociology teaching on the Project 2000 Diploma (P2K) course. Many students appeared not to see the relevance of sociological perspectives, topics and issues to their future work. Indeed, even fellow tutors appeared at times to doubt the value of sociology and some mentor practitioners merely confirmed students' prejudices towards any broadening of professional nurse education when the students were on placement with them.

Teaching practices across the UK in servicing the P2K courses suggest that traditional sociology departments teaching externally did little to counter these prejudices. Sociology appeared to be taught perfunctorily for the most part and was seen as a means of inter-departmental income generation. Sociologists are often not concerned directly with "applications" when teaching sociology for sound methodological and epistemological reasons. There is a view that some basic principles need to be conveyed first. Applied sociology has been occasionally tainted by the assumed pull of "market forces". But my own experience has convinced me that the application of a sociological perspective upon learning organisations can prove productive of analyses of problems and is often suggestive of appropriate change solutions. In some respects I was attempting to formalise an interest in "clinical sociology" as "... the application of a sociological perspective to the analysis and design of intervention for positive social change at any level of the social organisation" (Iutcovitch 1997: 6).

I wondered if all health care professionals held similar views about the relevance of the social and behavioural sciences to their education and subsequent professional practice. It seemed that some comparative evaluation of the education of other health

care professionals was essential - do they adopt the same learning styles, the same organisational structures, curriculum content, curriculum development policies and so on?

This was not merely a concern with the effective learning of sociology. As an adult educationist, it has been my primary vocational aim to enable or facilitate a valuable and valued educational experience. This must take place on a practical level, on a professional level, on a personal level and on an intellectual level. A strategy that I have developed over time is first to encourage students to analyse or reflect upon prior learning experiences with a view to getting rid of the bad and facilitating the good. This may be done by identifying the learner's primary motive for engaging the learning experience and ensuring that this is accomplished in the current learning experience. Further motives for learning may then be accumulated - all of which are intended to "add value" to the learning experience. But care must be taken with these extra motives. Thus, to illustrate with reference to current demands made on my nurse lecturer colleagues, it is not enough to "have to" become research-aware, clinically effective and practice evidence based health care in multidisciplinary settings - one must also feel that these things are worth doing.

My key research question became: what makes for effective learning in health care professionals? The learner's style must be influential, and a key element in style is the learner's motivation. However, the link between learners' motives and their effectiveness as a learner might not be as direct as one supposes. Thus, for example, someone who makes a lot of money might not have learned how to do that well simply because of a drive to make money. An accountant who loves juggling figures might become financially successful as a consequence of a keen desire to play with figures. An entrepreneur might learn how to become a successful business person as a result of a love of being adventurous with new ideas. A best-selling author might not be a "good" writer, but if they are motivated to write the sorts of things that sell well, then their success is almost incidental.

Similarly, health care professionals might learn how to perform their job better if, say, a keen desire to understand how the human body works and why it goes wrong

supersedes their desire to "care". In fact, some might say that too much caring could cloud clinical judgement. Thus the desire simply to "help people" might interfere with learning effectively to do that. But it is important to remember that being effective learners in clinical terms does not mean that they are good at learning, say, how to communicate. In terms of what one is learning for, it is vital to decide what matters most. In terms of service delivery it might be more important to have the correct mix of learned accomplishments.

From the patient's view this could sound a little heartless - but it might be in their better interests. One might secure more favourable outcomes from a knowledgeable carer than from one who merely "really" cares. Effective learning, therefore, need not be distinct from effective caring.

There is, however, a fundamental methodological problem - how to get at the learner's "real" motives and style of learning? In a field where the espousal of a caring demeanour seems to be a key qualification for entry and success, will students readily admit to having other, less caring, motivations for learning? Which sets of motivations are more likely to lead to professional and/or academic success?

Methodology: Issues and problems

This problem of accessing learner motives was essentially similar to a research question I had addressed previously in a study examining the motives of mature students in long term adult residential colleges in the UK (Iphofen 1992; Iphofen 1996a). By means of a triangulated research strategy, consideration was given to what extent student motives are influenced by background factors or by the educational institution as they progress through it. I was concerned to discover if students recognised and espoused institutionally legitimate motives that differed from their "real" motives in order to gain access to a course of study.

The data suggested that students made use of the institutions for their own purposes but not cynically. While the residential college experience changed people intellectually and personally, students' motives remained fairly stable. The influences

from the educational organisation include a boosted confidence in their ability to achieve original aims, increased security in altered educational identity and their vocational aspirations as a consequence of the intellectual and therapeutic advantages of living in an educational community. Thus the organisational context of learning becomes vital to the perceived accomplishment of cherished goals.

In that work I argued that it was necessary to ask how the students see the institutions as playing a part in the achievement of their aspirations as well as investigating the historical origins of motives within the educational organisation itself in terms of prevailing social, political and economic constraints. A composite view of motives in learning requires not only an analysis of learner motives but includes institutional tradition, the requirements of governing and funding agencies, and the aims and aspirations of lecturers. Dependent upon social context (economics, politics and culture), institutions survive according to the "legitimacy" of their aims in the eyes of funding agencies and of clients - of all stakeholders. Students must see available institutions as fulfilling their specific wants or needs or they will not seek to access them. Meeting such a range of aims requires the provision of particular types of curricula. Once a course is under way, the aims of institutions and the motives of individuals come together in the accomplishment of particular goals - the course as received, rather than the course as conceived.

This means recognising the often mixed individual motives and composite institutional goals which characterise educational organisations. Any analysis must incorporate the dynamics of individual and organisational change (Tight 1985: 16-17). One of the problems facing educational administration is the tendency not to build in recurrent opportunities to address such changes. Once goals have been established and a process for accomplishing them has been set up, many organisations tend to an inherent conservatism which leads to the classic organisational dysfunctions of behavioural rigidity and the displacement of goals.

I argued that to extend this work required a more detailed organisational analysis which includes an investigation of institutional change and which uncovers the broader socio-political context in which educational organisations must operate (see,

for example, Milham et al. 1975). The institution's goals should be linked to the interaction between its formal and informal social system, the adaptation of participants to its requirements and the range of external influences on the institution.

In this earlier work I had noted that the degree of interaction between researcher and subjects was bound to be high in a residential situation so that the research must, in some way, interfere with the respondents' perceptions of themselves, their reflections upon their motives and their reaction to the learning process. I see no reason to believe that this should not be the case in the non-residential situation, but perhaps even more so when the developing relationship between student and tutor is as vital as it is seen to be in health professional education. Research of this nature will necessarily tend to become pro-active and, consequently, this should be allowed for in the research design and across all learning situations. The subjects of the research (in this case students and staff) would need to be involved from the outset and perhaps even participate in structuring their perceptions of the process by attempting to identify the "phased" changes that are taking place. The adoption of a "personal construct" approach was useful in my earlier research to allow for the more naturalistic emergence of motivational criteria, but it became hard to see how one could remain a detached observer when adult learners (again, staff and students) would be being made aware of how their aspirations relate to how they learn.

Researchers have pointed to the particular advantages accruing to the adult participant observer in an adult educational setting (Payne 1990: 87-8). Subjects are less likely to see the researcher as an agent of the authorities merely because of his or her age. Consequently I wanted here to advocate collaborative and participatory research, where the population under study was involved in the research process from the outset, participated in the design and in learning from and using the study's "findings" for the improvement of their lives. Nevertheless, there were times in this research process when I <u>was</u> seen as an external agent and this certainly impeded the progress of the action, if not of the research itself.

One of the repeated advantages of residential education is the opportunity for learning together that can be made available in residential situations. Research on motivational

perspectives in co-operative learning suggests that team-based learning creates pro-academic norms which enhance student achievements. Individuals do better as a result of mutual support and are less likely to be condemned for high achievement. Similarly, weaker individuals can gain from sharing in the success of the group (Slavin 1990: 13-14). But there is certainly a need to develop a more sophisticated understanding of the learning process which takes place within a college; I have noticed that a great deal of learning is individualistic and occasionally a lingering anti-intellectualism is espoused as a marker of student culture. And there appears no reason to suppose from the present work that the attitude is any different amongst students of the health professions. I felt the need to develop a research technique which "included" the participants, but which also allowed them to remain free to express their learning motivations independent of any constraining group culture. (Both the vision workshop approach of Chapter 6 and the device for collecting motivational narratives reported in Chapter 5 are attempts to accomplish this.)

There are certain points in the educational process at which motivational questions "naturally" arise. Cross's (1981) work on the seven phases of the life cycle, for example, shows the importance of a career-based model since it parallels naturalistic conceptions of human biography and development. Social role categories may be more useful indicators of developmental phases and the clustering of motives than chronological age. In fact, my earlier research led me to suspect that many adults seek particular educational opportunities in order to remedy what they see as a failure to fulfil the expectations associated with a particular and earlier phase in their life. This is where a "second chance" motif gains credence - an opportunity to fill in gaps in an "idealised" life cycle. Thus an important research question worthy of investigation is the connection between age, self-concept and learner motivation - all of which may be undergoing continuous change (Spencer and Tordoff 1983).

Most importantly the credibility of pro-active research does depend on findings being fed back as soon as possible to improve the lot of participants and guide future policy. That was certainly accomplished as soon as possible within this present organisation. Having said that, given that this thesis reports a cumulative series of case studies located in a single organisation, it would be unwise to make excessive or unjustified

broad generalisations to other settings without support from the existing literature and research. The justification for such broader inferences will be indicated throughout.

The current thesis is an attempt to build upon my own previous research and reflection in educational practice and provide comparisons with a different student cohort (with narrower or more specific vocational aspirations) and in a different educational organisational context (one in which funding and course content are more directly linked to the human resource demands of key stakeholders). Chapter 2 draws upon the extensive literature in this field, examining the socio-economic background to developments in professional health care education and then relating these issues to the specific setting under study.

Conclusion

A thesis of this nature cannot be entirely my own work. It is constituted from my work alongside colleagues and students together with my own independent research, thinking and writing. Dissemination of the work is indicated in Appendix I. The majority of the work reported here was under my direction and published work was written by me as indicated. As I progress through the thesis, I will indicate the nature and extent of others' contributions. All original contributions to knowledge offered in this thesis were of my own devising.

There will also be an attempt to convey a broader contextual understanding of the climate within which this work was conducted. Changes were taking place rapidly. Relatively novice teams of researchers and HE educators had to put together competitive research tenders with little institutional support and guidance, divisions between educational structures (pre- and post-registration education, midwifery and radiography education and research activity) had to be overcome and contractual obligations for educational delivery while implementing curriculum change had to be met. These I count as extra reasons for adopting the participative research approach.

Given that a thesis is written retrospectively, in light of the research it reports rather than in advance of the research activity, it may give a misleading impression of

coherence and advanced strategic planning. This research broadened its focus in the early stages due to several fortuitous opportunities which were seized upon in a manner consistent with participatory action research (see Reason 1994). The early stages were more collaborative and dependent upon the "team" of research active staff which will be mentioned in Chapter 2. Later stages of the research depended upon my own interventions and analyses. Consequently the chronology in Appendix II is not intended to suggest advanced research planning nor the testing of successive "hypotheses". It is my contention that action research cannot proceed in that way since it remains dependent throughout upon the willing participation of members and leaders of the organisation.

In many respects all research entails moving from the messy nature of human experience to the neatness demanded of systematic enquiry. The tidy arrangement of findings I wish this thesis to present seems essential to drawing conclusions and recommendations - when in the midst of the interventions and action I can confirm that the experience had a "messy" side to it.

Reflective Commentary - 1

Many good stories begin at the end. So my reflections start from my reaction to the experience of the Viva Voce examination, which, as an assessment for a PhD, is the apparent culmination of this work. In some ways I hope it is more of a beginning. I intended this work to be read and acted upon by my colleagues in the hope that improvements would be made in the organisation in which I work. To achieve that I was advised by the external examiners of this thesis to introduce more of "myself" into the work and so these reflective commentaries have been written with that advice in mind.

I tried to rearrange these reflections to fit into either the "plan, act, observe, reflect" spiral of the action research cycle (Zuber-Skerrit 1992: 13) or to the Kolb cycle of "experience, observation/reflection, concept formulation, testing implications". As I argue in Chapter 3 of the thesis these "stages" are in no way mutually exclusive. At times while planning one is reflecting and certainly observing while acting, try as I might I cannot see them as discrete activities. So I have applied these categories as sub-headings to give some general idea of the more dominant or the mix of activities I believe I am reporting.

Reflection upon Experience

Since one can begin at any point in either of the cycles, I start with reflection upon the Viva. It was a challenging experience and full of ironies. The examiners basically "passed" the work with the proviso that I improve it as described above. They said I defended my thesis well, that I write well and that it was certainly adequate for doctoral standard. Since this thesis is about improving people's experience of learning it would be a pity to omit my own experience of learning. And since I stated my own practice principles (p.10) it would be disingenuous not to be prepared to apply them to myself. In fact, one of the aims of the first Chapter in the thesis was to try to explain the stimuli to this work, the background from my own prior reflections and experience and the strategic attempt to extend previous research that I had conducted and published. So learning goes on throughout life – whether we intend it or not. I thought I might learn something in the Viva and I did. I learned that no

matter that you think you have done everything, if the examiners think not, then, as the final arbiters, you have to adjust it to accord with their recommendations. To make the necessary amendments in order to receive the hard-earned award is at worst an example of "instrumental rationality" which is discussed in the conclusion to this work, but at best an opportunity to improve upon something that matters a great deal to the writer.

It was suggested that I write more personally. There was some irony in this too in that I wrote as personally as I could without engaging in undisciplined anecdote. (One of the things I would probably advise my own students against doing.) In fact, after consultation with my supervisor in the planning stages of writing the thesis I had decided to omit the "too personal" comments and anything that was in danger of perpetuating the very problems I reported. Indeed the examiners advised that I report even the negative incidents and interventions that did not "work". In fact, I tried to leave nothing out, merely reported the incomplete or negative projects briefly, and did not report anything that was not part of a planned intervention. Other "actions" occurred during the lengthy period of this research which were similarly opportunistic, but not part of an original and sustained action plan. These additional events will now be reported in these reflective summaries between each of the Chapters of the thesis. On re-reading the thesis I realised how my attempt to write sensitively might have obscured part of the message. Anyone who was party to these events will understand what lies behind some of the subtlety of my expression. But if the thesis is to be read and used more widely then these reflective commentaries are intended to clarify more of the background to the work.

Many incidents and observations will still have to remain unsaid or this thesis will be unable to achieve its intended effect. It will become a public document, so there are considerations of territoriality, ownership, sensitivity and so on that, for reasons of diplomacy and care for the feelings of others, have not been reported. I have attempted not to say anything that could be considered defamatory and have removed comment that identifies specific individuals or I have sought their permission for the reporting of such observations. Not "everything" can be reported since this thesis is by no means the sum total of what I had to do in my post during these years. What has been also left out is the organisation, validation, teaching and assessment of courses;

the tendering for, management and conduct of other research projects – in other words, the ordinary day-to-day business of being a university lecturer.

Another charge I had to confront in the Viva was that each of the concepts referred to were somewhat "voguish". These included the concepts of learning style, andragogy, and the learning organisation which are dealt with in successive chapters. If this is a criticism I can plead some guilt – but then one thing I am sure of in contemporary health care research is the need to identify and feel comfortable with the reigning vocabulary. The problem with such fashionability is that one has to learn when to apply the charge of cliché. The concepts referred to above were only just "in vogue" when I started the work and have become clichéd over time. Andragogy was well supported when I first started reading about it and nurse educators were using the word but not necessarily doing it. (In fact, so much so that I was prompted to write something fairly polemical about it (Iphofen 1996c)). Learning styles were all the rage in the late 1980s and early 1990s and, even though I had my doubts about the approach, my colleagues were keen on it and the professional educational bodies were seeking tenders for research into it. The concept of the learning organisation had fallen slightly out of fashion in commerce and adult education when I came to use it – but higher educational institutions had barely taken account of what it might mean for their own development. Along the way we have moved through the trends of "research awareness", "reflective practice", "evidence based health care" among others and, for now, the interest is focussed upon "clinical governance". Nowhere did I find any research on what became a central concept to the conclusion of this thesis - the "caring learning organisation". Nor was there very much on the "vision workshop" as vehicle for organisational introspection and change even though the seeking of a vision has become almost as clichéd as the need to establish a mission. I still don't know if the metaphor of the mystic is more apt than that of the evangelist. What matters is that such vocabulary seemed appropriate to and was accepted by my colleagues when this research was being conducted.

I suppose it only natural that my commitment to the project has waxed and waned according to the various fortunes that beset it. At some times I had more passion for the work than at others – one of my lowest points was to have one external examiner tell me he was bored by my conclusions and recommendations. I had to tell myself -

why shouldn't he be? Those conclusions only matter to someone finding themselves in a similar organisational setting and wanting to do something about it. I certainly hope that someone is interested enough to try out my ideas and will let me know whether they made a difference or not.

Planning (with some Reflection)

To give some idea of the grand sweep of the project: I started with a group of colleagues planning to raise levels in the academic disciplines for which we held responsibility, help develop the curriculum, improve democratic decision-making in the organisation, and encourage research activity. These aims were something we shared and I discovered that in frequent meetings with that group. In addition I had my own a particular concern to improve the learning experience for all involved (lecturers and students) and that was something I brought from my previous work in adult residential education. There was something utopian about the adult residential college which I held dear and believed could apply in the apparently much more pressurised nurse education situation. I do not reproduce those ideals in full here since I have written about them at adequate length elsewhere (Iphofen 1980, 1988, 1999). It is perhaps enough to say that they included notions of collaborative teaching, co-operative learning, a therapeutic learning community and a critical reflection upon the pursuits of higher education. I believed that such principles must be hard to attack and so should easily be shared by colleagues and students alike in my new post.

I also wanted to conduct research that was both of relevance to myself and to the organisation. I had brought along some questions and concepts that I wanted to address and it was immediately evident to me that these issues related to the work of SNMS and to my nurse lecturer colleagues. With the research I conducted for my MSc I had come to realise that there is with adult learners an almost inevitability that research questions will have reactive consequences for their experience of learning. I felt that I had to take responsibility for the consequences of those interventions and so participative action research seemed the most appropriate model. I had also been trying to tease out the influence of the educational environment upon the learning process. Was there something special about adult residential education that enhanced

learning? Was there something that connected the learner's motives for learning, to the institutional ethos and thus improved learner effectiveness? The liberal educational philosophy of the residential colleges certainly endorsed those possibilities and colleagues explicitly shared that belief whenever the opportunity arose.

I had, of course, come across practitioners within adult education who fundamentally disagreed with that ethos. Their critique was largely a political one and side-stepped the effectiveness of the learning process within the residential college. They saw such colleges as "finishing schools" that drew the more intelligent members of the working class out of their roots and embourgeoisified them so that they posed less threat to the political order. What I discovered was that most students already held fairly "bourgeois" aspirations and used the colleges as a step toward those aspirations. Those that held institutionally congruent motives found the process easiest of all. The adult residential college was a conducive learning environment both for the individualist and the more collectively-oriented aspirant. Necessarily, the institutional ethos of the colleges had changed somewhat over their eighty year history – if slowly. What I was concentrating on was the importance of getting the context "right". Whatever was sought by the student could be provided if the learning environment did not get in the way. And the one thing the adult residential college did not do was "get in the way". I suspect that it is for such reasons that they can be regarded as "therapeutic communities".

Acting

All of this means that when I find myself in any new learning environment, I ask if there is anything about the organisational structure that does "get in the way" of the learners' attempts to learn and to achieve their set goals. I had come to the view that what makes for a motivated and, therefore, effective learner was a combination of what they brought to the situation together with what certain features of the situation did to them. And, of course, sometimes people learn in spite of their situation – they learn effectively because they learn how to make use of institutions.

Observation and concept formulation

I was struck immediately upon arrival in SNMS by the size, rate and pace of change that staff had experienced and were still experiencing. The pressure upon them appeared considerable. Students and staff willingly expressed a range of dissatisfactions. There were many conflicts and some explicit hostilities. How could students learn well in such an environment? Indeed how could staff learn well and encourage learning in others in such an environment?

It is true that there is an episodic quality to this thesis which is a necessary consequence of the various discontinuities in the research process and which will be discussed more fully throughout the subsequent reflections. As I explained in the first chapter, there is no neat chronologically developing thesis which successively tests a series of hypotheses. Thus it is not a longitudinal study. It is a multi-layered series of studies which took my work through "phases" of development. The thesis is written in a chronological sequence but it is necessarily a post hoc rationalisation. I did not write the thesis before I did the work. (Auto)biographies are written in the same way – one can't write them until at least much or all of the life it reports has been accomplished. The same goes, of course, for these reflective commentaries.

If a thread or theme throughout the thesis is to be sought then it could be assumed that I was the one constant in the reported research. Through each of the episodes/reported cases, as the organisation is being transformed, I was there as observer, facilitator, and participant. However, I do not believe that I, as a learner, can possibly be a "constant". The physical being, the part of myself that inhabits the role who was doing the interventions, observations and analysis, might be considered to be constant – but the "I" who changes with the findings, consequences, comments, reactions from colleagues was not the same as the "I" was when this started. I had not planned for this action research to be quite so comprehensive, nor to take quite so long. Some of the reasons why this happened will also become clear in this reflective account. And there are issues, ideas, hopes, aspirations, plans and concepts that have acted as anchors to the reasoning self, the undetached observer that I had to be.

The work has to be seen as cumulative. It was not, nor could it be, deliberately and systematically planned in its entirety from the outset. I did engage in some more detailed planning with one colleague who I worked particularly closely with to create as many collaborative working opportunities as possible. Many of the interventions, research projects, curriculum plans and writing schemes were done with this collaborative goal in mind. But the requirement to adjust proposals according to circumstances means that I would not have engaged in some of the actions of the later stage of the research if it hadn't been for some of the things that took place in the earlier stages. Another contributory influence to the episodic quality of the work is the need to be opportunistic. Not only because the work was conducted part-time, but interventions could only occur if the opportunity was presented or could be facilitated in some way. As I wrote at the end of Chapter 1, the formal writing up of research presents the world as a much tidier place than we all know it to be in reality.

Chapter 2 Change in Health Services and Professional Health Care Education

Introduction

The very existence of my post as a teacher of social and behavioural sciences within the education and training of health care professionals is one consequence of major changes in the system and service of health care in Britain, which lent a greater urgency to the professionalisation of occupations allied to medicine. Similar pressures have led professional associations and educational validating bodies to fundamentally reorganise courses, to raise their academic level, and to encourage research into learning styles, continuing professional development and alternative educational delivery modes such as open and distance learning. This chapter draws on the literature on policy changes, on my direct experience of designing, implementing and evaluating courses for health care professionals, on discussions with nursing, radiography and medical students and lecturers and makes observations about the relevance of such policy changes for effective learning. References will be made both to the broader societal changes in health professional education and to the specific experiences of SNMS, UWB.

Change in health professional education

I doubt that I would have been teaching sociology to health professionals, and therefore in a position to conduct this research, if it had not been for the radical changes taking place in health professional education in the 1980s and 1990s. The most significant stimulus to the growth in sociology applied to medicine and health care has been a concern to raise educational levels among health care professionals and to redirect aspects of the curriculum toward primary care. This has helped problematize the organisational and intellectual dominance of medicine in the field of health care and has given weight to applications of sociological perspectives to health service organisations, and to health-related behaviour. I have argued fully elsewhere (Iphofen and Poland 1997, Iphofen 1998a) that this makes issues in teaching sociology of special relevance in supporting the professional empowerment of health care occupations such as nursing and midwifery. In this chapter I am not so concerned narrowly with the role of the social and behavioural sciences, instead I want to look at changes in the education of health care professionals more broadly.

The recent pressures for change in health care education in the United Kingdom have arisen from an interplay of demographic, economic, and political factors. The decline in the numbers of young people available for recruitment into health professions alongside the rising health care needs of an ageing population has led to projections of a serious cumulative labour shortfall. Women now make up just over half of admissions to medical school and are demanding more flexible working patterns and presently there is an over-reliance on doctors from overseas who constitute a quarter of the UK medical workforce (Hinde 1998a).

In nursing there was an anticipated shortage of at least 10,000 qualified staff by the year 2000. The present Government has provided funding to increase the nursing workforce by 15,000 up to 2003 (DoH 1999: 18). The workforce has an ageing demographic profile, the average working life of a nurse is only 7.1 years and 30,000 leave the profession every year. The Medical Workforce Standing Advisory Committee recommended (December 1997) that the UK needed to train 1,000 extra doctors a year and develop clinical courses for graduate entry. Prompted by the last two Conservative Governments, health service management put increasing emphasis on cost-effectiveness and value-for-money and this has so far not changed radically with the election of a Labour Government in 1997. Proposed solutions to the material and human resource issues have included increased community provision of health and social care, more concern with preventive medicine, and transferring resources away from tertiary and towards primary care (DoH 1992, DHSS 1989). This has led to changes in the context of care. Public expectations have altered with increasing knowledge about health, about service entitlements and a demand for instant services (DoH 1999: 7).

Education and training reforms became inevitable in order to maintain standards of care and to improve clinical effectiveness (Wojtas 1996). One emphasis has been to accelerate the entry to and professionalisation of caring occupations. There has been a growth in "Return to Practice" courses for nurses who had taken a break to raise a family and such courses have to meet a brief to update in terms of skills and responsibilities as a result of changing technologies and an enlargement of duties (Hanson 1998). Professionalisation is assumed to improve job satisfaction, reduce staff wastage rates, attract higher calibre recruits, and encourage experienced returnees to an occupation with enhanced status. This policy was initially promoted within the professions of nursing, midwifery, and radiography (United Kingdom Central Council for Nursing and Midwifery Education (UKCC)1986, 1990). Similarly the undergraduate medical curriculum is being radically altered. The burden of factual

information typically imposed on medical students is being substantially reduced in favour of more problem-solving and critical evaluative approaches (Percy-Robb and Lloyd 1996). Communication skills and awareness of social and environmental factors in disease are to be stressed as essential to effective clinical practice. Learning is seen as lifelong and, therefore, integral to the experience and practice of being a modern doctor (General Medical Council 1993, Pereira Gray 1998). Only more recently has the dental profession begun to address similar curricular changes. This is a consequence of changes in routine dental practice that have followed the dramatic decrease in dental caries and periodontal disease in most industrialised countries in the last 20 years (Sheiham 1996). Proposals have even been made for three year accelerated medical degrees for graduates instead of the five year training course - although the General Medical Council (GMC) recently appeared only willing to countenance four year courses of this nature (Hinde 1998b).

Such policies produce different occupational expectations and demand different skills on the part of both students and learning organisations. Educational providers are also having to cope with increased numbers of mature students, both as new entrants and as returnees to professions allied to medicine. Continuing education and training is to be expanded, in order to maintain and update professional expertise. Correspondingly, there is a growing need for improved staff development for teachers of health professionals, to raise the level of their academic qualifications, to ensure that their professional practices remain up to date, and to encourage the development of research expertise within the higher education arena.

For some time medical education has been in crisis. Undergraduates experience an excessive burden of information, and develop attitudes to learning that are based on passive acquisition of knowledge rather than on curiosity and exploration. Their progressive disenchantment with medicine accounts for their leaving the profession in large numbers. There is also a serious problem of providing adequate clinical experience for medical students at existing teaching sites, largely because of the reduction in acute bed numbers, increased patient throughput and clinical specialisation. Moreover, student evaluations of teaching staff reveal that lecturers are perceived as unconcerned, discouraging, derogatory or hostile, with only about half of them rated as effective educators (Iliffe and Zwi 1994).

The rate of change in health care systems, uncertainty about the precise requirements of the job, and the need for multi-agency, multidisciplinary approaches in health care

practice suggests a need for open-minded, flexible professionals who can learn quickly and effectively. They cannot remain complacent about the durability of their professional competence or their qualifications. Currently the Government is anticipating a four stage career structure in nursing - health care assistant, registered practitioner, senior registered practitioner and consultant practitioner - with flexible exit and entry points (DoH 1999: 35). Such flexibility is essential to continuing professional development and effective learning contexts. A comprehensive survey of recently qualified medical students in the 1980s revealed rigidity in conceptions of training routes, in anything other than "conventional career" patterns, and inadequate careers guidance throughout the training process, to say nothing of continuing practices of gender discrimination in medical education and employment (Allen 1992: 343-5). Fortunately, doctors now are being challenged to remain more aware of their continuing learning requirements after qualifying which should help produce more flexible exit and entry points to medical skills training and more innovative forms of educational delivery (Faculty of Public Health Medicine 1994).

Structural changes in the workplace required for the new, upper-level educational programs to succeed include more flexible inter-professional working arrangements, and an integrated, nation-wide system of health care (Walby et al. 1994). In nursing, for instance, a three-tier structure was initially envisaged, headed by specialist practitioners, then registered nurses (so-called "knowledgeable doers"), helped by support workers at the bottom of the hierarchy. This model was borrowed, after a considerable time-lag, from the North American experience.

Along with nursing, midwifery is becoming less ancillary to medicine. Midwives are gaining increased practitioner autonomy, assuming paramedical duties, and engaging in team working in which discrete professional contributions to knowledge and research from a range of different disciplines are mutually acknowledged. Some of the more routine medical tasks will be performed by nurses and midwives leaving junior doctors more time for training at early career stages. This would also offer both nurses and doctors opportunities for effective specialisation. Radiography specialities are also multiplying with the promise of new radiographic technologies and applications. This occupational reorganisation must be set within radical changes in financing and in management structure which took place after the creation of an "internal market" in the British National Health Service, and the consequent growth in private health care schemes (Harrison 1993).

Similar rapid and profound changes in the structure of educational funding have taken place in a short period of time. There has been a move from central funding and control toward "local market principles" commensurate with the change in health care system in general. Training for nursing and the professions allied to medicine prior to the 1980s was funded centrally by the NHS. Funding then moved to regional health authorities, to central purchasing units and, from 1996, has been dependent on local consortia formed between health authorities and trusts. Funding and organisation for medical education remains determined by the "ten key principles" agreed between the NHS and universities and intended to be part of an education to take place in "... an atmosphere which combines high professional standards ... with a spirit of intellectual enquiry and innovation based on active research and development programmes" (DoH 1996 Circular 96/79).

Changes brought to the NHS in 1998 continue to devolve responsibilities to local primary care groups and reconfigured acute and community health care trust organisations. As yet it is unclear what changes to the system of educational funding are implied, although it seems inevitable that such changes will occur. Planning to meet the particular requirements of approximately 100 consortia nation-wide makes the establishment of a national professional education system difficult to accomplish. It is hard to understand why professions allied to medicine should be subject to the funding diversification that other professions are protected from. In fact, the prospects of local consortia control has led to a reaction and pleas from senior figures in professions allied to medicine to plan and finance courses centrally at a national level (Hinde 1997a). While maintaining national standards seems possible through some national centralising body, consistency in curricula content and recruitment policies may be more diverse following the influences of decentralised educational purchasing decisions; and this is likely, in turn, to have some effect upon educational quality.

Accountability for the NHS remains ultimately with a Secretary of State for Health, who has responsibilities for national planning and funding, and health care professionals will still seek employment outside the NHS system. Centralised educational funding seems essential to co-ordinate effective national provision and the maintenance of professional standards across the UK. It is this sort of rationale which kept both initial and postgraduate medical education centrally funded for some time (Walker 1994). But even this has broken down now into local consortia which hold a brief to provide pre-qualifying education and training, a commitment to lifelong learning, to shared learning across professional and organisational boundaries and to consider introducing alternative modes of educational delivery such as modular, part-

time and open/distance learning (Jarrold 1997). All of this is in turn subject to human resource planning requirements from Local Medical Workforce Advisory Groups (Winyard 1996). It is already evident that the election of a Labour Government has not lead to such radical reform that the internal market and its educational consequences can be easily dismantled and it may be that elements of it will remain for some time (Welsh Office 1998a).

The first step in the structural change in educational provision was the incorporation of independent colleges of radiography, nursing and midwifery within the existing university structure. Professions allied and/or supplementary to medicine have had a long-established tradition of providing education independent of the universities in Britain. The subsequent assessment of the quality of health care education relative to existing undergraduate standards is part of a broader strategy to establish uniformity in standards across all of British higher education (Robertson 1994). Medical schools had long maintained university links while retaining immunity to centrally directed, systematic reviews of the quality of curricula and teaching methods. Given a staff-student ratio that remains at 1:12 on average and with a high proportion of training in practice settings, the initial aim for nursing and midwifery was to raise the academic levels attained by all newly registered practitioners to at least the second year of a first degree. These courses needed joint academic and professional validation. The professional pressure to raise this standard fairly rapidly to first degree level, as has happened with radiographers and physiotherapists, is fairly strong but this has been resisted by government and employers who fear rising unit costs for better qualified labour. In fact, doubts have been expressed about the wisdom of too rapid a rise in academic nursing qualifications which imply a raising of competence which is not specific to the needs of the workplace and a fear that the minor procedures once performed by junior doctors have in essence been "dumped" on nurses keen to accept this as an enhancement of status (Irwin 1996, c.f. the comments made by Minister of Health, Frank Dobson in 1999).

The seminal work of Carr-Saunders and Wilson (1933) has linked the professionalisation of an occupation to higher status within the community, leading to greater political and economic power for its members. Professional associations assume greater disciplinary control over their members, their education and training, and their adherence to a professional ethos (Friedson 1994). Thus there is some pressure for a broader training that provides transferable analytic skills. There is widespread recognition of the need for today's health professionals to become autonomous learners with a critical research awareness (Alexander and Hunt 1996).

An increased premium has been placed on such learning in the more market-driven UK health economy, with its heightened emphasis on clinical effectiveness and quality assurance. In fact, as Robert Reich points out, economic globalisation focuses a nation's assets in the portfolio of skills possessed by its individual citizens and implicates them within an enterprise web (Reich 1991:89) in which the ability to work in teams is critical. The growth of jobs entailing what he refers to as "symbolic-analytic" services will increasingly call on suprapersonal skills such as identifying and solving problems and engaging in brokerage for clients. These are skills that will supplement health care workers' predominantly "in-person" services. "The formal education of an incipient symbolic analyst thus entails refining four basic skills: abstraction, system thinking, experimentation and collaboration" (Reich 1991: 229). Economic survival and growth depend on the ability of individuals to develop the kind of autonomy and flexibility once reserved for the freelance professional, together with the ability of the professional education system to provide for the cultivation of such an outlook amongst its students. It was such an awareness that informed curriculum development plans within SNMS.

Health professionals need to be decision makers and problem solvers whose flexible outlook allows them to operate across increasingly diversifying post-Fordist work settings (Walby et al. 1994). Occasionally they will work independently but, more often, they will have to adjust to working in a variety of formal organisations that are more likely to adopt a shamrock pattern or even become "virtual" in the future in ways once thought impossible for health care provision (Handy 1989). It is interesting that such developments have already led to educational decentralisation in general practice with practitioners able to continue their education in their consulting room via their computer links to the Internet and NHS-Net (Pereira Gray 1998: 204).

In the past, most UK health professionals had limited experience of multidisciplinary working because of the constraints of protectionist traditional training, the dominance of a biomedical perspective on health care, and the greater standardisation of institutional provision. Now the shift in their occupational focus to primary care and to community settings and the growth of "humanist" and "anticipatory care" models enhances the importance of ability to operate in the informal local settings of communities or neighbourhoods. Correspondingly educational arrangements have laid stress upon practice attachments, projects and portfolios and small group work based around the primary care team (Hannay 1998: 180-1).

Background to Project 2000

Professional standards and legal registration of nurses, midwives and health visitors are presently set and maintained by the United Kingdom Central Council for Nursing, Midwifery and Health Visitor/Community Nursing (UKCC). The quality of professional training and education is set and maintained by separate "national boards" for England, Wales, Scotland and Northern Ireland. Although, yet again, changes are imminent for all of this system (UKCC 1999). The Welsh National Board (WNB) has been the body controlling curriculum and course validation for SNMS, UWB. Nurses can register with the UKCC only after gaining the qualifications awarded by the pursuit of courses recognised and validated in Wales by the WNB.

Registration with the UKCC confers the legal right to practise - subject to the UKCC's code of conduct and with accountability to them for such conduct and practice. Registration is the legal mechanism for maintaining standards of care in the public interest. The primary function of pre-registration education is to equip nurses, midwives and health visitors with the knowledge and skills necessary for professional practice. Post-registration education is intended to offer additional and more specialised skills needed to meet the special needs and further serve the interests of patients and clients.

Project 2000 was an integrated strategy for educational, training and management change for nursing which was seen by the UKCC, and the national boards as necessary to maintain high standards of care and meet the demands of health care into the 1990s and beyond. The background to the need for change lies in the pressures discussed above - demographic change, economic stringency and professional development to retain staff and encourage improved recruitment by improving job satisfaction and raising the levels of training (UKCC 1986, 1987).

The Project 2000 proposals introduced a three year, non-means tested grant-aided, sub-degree level course incorporating a core curriculum in the form of an eighteen month Common Foundation Programme. This was seen as the key to producing a professional practitioner with an enhanced degree of autonomy. While 20% of the course still requires education in "practice" settings, such service is directed by educationalists and not by health service managers. The staff-student ratio of 1:12 was to be maintained with improved staff development for teachers and course validations which are jointly academic and professional.

It was recognised that, as with the rest of higher education, the system would have to encourage and be able to cope with increased numbers of mature students, both as new entrants and as returnees to the profession. In fact, continuing education and training was to be developed - both to maintain and update professional expertise, but also to raise the educational and training level of Enrolled Nurses as this occupational category disappeared. Professional observers anticipated the complexities of consequent change in educational organisation and produced self-directed learning packs aimed at curriculum developers and educational managers. They advised systematic procedures for managing change and offered examples of best practice (ENB 1989, DLC 1989).

The five key concepts identified in the original Project 2000 Guidelines - nursing, the individual, society, health and health care (ENB 1989), necessarily imply the acceptance of a multidisciplinary approach to the curriculum. Tacit acceptance of profound curricular change has been occasionally balanced by fairly strong resentment amongst teachers on the ground. An enduring feature of the British education system has been that of early specialisation. There is an established culture of impatience on the part of medical and nurse educators and their students when educational activities are not directly related to their work. Now the wholesale move toward a more holistic biopsychosocial perspective on health and illness has forced the introduction of foundation subjects, and core behavioural sciences elements in both the pre-registration and the continuing professional development curricular. These new curricula have had to be developed rapidly to cope with the rate and scale of change in the workplace. In the past curricula evolved steadily to become effective. Now one must plan curricula to anticipate change. Every few years courses are re-validated and may be radically altered. New curricula imply criticism of old curricula and of those educated within them which, once again, may be a source of resentment and resistance.

Evidently there is nothing static about this process of validation and regulation. There is an onus on the modern practitioner not only to achieve but also to "maintain and improve" their professional knowledge and competence. The "enlarged scope" and "extended practice" of nursing are referred to continually (UKCC 1992). Recognition that care by registered practitioners can take place in health care, social care and domestic settings has raised awareness of the need for practitioners to be attuned to multi-setting, multi-agency and multi-disciplinary care. In educational terms this has meant replacing the "certification of specialist tasks" (a move away from the principles upon which qualifications such as NVQs are based) with a broader

awareness of diverse community settings, varying local agency policies, the client's family relationships, the responsibilities and accountabilities of "named" or identified practitioners, the co-ordination of care agencies' work, residential care needs, the supervision of health care assistants, a pressure to maintain continuity of care and an awareness of staffing (skill mix) requirements (UKCC 1993a, 1993b).

In a range of documents the UKCC has argued that such goals can be achieved by attending to certain basic educational principles. Drawing from this range of sources these principles are listed here in summary:

- minimum educational level for all practitioners of Dip.HE (CATS level 2)
- relevance to practice (the continual matching of skills and knowledge with client need)
- research awareness
- encouraging "shared learning" (avoiding territoriality in health care)
- avoiding duplication and repetition in courses
- clinical credibility of tutors through clear links with a practice base
- establish common standards for academic and professional credit transfer
- rational and cost-effective educational frameworks
- explicit standards (outcomes?) for programmes which clarify the preparation for clinical and organisational responsibilities and for professional development (e.g. in teaching, leadership, audit and quality assurance)
- introduction of "specialist" and "enhanced practice" qualifications
- flexibility in curricula
- adequate accreditation of prior (experiential) learning (AP(E)L)
- varied modes of course delivery and assessment
  (UKCC 1987, 1992, 1993a, 1993b)

Recent Government proposals only serve to endorse and extend these principles. The links with HE are to continue but to include more opportunities for the development of practical skills. Educational delivery is to become more flexible with enhanced opportunities to interrupt courses to meet the learner's domestic obligations. NVQs will offer a standard access point with the original Common Foundation introductory course being shortened from 18 to 12 months and possibly even being delivered at further education level. Professional role changes look likely to continue to diversify with expanded roles for midwives, school nurses and health visitors. In addition to the nursing role of specialist practitioner there will be an even higher tier of "consultant practitioner" leading to a salary of up to £40,000 (Goddard 1999, Brindle 1999, DoH 1999).

These proposals have yet to be implemented but they merely extrapolate changes outlined earlier and which have already framed the educational developments upon which this thesis is based. Throughout the development process described below it was recognised that any truly "effective" educational system must strive to meet as many of these summarised principles as possible. In light of this it seems essential next to outline the features behind the organisational development of SNMS.

Organisational background to the School of Nursing and Midwifery Studies, UWB

The Faculty of Health Studies, UWB was formed from the former two schools of nursing and midwifery in North Wales (Gwynedd and Clwyd) and from the existing North Wales School of Radiography. Integration into the then University College of North Wales (UCNW) was far from an easy transition. Staff comprised experienced nurse lecturers who, for the most part, held nursing and teaching certificate qualifications. The newly appointed staff were younger on average and while most of the staff were still acquiring a first degree, others had begun Masters' qualifications.

Funding for all nursing courses in Wales comes via an Educational Purchasing Unit (EPU) within the Welsh Office. This Unit is directed largely by representatives from the NHS Trusts and in the interests of the labour requirements of the NHS in Wales. Despite some resistance from the EPU, as part of the integrative strategy a Health Studies Research Division was established on the initiative of the Head of School to which a professor, a senior lecturer and six "specialist" lecturers in physiology, psychology and sociology were appointed.

The organisational structure that emerged after integration was a traditionally hierarchical "top-down" management system. The Head of School presided over Directors for Pre- and Post-registration, who were responsible for Senior Course Co-ordinators with course organisation and delivery responsibilities for each of the nursing and midwifery specialisms. Beneath them operated the lecturers working on the range of pre- and post-registration courses. Organisational changes brought about in the Summer of 1993 made little difference to the chain of authority and responsibility implied by this structure although new titles of Senior Education Managers (SEM) and Course Co-ordinators emerged. Pressure from the Academic Support Group (ASG) formed by the Research Division lecturers helped with the emergence of a more democratic HE model: separate boards of studies, sub-boards

and working groups for each of the divisions and for distinct areas of operation within them were established (and were to operate with "free and frank discussion", and bottom-up democratic decision-making). Subsequently an organisational action research project was set up to further rationalise the organisational structure - encouraging more independent action lower down the hierarchy in an attempt to augment both independence and responsibility amongst all staff. The action research that forms the backcloth to this organisational development is reported in Chapter 6.

The specific issues and obstacles were symptomatic of change elsewhere in the UK. Change had been rapid and intense both professionally and organisationally. The changes in health care system were compounded by change to HE and the corresponding ongoing changes in HE. The professional changes in nurse education were seen as essential to meeting raising professional standards and commensurate with the anticipated altered student expectations and altered employer expectations of both supernumerary students and lecturing staff holding a different relationship to the care institutions. Evidence from research across the UK suggests that nurse lecturing staff were experiencing difficulty in maintaining their multiple roles as mentor, supervisor, practitioner and educator. Even doubts about ability to work at the targeted Diploma in Higher Education Level of the Project 2000 course were voiced (White 1993).

Curricula were expected to become more flexible in accordance with more rapid anticipated changes in service requirements. The range of ability levels and mix of students altered and pressures were placed on staff to raise their own levels of ability in terms of research and extra qualifications. Occasionally heated interchange took place over levels between the "specialist" lecturers and the nurse teachers. Such intensity reflected national debates about levels in the "introduced" disciplines (Bunnell 1994). All of this produced extra staff stress and a variety of coping mechanisms were adopted.

Strategic plan for curriculum and staff development

The emergent strategy had to raise academic standards/levels, enhance participative curriculum design, facilitate the move to modularised courses and generate higher level courses by the introduction of a "fast-track" degree course at the pre-registration level and a part-time BSc at the post-registration level.

There was more opportunity for my own involvement at the pre-registration level and, along with a colleague, two co-ordinated interventions were planned which were targeted at the joint accomplishment of curriculum and staff development. These "vehicles" were a course in Study Skills (later called Lifelong Learning) and in Neighbourhood (or Community) Studies. These were designed to include all pre-registration students and as many staff as possible given the relevance of the content of both courses to all nursing and midwifery specialist "branches". Initially this was a productive strategy since most lecturers did get involved in some aspect of design, delivery, dissemination and related research opportunities. The implications of the Lifelong Learning course are dealt with more fully in Chapter 3, while the Community Neighbourhood Study experience has been described fully elsewhere (Iphofen and Poland 1994). In brief there was evidence to suggest that both courses contributed to more open discussion and debate about both the School and the curriculum than hitherto and to an emerging sense of collegiate "community" which could have vitally added to the dynamic of organisational development. There are however some dilemmas of community dynamics which undoubtedly impeded progress: building community required excessive meetings when staff had already been saturated with meetings attendance and collective progress is too easily undermined by the sensed exclusion of those staff unable to attend so many meetings (Iphofen and Poland 1994: 43). The nail in the coffin for cultivating such community dynamics and the gentle goal of growing sensed capability to innovate amongst staff came with the intense pressure to modularise the entire course.

As modularization emerged as the next stage of development a crucial part of this attempt to encourage a collective or communal strategy became a careful emphasis upon learning outcomes. These were used to clarify course and module aims; to offer a focus for staff and students; to enable the specification of clear links to professional goals; to enable a more rational, coherent course structure; and to avoid duplication, repetition and unnecessary overlaps between modules. I used this opportunity to rehearse the use of specified "learning outcomes" for each of the modules and for the course overall (Iphofen 1995) and to test the degree of willingness on the part of my colleagues to collaborate in the production of module protocols. Perhaps, there were seen to be no flaws with the protocol I designed, but, with the encouragement of one Director, it was passed on as a "given" with little opportunity for dissent. On reflection, I believe that an openly critical and questioning culture had not then been developed and such a protocol would now be treated to much greater discussion and analysis. Informal discussion with staff revealed a tendency to still "do one's own thing" as much as possible, so the lack of comment at the time might have simply

been due to undeclared staff independence or autonomy. My concern then was that this remained untested in any public sense, and acts as a restraint on the view of the organisation as a learning system which is discussed in Chapter 6.

The rest of the curriculum development process followed the basic principles laid down by UKCC and WNB. The existing course already specified some outcomes - linked to the attainment of the above principles and to the course ethos of Project 2000 - that is, an emphasis upon Holism and Health to counter a tendency toward the fragmentary study of parts of the body and of diseases. The bulk of shared learning across the nursing "branches" (Mental Health, Child, Adult and Learning Difficulty) was to take place in the Common Foundation Programme for the first eighteen months. Branch specialisms followed which were to maintain some interdisciplinary elements and foster further shared learning opportunities. Throughout broad integrative concepts were established alongside detailed, interlinking concept maps which then fed into more detailed statements of course content statements. For that original course, in all my HE experience, I had never come across such detail in seeking a validated curriculum. On more than one occasion I heard senior academic staff in UWB privately mock the sheer weight of the documentation. While junior colleagues meticulously followed the detail in the production of timetabled sessions - thereby producing a heavily packed curriculum with most of the "theoretical" time in the classroom accounted for. The model having been set by the time-consuming production of the original timetabled curriculum, was followed in the modularised Diploma and Degree courses.

Curriculum development teams with different responsibilities for the Diploma and Degree courses were formed according to interests. The protocol for module design was produced after consultation with other modularised nursing degrees. This was applied fairly directly and the design of modules using existing concept maps and content statements begun. The emergence of staff willing to act as module co-ordinators was encouraged and student theoretical assessments for each module were proposed with a view to minimising the overall number of assessments while allowing for some variety in type of theoretical assessment. Attempts were made to ensure links between proposed assessments and learning outcomes. The design of the overall assessment strategy was such as to meet required CATS levels. Once again joint validation (University and WNB) was sought (and widely varying advice had to be somehow reconciled!). Re-design to meet validation objections took place. For example, the number of assessment points was still considered excessive by the WNB adviser. Timetabling proved difficult as the learning outcomes still remained "fluid".

Horse-trading about content and leadership continued throughout this period, but an agreed guiding principle was to ensure links to a "core" module seen to be central to the thrust of the entire nursing curriculum - Communication and Caring.

Establishment of a research culture

(The "evidence" for the observations made in this section is based on a summary analysis of contemporary key internal documents.)

At my appointment in 1992 it was clear that health professionals in practice and in training were increasingly being exhorted to become "research aware". In fact, research has been stressed in the intervening period with a series of initiatives that first called for linking activities to local and national health gain targets (DHSS 1989, DoH 1992) next to "clinical effectiveness" and then "evidence based health care" (Welsh Office 1995a, 1995b, 1996a, 1996b, 1997) all of which were to be informed by a systematic and rigorous research base (Welsh Office 1998b). Such a systematic framework was specifically devised for nursing research and, as with other external policy documents, influenced the direction of activity within the School (Strategy for Nursing in Wales 1996).

Establishing such a culture within SNMS has proven to be a complex task, and discussions with colleagues in other HE incorporated schools of nursing suggest that the experience is a fairly common one although specific strategies have varied.

The first initiative within SNMS was to establish a distinct Research Division in 1992/3 with a Research Professor, a Senior Lecturer in Nursing Research and six "specialist" lecturers holding a combined brief for teaching, research and staff development. The University recognised the difficulties facing this infant Division and recommended a gradual reduction in the teaching demands placed on the specialist lecturers, the establishment of a series of Faculty research seminars alternating between the geographically diverse sites of the School, the setting up of a Division-based research committee to co-ordinate such activities and facilitate the managing and mentoring of competitive research tendering and collaboration with other named University departments was encouraged. The suggestion was made that the School should enter the 1996 Research Assessment Exercise (RAE) in a "moderately selective" way, recognising that the rating achieved would be low but that even that might act as a morale booster and make for the beginnings of a

recognisable research culture. A similar subsequent visit to the Department of Radiography Education in addition recommended establishing a strategic focus for Departmental research activities, attendance and speaking at conferences and the active seeking of research grant aid. Much of the subsequent history of Faculty research activity can be seen as an attempt to meet these initial requirements.

Initially activity grew quickly with the appointment of two research assistants, a full time PhD student and Faculty staff pursuing their own postgraduate studies part time. The first of many attempts to set out a comprehensive research strategy took place amongst then "research active" staff in 1994. Such strategy building exercises have continued almost annually ever since. Occasionally the drafting took place amongst small research active staff teams, subsequently, as attempts to introduce more participative democratic decision-making were made, drafts were circulated to more staff with critical comments being returned, and the last comprehensive strategy review included all staff in an "awayday" exercise in 1997.

Throughout this period documentary analysis reveals that the issues to be addressed remained substantially the same, although the vocabulary might have changed slightly in accordance with external (government and university) policy pressures (See Appendix II: Chronology of Events). These issues are listed below for convenience:

- attempts were to be made to unify health (and service) research resources across the University and across North Wales;
- research activity was to demonstrably support education and training activities (so secondary research of a scholarly nature would be encouraged to enhance subject/clinical/professional expertise);
- regularly updated audits of staff research interests, skills and experience were to be conducted and maintained in a centrally held database;
- administrative and secretarial support needs were to be identified and addressed;
- the pool of health service staff/clinicians with research skills and experience was to be identified and expanded;
- fact-gathering and the circulation to all staff of information about research opportunities (finances, scholarships, bursaries, conferences, research partnerships etc.) was to be maintained;
- networking opportunities with other institutions (regional, national and international) were to be established and maintained;
- equivalent access to opportunities and information for all staff on all geographically dispersed sites was to be ensured;

- ongoing research resources support for staff was to be identified, supplied and maintained (research assistance, project preparation, support and supervision, IT/computing; statistics, staff development in research skills - guidance, advice and time out from teaching);
- a system of quality assurance was to be set up and maintained;
- research teaching and training from undergraduate to postgraduate levels and for internal and external, staff and students was to be provided and expanded.

External NHS and health research funding policies substantiated the importance to the development of a research culture contained within these principles. There was an "irresistibility" to the more competitive funding measures in health that had already characterised HE and were to come with the implementation of the Culyer Report to NHS R&D funding within Wales.

Staff depletion was high in a short period so that the Chair and Senior Lecturer left in 1995, one of the specialist lecturers left in 1995 and one was seconded to another department and then died. Another specialist left in 1997, so that, until the re-appointment to Chair and Senior Lectureship in 1999 only three of the original staff remained. Given the perceived divisiveness of the School's "divisional" organisation and the resentment over the "specialist" designation of the Research Division lecturers, it was inevitable that a separate research identity should be removed to encourage all staff to consider themselves potentially involved in research. This began quite early on and was eventually achieved by the complete reform of the organisation structure of the School in 1997.

By this time the University's Research Committee's view of the School's research strategy had changed substantially after the apparently tactically well-advised decision not to submit for the 1996 RAE. There was a realisation that the teaching and clinical demands placed upon the majority of staff were already high, that Faculty of Health staff (as non-HEFCW funded) should be excluded from the Higher Education Statistics Agency (HESA) figures, that active staff (now considered to be 10% of staff) might be better advised to submit for a future RAE in other Units of Assessment.

Nevertheless, most of these original "goals" were accomplished in a gradualist manner as they took place within the routine activities of the School. After some experience of chaotic bidding processes, attempts were made to co-ordinate the

management of bids for funding. The research strategy consolidated and was conceived as a corporate business plan to be used and built upon for annual submission to the EPU, to the UWB Research Committee and as a basis for a draft submission for the 2001 RAE. Increased research training, winning competitive tenders, receiving research commissions, publishing and conference activity have all grown steadily. Some events stand out as key "markers" to these accomplishments and these include: the series of research seminars run on all sites and in liaison with the North East Wales Institute (NEWI) (a sister HE organisation also running health professional undergraduate and postgraduate courses); a system of collaborative research supervision which facilitated support for staff pursuing postgraduate research; the establishment of the Institute for Medical and Social Care Research (IMSCaR) within UWB, a research training course for health service staff at Masters level; and the emergence of the beginnings of a "graduate school".

All of this was accomplished under a great deal of duress and with, initially at least, a failure on the part of the University to realise the size of the project, the changing status and fortunes of the Research Division as a distinct entity and the constant realisation of the need to meet potentially limiting EPU requirements. At times it seemed that there was more time spent devising strategy than there was conducting the research it presaged. Some vindication for the strategy appears with the Government's latest statements about the key role of research in the development of the professions. The Government has announced a wish to apply rigorous and systematic assessment to evidence that could inform nursing, midwifery and health visiting practice. But in order to be able to seek out and apply this evidence: "As part of their clinical governance development plans, and investment in continuing professional development, NHS organisations need to improve the capability of nurses, midwives and health visitors to appraise and apply research findings to their practice" (DoH 1999: 50). Linked to their proposals for extended career paths and enhanced career mobility, the Government is proposing to strengthen the R&D agenda and have announced their commitment to "...developing the research base, and to the development of a cadre of nursing, midwifery and health visiting researchers ... to strengthen the capacity to undertake nursing, midwifery and health visiting research, and to use research to support nursing, midwifery and health visiting practice" (DoH 1999: 50).

Significant trends and influences

The preceding discussion and commentary leads to a number of summary observations about the implications of such large scale policy changes for educational delivery and organisation and, necessarily, for effective learning. These observations are based upon the preceding literature review and the analysis of the key internal policy documents mentioned earlier. The particularly significant influences and issues to be drawn from these sources are listed in outline below under separate headings for convenience:

A client status?

Rapid market changes lead to new views of the clients for health care. They are viewed both as consumers with rights and expected demands for satisfaction and as "persons" with values and concerns that call for holistic treatment. In the light of changing institutional structures in both health services and education this leads to changing perspectives on the nature, origins and destinations of students. With the widely differing demands of the health employment market - between the acute and community and between the public and private - more mature students are valued as recruits for their experience in their communities, their personal investments in them and their supposed flexibility in adjusting to subtle change in employment market demands. It remains to be seen as to whether they, too, as students are truly valued as "clients" within the education market.

Quality assurance

There is, as a consequence of change in conceptions of the client, an increasing concern with the quality of health care and of education for health care. In many settings there have been obsessions with crude quantitative performance indicators. Thus one sees confusions between audit and research and research that is driven by organisational imperatives as against the intellectual emergence of priorities within a discipline. In fact, these obsessions have resulted in over-evaluation leading to a range of "contaminations" of the research field in both health care and in education. Patients and students may all have to suffer an excess of evaluations in a quality assurance culture.

Varying validation criteria

There are obstacles and constraints to multi-agency collaboration and multi-disciplinary awareness linked to professional territory, finance and power. But the effort to understand and reconcile the interests of different disciplines and the responsibilities of different agencies is essential to effective professional training and subsequent practice. Working relationships are beginning to emerge both between care agencies and educational validation institutions. Validation is likely to remain independent of (if collaborative with) the Universities for most of the professions allied to medicine and pre-HE courses and qualifications remain subject to a variety of potential validating agencies.

Balancing individual and corporate needs

Issues of professional change necessarily point up the difficulty of balancing the needs, interests and expertise of individual staff with more strategic corporate institutional plans. This would depend upon the implementation of effective annual professional/independent personal review (APR/IPR) and there are real doubts as to how well this is done in practice or even can be done. Collective priorities may dominate at the expense of individual aspirations - or even career plans.

Funders' dirigeism

Topics and areas of study have been largely dictated by the concern of funding organisations. The central funding councils have been constrained by Government objectives and are likely to be so for the foreseeable future. There has been stress on multi-disciplinarity, on industry relevance, on cost effectiveness and on clinical effectiveness. All of these concerns are primarily determined by efficiency and economy. Health research funding while ostensibly decentralised by disbursal to separate regionally based agencies is still largely controlled by Department of Health targets. Some targets, such as audit and health gain, remain centrally determined and are not set by the individual patient/consumer/client. The Culyer research funding principles although well-intentioned in terms of removing a complex and chaotic system which did not guarantee best use of funds have lead to a further concentration in the hands of established researchers with good track records and, in any case, are tightly bound by cost constraints, heavy bureaucratic administration and resources rationing (DoH 1994, Culyer 1995). Similar charges have been laid against the US

federal government which has been seen as the single most dominant force shaping the development of health professions over the past 50 years (Dunivin 1994).

Changing management structures

Against the apparently "flattening" hierarchies in health service the emergence of institutional missions and increased central direction within HE balances uneasily. Multi-agency arrangements and interprofessional teamwork is ideal in theory but often difficult to make work in practice. This is the classic dilemma of professionals in bureaucracies - maintaining professional autonomy while meeting some centrally determined requirements. The concern with throughput (patients and students) is paralleled in both the health and the higher education services.

Stress upon teaching staff

In attempting to cope with the demands of routine educational delivery and incorporate the ongoing organisational and role changes it was inevitable that the negative stressors upon staff would be high. At times morale amongst lecturing staff was as low as amongst service staff and some staff members were forced to take sick leave under the strain. An intensive study of SNMS has shown that a combination of the rate and extent of the changes, together with inadequate preparation for them was the source of such strain (Bellis 1996).

The significance of these trends and influences will be revisited throughout the subsequent chapters but come to a critical point in Chapter 6, the part of the thesis that focuses on organisational issues.

Conclusion

The consequences of these fundamental changes in health care education are common to all the key professions. Clinical placement opportunities have been reduced. Service needs produce pressure to generalise rather than specialise. While community experiences may have been enhanced, the role of clinical teachers has changed so that clinicians and practitioners hold somewhat negative perceptions of their clinical status. Disenchantment with the possibilities for effective care work in such complex arenas is high. Obligatory continuing professional development (CPD) has been

perceived as a form of continued surveillance with its possible financial/professional penalties. Yet this is advocated despite neglect of empirical evidence to support oft-repeated assumptions of growth in knowledge and skills, improved attitudes, job satisfaction and staff retention (Barriball, While and Norman 1992). While credit can be gained for active research work, it becomes increasingly hard to compete for research funding in an elitist system of competitive tendering.

Some argue that the current system is becoming increasingly compromised by a lack of balance between clinical, research and educational forces. Attempting to remedy the poor performance achieved by most medical schools in the last RAE has led to a recruitment of non-practitioner medical scientists in order to boost research ratings. This has led to a fear that future doctors will be taught by competent researchers who are not practising doctors (Rees 1997). Of 2,621 newly qualified doctors sampled in 1993, only nine opted for a career in academic or research work (Health trends DoH 1997). Debate about the merits or otherwise of Project 2000 education for nurses has concentrated on the potentially diverging concepts of "fitness for practice" and "fitness for purpose" - the former being a concern of the professional standards bodies and the latter a concern of employers. There is a view that Diplomat nurses have the greater potential for change and further learning required of a modern health professional, but they lack the immediately necessary practical skills as they complete the three year course and take up initial employment (CHSS 1996). This may require continual re-working of the Diploma (and increasingly degree) courses or it may be an intractable dilemma in the boundary between professional education and service needs.

Some of the pressure for radical change in medical education has been reduced by the introduction of the curricular change advocated by the GMC (1993). Active learning methods, a reduced core curriculum, greater access to patients and more emphasis on public health and preventive measures have been seen as contributing to reductions in wastage rates which led to the call for increased intakes. Wastage rates have been reduced from around 10 or 12 per cent prior to 1993 down to an average of 5% by 1998 (Hinde 1998b, and see GMC medical education committee Website). The pressure on nursing continues and an all-graduate profession is envisaged by senior policy makers in the not too distant future even though this, in itself, offers no immediate solution to the "service needs" issue (Hinde 1997b).

It should be evident from the foregoing that there has been massive and ongoing professional and organisational change in the UK at large that has had specific consequences for SNMS within UWB. This constitutes the "context" of the present study. Chapter 3 now goes on to consider some theoretical approaches to effective learning within such a context.

Reflective Commentary - 2

Reflecting upon Experience and Formulating Concepts

To understand more about the broader context in which I had come to operate, I read widely about the nature of change in health services and in health professional education. The picture throughout was of widespread and endemic change, which was productive of high stress. All my previous professional experience led me to believe that surviving such immense change requires that internal conflict and divisiveness should be studiously avoided and that every opportunity to move forward collaboratively should be taken. In both of my previous full time posts I had experienced and was actively involved in large scale constitutional change. The adult residential colleges, although small, are intensely political institutions. The major changes they suffered were largely responses to internal pressures that were exacerbated by the general attack upon adult residential education engaged in by the Conservative Government of the early 1980s.

So I was no stranger to internal conflict within higher education and the institutional struggle to survive. But I had learned much about how best that might be accomplished. I had seen that the avoidance of malign discourse, hidden agendas and political factionalism was essential, as was the establishment of a principled sense of collegiality and the sharing of an ethos across all members of the institution. Initial observations in SNMS suggested that many of these principles were not being observed – throughout the hierarchy. There were common expressions about the ultimate institutional goal – the production of a professionally competent nurse, but little open understanding about how best that might be achieved. The curriculum seemed to me jargon-packed, convoluted in design and impenetrable and something very unlikely to be easily understood by the student.

Planning

Whatever was done as part of this project had to take account of the fact that my colleagues across pre- and post-registration education had, in a three year period, experienced three major curriculum changes, the introduction of two new degree

courses and a Masters programme followed by the modularisation of all courses. I believed that it was vital to gain acceptance as a constructive contributor to these developments and also there was an expectation that the lecturers in the Research Division were to take a lead in the discipline-specific elements of the curriculum. However, at this point there was no formal recognition of this position of "authority". There was responsibility without power.

To address these tasks the Research Division staff formed an Academic Support Group, which in effect, acted as a "pressure group" to bring a series of related concerns to the attention of Senior Management. Initial plans were worked out in this group, after which endorsement was regularly sought from Senior Management. (Appendix II lists the Chronology of Events to give some impression of how sustained these development attempts were and how often they were re-visited.)

These plans included encouraging all interested staff to be involved in the production of research tenders, the construction of an integrated curriculum with integrated assessments (that crossed disciplinary boundaries), some team teaching, facilitating staff participation in the decision-making process, and supporting staff development in teaching and learning in higher education. All of these plans seemed in accord with policies emerging from government, the health service and professional associations. Some colleagues across the University became vital to the success of these plans – in particular the Director of Staff Development and his staff and, through them, the Enterprise in Higher Education initiative.

Most planning was conducted within this small group of colleagues in the Research Division, but I had a particularly close working relationship with my sociologist colleague, Dr. Fiona Poland. Together we sketched outline development plans that would further those elements of the sociology curriculum which were most congruent with the interests of the School and steered away from the simple delivery of the broad based course in introductory sociology that had previously been commissioned and which staff were using at the time. We planned collaborative work in neighbourhood and community studies, introducing this as a module which brought interest across nursing and midwifery specialisms and linking it to research

opportunities. I had won a contract for an entry level text book and we planned to share the writing of and contributions to this with colleagues.

Acting

The idea for the action research forming the basis for this thesis emerged at this point. The possibility of combining my roles of active participant, reflective practitioner, educator and learner with that of action researcher seemed eminently possible. When the opportunity was offered I took a lead in suggesting that module planning and development could be facilitated by the specification of clear learning outcomes and presented a model for doing this which had proven successful from my role in validating and assessing Access courses. This module protocol then became the basis for the module design throughout the School (as reported on p.36).

Getting the university hierarchy to understand the differences between conventional academic departments and the work of SNMS was tortured. The initial "demands" placed upon the lecturers in the Research Division were unrealistic. For similar reasons I felt it would have been unrealistic to have treated the "requests" for organisational improvement (listed on pp.39-40) as performance or outcome measures as in conventional in organisational evaluations. SNMS was not merely operating in a conventional university situation. It had to confront pressures from HE, the NHS, the relevant health professions and the requirements of local health organisations. To apply any one series of outcome measures within an artificial time-scale would have led to a rush to judgement and an inevitable impression of "failure".

Coincidentally concurrent discussion within one of my professional Internet discussion groups on "sociology in professional education" was going on so I wrote a paper (together with Fiona Poland) for an American Sociological Association journal. Among other useful responses this later produced an invitation for me to act as panellist for a discussion on sociology in professional education at the 1998 International Sociological Association World Congress of Sociology in Montreal.

Observing and Experiencing

Again Appendix II listing the Chronology of Events gives some indication of how difficult these plans proved to be. Frequently the same points had to be made over again, adequate resources did not materialise, frustrations were many and frequent, shouting matches in meetings and in corridors testified to the strain. On one occasion I gained permission from a colleague to sit in the back of her class as an observer and subsequently ended up in a heated discussion with another colleague about my "qualifications" to "sit in judgement". Needless to say, I had made no comment about my colleague's delivery to anyone – but the assumption had been made that that was my function. When colleagues disagreed with the curriculum changes or assessment plans there could be heated exchanges, individuals storming out of rooms, or simply a reluctance to deliver the paper requirements of the curriculum. And that, of course, would only be revealed when students would say: "No, we haven't covered that!" Despite my sincere hopes conflict seemed unavoidable on many occasions, especially when I, along with other Research Division lecturers, was employed to "troubleshoot" problematic issues.

As hard as I tried not to appear the external agent (see p.13), some colleagues saw me in this way. It did not help that I was not a nurse. I appeared to be "in league" with Senior Management (perhaps in part because I treated them as intelligent human beings who had a rationale for their actions and should be expected to share that rationale with their staff). I was seen as representative of HE values (not therefore of professional nursing values which might contradict those of HE), and, finally, I was treated as an "enforcer" of the research culture esteemed by the University and of the educational changes deemed necessary in general.

The establishment of the module protocol mentioned in Chapter 2 produced a few of its own ironies. In spite of some reservations about the "learning outcomes" method, it did provide a systematic means for establishing points of agreement between colleagues. It was so successful that I sang its praises when we were consulted by the Director of the Wales Access Unit project on learning outcomes. She was a convert in any case and within a couple of years had convinced the HE and the professional education communities to the extent that the WNB was insisting that we use this

procedure in all future course design – it became a criterion of course validation. In such ways expediency is converted to bureaucratic necessity!

Reflecting

I have to admit to finding it galling to be informed of the correct "protocol" for module submission now. But I suppose that much of what we had planned did come to some kind of fruition – although I look back on this period as one of extreme frustration. And it was all too easy to lose momentum when periodic crises beset the organisation. More importantly I should have realised that it would be inevitable that certain form of "resistance" would occur. It is a common enough characteristic of "alienated labour". I discovered that staff frequently "did their own thing", relying upon resources and teaching materials and topics that they had used in the past – regardless of whether or not they met the specified outcomes. These are not unfamiliar coping strategies. In the same way, I am sure that the staff spirit for enhanced research activity was "willing" but actually doing something about it fell foul of the "weakness" of the body.

There were countless meetings during this early period which produced very little action. My annual mileage on this business alone for the first three years averaged 12,000 and that was solely on travel to attend meetings at each of the sites of the School. Frustrations within the School were matched by the apparent impossibility of getting the University hierarchy to see the problems. The University treated the School like any other academic department, ignored its history, the added professional requirements of the lecturers and its source of finance. The University's sights were set on "rankings" of all sorts and the pressure only came off with the realisation that SNMS staff and students should not be included in the Higher Education Statistics Agency (HESA) statistics upon which the published rankings were based.

I really should have anticipated these problems when I was asked at interview for my post how I would get colleagues to accept new ideas. I replied in something like the terms I wrote of above, stressing the assumptions of shared principles of learning and teaching. I had not anticipated the way in which I would be viewed by my new

colleagues - making such aspirations difficult to share. In organisational analysis terms it is easy to see the flaws. In a traditionally hierarchical institution, the worst thing one can do is put someone in to "troubleshoot" who lacks legal/rational or traditional authority. I did trade on some "charisma" for a while. I believe that I was personally liked by many colleagues. However, that was easily undermined in times of pressure. If I held to conspiracy theories I would be inclined to suspect elements of "sabotage" in some of the planning failures and the vehemence of the response to (democratically decided) proposed changes to assessment. Any failures of the "specialist lecturers" could serve as useful vindications of other criticisms of change. Moreover, I also came to feel at the time that we served as useful scapegoats for Senior Management. It wasn't necessarily in the interests of Senior Management to put paid to the nurse lecturers' resentments. Criticisms of change might easily be deflected in our direction.

In fact, the manoeuvring of some of the lecturing staff in response to the specialist lecturers over this early period is highly revelatory of staff anxieties. First they just wanted us to take over the teaching of the "'ologies" which had been a requirement of Common Foundation Programme (CFP) element of the Project 2000 curriculum. Next they supposed that we could present a threat to their job security - if we did all that teaching, then what would they be doing in the CFP? We subsequently experienced some isolation in being referred to as the "academics". We were the "aliens" from the university. However, it was then realised that this "exclusion" put us in an "exclusive" position. They wanted to know how come we could "come and go as we pleased" and so resented our autonomy. Moreover, we appeared to be taking our job descriptions seriously and were prepared to take an active role (or even a lead) in curriculum development. So the "ownership" problems arose again and we were initially marginalised when curriculum development was occurring. I now realise that there was very little hope in that climate of convincing my colleagues that I was not in competition with them for their jobs. As I wrote earlier I sought to work co-operatively and collaboratively as a team on the assumption that if the whole School succeeds then that would mean success for each of the individuals involved. Indeed when I recently resigned (June 2000) from chairing the School's Research Sub-Board I was told of the pressure put upon some colleagues to ensure that they voted for a "nurse" to succeed me rather than one of the few remaining non-nurse

specialist lecturers. It was no surprise that a nurse lecturer colleague was duly elected to Chair the Board.

Given the strength of feeling exhibited here it might seem hard to believe that anything "worked" as part of my thesis project. But, such reflections reveal the way in which my own narrative has to be read as subject to the same kinds of emotional pressures as my colleagues have experienced. Clearly some things did work and their success was entirely dependent upon my colleagues' co-operation. A key shared concern was what made for effective learning in our students and how they could then come to be effective in their caring profession. I suppose that this is another reason why effective learning became a central focus in this thesis.

Chapter 3 Perspectives on Effective Learning

Introduction

This Chapter offers a review of some significant work in the literature on effective adult learning. It is not intended to be a comprehensive review of the literature. That has been adequately done elsewhere (Jarvis et al. 1998) and would seem an artificial exercise in the present context since participative action research benefits from a clear theoretical strategy and focus. Instead this Chapter represents a review of works and writers significant to the approach adopted and reported here for enhancing the effectiveness of health professional education. There is a critical review of the research on learning styles, followed by a focus upon the concept of effective learning and the factors which are assumed to influence it. Any general observations made here are based upon this critique together with a focussed selection from the literature that has particular relevance to the education and training of health professionals.

While this project was ongoing the Dearing Report was published in July 1997 - a key document which has stimulated much debate and subsequent policy change in higher education. One of its major terms of reference was to investigate ways in which "the effectiveness of teaching and learning should be enhanced" (8.4). Unfortunately, Dearing's conclusions offer little more than a circulatory argument about effective strategies leading to effective learning, that effective learning requires students to understand their own learning styles and manage their own learning. Much is implicit in that about the nature and existence of styles of learning and about self-direction in learning. What is more concerning is the embedding, within the potentially neutral concept of "effectiveness" of an instrumental rationality; that is, effective learning appears essentially based upon the acquisition of transferable skills and is presented as almost independent of the content of learning and the nature of the learning relationship which the learner engages (Blake et al. 1998: 89-91).

There is a danger in leaving such assumptions unchallenged. Consequently the selection of perspectives in this chapter is based upon my experience as an adult educator and what has worked for me in the past, together with the seeking of work

which examines the thesis that one cannot separate the learner from the environment in which the learning is being done. I argue that understanding learner effectiveness cannot be accomplished separately from the sites of learning and from the learning relationships within which the learner is implicated. This includes the culture and structure of society and of the learning organisation(s); it includes the educator and the educator/learner interaction. Nor can learner effectiveness be separated from an understanding of the learner's needs. Noel Entwistle has stated that "...the single most important criterion of quality is what the student has learned" (Entwistle 1997: 1). He later goes on to explain how a range of factors influence learner effectiveness so it is evident that merely focussing on the product - what is known or what can be done by the learner - is far too simplistic a way to address "effectiveness". The rest of this Chapter considers some of these influences upon effectiveness, while in Chapter 5 the significance of the learner's view of the content of learning is considered more fully.

Andragogy and effective learning

The perspective that has had most influence on my own view of adult learning is Malcolm Knowles' development of the concept of andragogy (1980, 1985). In response to criticism and debate (summarised in Davenport 1993; and Jarvis and Gibson 1997: 71) Knowles' work has gone through some modifications since it was first published. In more recent work Knowles (1990: 57-63) claims that there are six basic assumptions of andragogy that distinguish it from pedagogy. They are summarised (with references to related work) as follows:

1) **The need to know:** learning is more likely to be effective if the knowledge gained, or the competencies acquired are perceived as necessary or useful to the learner. The entire thrust of the 1960s "deschooling" movement was about establishing just such a need (for example, Freire 1970, Neill 1968).

2) **Change in the self concept:** learning should be connected to the student's concept of themselves, to their identity and how it might change as they learn things. Adult students in particular are assumed to benefit from becoming more self-directed in their learning (Jarvis 1981). The learning outcomes may not only be those which have been envisaged by the tutors, but ones which are seen as important to the student.

3) **Experience:** the individual's experience becomes an educational resource and a base to which new learning can be related (Jarvis 1992). One has to be careful here because people will define "experience" in different ways (Burnard 1992, Cherrington and van Ments 1994) and they will not learn if they believe they already know the thing to be learned adequately - such as how to use a library or how to write an essay. They may need to learn new and more developed ways of finding information and of writing for specific purposes. So experience can be an obstacle to learning and humans do not always learn from experience. In fact the learning comes from the "reflection upon the experience" and this is why reflection without the necessity for direct experience is an equally valuable and, often, less stressful way to learn. Of course, the bulk of human learning is based upon reflection (anticipatory socialisation) and not all new learning can be related directly to all past experiences, but we may all learn together from the diversity of background experiences which we bring to the learning situation (Warner, Weil and McGill 1989).

4) **Readiness to learn:** individuals are better prepared to learn something if they can see its relevance to their needs. People will not learn if they do not see or believe something to be relevant to their needs. This means that tutors must show the relevance of what they are delivering and that students must strive to understand the relevance of things which do not seem obviously connected to their future needs. This is one of the hardest goals of autonomous learning to accomplish and it particularly resonates with those of us trying to teach social and behavioural sciences to novice nursing students (Rhodes 1994).

5) **Learning orientation:** adults tend to learn better when "solving problems" or when focussing on a topic or a particular issue rather than having to learn a "subject" or a discipline comprehensively as possible preparation for unknown circumstances (e.g. see Hengstberger-Sims and McMillan 1992).

6) **Motivation:** adults learn when oriented to incentives. Some may be external such as better jobs, a higher salary or promotion. Knowles regards internal incentives as more effective such as - job satisfaction, self esteem and quality of life. Even this seems to me a rather instrumental view of motivation and raises questions about how to measure and use it to which I return in more detail in Chapter 5.

In a variety of ways these principles have informed my practice for many years. Necessarily they formed the elements in this participative research. The interventions

employed in this thesis were based on the adoption of or attempt to clarify how these principles operate with health care professional trainees.

Types of learning style

An approach that has been particularly influential in addressing effective learning in nurse education has been the attempt to demonstrate and utilise variations in styles of learning. The models of learning style which have dominated the literature are those of Kolb (1976, 1984) and of Honey and Mumford (1986) which draws upon Kolb's original model. Both are four stage cyclical models of the learning process and as Ashton (1995: 412) suggests their categories can be seen as broadly similar:

Honey and Mumford	**Kolb**	**Principal Characteristics**
activist	accommodator	enjoys new experiences and experimentation; risk-takers, impatient, pushy.
reflector	diverter	imaginative, view things from many perspectives; think things through carefully before making decisions.
theorist	assimilator	enjoy constructing logical, theoretical models; abstract.
pragmatist	converger	how things work in practice; down-to-earth; practical solutions

Although it is argued that learners may have a preference for or tendency to employ one style predominantly, these categories are regarded as stages in the learning process and effective learning occurs when the learner has moved through all the stages and can make use of any of the categories according to their appropriateness in any particular learning setting.

The research on learning styles

In spite of the intuitive appeal of learning effectiveness being linked to the individual styles adopted by learners, there have been some doubts about whether significant differences in learning styles can even be detected (King 1986, Hodges 1988). Inadequate construct validation of measurement scales is just one of the several difficulties afflicting research on learning styles (Moran 1991).

A series of studies have cast doubt on the reliability and validity of the most frequently used research instrument - Kolb's Learning Styles Index (LSI) (Sims et al. 1986, Wilson 1986, Atkinson 1988, Sims et al.1989, Atkinson 1989). Ruble et al. (1990) found that, since estimates of scale consistency were diminished in a scrambled version of the test, this suggested the presence of a response-set bias for the standard LSI-1985. They also found that factor analyses failed to support the construct validity of the revised instrument (as did Cornwell et al. 1991) and such analyses also seemed to support indications of the presence of a response-set bias. Ruble et al. (1991) suggest that further revision of the LSI would be desirable to reduce the response-set bias and improve the psychometric properties of the instrument.

De Coux (1990) offered a trenchant critique of Kolb's LSI, suggesting that it has been over-used in spite of these doubts about its' validity and reliability. She raises serious questions about its' future use but Atkinson (1991) has suggested that since practitioners are attracted by its face validity despite its weak internal consistency and reliability, then continued applications of the 1985 version seem warranted for dialogic if not for precise diagnostic purposes. Ways of modifying the instrument to improve reliability have been suggested (Veres et al. 1991) and alternative measures of learning styles, in particular Honey and Mumford's Learning Styles Questionnaire (LSQ) (Mumford 1987), have been advocated but they still have problems (Allinson and Hayes 1990). There does remain some convincing evidence to suggest that different learning styles and preferred learning approaches have different influences on the effectiveness of student learning regardless of the measurement difficulties involved (Highfield 1988, Wells and Higgs 1990).

In spite of these reservations debate about the relevance of learning styles research in nurse education has continued. Olivieri (1991) has argued that the ability to determine learning style and its relationship to diagnostic reasoning may assist nursing students

in coping with the demands of the nursing curriculum and separate the fear of developing the nursing care plan from the experience of implementing nursing care in the clinical setting. This may not necessarily mean that measures of learning style are useful predictors of learning potential. Leiden et al.(1990), for example, found that correlations between measures of learning style and academic performance yielded low, nonsignificant positive correlations and were inadequate predictors of academic performance. It has even been argued that student nurses do not generally show any preference for a particular learning style and that there is no relationship between learning styles and learning effectiveness or the ability to solve problems (Ramprogus 1988).

Nevertheless a variety of packages have been developed which recognise the range of learning styles adopted by nursing students and the need to co-ordinate teaching methods to this range of learning styles and to the continuing education needs of qualified nurses has been asserted (O'Brien, Procter and Walton 1990, Huddleston 1990, Brudenell and Carpenter 1990, Rosenthal 1989, Nyamathi, Chang, Sherman and Grech 1989). Davis (1990) suggested a series of ways in which it is possible to assess and improve the learning environment for the student nurse, including human aspects, equipment and information.

Gregorc (1982a) identifies the two predominant learning styles used by students as "Abstract Random" and "Concrete Sequential". These learning styles are on opposite poles of a continuum in relation to the perceiving and the ordering of information. Murphy (1988) found that hospital nurses favour a reflective learning mode while non-hospital nurses favour an active learning mode. O'Kell's (1988) results indicated that more than two thirds of a sample of learners had active learning styles. Student nurses from mental handicap, psychiatry, and general adult nursing tend to have different preferences for the teaching methods of lecture and experiential learning used in their nurse training schools. Dux (1989) found that the student groups he sampled did not express a very strong preference for any one learning style, but for a combination of styles as did the teachers sampled. Similarly, Siplon's (1990) data demonstrated that nursing education is independent of students' preferred learning style and that a match existed between the preferred learning style of the students and their teachers. Jones, Miller and Tomlinson (1994) concluded that a broad definition of "learning styles" was necessary to cover the variations required between different learning contexts (classroom, community, hospital) and the variation in the nature of the links made between theory and practice according to the varying skills of tutors and students.

McMillan and Dwyer (1990) looked at the perceived need to identify different approaches to learning and the potential for matching teaching and learning styles. They suggested that a "facilitative" approach to teaching will accommodate students' learning needs. Staton-Cross's (1988) research results revealed that a majority of a sample population of traditional and non-traditional nurse students were concrete learners with accommodative and divergent learning styles. A majority of subjects preferred the demonstration mode of instruction. Pearson's (1989) data supported this and previous findings that nurses tend to prefer concrete, teacher-structured and interpersonal learning situations (see also Laschinger 1986). Laschinger and Boss (1989) found that learning style and "environmental press" perceptions were found to be significantly related to attitudes toward theory-based nursing. Concrete learners and subjects who perceived nursing environments to be predominantly concrete were significantly less positive toward theory-based nursing than abstract learners. Experience in nursing was found to be related to perception of environmental press. Learning style was not found to be significantly related to preferred method of learning nursing theories nor to preferred nursing theory for practice.

Brillinger (1990) identified some of the particular needs of mature nursing students on the andragogical grounds that adults possess life experience and a concept of themselves which affect their capacity to learn - arguing that adult learners want to be actively involved in their learning experiences and expect them to be relevant and useful. The work of Schmeck et al. (1991) similarly suggests that learning models should include the "self-concept" as a key variable affecting the learning process. While some favourable responses to self-directed learning have been reported (Brunt and Scott 1986), it must be noted that Staton-Cross's (1988) subjects significantly rejected the self-paced and self-study modes of instructions and O'Kell (1988) found that learner nurses become less oriented toward self-directed learning with each successive year of training. Doubts have also been expressed about the advantages and implications of increased use of interactive video/simulations in nurse education on the same grounds (Rizzolo 1988).

On the whole, research findings appear to endorse the need for planners of teaching/learning activities to make available a variety of learning styles in adult nurse education. While work by Lundstrom and Martin (1986) suggests that matching instruction to student learning style, at least at the college level, may not provide any significant educational benefits; others point out how recognition of the variety of learning styles can enhance a practitioner's or a learner's performance (Fox & Guild 1987, Lacina 1991). In spite of all the difficulties, Ismeurt, Ismeurt and Miller (1992),

for example, argue that assessment of learning styles and the cognitive process is necessary for the implementation of successful orientation programs. Even Cavanagh, Hogan and Ramgopal (1995) who found no statistically significant associations between learning styles and student demographics conclude that continued re-examination of educators' perceptions of student learning needs was necessary and the making available of a variety of learning style opportunities. It was for this sort of reason that the research to be reported in Chapter 4 was conducted.

Problems with the Kolb model

Quite apart from the scale measurement problems, while one can understand the intuitive appeal of Kolb's model there are problems with it which deserve comment. The distinction between prescription and description seems inadequately made. Conceptually the model seems caught between a "structure" and a "process" perspective. This results in a problem on the methodological level - is there a learning process which students apply in a learning situation (i.e. a four-"staged" enquiry procedure), or do they tend only to apply one of the "stages" according to the sort of learner they are? The LSI tends to produce a snapshot of the learner at a particular stage in the learning process, so it does not resolve the ambiguities in the model. The inference is drawn that, on the base of this snapshot, the learner is of a certain "type". To test this model the possibility of the following have to be allowed :

1) That learners may change their style over time as they move through the learning process. At different points in the course, different learning styles may be cultivated, encouraged or adopted.

2) That different learning styles may be more or less appropriate to learning different subjects or topics (or for different courses). The style could be adjusted by the learner according to the circumstances in which they are learning.

3) That context (or environmental press) may *oblige* students to adopt a particular learning style. For example, tutors might hold preferences for different ways of learning and might hold judgements concerning the correct learning style for their profession. This may not necessarily "maximise" the student's learning potential. Teachers' views may be that this should not happen for professional reasons. For example, they may fear that too critical or

analytic a student may be professionally disruptive, radical or difficult to place in work. On the other hand even static teaching staff may occasionally try out new ideas - in which case the student's style would have to adjust accordingly.

4) The logic of the sequencing to the four stages approaches a "science as commonsense" approach. It is almost quasi-experimental. As philosophers, historians and sociologists of science would argue, this represents a rather idealistic view of the process of enquiry. True scientific endeavour or discovery rarely mirrors this idealised model. Learners could start anywhere in the process and not necessarily pursue the four stages in any particular order.

Self-direction and autonomy

Underlying most of these models of effective adult learning lies a set of assumptions linked to self-directed education/learning and learner autonomy. What seems implicit in andragogy and in experiential learning is the notion that effective learning occurs when the learner controls or directs the learning experience to a great extent. There is also the implication that the independence required for self-direction is a factor in the quality of the learning done.

Stephen Brookfield (1986) counsels caution with the idea of self-direction. He warns that part of the temptation for the concept is its professional appeal to adult educators in marking out a field of research and practice which can be deemed exclusively theirs. But it also confuses the achievement of effective adult learning with the more political goals of liberal, democratised adult education. What is more the empirical research providing the bulk of the evidence in favour of self-directed learning is based on the formally structured surveying of groups of relatively advantaged groups of middle class (largely professional) adult students (Brookfield 1986: 40-59). I would hesitate to designate student nursing groups in the UK as falling predominantly into that category and so would have to have question any ill-considered, automatic application of self-directed learning to them.

Without wishing to broaden the argument excessively and address here the inevitable ethical concerns that arise from the notion of self-directed learning (Jarvis 1997: 97-109), it is important to note that learner autonomy raises questions of responsibility for learning outcomes which are too frequently ignored. Facilitating self-direction is not a matter of abrogating educator responsibility. Indeed since no learning can ever

be entirely independent, its effectiveness remains highly dependent upon the responsibilities assumed by the educator for the directions taken by the learner. The learning experience and environment is mediated by educators and autonomy is enhanced or limited by their actions. If self-direction becomes a means of depersonalising learning and "leaving the students to it" then moral responsibility as well as effective learning opportunities are likely to be sacrificed (Jarvis 1997: 106). (I return to the issue of responsibility in Chapter 6.)

Perhaps the attainment of autonomy is the desired outcome for all learning, without necessarily providing the means by which that attainment is achieved. This would suggest that the facilitative role adopted by the educator may be crucial - allowing the correct balance between self- and other-direction, while steering the learner towards pre-agreed outcomes (Brookfield 1986: 60-89). What such autonomy enables is informed and conscious choice between alternative thoughts and actions. The educator facilitates by engaging in appropriate dialogue with the learner. This dialogic approach has found particular favour within medical education.

Notions of effective learning in medicine have been influenced by the key document "Tomorrow's Doctors" (General Medical Council 1993, Bryant 1993). This was a product of changes in attitude world-wide towards medical education and which was part of a reaction to a traditionally factually based curriculum that was delivered didactically and geared to an assessment system obsessed with factual recall. The main concern was that this produced practitioners with only "surface learning" who regarded themselves as passive recipients of knowledge and who lacked the ability to apply higher level cognitive skills such as evaluation, synthesis and problem solving (Boelen 1993). Many of the innovations in the medical curriculum which were an outgrowth of these influences were targeted at making medical students more effective learners - learning the appropriate methods, content and attitudes required of a modern health professional (Exley and Dennick 1996). These new curricula targeted in particular problem based learning, multidisciplinary team working, and body "systems" approaches (rather then more narrow discipline based learning). Emphasis was also place upon communication skills and information retrieval abilities (Exley and Dennick 1996: 5-15).

The various research and development projects which grew out of this tried to understand how hospital doctor training is set in a context of mixed and alternative modes of educational delivery (Iliffe and Zwi 1994). In fact there is much it holds in

common with learning any practical action where interaction with the environment - people and things - is expected. But there are important differences between the learning processes involved in "training" and in "coaching". The trainer explains, shows, enables practice and then instructs. The coach does the action (i.e. "models" it), enables practice, observes the practice and then offers constructive feedback. Traditionally medical education has mixed an educational theory based on inductive reasoning following fact acquisition, with educational practice that essentially requires pattern recognition and hypothesis testing with little attention to critical thinking and problem-solving. Other things which the student must learn are seen to be better done elsewhere (such as the study of anatomy) but the theory is only really learned in combination with practice. So medical education might need to redress the balance between the mix of training and coaching. Both may be necessary for effective interaction with the environment. This points to the importance of making available alternative and mixed modes of educational delivery (Studdy et al. 1994).

The kinds of problems the health professional "coach" has to deal with include instructor fallibility, potential threats to authority (which have implications for accountability), "real time" training (time is a luxury and some patients may be in more serious conditions than can allow for learning time), and service or patient needs still have to be met while educating (Hind 1995). Nonetheless, that still replicates a coaching model - the coach remains vital while the action is being performed.

There have been some suggested model ways of accomplishing this balance or mix of educational opportunity which have been seen to facilitate relevant, enjoyable and rewarding developmental experiences. In a mentorship arrangement authority becomes a catalyst for learning. Buddying systems enable equals sharing and learning together (Petersdorf 1994, Rawls and Penny 1994). Co-tutors are equals with differing experiences who can tutor each other (Graham-Smith 1994). Portfolio and/or reflective journal compilation has become quite common and its success depends on the choice and skills of portfolio/journal reviewer(s) (Jones, Miller and Tomlinson 1994, Wood and Campbell 1995). Adequate time allowed for study leave seems essential and the opportunity to access a multidisciplinary skills centre allows a movement beyond the potentially narrow focus of any one profession (Abernethy 1994, Buckley 1994, Navaratnam, Biswas and Russo 1994).

Summarising the conceptual issues

All of these perspectives represent related angles on the issue of effective learning. They imply the almost common sense view that how one learns affects how well one learns. There is an immense literature dealing with the topic of when it can be said that someone has learned something, but I wish to move quickly to clarify what is meant by effective learning for the purpose of this thesis.

Learning has occurred when the learner knows something they did not know before. They hold information or knowledge of which they were not aware prior to the learning episode. This is conventionally what is tested in written examinations. The added knowledge (cognitive change) is demonstrated by the ability to answer set questions. Some writers suggest that learning has not occurred if the learner's behaviour has not changed as a consequence. Pedantically one could argue that their behaviour has, in fact, changed since they are now writing about something (in the context of the examination at least) that they could not have written about before. To extend that, since they are no longer ignorant of something they have the "potential" to alter their behaviour as a consequence of cognitive development and so can be said to have learned. In other words, they are in a position to make a conscious choice about their actions consequent upon the knowledge acquired.

The related question is: have they learned when their behaviour has changed but they do not know why it should have changed? It seems that one would have to affirm that learning has taken place even when a non-conscious habituated behaviour changes. So even a change in a conditioned response is learning.

The pertinent example here is the health professional who always does things a certain way because that is how they are done. If new procedures are introduced for administrative reasons, such a professional then changes their behaviour and reasons that now it has been done "because management say so" has, necessarily, learned something. In terms of the modern requirements of the educated health professional that however does not constitute "effective" learning since it is fixed and dependent upon stimuli to change which remain "external" to the individual learner. I do not mean to imply that all health professionals whose learning is based on practice are necessarily atheoretical; in fact, many professionals improve their practice by adopting a practical logic which is theoretical and cumulative even if they do not

recognise it (Durgahee 1992). I use the example merely to indicate the potential for practice to change even without effective learning having taken place.

Stephen Covey argues that effectiveness is not something that can be instantly acquired; it has to become habitual (Covey 1989). He suggests that effective learning requires *knowledge* (knowing what to do), *skills* (knowing how to things) and *attitude* (knowing why things need to be done/ wanting to do things). Covey argues that the habit of being effective requires doing all three of these things. These are the determinants of what he calls "production capability" (PC). His formula for "effectiveness" = P/PC, where P is the production of the desired results (Covey 1989: 52-5). Thus the chances of gaining desired results are diminished to the extent we fail to achieve knowledge, skills and attitude. (I suggest that instead of the word "attitude", Covey has in mind what I consider later to be the learner's "motives" and deal with this in some detail in Chapter 5.)

Moreover Covey suggests that one becomes "socially" committed to the material to be learned if one first "learns" and that requires mental effort; then one must "teach" it shortly after learning it; and, finally, one must "do" whatever the learning has entailed. This means assuming the "role" involved with the learning outcome. Such a paradigm seems ideally suited to any professional or vocational education. There is a paradigm shift entailed in the learning process akin to the gaining of maturity. It begins with dependence upon others, moves through independence - a form of determined self-reliance and toward interdependence. Learning to accomplish things with others is a form of effective learning that is particularly important to the team-based nature of health care work.

Ideally then effective learning is when someone has general and/or technically specific knowledge, knows why they engage in certain actions and could change their behaviour if they so chose. By focussing upon effective learning there is a sense of evaluating one type of learning above another. Cognitive learning is superior to behavioural modification. The former shows some intellectual ability while the latter could be as a result of unthinking habit (or any range of non-conscious influences upon behaviour). Thus the health educated smoker has learned more than the mentally handicapped "genius" (the *idiot savant*). It is for this reason that taught competencies are not enough. Even though trainees are often still impatient to be taught practical nursing skills and government and professional policies are attempting to reverse the excessive intellectual/academic trends. Effective learning

must be linked to the development of the individual professional and thus the further development of the profession. This depends on cognitive skills being acquired so that the individual is able to determine their own intellectual progress and subsequently control their own behavioural modifications in future.

This is the nub of the andragogical dilemma - students will learn "better" if allowed to determine their own needs - but the tutors/profession often has a better notion of what is needed for individuals than they might do themselves at first. Of course this is also the classic dilemma for all educationists - the paternalism which says the tutor knows what is good for you, producing a reluctant learner if he/she doesn't agree, as against the willing learner who sets their own goals but is learning all the "wrong" things. For example, some young truants escape learning in school to learn something else, usually very effectively, such as how to "take and drive away" somebody else's automobile. This problem of wants and needs was addressed so successfully by progressive educationalists such as A.S. Neill and Paulo Freire in quite different settings. (A discussion of such broader educational issues is contained in Iphofen and Poland 1998, Chapter 5.)

The next problem becomes: how does one assess "effective learning"? Some attempt to measure the following would have to be made so that learning could be said to be effective when:

1 the outcomes of learning (knowledge and/or skills) can be clearly identified

2 the outcomes of learning are demonstrably acquired (by some form of assessment of the individual learner)

3 the outcomes of learning can be applied comprehensively, or at least successfully in appropriate circumstances (behaviour change is demonstrably possible)

4 one is aware that one has learned something and can use that awareness in other settings (workplace and/or formal and informal learning)

It is for these sorts of reasons that learning can be seen to be "efficient" by delivering the training or education in the "best" way (a provider quality issue); but not

necessarily "effective", which has to do with offering the "best" training (an educational philosophy issue).

What counts as the best or appropriate knowledge remains open for debate. Much of the research on learning style, self-directed learning and learner autonomy makes little distinction between the "contents" of the learning. This is certainly something upon which the learner's judgement must be crucial. Content which is evaluated by the learner as "less important" will not be so easily studied and retained. It is possible that in the earlier stages of training, what counts as appropriate things to know is a broader problem for the profession and for the discipline within which the profession is contained. But an effort still has to be made to demonstrate the relevance of such content to the new learner (see, for example, Iphofen and Poland 1998, Ch.1). In later stages, and certainly during CPD, the learner's knowledge, interests, needs and experience become increasingly valid - partly because they now come to constitute the profession and contribute to the development of the discipline. Of course this cannot mean that the learner's needs and interests can be legitimately ignored at first. (Whether all of this remains clear both to tutor and student on the ground is another problem.)

Drawing upon the above discussion and literature and a range of other sources (for example, Beaty et al. 1996, Brown and Atkins 1988, Cryer 1992, Entwistle 1994, Marton and Saljo 1996) learner effectiveness will depend upon:

(1) A range of interrelated factors linked to the learner:

motives,
learning techniques/skills (problem solving ability),
learning style (orientation to learning, a need to know),
reflective abilities (concepts of self and identity),
relevance to experience (past and present).

(2) A range of interrelated factors linked to the educator:

motives,
teaching techniques/skills (problem solving and problem setting ability),
teaching style (a cultivated orientation to learning, ability to encourage the need to know),
abilities to stimulate reflection + reflective abilities of their own (understanding the student's concept of self and their own ability to make relevant applications; self concept/identity as educator).

(3) A range of interrelated factors linked to the setting:

professional influences (policy, salary, career progression),
epistemological influences (the discipline),
formal educational setting (the School, the University, HE pressures),
informal broad educational setting (community and society),
practice placement setting (the workplace).

One aim of this thesis is to examine some of the more significant of these factors and find ways to assess their influence upon learner effectiveness.

Preliminary observations on motives and learning

The study of motives is clearly important in terms of student achievement. Several theories of learner effectiveness make a link to motivational processes (see Schunk, 1991, Ch.8). Research into adult students' motives has employed variants of factor and cluster analysis using in-depth interview, social survey and psychometric measures as research instruments (see the origins of this in Boshier 1976, Boshier 1978). Such an approach leads to a failure to separate motivation, aspiration and factors linked to participation. Much of the research acknowledges this difficulty and makes general comment about motivation, aspiration and participation. It is for this reason that we do not fully understand why some participants appear inadequately motivated. Factor analyses artificially fragment motivational accounts and do not look in detail at the emergent process of accounting for entering and continuing to pursue any course of education.

Ford's (1992) comprehensive exegesis of his Motivational Systems Theory concludes with key formulae for understanding effective learning (although he claims they apply to effective functioning in any field of human endeavour).

$$\text{Achievement (or competence)} = \frac{\text{Motivation x Skill}}{\text{Biology}} \times \text{Responsive Environment}$$

In other words: "..... effective functioning requires a motivated, skilful person whose biological and behavioral capabilities support relevant interactions with an environment that has the informational and material properties and resources needed to facilitate (or at least permit) goal attainment. If any of these components is missing or inadequate, achievements will be limited and competence development will be thwarted" (Ford 1992: 248). In motivational systems theory, motivation is a psychological concept that is a future-oriented or anticipatory as well as an evaluative

phenomenon which is not instrumental, instinctive or biological. Thus the formula for motivation is:

Motivation = Goals x Emotions x Personal Agency Beliefs

One can see how tempting it might be methodologically to establish rating scale checklists appropriate to each of these above components and, once again, profiling students as motivated within particular types. In fact, taxonomies applied to accounts or rationales elicited from learners has proven quite fruitful in much previous research. Houle's (1961) classification of three motive sets: goal-oriented, activity-oriented and an orientation to learning for its own sake has been durable if rather broad. Most researchers discover more detailed, specific and composite motives and so offer more detailed lists as will be discussed in Chapter 5. Wood (1974), in fact, argued that the distinction between vocational and non-vocational education does not lie with curriculum content but with the motives of the student for taking up their further education. This implies that, regardless of the formal institutional goals, students may still retain their own notions concerning their aspirations - whether or not they are congruent with the organisation's goals. Motivation thus inheres in characteristics of the individual, but not in isolation from the environment in which that motivation is to be applied.

The learning environment

It is clear from the preceding discussion that much more attention needs to be given to the environment within which learning takes place. For example, the workplace setting is not just "practical" nor "incidental" nor "untheoretical". Experiential learning is more than just what happens in a "practice placement". There is a continuous need to provide a health service. As with other apprenticeships, the job still has to get done while learning takes place. Perhaps not "incidentally" but as part of the service delivery process and perhaps not untheoretically. In other words the links between theory and practice could be vital. Davis (1990) has suggested that the "... social and physical structures existing between and within the classroom and the clinical setting are potent influences..." (Davis 1990: 409) upon the nature of the learning done. Methodologically it is vital not to assume that such factors are static - thus predisposing a "snapshot" methodology. Factors in the learner, the educator and the setting are in constant flux.

Key characteristics of the learner are likely to adapt in response to such significantly formative experiences. Thus one cannot assume that motives about and for learning are constant or so fixed that they might not change. Nor can one assume that motives are always truthfully given (to others and to oneself). Both for one's own sake and in mediating relationships with others (lecturers, mentors, practitioners, clients) motives will be re-presented to serve a range of different purposes. Also it would be rash to assume that techniques and styles of learning are applied constantly and uniformly. Even the best of learners might neglect to adopt their best techniques on all occasions. It is difficult to apply consistently our learning instrumentally, mechanistically and repetitively. Thus, sometimes one forgets an apt experience, does not always effectively apply something that has be learned and applied in the past, or one adjusts one's style - sometimes aptly and sometimes inappropriately. It is for this reason that behaviourist learning theorists adopt "devices" which the learner is to apply rigidly in set circumstances. (But I doubt that that is effective learning by the criteria outlined above - it certainly might preclude the awareness element) Thus for example I would argue that learning is effective if, at the end of the process, I not only know what knowledge I hold and what I can do, but I also know what I do not know and what I cannot (and, certainly, should not) do. This, too, is a particularly important element in the learning of clinical practice.

The learning theories of most value for learner effectiveness are linked to the authenticity of their perspectives upon the human learner and so are more likely to adopt holistic approaches to the study of human attitudes, cognition, behaviour and emotions. Thus Carl Rogers argues that "... to learn as a whole person... involves learning of a unified sort, at the cognitive, feeling and gut levels, with a clear awareness of the different aspects of this unified learning" (Rogers 1980: 266). He warned of the dangers of "knowledge without feeling" and the concentration on ideas at the expense of emotion (Rogers 1980: 268). He listed the essential attitudes for "real" learning (by which he meant self-initiated learning that was linked to experience) as follows:

(1) genuineness in the facilitator of the learning;

(2) prizing, accepting and trusting the learner;

(3) empathic understanding - not merely judging or evaluating the learner;

(4) having the learner perceive and/or be aware of the existence of the three preceding attitudes existing in the educator.

(Rogers 1980: 271-2)

Conclusion

Learning changes us. On the whole we resist it because humans are creatures of habit. We find it uncomfortable to have our habits threatened. Prejudice is perhaps the greatest barrier to learning. In order to learn the first thing we have to accept is that change is inevitable. Consequently, learning must take place or change will merely be resisted because of the threat it poses to comfortable habits. Unhappily the same can be true of educationists even when they expect it not to be true of their students.

The effective learner is evidently one who accomplishes a set goal. The problem remains: who sets the goal and who judges whether or not the goal has been accomplished? In the case of professional educational validations - particularly when the care of the vulnerable is at issue and although there may be good educational reasons for it, the goal cannot be set only by the learner as the nature of change detailed in Chapter 2 suggests. And yet it remains essential that the learner participates in the goal setting. One way of accomplishing this is through a learning contract. But there is the ongoing danger of bureaucratising the process and treating learning as if it were static. Others have focussed upon problem based learning as a way of maximising learning potential since it allows of some compromise between didacticism and self-direction. Of course the teacher remains as the intervening variable - the facilitator. All of these approaches are intended to target and improve learner motivation.

For these reasons this thesis next goes on to look at the characteristics of health professional student groups and consider first to what extent they exhibit and apply different styles of learning and how self-directed they perceive themselves to be and then on to look at how more individuating student motives might be brought authentically into the learning process.

Reflective Commentary - 3

Reflection and concept formulation

The content of Chapter 3 finds its place in this thesis to assist the logic of the argument. It was not fully worked out until the research reported in Chapter 4 had been completed. I earlier indicated the importance that I placed upon the learning environment. Both Ford (1992) and Covey (1989) stress the vital importance of the environment and Jarvis (1995: 45-82) argues at some length about how learning is dependent upon a particular reaction to experience within the specific sociocultural milieu of the learner. The relationship between the individual's biography and their understanding of the situation is important as a stimulant to the change that is necessary for learning to occur. My previous experience and my previous research (Iphofen 1992, 1996a) led me to endorse a view that effective learning depends upon getting that environment right.

I was trying in Chapter 3 to work out my own understanding of effective learning. It is interesting how information appears to present itself synchronously when one is focussed on a particular topic or concept – selective attention I suppose. To illustrate, I came across an article by Simon Midgeley (1998) writing about Steiner education in which he argues that personal development should take priority over academic achievement. He wrote that the holistic nourishment of physical, emotional and intellectual needs is what produces effective learning – learning that sustains throughout life – and academic achievement should be really merely a consequence of the observance of these fundamental principles. Similarly I came across several references to Epicurus during this period who was reported to have said that effective learning requires constant reflection. That is certainly encouraged by these reflective summaries – as I engage in them I am aware that I am continually enhancing my learning effectiveness. As I re-read Chapter 3 I am constantly aware of how my own motives, intentions, commitments, techniques and abilities varied greatly as I progressed through the material. My sense of achievement of a learning end state is certainly related to what I know now and those things I now know that I am liable to forget. However there are some mistakes I intend never to make again – given the opportunity!

I suppose that I was also concerned with "de-neutralising" the concept of effectiveness in learning. In parts of the literature and in the Governmental approaches to education and to learning there is an implicit assumption that effective learners are those with transferable skills and who are critically aware of their own learning style – regardless of what it is they are studying and how well they study it. Once again more educationists seem currently to be concerned to address this issue.

Testing implications

I read widely about learning for this research and given my focus of attention could not help coming across more observations about effectiveness. The problem then becomes – when to stop. I felt that there was no need to display the breadth of that reading for the purpose of this thesis. It would seem an artificial exercise and not central to my argument. Others have adequately surveyed the field of learning (for example, Jarvis et al. 1998) and I had previously made decisions about those perspectives that would prove useful, applicable, relevant and influential in the action research. I was also concerned personally to "test" the perspectives that particularly influenced my approach to learning. Andragogy was just such an approach that was readily understood by colleagues and students alike.

In fact, andragogy served an ideological function in this regard and is a point of disagreement that I have with Knowles. When Knowles tried to address the substance of his critics, he explained that sometimes andragogy works with children and not pedagogy, while sometimes pedagogy works with adults better than andragogy (Knowles 1990: 63). So he did not see these paradigms as crudely opposing models. However, he did complain that pedagogy is ideological in that it holds to certain principles - (ideology being a systematic body of beliefs that requires faith and adherence) and can lead to things like normative assessments based on a normal curve. It can lead to a rigorous norm-referencing which takes little account of "unusual" circumstances.

Reflection upon Experience

I know that one reason this chimed with me was an experience with dogmatic norm-referenced pedagogy I had had in one of the adult residential colleges I worked in. I had an ongoing disagreement with a respected professor who held a senior position in the college when one cohort of my students performed so well that a graph of their exam results produced a curve skewed highly to the upper end of the marking scale. He argued that that could not be allowed (in fact he argued it was not possible) and implied a bias in the marking. I tried to argue that it was possible that one cohort could perform extremely well and while a normal distribution in the marks would be expected - possibly due to a more fundamental underlying "bias" in the expectation in the examiner of a normal distribution. I subsequently examined the marking distribution in successive cohorts and, over a six year period, found it to be normally distributed. Evidently some cohorts performed worse! This illustrates one danger in the ideology of pedagogy and it might help understand the appeal of andragogy to me. What was more important for Knowles was that pedagogy excludes andragogy – whereas, he claims, andragogy is a set of assumptions about learning that allows for the inclusion of pedagogy.

Again coincidentally while working through my ideas on teaching and learning during this period a concurrent debate was occurring in one of my internet discussion groups. The subject "What is pedagogy?" ran for a couple of weeks during November 1997. It was my view then that despite its roots pedagogy means something different now precisely because of Knowles' attempt to encourage andragogy. Thus, rightly or wrongly, there is an assumption that pedagogues are too didactic and that andragogues are more inclined to treat students in a more mature fashion - assuming them to be autonomous learners who can be held responsible for their own educational development. So it now becomes hard to find anyone willing to admit to being a pedagogue since such an approach appears to be based upon a less favoured educational learning theory. One of the side issues that bothered me more was the idea that educators can pass on "knowledge". We can pass on information, and we may be able to display our own knowledge. But the whole point of educating - whether andragogically or pedagogically is to facilitate knowledge development in the learner.

Thus I do not concur with Knowles' view on the necessarily exclusive nature of pedagogy. It is feasible to switch between the two – an option dependent on the needs of the learning context at the time. All learning perspectives can serve ideological functions. It was quite easy to get my colleagues to agree to treating the students as if they were mature; and students certainly appeared to feel respected when treated in this way.

So Chapter 3 represents my conclusions upon effective learning derived over the full period of this research. As I revisited my notes and ideas in order to enhance the elements of reflective practice to be found in the work I realised that I had been engaging in what Carr and Kemmis (1986 in Zuber Skerrit 1992) call an "emancipatory" model of action research, in that my role is that of a "process moderator" and any relationship with the participants was collaborative with a view to organisational transformation.

My own exercise in critical reflection has thus become an attempt to excite the reader into making use of some of the elements of this thesis. I do not want it merely gathering dust in some library shelf. Although many sections of the work have already been published separately, if it is to "make a difference" then I need the reader to stay with me to the end – to my main conclusion and recommendations. It is in the last chapter that the changes to my practice and, with luck, the potential for changes to the practices in the organisation under study are to be found.

Chapter 4 Learning Styles and Lifelong Learning

Introduction

Two "interventions" were planned for this stage of the project. The first was the creation of a study skills course and associated handbook which was to help a little toward standardising delivery across geographic sites of SNMS and between different tutors delivering to different cohorts, but also to ensure a more collaborative approach to the development of the curriculum. The second intervention was intended to enhance the "active" learning engagement of students first by analysing their styles of learning and then by introducing them to a learning styles approach, which might encourage reflective learning on their part but also demonstrate that an andragogical approach was being attempted by the staff.

The adoption and dissemination of the handbook and the collaborative design for this curriculum development were intended from the outset to help cultivate an ethos of autonomous "lifelong learning". The notion of transferable study skills assumes that learning about learning commences with the current course of study, will continue into CPD and, therefore, in some senses never ends. Transferable learning skills have been seen as essential to the survival of health professional students on courses which are now part of a higher education system and also of value to subsequent continuing professional education. Successful study skills courses depend upon understanding and implementing the best features of an andragogical learning perspective and upon a flexible and collaborative attitude amongst tutors and students. Contemporary thinking in nurse education approaches learner autonomy through experiential methods and concepts of reflective practice as described by writers such as Kolb (1984), Benner (1984) and Coutts-Jarman (1993). Their models of "reflection in action" incorporate theories of adult learning and have come to be accepted as key conceptual frameworks among nurse educators for explaining the learning process in nursing practice.

This chapter is based on reported participative action research that took place between a defined period - 1993 to 1995. It may be that in the light of recent research constructive changes could have been made to this part of the project. It should be read in the context of the contemporary development of SNMS and the research

evidence available at that time. The chapter reports an attempt to "test" the validity of the general critique of the learning styles approach reported in Chapter 3, considers the validity of one way of enhancing the learning environment (study skills packages) which emerged in the discussion of the literature from the preceding chapter and makes some general practice recommendations which were based both upon the quantitative data analysis and the more open-ended qualitative responses to evaluation questionnaires by the students and in a staff workshop. How generalisable such recommendations are to other settings continues to remain a moot point.

Course and handbook

The Study Skills course was first developed for the original Diploma in Nursing Studies, was then converted into a module - "Lifelong Learning" - as part of the newly modularised Diploma and the newly validated Degree in Nursing Studies. Evaluation of the initial course and integral research on learning styles culminated in a Faculty Workshop held at the Postgraduate Medical Institute, Wrexham in February 1995 and, after seeking comments from non-attending members of Faculty, was followed up by a Report circulated throughout the Faculty and to interested parties in UWB. In all 35 members of staff contributed (Hesketh, Iphofen, Poland and Wright 1995). The module now (1999) forms part of a large composite module entitled Communication and Caring and Lifelong Learning which was created during the re-validation (1998) of the Degree and the Diploma. The handbook was also used elsewhere in UWB and is now being incorporated into a networked, on-line UWB package.

The course was introduced with the March 1993 student intake and delivered simultaneously across the geographically dispersed sites of SNMS. Teaching staff had already appreciated the need for some attempt to address the students' weaknesses in the area of transferable, core learning skills and that this would need to be made intensively and early in the course. Students enter nurse training today from a variety of educational backgrounds. Although there is a minimum entry requirement of five GCSEs some students have no formal qualifications while others have A levels and even first degrees or the occasional Masters qualification. Many of the mature students have little recent experience of formal study - although a growing number are entering via "Access to Health/Higher Education" courses in local further education colleges.

Recognition that deficiencies in study skills could account for difficulties in coping with the course and with student attrition has been confirmed elsewhere (Smith 1990). The ability to survive the Diploma course academically (Dolan 1992) and to continue to meet the demands of contemporary post-registration continuing education evidently depends upon the adoption of effective techniques for learning (Dewar et al. 1994).

In order to maximise staff identification with and ownership of the course we decided against an off-the-shelf package (of which there were many - see for example Gillett et al. 1990, Fairbairn and Winch 1991, Allan 1991) and suggested designing our own materials which would be collaboratively produced out of a paper brainstorming exercise between colleagues. It was hoped that this project would enhance team-working in course design and delivery, improve communication throughout SNMS about students' learning needs and so produce a united attempt to solve any problems consequent upon their learning difficulties.

All tutors were asked to fill in a skills/interests audit questionnaire indicating their abilities in study skills, their desired level of involvement and to send any ideas, further issues they would like to confront and samples of materials or exercises which they had used successfully in the past. By this means we were able to acquaint staff with the goals of the course and, at the same time, construct a human resources database which facilitated course delivery, time-tabling and staff cover during illness and vacation. (Most nursing diploma courses operate on two student intakes per year.) In addition, learning materials were drawn from the National Extension College, the Open University and the School of Education and Enterprise in Higher Education Unit at UWB and the work of Graham Gibbs.

Course philosophy

This attempt to improve students' transferable study skills was planned as part of the overall curriculum strategy outlined in Chapter 2. The course was designed to fit in to the combined ethos of the School of Nursing and that of the University; an ethos which reinforces both the principles of Project 2000 and of contemporary higher education. The School states its commitment to a "holistic" perspective in its curriculum - this means attempting to understand human life in its totality, not just in terms of illness and disease. The University is committed to maintaining standards of excellence in higher education. This means encouraging and enabling students to become independent professionals with an ability to think critically and analytically.

Both School and University emphasise commitment to a widening of access and to offering increased opportunities for the non-traditional student.

The combined success of these two philosophies seems dependent upon the production of "autonomous learners" - independent, self-reliant students. People who can think and learn for themselves and so, ultimately, become well-trained, critically aware professionals who can competently care for their clients and use their awareness to continue their own professional development. For such people learning does not stop when they qualify, it must become part of their life.

Most of the principles underlying this course were accepted contemporary thinking in adult and continuing professional education as discussed in Chapter 3. The course was experiential in that it asked the learner to draw on past experiences and to use current experiences as they engaged their current studies. The things they learned during the skills workshops were to become increasingly relevant as they proceeded through their Diploma and Degree. Students were advised that study skills should not be regarded as something separate from all the other things they are learning. They were to be treated as suggestions, ideas and advice that would help them with the *process* of learning. Students were, of course, learning about learning.

The precise skills needed from a study skills course will differ according to the various tasks they have to accomplish within the different elements of the broader course. Lecturers were to give them further ideas about the skills needed for their particular subjects and they were advised to make continued use of their personal supervisor - someone who could keep a close watch on how their learning was developing and who could give the specific advice appropriate to their personal requirements. The lifelong learning element of reflective practice is something which not only applies to the initial learning situation, but must become an almost instinctive element in continuing professional development (Jarvis 1987).

The initial stated aims of the course were modest:

#1 To equip the student to cope with the demands of studying the Project 2000 Diploma course.

#2 To appraise students of the variety of study techniques available and which will prove useful to the successful completion of the course.

#3 To anticipate some of the difficulties of studying and learning which will occur as the course proceeds.

The stated aim to move away from a "pedagogical" approach to learning towards the "andragogical" approach in which learning is more closely related to the needs and abilities of the learner was made explicit to the students and agreed with staff. It seemed important to have the staff concur with such an approach and to embed it in the philosophy of the course from the outset - thereby ensuring some institutional commitment to treating the students as adults. This was made clear in the course handbook.

All of this meant that the course could not be too didactic. If tutors were merely to give lectures on study skills, the students' reactions would be predictably negative. In fact mixed delivery formats were seen to be essential to maintaining their interest and exploiting their own experiences.

Learning outcomes

Effective course design in study skills requires a fundamental appreciation of epistemology - how to **acquire**, **organise**, **access** and **apply** knowledge. A study skills course should be about facilitating this process and so it should entail ***enabling*** skills, ***communications*** skills and ***problem-solving*** skills (Ainley 1991). Most effective experienced educators come to do this tacitly, but one of the advantages of designing a study skills course afresh is the opportunity it provides to confront the overall aims and objectives (or mission) of a curriculum. This is particularly apt in the education of health care professionals where the need for these particular skills have been highlighted as especially vital to the holistic approach to client care.

For this reason we opposed the view that most essential learning skills are subject specific (McIlroy 1994). It may be true that, say, essay writing in one's chosen discipline is best not taught writing an essay on <u>any</u> general topic, for the andragogical reasons outlined earlier. However, the skills of gathering, organising and using information in practice or in communication to others can be acquired in general terms and applied to any subject.

Initially the implicit assumptions about the sorts of topics which had to be covered were confirmed by the staff skills/interests audit. These amounted to little more than learning outcome headings such as "reading", "writing essays" and "note-taking" which were supplemented with similarly succinct heading such as "referencing", "word-processing", "listening" and so on. We soon realised that further clarification was necessary to demonstrate the importance of some of these topics to the learning

process, so we converted the headings into statements which we felt represented the core transferable skills which could be seen as useful for students to acquire - both in order to survive a course of higher education and for their further professional development.

Since we did not intend to assess study skills competencies separately from other course requirements, these statements were then used as a basis for students to negotiate with tutors about whether or not these outcomes had been achieved. This process of specifying learning outcomes went through several phases - including a brainstorming session where we asked the students to anticipate their own study skills requirements and, thereby, produce their own personal skills audit. A summary outline of the content/ learning outcomes which was then established and laid out according to agreed module protocols is reproduced in Table 4.1.

Having determined that enough interest and expertise was available to put together a viable course, an initial draft "package" was compiled which was rapidly circulated around all interested parties for comment and amendment. The draft was offered in a spirit of evolution. Most of the exercises and ideas included were drawn from a literature review and many had already been tried out and modified by those contributing to the course materials.

Previous personal experience, the research evidence (see for example Gibbs 1981, Rogers 1977), the problems and prospects for health professional education discussed in Chapter 2, the theoretical bases of learning discussed in Chapter 3, and the overall collaborative participative intent of this current thesis suggested that the following principles be applied as far as possible:

(1) Given the range of variety of learning skills which could be successfully applied, as many of the academic staff that could be were involved in the delivery of study skills advice - but only so far as they were convinced of the worth of such a course themselves. If they remained unconvinced then steps were taken to avoid having the course undermined by any negativity they might display.

(2) Study skills courses should be designed collaboratively. Only then can the naturally occurring range of educational philosophies, individual preferences and valuable idiosyncrasies of difference be incorporated into an overall educational philosophy which might be seen to be representative of a School

or Department. This makes it possible to present a reasonably integrated picture to the student. One which should not then leave them confused about what is expected of them and what they can expect from the staff.

(3) Study skills courses can never be static. To be delivered effectively they require imagination and enthusiasm. Change is necessary to sustain excitement about learning. Moreover learning skills will always have to change and grow in response to the ever-changing educational and work environment. Nothing could be more apt than this in the "fluid" fields of higher education and of health professional education at present.

(4) Study skills cannot be taught in a vacuum. They have to be related to the students' immediate learning needs. So they need to be focussed on the particular course the student is involved in and, just as importantly, they cannot be taught effectively if only delivered in intensive modules which are separated from the duration of the course. Students need to be "eased" into the demands of a course and intensive introductory workshops need to be supported by further sessions which are integral to the rest of the curriculum and through which students can revisit learning issues and problems at appropriate stages throughout their other courses. This also means that what is addressed in study skills should match the problems being confronted by the students elsewhere on their course.

(5) This sort of course, at this level in the higher education system, can never be a substitute for the kind of work done by personal supervisors in one-to-one settings with the student. It can never be "remedial" in the sense of repairing fundamental deficiencies in reading, writing and numeracy. It can only offer initial advice and guidance and lay down some foundations which will be comprehensively supplemented in personal supervision. The multiple roles of personal supervisors in health care education are, for many good reasons, jealously guarded. Becoming a trusted mentor, intellectual guide and, often, personal counsellor can even be facilitated through support for the more mundane mechanics of learning skills.

Table 4.1: Lifelong Learning Module Outcomes

General Category		*Specifically, you must be able to.....*
Orientation to learning		Appreciate the need for a positive attitude towards study skills and show awareness of some of the more important skills to be acquired. Appreciate the need for criticism in intellectual endeavour; be able to take constructive criticism without reacting negatively; and show ability to constructively criticise the work of others. Demonstrate awareness of the importance of a developed relationship with personal supervisors and tutors. Assess your own strengths and weaknesses. Possess or develop motivation/commitment to learning.
Information retrieval	- finding	Use a library to find, select and acquire information efficiently. Use books and other written material to find and extract information efficiently. Use modern information technology to find and manipulate information.
	- interpreting	Summarise and make notes from a book or article. Identify the structure of a lecture/teaching session and acquire useful and relevant information from a lecture.
Disseminating information		Describe, analyse and evaluate information, opinions and statements. Produce a competent written assignment which contains a substantial argument on a theme and which is correctly referenced. Make a public presentation orally and/or using other audio-visual/ graphic means.
Managing learning	- self	Organise files, manage time. Reflect on learning style, assess your preferred learning style and adjust it (or add to it) according to specific learning requirements Plan for all work tasks. Plan your own career or professional development Manage the stresses and strains of learning Maintain an ongoing journal (diary/personal profile)
	- others	Discuss a topic rationally and intelligently with other people in a seminar or other group setting. Work effectively in a group or in a team.
Assessment		Cope with unseen exams (various formats) Demonstrate competence in practice Produce acceptable assignments/essays Conduct project work Write lengthy dissertations

Learning styles in pre-registration education

At this point in the development of the course an opportunity arose to further the established principles and initiate a collaborative enquiry into how students learn prompted by a submission for a competitive tender to investigate nurses' learning styles for the English National Board for Nursing, Midwifery and Health Visiting Education (ENB). My own interest was evidently connected to the need to understand processes of learner effectiveness and learner motivation. The main questions raised by the ENB tender are numbered below, the sub-questions which were generated by the tender team are listed in relation to each of the main ENB questions as follows:

1) Do nurse teachers attempt to identify individual learning styles?
   - Are tutors aware of differences in learner styles?
   - Are students aware of their own learning styles?
   - Is there a variety of learning styles amongst students?
   - Do tutors try to find out if there is variety of learning styles amongst students?

2) Do nurse teachers create a learning environment which facilitates a variety of learning styles?
   - Do tutors attempt to provide a range of learning opportunities to suit the variety of learning styles?
   - What efforts are made to help learners to learn?
   - Is there sufficient flexibility in the curriculum to allow for attention to a possible variety of learner styles?

3) Are there any effects on student learning when nurse teachers respond to individual learning styles?
   - Do students become more teacher-led (or influenced) with regard to learning styles through time?
   - Do students become more effective learners when attention is paid to their individual learning style?
   - Assuming an effective learner to be one who fulfils the course objectives - then are such objectives clarified in terms of "learning outcomes"?
   - How can students' "learning potential" be maximised?
   - Do teachers attempt to discover their students' learning motivations?

In spite of the reservations raised about the learning styles approach raised in the previous Chapter it is interesting to observe that the ENB tender took for granted the existence of variations in students' learning styles and their consequences for effective learning. In the same way that the needs for caution with the concept of self-directed learning was discussed in Chapter 3, I was mindful of the dangers of what Gouldner (1967) referred to as methodolatory - the framing of research questions being dictated by the availability of a popular, convenient, hegemonous, easy to apply measurement scale rather than by the "problem" as seen in context. Gouldner saw methodolatory as a pathology of method that occurs when the process of reason becomes "... compulsively preoccupied with a method of knowing which it exalts ritualistically and quite apart from a serious appraisal of its success in producing knowledge" (Gouldner 1967: 338).

Given all the above principles, assumptions, general ethos and caveats it seemed essential to try to answer some of these questions and make an attempt to investigate to what degree we might be producing someone who was, or someone who saw themselves as such an autonomous, self-directed learner. We were looking for something which could serve both analytic and diagnostic purposes; something we could feed back to the students and which they could use in some way to improve their ability to learn how to learn and in such a way be regarded as "facilitative" to learning. This had to be over and above and more useful than simple course evaluations.

We chose to use a modification of a 48 item questionnaire initially developed by Boydell (1976) for use on management training courses (Nolan 1993). Boydell's questionnaire aims to estimate the degree of student self-direction facilitated by a course and to enable comparison between courses on the basis of a profile of learner responses. (We were less concerned with comparison with other courses than with comparisons within a student cohort over time: between learner expectations of what the course was going to be like and their perceptions of what they actually got.) Behind the 48 items lay 12 dimensions varying along a continuum from learner-centredness to tutor-centredness. This can be seen in Table 4.2.

The questionnaire wording was amended to be specific to Project 2000 courses and administered (as Q1) to three student cohorts (biennial intakes) on each of the Bangor and Wrexham sites during the beginning of the second week of the course and one cohort of student radiographers amounting to over 300 students (A copy of Q1 is in

Appendix III). Questions were framed in such a way as to elicit students' expectations of the learning styles appropriate to the course. An amended (change of tense to past and present) follow-up questionnaire (Q2) was administered on both sites during week 16 of the course to elicit students' experiences of the course to date - at the same time feedback on the results of the first questionnaire was given to each group. Successive cohorts at 16 weeks were introduced to the results from the administration of both questionnaires to their preceding cohorts. In this way they were receiving feedback of the results of our earlier findings. Follow-up with student radiographers was precluded by time-tabling difficulties, but comparative analyses with the student nurses cohorts was possible.

Using SPSS for Windows the response scores were calculated and tested for significant variations between Q1 and Q2 within student intake cohorts and, for each intake cohort, across geographic sites (Bangor and Wrexham). These scores are reported in Tables 4.3 to 4.8 below. It is evident that the "t" tests of significance for each dimension and analyses of variance within and between sites and cohorts do not suggest any strong, patterned groupings of dimensions. Generally, there was no great difference across the sites. This means that student expectations were about the same apart from a highly expectant 1/93 intake in Bangor. There was no clear association for most cohorts with age, gender and previous experience of self-directed learning.

Table 4.2 **Dimensions in Boydell's Learning Styles Questionnaire**

DESIGNATION			
Dimension Title	**Tutor-Centred**	**Learner-Centred**	**Item Numbers**
1. Goals (GOALS)	Goals set by the tutor, in advance to meet needs that he has identified.	Goals set by the learners, with assistance by the trainer, to meet the learners' diverse needs as they evolve.	5, 10*, 25*, 31
2. Homogeneity (HOMO)	All learners go through the same learning experiences; at any one time all learners attend some sessions, do the same things.	Wide variety of activities; at any one time, various learners will be doing different things, to suit their own needs at that point in time.	3*, 13*, 22 , 43
3. Sequencing (SEQUENCE)	The sequencing, or order in which things are taught, is fixed in advance by the tutor according to his preferences and programming planning techniques.	The sequencing is very flexible, not determined n advance but according to felt needs of learners. Similar items may be learned in different sequence by different learners.	11, 24, 30*, 40*
4. Control (CONTROL)	Decisions made by the tutor, who maintains control over the course.	Decisions made by learners, or jointly by tutor and learners. Hence joint control over the course.	12*, 21, 29, 34*
5. Evaluation (EVAL)	Tutor evaluates course in terms of extent to which tutor's goals are met.	Tutor evaluates course in terms of extent to which learners feel their goals are met.	7, 16*, 26, 32*
6. Methods (METHODS)	Relatively new teaching-learning methods used. Methods selected by tutor according to his preferences or ideas.	Wide variety of teaching-learning methods, selected by learners according to their individual preferred methods and styles.	6, 16, 20*, 37*
7. Tutor-learner relationships (TUTLEARN)	Distant, closed formal relationship.	Close, open, personal relationships.	8, 41*, 45, 47*
8. Group (GROUP)	Not trusting, people relatively distant from each other	Trusting, supportive, closed, deep relationships	2, 23*, 46*, 48
9. Tutor-as (TUTORAS)	Tutor seen as a role, rather than as a person	Tutor seen as a person, rather than as a role.	18, 36, 39*, 42*
10. Feelings (FEELINGS)	Generally not considered legitimate for people to express feelings about each other, the learning process, or the content of the course.	Full expression of feelings permitted and indeed encouraged.	9*, 19, 28*, 38
11. Expository versus Discovery Approach (EXPOS)	Expository approach to teaching. Information and ideas put over to learners by tutor.	Discovery approach to learning. Situation and resources provided for learners to generate, experience and discover ideas for themselves.	1, 14*, 33, 44*
12. Certainty	Positivism: ideas presented as though definite, authoritative, 'the right answer'.	Relativism: emphasis on the fact that there are no right answers, that each person's opinion is valid.	4*, 17, 27*, 35

The statistically significant differences are summarised in Table 4.9. Three cohorts' expectations of a rewarding "group" experience seem to be significantly unfulfilled, as were three (not the same) cohorts' expectations of the tutor coming across "as a person" rather than "as a role". Only two cohorts noted significantly an unfulfilled expectation of a "close, personal relationship" with their tutor. In fact, only one cohort (Wrexham 1/93) reported expectations fulfilled better than originally anticipated on these three dimensions - as one would have hoped for all. Two successive Wrexham intakes (2/93 and 1/94) perceived a move in the learner-centredness of how tutors evaluated the goals of the course. Again one would have hoped for all scores to have moved significantly in such a direction.

The results of one way analyses of variance to examine any differences between groups showed no significant patterns. The only marked variation was for Wrexham 1/93, which demonstrated lower expectations of a learner-centred course on all dimensions. The demographic measures were fairly basic and the main variable emerging consistently was "age" as a determinant of expectations of learner-centredness: older students had higher initial expectations of more "personal" relationships with tutors and self-direction, which were unfulfilled at Q2. Thus, as might be expected, older students are more likely to have entered Project 2000 after recent "access" courses which might have utilised more learner-centred teaching and learning methods, but found that such expectations were not maintained after 16 weeks into the course. The two significant sets of variation by "sex" (one for Bangor and one for Wrexham cohorts) are both related to the "evaluation" dimension. But little should be inferred from sex differences since males accounted for only 10% of the total for all cohorts.

There is some slight evidence of significant variation in "site culture" in terms of learner-centeredness expectations - there seemed to be higher expectations of learner-centredness in Bangor than in Wrexham, none of which were reversed in Q2, so suggesting more unfulfilled expectations in the Bangor cohorts. (Although no such results of statistical significance emerge.) Since this site variation is based on the scores for Q1, it seems that the cultural expectation must come from the strongly regionally-based origins and experiences of each of the groups. An observation which is certainly suggestive of further research and could be crucial to the success of any attempt to make use of reflections upon learner style in any cohort. No significant variation between student radiographers' and nurses' scores was noted.

Table 4.3 **Differences Between Wrexham and Bangor Site Cohorts Questionnaire 1 (Q1).**

Intake 1, 1993

Domain	Mean	Sig.
Evaluation	B 3.15 W 2.94	(p=.008)
Expos	B 3.77 W 3.73	(p=.001)
Sequence	B 3.14 W 2.83	(p=.009)
Tutor-Learner	B 4.33 W 2.78	(p=.027)
Tutor-As	B 3.72 W 2.92	(p=.053)
Group	B 4.74 W 3.93	(p=.053)
Control	B 3.62 W 3.53	(p=.003)

*In all dimensions Bangor students have higher expectations of Learner-Centred course.

Intake 2, 1993

No significant differences between Bangor and Wrexham

No significant differences between Student Nurses and Radiographers

Intake 1, 1994

Certain	W 3.46 B 3.67	(p=.06)

All others non-significant

Table 4.4 **Differences Between Wrexham and Bangor Site Cohorts Questionnaire 2 (Q2).**

Intake 1, 1993

All non-significant

Intake 2, 1993

Control	B 2.42 W 2.54	W>B	(p=.033)
Group	B 3.90 W 3.88	B>W	(p=.043)
Tutor-Learner	B 3.67 W 3.56	B>W	(p=.018)

Intake 1, 1994

All non-significant

Table 4.5 **Details of Significant Differences Between Q1 and Q2 Wrexham**

Domain	Mean	N	Sig.
Intake 1, 1993			
Expos	Q1 3.73 Q2 3.62	Q1>Q2	(p=.004)
Methods	Q1 3.77 Q2 2.93	Q1>Q2	(p=.010)
Homo	Q1 2.99 Q2 2.55	Q1>Q2	(p=.006)
BUT Tutor-Learner	Q1 2.78 Q2 3.37	Q2>Q1	(p=.001)
Tutor-As	Q1 2.92 Q2 3.40	Q2>Q1	(p=.000)
Group	Q1 3.93 Q2 4.15	Q2>Q1	(p=.006)
Intake 2, 1993			
Control	Q1 3.70 Q2 2.54	Q1>Q2	(p=.010)
Feelings	Q1 4.16 Q2 3.09	Q1>Q2	(p=.029)
BUT Evaluation	Q1 2.94 Q2 3.07	Q2>Q1	(p=.067)
Intake 1, 1994			
Tutor-Learner	Q1 4.25 Q2 3.50	Q1>Q2	(p=.035)
Tutor-As	Q1 3.61 Q2 3.36	Q1>Q2	(p=.015)
Group	Q1 4.64 Q2 3.82	Q1>Q2	(p=.020)
BUT Evaluation	Q1 2.91 Q2 3.01	Q2>Q1	(p=.055)

Table 4.6 **Details of Significant Differences Between Q1 and Q2 Bangor**

Domain	Mean	N	Sig.
Intake 1, 1993			
Tutor-As	Q1 3.72 Q2 3.61	Q1>Q2	(p=.056)
Intake 2, 1993			
Tutor-Learn	Q1 4.12 Q2 3.67	Q1>Q2	(p=.000)
Methods	Q1 3.91 Q2 2.76	Q1>Q2	(p=.062)
Group	Q1 4.58 Q2 3.90	Q1>Q2	(p=.002)
Intake 1, 1994			
Tutor-As	Q1 3.84 Q2 3.22	Q1>Q2	(p=.007)
Group	Q1 4.74 Q2 4.30	Q1>Q2	(p=.046)
Goals	Q1 2.95 Q2 2.28	Q1>Q2	(p=.058)

Table 4.7 **T-Tests by Sex, SDL, Age for all Groups**

Bangor/01

Age	**Sig.**	
Tutor-As	(p=.059)	>4 higher L.C. expectations
Sex	(All n.s.)	
SDL	(All n.s.)	

Bangor/02

Age	**Sig.**	
Feelings	(p=.002)	<4 higher expectations
Tutor-Learner	(p=.051)	<4 higher expectations
Sex		
Eval	(p=.027)	F>M
SDL		
Control	(p=.057)	No>Yes

Wrexham/01

Age	**Sig.**	
Homo	(p=.009)	>4 higher L.C. expectations
Sex	(All n.s.)	
SDL	(All n.s.)	

Wrexham/02

Sex	**Sig.**	
Eval	(p=.046)	F>M
Age		
Eval	(p=.051)	>4 higher expectations
SDL	All n.s.	

Table 4.8 **Results of One Way ANOVAS Examining Differences Between Groups**

Bangor Questionnaire 1	All domains N.S.	
Bangor Questionnaire 2	Group	(p=.009)
	Bangor 2/93 lower	
Wrexham Questionnaire 1	Group	(p=.00)
	Sequence	(p=.04)
	Tutor-Learner	(p=.00)
	Tutor-As	(p=.00)
	Goals	(p=.06)
	Method	(p=.06)

- *In all cases Wrexham 1/93 has lower expectations of Learner-Centred course.*

Wrexham Questionnaire 2	Control	(p=.01)
	Feelings	(p=.00)
	Group	(p=.02)
	Homo	(p=.01)
	Methods	(p=.02)
	Sequence	(p=.01)
	Goals	(p=.07)

Table 4.9 **Summary of Significant Differences Between LSQ's Q1 and Q2: Within Site Cohorts**

Wrexham 1/93			
EXPOS METHODS HOMO	Q1>Q2	TUTLEARN TUTORAS GROUP	Q2>Q1
Wrexham 2/93			
CONTROL FEELINGS	Q1>Q2	EVAL	Q2>Q1 (.067)
Wrexham 1/94			
TUTLEARN TUTORAS GROUP	Q1>Q2	EVAL	Q2>Q1 (.055)
Bangor 1/93			
TUTOR-AS	Q1>Q2		
Bangor 2/93			
TUTLEARN METHODS GROUP	Q1>Q2		
Bangor 1/94			
TUTORAS GROUP GOALS	Q1>Q2		

Boydell suggests that another way of handling the scores is to plot a profile for the "course" by taking the mean score on each dimension for each cohort and plotting a profile. These profiles are presented in Figs. 4.1 to 4.6. Apart from the significant reversals noted above, there is a clear visual shift in each cohort between Q1 and Q2 away from learner-centredness. This, in itself, is problematic. Even if the shift is not significant in terms of individual items, the fact that the group profile is moving in the opposite direction from the stated intent of the course is something that the staff (and the students) would have to take into account. For this reason this profile data was fed back to both students and staff in module evaluation sessions and their responses reported below.

Fig 4.1 Bangor 1/93 Q1 & Q2

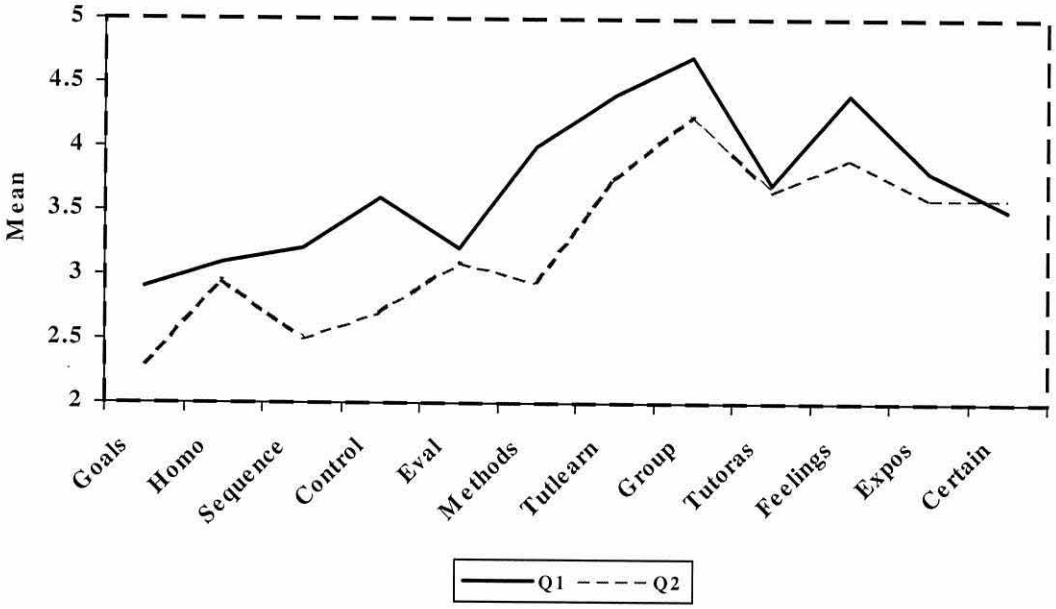


Fig 4.2 Bangor 2/93 Q1 & Q2

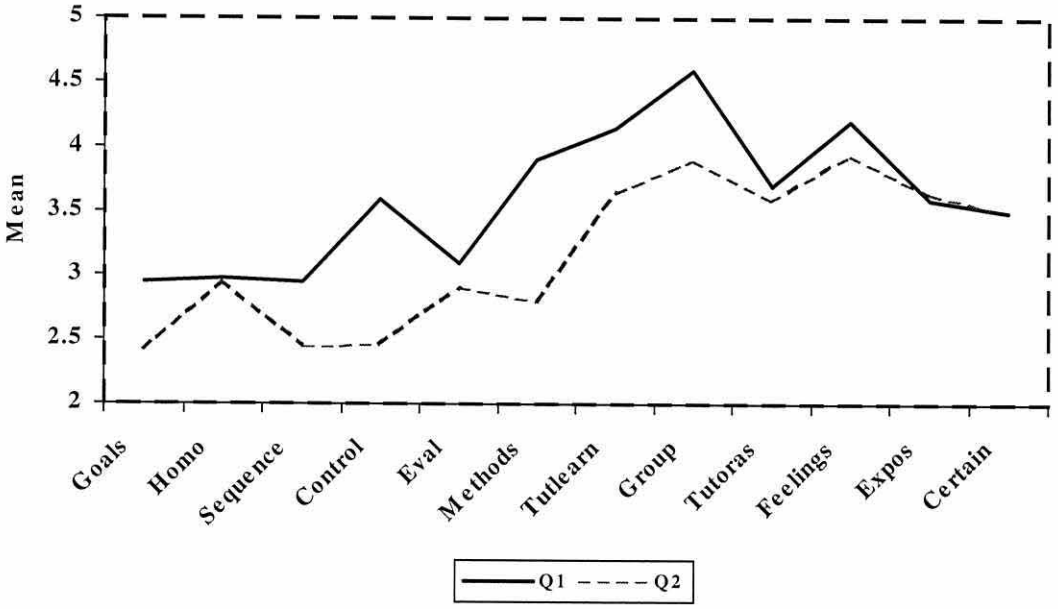


Fig 4.3 Bangor 1/94 Q1 & Q2

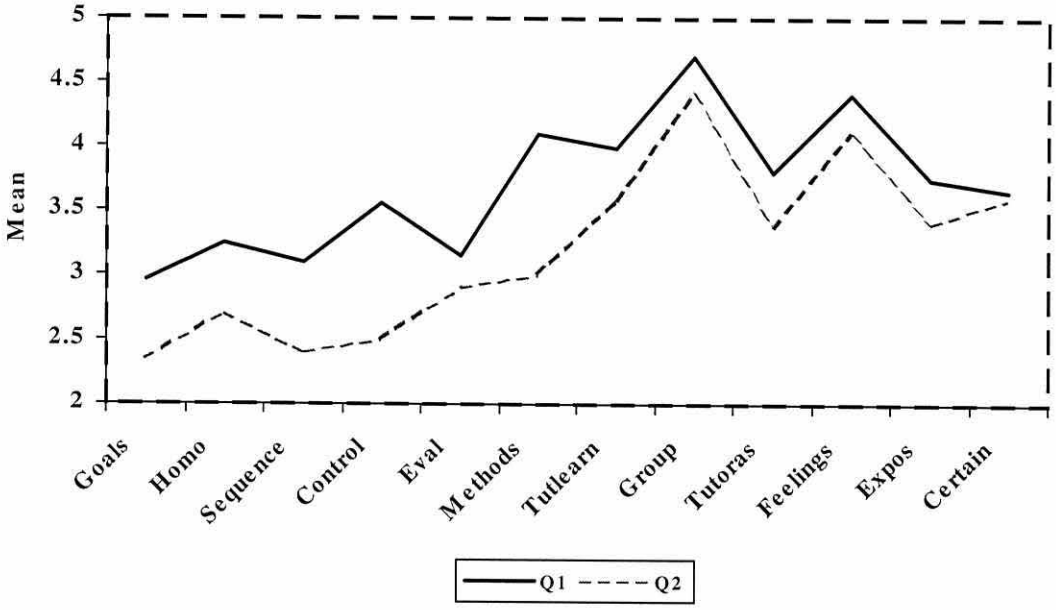


Fig 4.4 Wrexham 1/93 Q1 & Q2

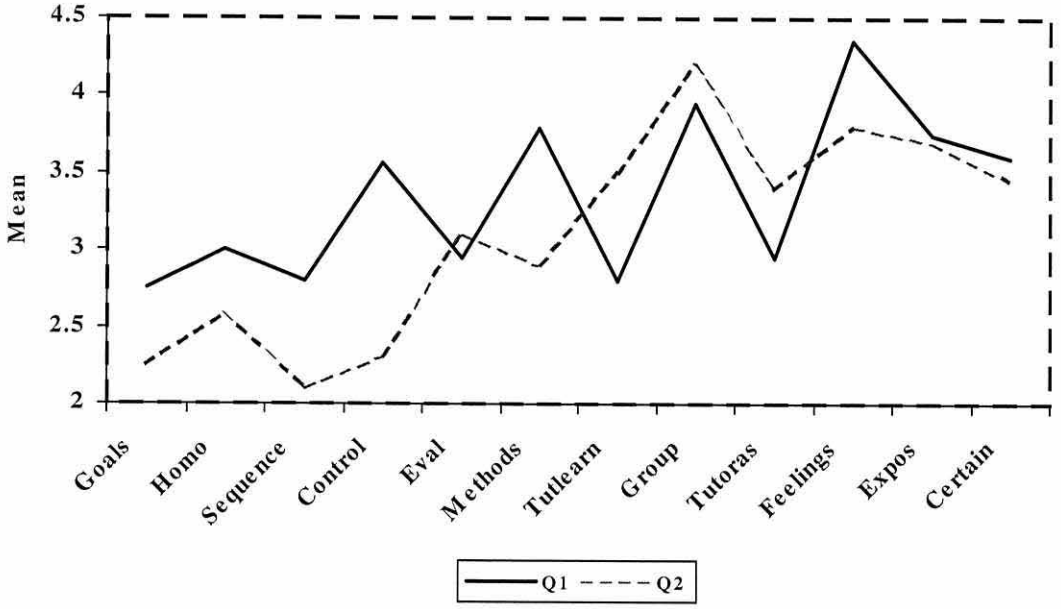


Fig 4.5 Wrexham 2/93 Q1 & Q2

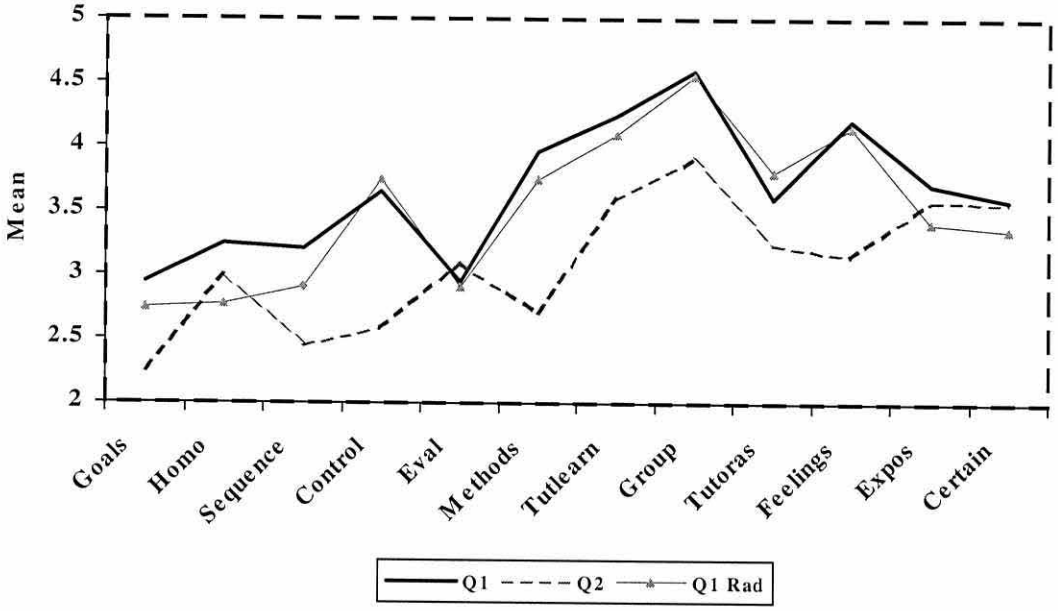
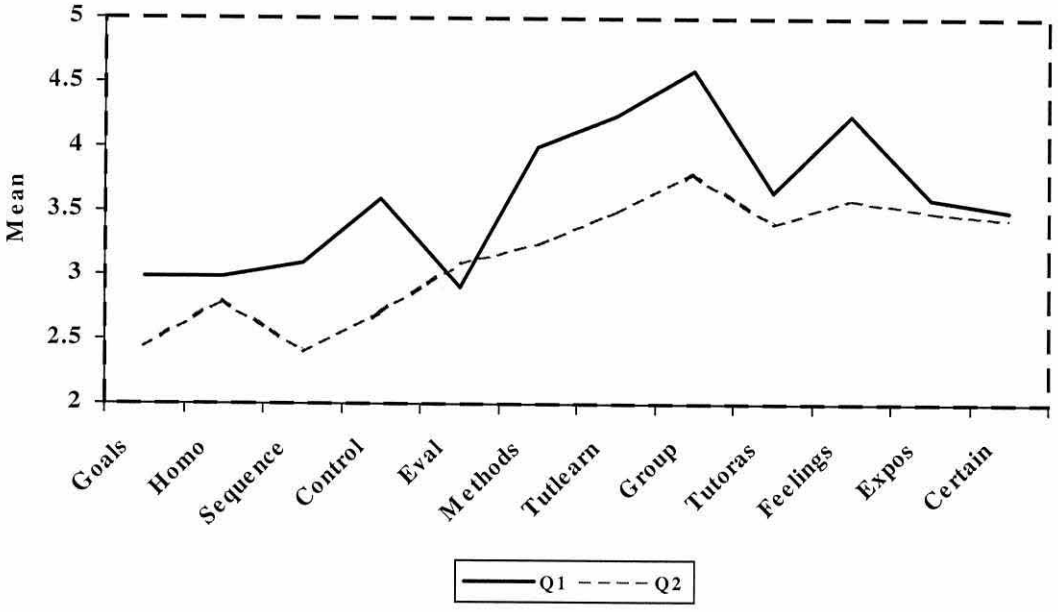


Fig 4.6 Wrexham 1/94 Q1 & Q2



Reflecting on learning styles in post-registration education

Increasing learner autonomy and self-direction were themes being considered in parallel concurrent research conducted by colleagues in the Post-Registration Division of SNMS. My own role in this research was advisory and consultative and so it is not presented in this thesis as a planned intervention in my own participatory action research. However, the research is reported here as it proved to offer supplementary insight into the learning styles approach (Iphofen, Lavelle and Patterson 1997).

Qualified nurse practitioners bring with them the usual diversity of educational and occupational experiences that is typically found throughout adult education. From initial training and throughout their continuing professional development, students struggle with their expectations about the learning situation. They often find it hard to accept the validity of what they bring to each new formal learning experience. As part of their continuing professional development, post-registration nurses are expected to become proficient in teaching and assessing so that they can act as effective mentors for nursing students who come to them on placement and so that they can improve their own learning ability. One might expect a high degree of autonomy from such individuals yet, as Rogers (1986) says: "Some adults re-entering education after some time away from school expect to be treated as children."

In helping the students to understand the learning process through examining their own past learning experiences these colleagues adopted their own form of "action learning" strategy. They set out to explore the four learning styles outlined by Honey and Mumford (1986): *Activists* immerse themselves in new experiences without pre-judgements; *Reflectors* like to stand back and think about their experiences; *Theorists* try to integrate their observations into some broader framework; while *Pragmatists* want to see how what they are learning works in practice. From their previous formal learning experiences, students were first asked to recall how they were taught, their own role in the learning process and what they considered to be good teaching practice. This exercise was conducted with fourteen groups over a period of three years - amounting to approximately 235 trained nurses.

Fearful learning

The features which most notably emerged from these recollections were the experience of didactic teaching methods with little student participation and a stress

upon rote learning which required little effort at understanding. Learner motivation was often described as arising from the degree of fear induced in the setting. Fear was experienced when not learning what was expected by the teachers and an opposing threat came from their peers if they were perceived to be "doing well". This feeling of being threatened when learning arose consistently across groups and appeared to be common to the majority of students' experiences.

For most, learning had become a competitive experience surrounded by fear and humiliation. The strength of feelings and anger associated with these experiences was enduring and was easily recalled by students. What is worse, they described similarly didactic approaches, allowing little autonomy and active participation, in their initial nurse training. Students complained that they had never learned how to learn, but had been encouraged to repeat facts which were difficult to recall, were of limited perceived value at the time and appeared no more relevant with the benefit of hindsight.

Student accounts such as these raise the question of how past learning experiences impinge upon current professional development. Much of the anxiety students expressed about public participation in class exercises arose out of recollections of past situations in which they were threatened and embarrassed or otherwise humiliated. Learning processes that encouraged active participation and where student contributions influenced the nature and content of the session came in direct contrast to their prior experiences. Evidently the use of a reflective teaching strategy in post-registration education initially heightened the anxiety of most students. It was only after increased familiarity with this teaching style that students were gradually able to relax, to join in and, eventually, to enjoy the sessions.

It seems that from such experience the development of the reflective nurse practitioner may not be so straightforward as merely offering reflective learning opportunities. Students' earlier experiences may inhibit their recognition of the validity of this approach to learning and prevent them from realising that any learning is indeed taking place. Didactic teaching might be expected to produce students with a low capacity for reflection. It might be assumed that this approach to learning was not already possessed by nurses, who were mainly concerned with the application of established ideas, along with the performance of routine nursing tasks. By Honey and Mumford's criteria most of the post-registration nursing students might have been expected to turn out to be "pragmatists".

Researching learning styles in post-registration education

To discover the distribution of learning styles among post-registration students, and to assist individual students in identifying their own learning style, Honey and Mumford's forty factor abbreviated learning style questionnaire was administered to 134 students over a three year period. In each session, individual scores were collated and a group profile produced and fed back for immediate discussion. Analyses of the data produced an apparent paradox with the dominance of the "reflector" style clearly emerging although theorist, pragmatist and activist styles are also present (Iphofen, Lavelle and Patterson 1997). Of course, Honey (1988) suggested that no superiority in any of the styles should be implied. He argued for developing some balance in the use of different styles. In discussion, students themselves pointed out how they would draw differently on each of the approaches in different learning situations and this has been supported by Sutcliffe's (1993) study of postgraduate nurses.

An important lesson from such findings is that educators question their dominant assumptions about what qualified practitioners bring to their continuing professional education. Teachers and professional bodies are so keen to encourage reflective learners that they may fail to realise that they do not have to "start from scratch". In spite of, or perhaps because of, early negative learning experiences, trained nurses do bring a capacity for reflection to their new learning experiences. Even if this is not a consequence of an initial recruiting bias, common sense observation would suggest that the range of human needs, emotions and vulnerabilities witnessed in the clinical profession of nursing must cultivate reflective inclinations in all but the most hardened individuals.

Further learning styles research

Evidently a much more extensive longitudinal approach would be necessary in order to assess the learning styles adopted by students on entrance (prior learning styles plus anticipated learning styles), changes in styles as the course proceeds, the effects of the nature of teaching provision (the adoption of pedagogical/andragogical styles in practice) and learning performance or outcomes assessment over time. This suggests even pursuing the same student cohorts into their CPD. Although at least one longitudinal study has shown no significant changes in learning style preferences over the course of a college career (Pinto and Geiger 1991).

Given the reservation about learning styles measurement discussed earlier, a well-proven research instrument - adequately tested for reliability and validity - is essential. But so many variables are neglected in most of the instruments. Even the Boydell questionnaire we employed neglected to include data on: subject variations ("discipline"); the topic under study; practice setting; practice experiences; actual learning styles; actual teaching styles; learner motives; teacher motives; learning potential; learner effectiveness (course aims/ achievement of learning outcomes); and self concepts (of both learner and teacher). Any adequate further research would have to include these factors but constructing such composite instrument would be unsatisfactory as it would be too unwieldy - defeating both diagnostic, methodological and "therapeutic" intent.

The post-registration research, however, argues against a complete rejection of Kolb's experiential learning model despite its limitations as outlined earlier. Instead learning models which can be seen as amendments of or extensions to Kolb's approach and which draw on personal construct theory and develop a "reflective learning" and "self-organised learning" perspective could be advocated. Such models suggest that "self-direction" needs to be consciously facilitated. It cannot be merely stated and hoped for.

A model of learning cannot be separated from a model of teaching. Learning styles and learning outcomes depend on the interaction between teacher and learner. Thus it might be that both teacher and learner need to be flexible in learning style when confronting any particular learning task. A modified, composite research instrument would have to take account of this - there would have to be a measure of student learning preferences and competencies that were linked to tutor preferences and competencies. This could then become an effective diagnostic tool, especially if employed in a flexible and reflective manner. However, there remains the problem that not all lecturing staff are easily able to recognise variations in learning styles. Pettigrew and Buell (1989) found that while a wide variety of learning styles existed among the students, neither experienced nor pre-service teachers accurately diagnosed the measured learning styles of their students.

After discussion with staff (and in the spirit of the participative action research engaged in here) it was felt that the weaknesses of the data and the consequences of its feedback to students was insufficiently remarkable to warrant the use of course time and staff resources to continue using the learning style questionnaires.

Consequently I am a little inclined to suspect that the interest in the precise measurement of learning styles has been somewhat "methodolatrous". A summary overview of the consequences of evaluations of all the above reported research now follows.

Staff and student evaluations and recommendations for future practice

(Student evaluations reported here were derived from end of course questionnaires and discussions, staff views were solicited in the concluding workshop and in the further seeking of written and verbal responses.)

The lack of congruence between wants and needs seems part of the human condition. What we want does not always match what we need. This has often been the case in formal educational settings, indeed the fact that some degree of dirigeism and paternalism is inevitable in formal education was outlined in Chapter 2. Policy makers, funding agencies and professional educators feel that they have a responsibility to tell education providers and, in turn, the student what is needed to produce an adequately educated practising health care professional.

But the evaluation culture we all live under today has only exacerbated the student's natural assumption that their wants will match their needs. And the more mature students a group contains then the more likely they are to express their views forcefully. Initial evaluations of the study skills provision were critical along the lines that too much time was spent on study skills, that sessions were too long, some sessions came too late, some tutors were patronising, some work was irrelevant and a waste of time. There were particular grievances about apparently conflicting essay/assignment advice from tutors and some expression of the difficulty of dealing with the contrasting styles of tutors. As we introduced the possibility of opting-out of individual sessions that could be accredited for prior learning (APL), the evaluations improved. At the same time we tried to encourage principles of teamwork and co-operative learning - suggesting that experienced students could encourage and help their less experienced colleagues. As a result the perceived moral obligation to attend grew, even amongst the more academically experienced students.

Indeed, the most popular session in the course was the concluding evaluation session in which the results of the research on their learning styles were fed back to the students. The extent of the shift away from anticipated learner-centredness came as a

vindication to the students of their own observations of the nature of the Diploma course and their relationships to tutors at that point. Many did not feel that they were being treated as adults, in spite of the stated andragogical mission and this appears to have been common across the Project 2000 experience (Farrington 1994). At least this observation stimulated some resolve to ensure that this perceived shift might be redressed somewhat. In this way "diagnosis" might actually prove a key part of the "therapy".

A cautionary comment is apt here in that in the pre-registration evaluations and feedback on learning styles we made no comment on individual responses. We treated the data as evidence about the course and the group. Meyer and Scrivener (1995) report the advantages of individualised feedback. But there are certainly many risks in applying learning styles labels to individuals quite apart from the weakness of the instrument. Packwood and Sinclair Taylor (1995) point out the dangers from the "emotive labelling" that may be attached to the styles categories and the negative effects of the potential for hierarchically evaluating individuals according to what may be seen as the "best" or most apt styles (Packwood and Sinclair Taylor 1995: 222).

In general, there has been some feeling that with each student intake there has been almost a cascading of awareness of the skills needed to succeed. At first students held very fixed opinions about their prospective vocation, questioned the need for any abstract learning skills and rather tended to believe that their real education began with the "apprenticeship" on the wards. Subsequently students in both pre- and post-registration education have sought more help with writing, referencing, information retrieval, passing "theoretical" assessments and in coping with modern information technologies. Those students who made use of the APL opt-out tend to be the younger ones who had recently completed GCSEs or 'A' Levels. Their self-assessment frequently proved to be disastrously inaccurate and they returned for further help later in the course. The offer of the crutch of the written handbook containing all the facilitated sessions on payment of a deposit refundable on the return of the package seems to have been appreciated. Only a few students ever reclaimed their deposit - even at the end of the course.

The ability to direct oneself in study terms, which is the ultimate goal of the course, can only be achieved if reinforced through the other elements of their professional education. Even for graduate students accomplishing self-direction remains

problematic (Jasper 1994) and other related research I have been involved in suggests that many other factors - in both theoretical and placement learning - can counter many of our best efforts to encourage autonomy.

Staff reviews of the Lifelong Learning module added the following sets of observations:

1) **Shared Learning**: There was a generally favourable view of "sharing learning" opportunities in study skills across all courses in the Faculty, but problems of equivalent abilities and needs of students and equitable sharing of resources were raised. The need for an inclusive preparatory package was acknowledged as long as it contained self-assessment, diagnostic and APL elements. The main obstruction to sharing learning were problems for time-tabling, module synchronisation and co-ordination across the Faculty given that the spacing of placements and theoretical time in College vary between pre-registration, post-registration, radiography and midwifery. Nonetheless, it was acknowledged that an attempt should be made to overcome such obstacles. Very little time is devoted to "learning how to learn" in most courses, even though most students would benefit from some guidance in this area. Study skills are really required at all levels - from '0' to 'M' - and even the oldest students amongst us need to be reminded occasionally of some basic principles, so effective learning might require continuous review of the individual learner's current problems (and abilities).

2) **Alternative delivery modes**: Some joint classroom sessions, where possible, together with a learning package suited to a range of needs is recommended. Whatever form the package takes, students should have access to their own hard copy. A computer-assisted learning (CAL) programme seems ideal, with the opportunity for students to download to their own floppy disc or print out from a word-processor in College. The existing (text-based) package would not work in a solo, interactive form - so a CAL programme would have to be made more interactive. Alternatively, a suitable a pre-written CAL programme might be identified, evaluated and purchased.

   CAL packages allow more flexibility to meet the individual needs of students and, for some, will encourage an introductory contact with Information Technology. A pilot package from Edinburgh University was evaluated with

the March 1995 intake of Diploma in Nursing Students but proved to be unsatisfactory. (Funded by a grant from the Teaching and Learning Committee, UWB.) Whatever package is adopted, a Welsh version would have to be also made available.

3) **Significant omissions**: Computer literacy in word-processing, presentations, desktop publishing, spreadsheets and database enquiry in general ought to be covered. Health Faculty students were seen to be inadequately served with use of and training in these resources and this was strongly endorsed in the students' evaluations. Liaison with the then SNMS Information Technology working group was seen to be vital. Some attempt to investigate and address numeracy difficulties would also be advisable.

4) **Responding to evaluations of the existing package and sessions**: It was recommended that care should be taken over the excessive size of the group for some of the classroom sessions. More importantly, there is a need for continuity in study skills learning across the whole of the Diploma and the Degree courses - indeed continuing beyond initial courses and qualifications. To be effective the initial learning needs to be reinforced in an integrated way, within all aspects of study. Opportunities for practice followed by feedback, and then more practice, needs to be provided throughout each course. Thus the basic skills acquired initially can be built on and developed. This would also enhance relevance (and thus value) for students. Responsive education should recognise and attend to the needs of the learner.

5) **Encouraging autonomous learning**: There was a widespread view that autonomous learning is not genuinely and comprehensively valued across the Faculty. Although the stated aims of SNMS, UWB and professional bodies espouse autonomous learning this is not so actively encouraged in practice either in education or in the workplace. The most obvious problems appear to be with those clinicians who work with students on placements, who largely have no understanding or appreciation of the concept of autonomy for learners. Their insecurity, either real or imagined, stemming probably from fundamental changes in the professional courses since their initial training, their perceived lack of knowledge and their perceived loss of power, all affect the way they work with students. Many do not help students to apply their knowledge in the development of skills and actively discourage autonomous

learning habits. Autonomy does appear to be under constant threat in the workplace - both from health service management and in terms of the obligations of teamwork, skill mix and the assumed authority of doctors. But there are areas where educators do have autonomy and these could be identified and built upon.

In part, the element of "mystification" in professional practice and, indeed, of learning itself at certain levels, may not encourage learners to use the professional as a model. Any demystification of some areas of professional practice should encourage accessibility to knowledge and practice and this could help disabuse some students of the expectation that they will simply be "spoon fed".

The control of course organisation and the rules on student attendance imposed by the professional bodies and the schools themselves, do impose considerable restraints on autonomous learning. The students' access to help from tutors was controlled rigidly at the time (e.g. three statutory revision sessions with tutors for written assignments in pre-registration nursing). Precise documentary requirements for student-tutor revision sessions were introduced in radiography education. Both systems were designed to regularise tutor-student contact time and to provide detailed information in case students appealed against grades. But they tended to make tutor support rather prescribed and did little to foster the open, positive and supportive environment necessary for developing autonomous learning.

While many members of staff are committed to encouraging autonomous learning, there are others who feel threatened by autonomous learners and as a result, actively discourage them. Others still are ambiguous in their treatment of students and while paying lip-service to autonomous learning, may impose conditions on students that exclude it. This helps account for the shift away from learner-directedness evidenced in the learning styles research reported here. Many students entering nursing and radiography courses generally have little concept of autonomous learning and find the change from the dependencies embedded in pre-UWB courses difficult. Many staff currently attending post-registration courses have little experience of autonomous study and of taking responsibility for their own learning. If autonomous learning is not now encouraged at the pre-registration stage, continuing problems can be envisaged for further professional education.

These influences, together with some traditional notions about lines of authority in each department suggest there are fundamental problems of the institutional ethos which must be addressed. Autonomy and responsibility for students depends on staff autonomy and responsibility. A culture of autonomy which values learning would act as a model for learners. All members of the institution need to feel valued in order to encourage responsibility for successful learning. These issues are considered further in Chapters 6 and 7 of this thesis.

6) **Strategy for further developments in lifelong learning**: There are, inevitably, resource issues - but they are not insuperable and, given how vital a "learning culture" is to the institution, they must be confronted. It is possible that more flexible course delivery would facilitate forms of shared learning that could encourage more autonomy and responsibility amongst tutors and students alike. Given that students are highly motivated by credit, lifelong learning can be encouraged in practice by the co-ordinated use of learning journals/profiles/contracts which can be linked to any module or package which deals directly with study skills. Personal tutors must continue to be the central guidance point for a student in terms of their study skill progress. All staff have to be involved in the process of encouraging lifelong learning. It should be a concept that all professionals support, along with reflective practice. At least they should all be aware of the need to provide appropriate, effective opportunities for practice in learning.

SNMS needs to have and be seen to have, a real commitment to developing the culture of autonomous lifelong learning. This requires the support of an effective staff development policy that will enable all members of staff to become lifelong learners themselves, to deal with and encourage autonomous learning by their students, so that they can provide consistent support to students. There can be no encouragement of a learning community amongst students if such a community is not encouraged amongst staff. Applying principles of time management is particularly appropriate to the development of autonomy and responsibility. Continued and increased links to ongoing UWB projects on staff development can help with this. Opportunities for better communication between educators would facilitate the sharing of learning and resources. This in turn could engender better communication between learners themselves and may lead to the demystification of some professional practices.

There is always the problem of "preaching to the converted" when reviewing staff evaluations such as these. Those who advocate such actions are those probably most involved in such practices themselves. It is hard to imagine that the staff producing these recommendations are the ones the students have in mind when they complain about being treated as children (Farrington 1994). The problem for participative action research remains that the "culprits" are hard, if not impossible to identify and, therefore, maybe even harder to reach. All one can do is point out that the active and interested staff advocated that teaching-learning environments in general should become less rigid, more active and more motivating. These staff members also argued that SNMS should involve the clinicians supervising placement students in autonomous learning through specific and post-basic training. Responsible and responsive educators may encourage responsible learners, once responsibility has been assumed by the learner this should stay with them throughout the learning process - which, of course, may never stop.

Conclusions

The essence of lifelong learning is flexibility and the ability to adjust to individual preferences, skills and needs. In many cases, it may be the indirect benefits of a discretely delivered study skills course as much as the direct ones which are important. As I have argued elsewhere (Iphofen and Poland 1994, Hesketh, Iphofen, Poland and Wright 1995, Iphofen et al. 1996d), and as is endorsed by the preceding reported evaluations, study skills courses can be a useful way to establish a learning community amongst students without implying serious threats to their competence in the substantive aspects of their professional course. They are able to address their inadequacies as a learner without this raising doubts about their abilities as a trainee nurse, midwife, radiographer or doctor. This can help allay fears and anxieties about their forthcoming education and training and about learning in general. It can help show that tutors understand the problems that students will have to face in succeeding on the course - that they care and will help.

At the very least such courses are about building confidence for the future. The student can believe it entirely possible that they are capable of writing well, finding out information and using it in effective, research and evidence based health care. As with all skills, their acquisition and application depends upon them being reinforced

in other contexts. They must be seen as just as important as all the other "practical" skills an effective carer needs to acquire. If they are seen as merely relevant to the more "theoretical" or academic parts of the course then they are unlikely to become habitual and their importance to the continued acquisition and application of knowledge undermined. It should be obvious that it does matter that nurses, midwives, radiographers and doctors can write well, that they can communicate clearly and effectively and that they can efficiently acquire and apply new knowledge. There isn't much time to learn how to do this once in practice; by then it should have become second nature for all modern health care professionals.

The core of the problem for effective learning remains: Whose needs are paramount in any course? In terms of the principles of andragogy, for effective learning to take place, the needs of the student should predominate - but then what about the tutors, the institution, the validating bodies, the Government, the tax-payer, the profession and so on? In any case, how good is the student at recognising their own needs? It is vital that nurse lecturers, as adult educators, concentrate on exploiting the evident existing capacity for reflection in both pre- and post-registration students, rather than attempting to artificially induce it or following mechanistically some "scheme" for the encouragement of reflective practice (Jones, Miller and Tomlinson 1994). This, of course, must also hold for any cherished principles of "self-directed" learning. Care must be taken to develop curricula and teaching methods which encourage a learning style adopted in everyday life but which is under-utilised in formal education settings because of alternative teacher and student expectations about what the learning experience may be like. Conscious awareness of the learning process must be encouraged in the students and facilitated by the educators to permit the flexibility and required adjustments to the learning experience to be made. I have suggested elsewhere that the means for respecting nurses as mature learners and for removing learning obstacles can only be embodied in the combination of module design and pedagogic technique (Iphofen 1996c).

Colleagues of mine have pointed out how nursing students do not take to self-directed learning as willingly as the adult learning and nurse education literature had originally anticipated or hoped (Noland and Nolan 1997a). The evidence from the data presented here implies that the students themselves initially expect a high degree of

self-direction but, for some reason, soon find this not so easy to achieve. The expectations of the older students having been particularly not met. To discover the influences on such change is a complex problem, particularly when staff themselves advocate increased learner autonomy. It is possible that students discover that their own initial judgements about how their needs should be met are unrealistic given the legally required competencies they must meet. And even the staff's educational aspirations might have to be sacrificed to the exigencies of core course demands. Boydell's questionnaire lacks the sophistication required to test the balance and change between ideals and reality. Perhaps an autonomous learner is not necessarily self-directed. Learners might require sufficient autonomy to decide how much pedagogy and how much andragogy is required at different stages and in different contexts in their education and training. The key questions then become: under what conditions might students make use of particular styles most effectively, and how might the best balance of styles be cultivated within the adult learning experience? Similarly, in spite of an expectation that learning would continue to be an unpleasant experience, registered nurses recognise the necessity of continuing to learn. They may not be vocal about their doubts, but they do have serious questions about the worth of elements of the curriculum (see Iphofen and Poland 1997). Their learned anxiety about formal education can be overcome upon the careful exploitation of their developed ability to reflect - one that may be more a consequence of practice than education - a serious indictment upon parts of the education and training system. There is a responsibility upon adult educators not to intensify the errors of the past. Negative learning experiences are, undoubtedly, obstacles to all new learning. A willingness to question assumptions and to confront paradoxes offers a means to removing such obstacles and represents a sign of the truly reflective intellect. Yet no matter how desirous one is of cultivating autonomous learning very few learners can be truly independent. Learning is always done in some sociodynamic context: in seminar, in lecture, amongst the family or friends or, in response to or in the knowledge of relationships to family, friends, colleagues and so on (Brookfield 1986). The learner's effectiveness has to be influenced by this context.

Perhaps more importantly, research into nurse education seems to have been more concerned with learner style than learner motives, and this has the consequence of neglecting aspects of institutional and interpersonal ethos. Thus the focus has been

upon the reflexive nature of vocational learning, upon reflective experiential learning and an attempt to measure "style" in order to understand variations in learner effectiveness in such contexts. There may be nothing particularly "special" about nursing as a learning experience, but there seems to be an insistence that there should be. Ironically an obsession with technique, even if that technique is "self-direction", might be a relic of a traditional teaching and learning methodology. If vocation remains a key element of health professions then it would seem valid to ask: What is the spirit of the place and of the person and how do these factors influence the quality of learning? The next two chapters address these questions - first with students and then with staff and the full implications of the concluding discussion to this present chapter will be drawn together in the recommendations made in Chapter 7.

Reflective Commentary - 4

Planning and Concept Formulation

Given what I have written in Reflective Commentary 3 it would be misleading to suggest that when I introduced the study skills and learning styles projects I had fully worked out what I thought constituted effective learning. I had doubts about the nature and value of study skills courses, but more particularly about the learning styles approach and too crude an understanding of learning stages – these doubts were summarised in Chapter 3.

But once again opportunities were presented that were too tempting to resist. I was asked by a Senior Manager to produce a study skills course, a group of us were putting together a tender for research into nursing students' learning styles for which we were short-listed and funding became available for innovative curriculum development which we wished to take advantage of.

My colleague Fiona Poland and I decided that a collaborative and participative curriculum development could be promoted on two fronts. One was to be a module on "Neighbourhood and Community Studies" and the other was the Study Skills course reported in detail here in Chapter 4. We had learned from our work on the Sociology course that an "imposed" curriculum did not achieve the collaborative ends we sought. Such a curriculum tended to be delivered perfunctorily and with a pedantic concern for ensuring that all the elements of the syllabus were somehow covered – almost regardless of the interest of students or the time available. The sociology curriculum had been devised on the basis of a UKCC outline that had been "recommended" to all Project 2000 courses and was delivered by following a syllabus that had been written by a sociologist who was not a member of the School. This was certainly not an approach that we observed to have inspired the eager and committed support of the staff (let alone the students) and, moreover, appeared to undermine their autonomy. While it was possible only to change the sociology curriculum slowly, the introduction of new modules, allowed an opportunity to encourage a shared responsibility for curriculum design and delivery.

The Neighbourhood Studies module worked extremely well at first. Most lecturers acknowledged the importance of a community care focus, including those more comfortable in the acute setting, and there was active involvement from a high proportion of the staff. A one-day conference of staff and students, a poster exhibition, a video and a range of community-related activities achieved tremendous consensus in support of the approach. Over time commitment dwindled and the course is now run by only a few colleagues with a sustained interest in the field.

Experience and testing implications

There seemed little need to invest similar resources in the Study Skills course since there appeared already to be a consensus that something needed to be done about the basic academic skills of the students. Having taught such courses in adult education for some years, I had fairly clear ideas about the relative merits of different methods of organising and delivering such courses and could easily have drawn a course from my filing cabinet. But that would have repeated the errors of the sociology course. Instead I circulated a paper brainstorming exercise (p.78) to all staff seeking their views about course content and teaching techniques, hoping once more for an enhanced opportunity to share ideas. All tutors responded to greater or lesser degrees with some providing materials and practical suggestions.

Although nothing "new" to me turned up from the brainstorm, that was not the point. Once more tutors did respond to a collaborative opportunity. Some time was taken on sharing the course philosophy (p.79) and also on ensuring that the students understood this philosophy at the start of the course. This applied particularly to the stated intention of moving from pedagogy to andragogy (p.81). What lay behind this was an attempt to encourage the lecturers to consider more carefully their own teaching styles. Some of the negative course evaluations had already complained precisely about inflexible, didactic delivery styles – about being treated like schoolchildren and having to copy notes verbatim from a board. So the discussion on course philosophy was intended to act as a subtle message to those who were still adopting such delivery methods without considering its appropriateness to the topic and to the type of student and to encourage the consideration of alternative modes of

delivery. If all lecturers adhered to the philosophy, then students would be less likely to be "turned off" in that way.

Perhaps the goals of the course came together in the concern to encourage an interest in enquiry, in finding things out for their own sake, but more specifically in finding things out of relevance to knowledge about nursing care. These goals became formalised for the purpose of providing the requisite learning outcomes. The important point was that these were not merely imposed upon my colleagues – nor upon the students. The completed module protocol reproduced in Fig.4.1 was derived in a genuinely co-operative and evolutionary manner, with drafts and re-drafts, to arrive at something that I would probably have written in the first place. Thus the summary of principles (p.82) derives from the experience of the success surrounding this particular intervention.

Planning

Given the interest shown in the Study Skills course, when the opportunity to conduct research into learning styles arose, it seemed another opportunity for further collaborative work. In particular it was a research and development opportunity consistent with my concern to engage in work with a direct relevance to teaching and learning in the organisation.

Once again we started in a spirit of open collaboration – asking any interested lecturers to join the team putting a research tender together. This time the response was considerably diminished – perhaps because it seemed to offer much less in meeting the pressing demands of immediate course delivery. Still a small team was formed and co-operatively came up with a series of research questions to pursue (p.85). My personal view at the time was that the obsession with learning styles in the nurse education literature at the time was methodolatrous (p.86), but I hoped that the gains from working in a team on a research project would more than compensate for my own reservations about the topic.

The decision to test the nature of learning styles and the degree of perceived autonomous learning using the Boydell questionnaire was at the suggestion of a fairly

influential member of the group in a senior research position in the School. I was happy to go along given that the questionnaire seemed not to suffer the more obvious flaws of the Kolb approach to learning styles. Although short-listed, we did not win the original tender we were seeking but funding was eventually found from the Enterprise in Higher Education initiative so the project went ahead albeit in a less ambitious way. By this time most active support from nurse lecturer colleagues fell by the wayside and it was left to me to direct and manage the project. For all the reasons suggested above I wanted to continue the work and hoped for something substantive in terms of research results but I also wanted to maintain the interest and support of colleagues in a teaching and learning related project.

Reflection

Much later on I realised how Boydell's approach paralleled Basil Bernstein's work on the classification and framing of educational knowledge (Bernstein 1972). Learner-centredness relates to what Bernstein called the "integrated" code and tutor-centredness related much more to a "collection" code. Like Bernstein I tried to see these as comparative descriptions of different ways of arranging educational knowledge – but I held a clear personal preference for learner-centredeness and integrated curricula as ideals. I now have doubts given the realisation that different curricula might be suited to different learner goals and effective learning depends on matching curricula with those goals. But I also came to see that resolving some of the central dilemmas of health professional learning perhaps requires a movement between these dimensions according to the learner's needs at the time.

The problem is that while learner-centredness might be favoured andragogically, offering some autonomy, flexibility and respect for the student's maturity, this will not meet all of the students' recognised professional needs. The dilemma is that while the students do not want to be treated as schoolchildren, they still need to acquire quite quickly some very basic skills in order to feel some competence and confidence when on placement. I'm not sure the students see the contradictory nature of the demands that they place upon the staff and it should not be surprising if the staff occasionally get the "balance" wrong. The increase in mixed-age student cohorts only exacerbates the problem.

Planning and Acting [The Styles of Post-Registration Students]

I reported the post-registration research in this thesis because it offered a slightly different angle on learning styles with a different student type. In addition it does offer some insight into the growing acceptance by colleagues of my research developmental role in the School. The lecturers involved had gathered the data systematically, but in an exploratory way without a clear initial plan or hypothesis to test. They wanted to do something with the data which, at face value, was proving interesting. My role was to show them how to enter the data into SPSS, analyse it and represent it in an informative way. I also managed to get the work published. This was exactly the kind of contribution that was in line with my contractual requirements and my collegiate aims and intentions.

Observing and Reflecting

What matters more for the substance of this thesis was that the post-registration students consistently reported fear and anxiety about present learning as a consequence of their early learning environments, which they had also experienced in their initial nurse training. This disclosed an inhibitory attitude to their new learning which my colleagues first had to confront before creating a more enabling environment for their continuing professional development. This confirmed my own experience of conducting sessions on study skills with post-registration students on a palliative care module. My strategy was a pragmatic one – how to make studying, learning and writing seem straightforward and "do-able", not artificially scholarly and removed from the students' experience and needs. The students were fairly uniform in their response: "Why has nobody shown us how to do it like this before?". The disclosure of the students' anxieties encouraged by my post-registration colleagues was, of course, necessary to begin to recreate the supportive environment. Clearly, with experienced nursing staff as students, more of a balance toward andragogy was possible. Moreover the use of the Honey and Mumford framework and the clear dominance of a "reflector" style (despite, or perhaps because of, anxieties induced by earlier learning experiences) facilitated the possibility of employing a more learner-centred approach.

Work like this could benefit more from a longitudinal study – it if were to be done at all. The lifelong learning exercise was of lasting benefit but I retain doubts about the learning style study. Even if it were possible to find the appropriate "learning style" measure there are pragmatic issues of how to "use" the measurement process to improve the learning environment. For example, should the measurement be of the learning group or of the individual doing the learning? How would the information gained be "fed back" and how would it be made useful to the learners? The post-registration research suggests some merit in the approach – but these are much smaller groups of students (about ten to fifteen as opposed to the forty to fifty (plus) students in the pre-registration groups). I felt that we had gained as much from the work as possible at this stage and (also lacking funds) recommended discontinuing the research. In any event, learning styles should not be measured separately from teaching style – together they constitute the key components of what is meant by the "learning environment" – not just the physical building, nor the educational institution.

Planning and Acting [The Practice Placement Project]

However, the research did also prove useful in encouraging other colleagues to come to seek my assistance in researching the kind of learning that goes on in the practice placement environment and with processes of mentoring and assessing the students on placement. Again I was keen to respond in that it provided another collaborative opportunity and possibly to offer a test of my views of the effects of different learning environments (p.105). This entailed a detailed questionnaire to students and to the placement staff responsible for their mentoring which was to be analysed both quantitatively and qualitatively. I gained the funding, advised on questionnaire design and data entry and analysis. One colleague is still attempting to complete this work for his own postgraduate thesis.

Observing

This latter work has proven to be quite a sensitive research area since it implied some criticism of the School's placement assessment methods, but the dedication and commitment of the leading partner in this research saw it through data collection and

some of the analysis. Sadly, she died during this phase and the project was left for some time before being taken up again by her colleague who is now nearing completion of the qualitative data analysis. There remains some sensitivity to research of this nature, posing problems of publication and dissemination of findings.

Reflecting

All of the issues raised here did come together in the concluding workshop and report which produced the collective recommendations reported in the thesis (summarised on p91). I was heartened by the co-operative spirit of those contributing to that workshop and felt that real progress had been made. It also helped maintain my determination to continue to engage in co-operative and collaborative research development. There was enthusiasm amongst these active members of staff for building on the findings and designing a curriculum pervaded by the ideals of lifelong learning. Obstacles remained in limits to "shared (interdisciplinary and cross-specialism) learning" due to time-tabling difficulties, some professional protectionism, the lack of good computer assisted learning packages for study skills, and the inadequate IT facilities. In response to the suggestion for furthering IT skills a research project utilising a CAL package for study skills was trialled (referred to as the CAL Project in Appendix II). This proved a distinct failure for many reasons including package design and obstacles to gaining access to the technology (p.106). Once again this was not reported in detail in the present thesis since it was not central to my main project and lacked adequate data for a comprehensive evaluation. In fact, the IT skills requirement remains a concern that has been raised in recent Government and professional policy documents and may be more fully addressed in a current research project funded by the new Welsh Assembly and about to commence within SNMS. It is to be hoped that this project will allow the possibility of remedying the defects noted some years ago and which have been recurring ever since. Of all these projects, the study skills course continues to operate, although with a name change (Lifelong Learning) and is being taught by fewer staff.

Autonomous learning does still seem to be hard to achieve in placement settings. While it is vital to the learner's sense of worth and to their ability to develop independently, autonomy may always have to be circumscribed prior to the learner's

registration as a competent professional. After that there should be no excuse since the learner should be cognisant of the limits of their own competence. But it seems also the case that autonomy may be too threatening to some clinical staff and to some educational staff. My colleagues stressed the need for a culture of lifelong learning in the staff too – a recognition of their own need for some autonomy which would enhance their ability to learn as educators, mentors, assessors and clinicians in whatever setting they found themselves in (see pp.108-109).

I have come to see the establishment of a lifelong learning culture within both health care and educational organisations as a way of moving beyond the more mechanistic accomplishment of reflective practice. In fact, the danger as I see it is ironically of reflection becoming an activity engaged in separately from practice. This is something I have reacted to when I have seen reflection espoused in a formal, systematic way. I do not believe that it is done well if only done to a "formula". For me reflection has to be something endemic to the exercise and habituated – as all effective learning must be and as I am striving for in these, my own, reflections. For my own postgraduate students I have encouraged the maintenance of a research diary which catalogues daily progress in their work, addresses in an open-ended manner their theoretical and methodological concerns, and also offers a vehicle for their intellectual and emotional progress. It is from such a diary that these present reflections have been drawn.

Chapter 5 Motivational Narratives and Effective Learning

Introduction

Coming from many years of teaching sociology to mature students in adult residential colleges to teaching sociology to students of nursing, midwifery and radiography there was some inevitability about my reflecting on the connections between motives and learning. Mature students attending a residential college and seeking a liberal studies diploma as a means of university access, frequently made the sacrifice of leaving family, friends and community for two years in order to remedy their strong sense of prior educational disadvantage. Professional health care students - a high and increasing proportion of whom are mature - have distinct vocational aspirations so they may merely tolerate the intrusion of a discipline the immediate relevance of which to their professional vocation they either provisionally accept, doubt or hold an antipathy towards. The contrasts in motives for learning sociology could not have been much greater and, therefore, the tasks facing the educator apparently substantially different.

Theorising about motivation in learning has progressed from basic stimulus-response ideas, through reason-producing taxonomies and questionnaires, toward analysis of authentically produced motivational accounts or attributions constructed in a learning dialogue. Changes in theoretical perspectives have methodological implications for the identification of learner motives and for the attribution of responsibility for learning. The approach I have adopted derives from the sociology of accounts - the study of the reasons that people give for their actions, the reasons they give for others' behaviour and the consequences of these "accounting" processes for their interaction. In simple terms my research question is: What stories do people tell about their own and others' learning experiences and the beliefs and feelings that accompany them? And, how do those stories relate to the effectiveness with which they learn?

The methodological problems which this poses include the difficulty of gaining access to those accounts given the need for them to be produced realistically and not through the employment of an artificial research instrument. Once accessed there is a

problem of how to make sense of them separately from the context in which they were produced - how to set them in an organisational and learning context but also how to employ those accounts in some "measurable" way. Finally, there is a question about how to link the accounts to the learning process.

The approach reported in this Chapter entails the analysis of motivational narratives offered by three cohorts of nursing students and one cohort of radiography students. These take the form of profiles that can be applied to and modified by the stories given about their motives for pursuing the present course of study by the students. The Chapter concludes with the argument that taking responsibility for learning depends upon educators and learners' mutual recognition of their motives and the application of that recognition in a range of learning settings. There is discussion of the links between motives and effective learning, while the practical suggestions for using motives to learn consequent upon this part of the research are outlined in Chapter 7.

Work in the area of motivational accounts draws upon a sociopsychological tradition which treats motives as part of a narrative account of the reasons for human actions, thoughts and attitudes. It has links with other approaches such as attributions, explanatory style, representations, and self-efficacy. The study of narrative can be conducted with such mathematical rigour that it offers a means for systematic comparative analysis rare in qualitative research (Abell 1986). My reservations about such an approach include the loss of relationship to meaningful content (which is one of the claimed advantages of qualitative research) and the lower likelihood of "user-friendliness" for the diagnostic and therapeutic purposes to which narrative analysis may be put (Monk et al. 1997).

In other work with narrative I have taken a life history approach to the study of the management of episodic and marginal deviance (Iphofen 1990). Unfortunately, while rich in meaningful data, the full life history is extremely time consuming and could never be conducted quickly enough to produce a comparative profile of a student group that could be used during their learning process. The framework and analysis offered here extends my previous attempts to make available an accessible framework

for analysing narratives in health (Iphofen 1996a) in learning (Iphofen 1998b) and in personal development and well being (Iphofen 2000). I treat motives as "accounts for action" and hope thereby to understand how they frame the learner's experience of the learning process.

Theoretical background

The theoretical bases for the understanding motivation used here draws upon two sociopsychological traditions - the sociology of accounts (originating with Wright Mills 1940 and summarised in Buttny 1993) and attribution theory (originating with Heider 1958 and outlined by Weiner 1991). Both approaches attempt to discover the processes of interpersonal perception, communication and negotiation which act as determinants of motive attributions. Motives are "... not subjective springs of action *in* the individual" (Wright Mills 1940: 905) but must be seen as the linguistic, paralinguistic or other symbolic modes of communication which are used by human beings in order to interpret and manipulate phenomena in their world. They are constructed responses to social and psychological cues. In essence, they are the terms or words that humans use about other individuals or things.

Motivational accounts or attributions usually set up a rationale for action by linking an actor to an act or a 'type' of person or thing to a 'type' of event. By defining acts and identifying roles and by linking behaviours to identities using motivational terms, individuals can guide their own behaviour as well as the behaviour of others. Such perspectives have a number of consequences for what motives are and how they work.

As accounts for action, motives can never be entirely "pure" in the sense of being confined to a single goal or permitting of only one form of behaviour. If one holds a motive such as the intention to achieve success - there can be many ways of accomplishing it. One cannot necessarily assume a dominant motive; nor, even, can one assume a priority list of motives. Significant motives are frequently accompanied by secondary (implicit and explicit) motives which, when taken together, not only specify a desired outcome, but also contain a particular means for achieving it.

Similarly, motives cannot be assumed to be permanent. They are likely to change according to time and place.

If this is the case for individuals then it is likely to be even more complex for a group. Thus a class of students will not all uniformly hold the same motives for learning, or even for being in that class or, even, in that learning environment. The group may possess a motivational profile, but that is liable to change as the broader institutional context changes, as the group acquires a history and as shared incidents impinge upon the life of the group.

When individuals offer motives they do not do this just to suit a set of categories made available by social science. Motivational accounts are "chosen" according to the individual's unique experiences, in response to particular environments and with that individual's wants and needs in mind. Consequently, a mix of motives with a range of motivational profiles and priorities is likely to emerge in any setting.

The true test of an effective educational system lies in its capacity to meet the requirements of a variety of motives - to satisfy a range of wants and needs. If there were adequate variety of provision, none could claim that their motives remain unsatisfied (see Iphofen 1996a for a fuller discussion).

If motives are plural, complex and dynamic, they can be observed only in terms of their use in a specific context. This has led to motivational accounts being taxonomised as, for example, 'techniques of neutralisation' routinely employed by juvenile delinquents to alleviate the imposition of sanctions by social control agencies (Sykes and Matza 1957); or as the means for allocating personal responsibility via the employment of excuses, justifications, praise and blame (Lyman and Scott 1968; Taylor 1972; Bull and Shaw 1992).

This does imply a certain relativism - that people's motives vary according to the situation. But, since motives are here treated as accounts, this accords with a common-sense view of the process whereby people know that only certain things can be said or admitted in certain situations.

The alternative is a form of reductionism which either assumes a motive to be some form of hidden psychodynamic "charge", or establishes a priority ordering of motives according to some hierarchy of credibility and disguised hierarchy of value judgements (Becker 1967). It is in this way that people are assumed to be "not motivated" when they do not participate in higher education, students are regarded as "un-motivated" when they participate for the "wrong reasons" and get "de-motivated" when we fail to provide an adequately stimulating environment within which to learn.

In the same way, a crude intrinsic/extrinsic categorisation of motivation ignores the real world complexity of motives as accounts. If I enthuse about something (my intrinsic motive) to a student who then does something for me due to my enthusing has he caught some of my intrinsic energy or is he being extrinsically driven by motives outside himself? As Paul Pintrich has indicated (in SEDA conference 1997) - motives lead to strategies, it is the strategies that produce the achievement.

The failure to realise inherent value judgements may produce an almost simplistic assumption that intrinsic motivation is somehow "better" than extrinsic motivation. When we make the judgement that there are some right and some wrong reasons for doing things, we need to clearly outline the validity of that judgement. The accounts and attributions approaches point up the rhetorical power of motives and their sociocultural context-specific nature. To suggest that some rewards are to be seen as more legitimate than others is to hierarchise the motives to which such rewards are applicable. It is a political act.

Rarely are students "de-motivated" by the higher education experience. This would suggest total apathy - that the experience somehow managed to extract all inspiration to act, removing their "charge". Instead, what happens is that students' motives may change and we, as educators, participate in that change. We are participating in the students' disenchantment. So we have to be prepared to ask, what is it that we or the institution or society does to them to cause this change?

If students are "only" motivated by assessment, that says something about the way students perceive the rewards of higher education, about the kind of society within

which those rewards become measures of an individual's potential and about the way we structure the curriculum to comply with those demands. I have heard staff suggest that the alienated labour of assessment-obsessed courses is an appropriate preparation for the alienated labour to be anticipated in the real world!

Unfortunately, the most common method for deriving motivational statements - the administration of a "reason-seeking" questionnaire has serious methodological limitations in the assumption that motives are internalised in the human being and dormant until called upon, either via a crude stimulus/response mechanism or subsequent to skilled probing. A factor analysis of frequently proffered responses only elicits a count of responses deemed legitimate or apt in the context of a particular discourse event: that is, the context of responding to a questionnaire item. Similarly tests for reliability and validity cannot separate a measure of the research instrument from a measure of the strength of attributions which have become institutionalised. Their "snapshot" nature cannot test the stability and consistency of particular motive accounts.

Similar problems arise from self-reported questionnaires or open-ended devices which ask students what motivates them - this produces a context-specific account which varies according to the common-sense view held by the student of what motivation is - again likely to be seen as some internal entity of enthusiasm or commitment; and by what they believe it is appropriate to report in answering such a questionnaire. Both questionnaires and projective devices (such as a repertory grid analysis) unnaturally force a focusing. The authentic production of motive statements and attributions in human discourse is the essential site for motive investigation. Motives must emerge according to criteria established by the mutually interested parties, not those of the visiting behavioural scientist.

(The preceding summary of theoretical issues condenses for the purpose of this thesis my conclusions to an extensive debate in the sociological literature that includes the work of the following: Wright Mills 1940, MacIver 1940 & 1964, Peters 1960, Blum and McHugh 1971, Bruce and Wallis 1983 &1985, Sharrock and Watson 1984 & 1986, Turner 1987, and Campbell 1996)

Motives for learning

The problems confronted by most educational systems often have to do with the mixed, sometimes contradictory, motives held across the range of stakeholders. Fostering a corporate educational spirit is impossible if the institutional ethos or mission statement fails to match practice. Institutionally legitimate motives for educational provision have to be clearly spelled out and prioritised since they are continually monitored by the relevant support agencies; institutions survive according to the "legitimacy" of their aims in the eyes of funding agencies and of clients (see Mee and Wiltshire 1978, Ch. 3).

While institutions are required to state their general ethos - their pedagogy and/or their andragogy; individual students have their own more particular motives, whether practical or ideal. They see available institutions as fulfilling specific wants or needs and their entry to a course depends upon the legitimacy of their aims as stated in the admission process. The broad aims of institutions and the specific motives of individuals should come together in the accomplishment of particular educational goals. The survival of education institutions has often depended on how well the ambiguities and potential contradictions between disparate stakeholder ideals have been balanced. "Crises of legitimation" are almost inevitable.

In my earlier research I wanted to discover how far the motives of mature students in long term adult residential colleges are influenced by background biographical or sociodemographic factors or by the educational institution as they progress through it (see Iphofen 1996a). What I found was that the strongest motivational orientation of the great majority of the students was "individualist" and "instrumental" in the sense of aspiration towards higher education and ultimately a valued occupation. But it would be too crude to portray this as "extrinsic" motivation. Students do make use of institutions for their own purposes, whatever the stated institutional aims. While the residential college experience *does* change people intellectually and personally, students' motives remain fairly stable. There appears to be no significant boosting of gateway or access motives during their course of study.

Students gain confidence in their ability to achieve their original aims as a consequence of their academic achievements; they become more secure in their personal identity and their goals as they progress. This gain in confidence is acknowledged to be a prime advantage of all preparatory courses for mature students. By enhancing their familiarity with a higher educational environment, acquainting them with coping skills, having them meet staff and fellow students, they have an experience which reassures them that they have made the right decision (see Acland and Comrie 1997).

In spite of minimal avowal of collectivist ideals, a communal life is seen as vital to their experience despite its acknowledged disadvantages. Its value lies in offering mutual support and understanding a consequence of the intellectual and therapeutic advantages of communal living - a "therapeutic community" which might be essential to the students' developing legitimation for their "new" identity. The importance of identity in motivation is long established within the accounts tradition (Foote 1951).

Students expressed no great disadvantages and seemed prepared to accept the costs of being in residence while studying, which were not so high as to outweigh the benefits. They engaged in adult learning out of an aspiration toward intellectual achievement. They held the assumption that educational attainment was linked to raised social status. But equally important was that this should take place in a conducive environment - the learning process must be interesting and enjoyable.

Categorising learner motives

Detailed surveys of the literature (Jarvis 1983: 65-68, McGivney 1990: 23 et seq.) demonstrate that there are many typologies and taxonomies which offer a range of more detailed, specific and composite motives. The following motive list is drawn from sources indicated below:

1) Need to remedy suffering caused by earlier educational experiences - bad teaching, no encouragement.
2) Learning new skills.

3) Discover or stimulate new interests.
4) Discover and develop unrealised personal talents.
5) Cultivating one's own personality - a form of personal, self-development.
6) Making new friends.
7) Escape from social, mental or physical isolation.
8) Opportunity for self-expression which is frustrated elsewhere.
9) Opportunity to reconsider one's own acquired beliefs in a rapidly changing world.
10) Opportunity to engage in a lifelong interest or pursuit, shared with others with similar interests.
11) Need to find "something to do" as a result of growing leisure time &/or early retirement.
12) Desire to acquire qualifications and/or skills- for job or career advancement (i.e. economic, promotion or career-switching reasons).
13) Service to the community for social, political or moral ends - whether in a vocational or voluntary capacity.
14) Prompted by expectations, needs or responsibilities to do with a membership reference group (e.g. family, church, trade union, workplace).
15) A desire for knowledge for its own sake.

(The main sources for these factors are Jarvis 1983, 1985, McGivney 1990, Wood 1974, Boshier 1978, Courtney 1981, Norman 1974 Rogers, 1989: Ch.2.)

My previous research into student motives employed a comprehensive taxonomy which was applied to students' entry motives declared on application forms (Iphofen 1996a). In theory such taxonomies could provide the basis for a content analysis schedule which could be applied to any motivational narratives however generated. One could anticipate most accounts in students of the health professions to include items 10 and 13 as primary motives, with 2 as a supportive motive.

On reflection although this was a convenient means of categorising fairly succinct sets of motivational narratives which could be seen as authentically generated, it could become much more complex when applied to any more fluent narrative - such as a transcribed interview or a piece of written continuous prose. Moreover, while some of these motive sets may not be seen as congruent, many are not mutually exclusive and often they overlap and complement each other. To have constrained the analysis by a

pre-arranged schedule of "content" would seem to be an excessive external imposition on the free production of motives required.

Motive-oriented narratives

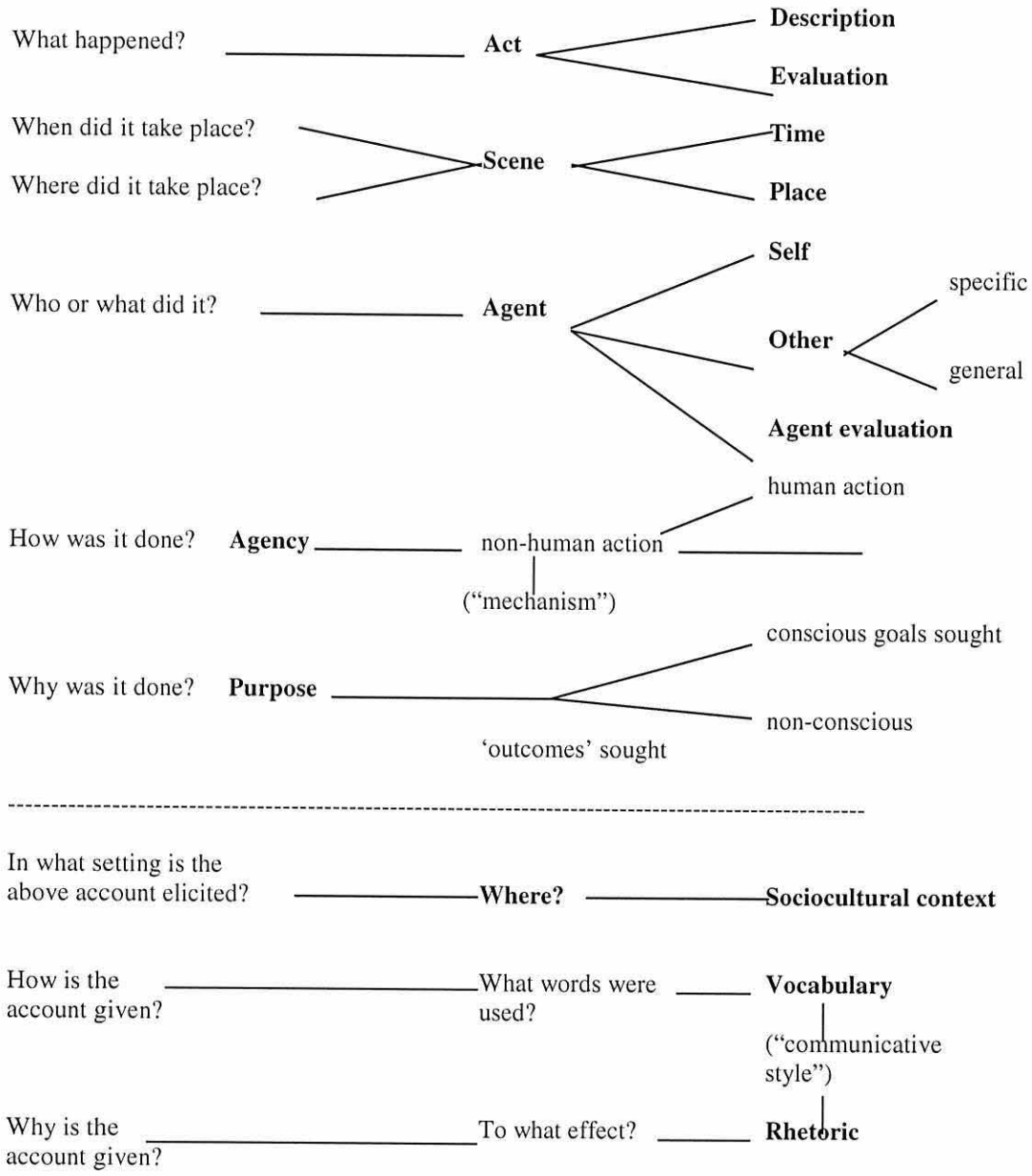
My own attempt to establish motivational "profiles" for each student based on a broad accounts taxonomy led me to realise the difficulties of assigning weightings to students' self-reported motives. Earlier work in the accounts tradition developed by Kenneth Burke (1962) appears to offer a way in which any weightings may be more authentically provided by respondents themselves in the body of a discourse which offers a narrative account of an educational trajectory.

Using a dramaturgical approach Burke (1962) pointed out that the motives for all human behaviour can be questioned by asking "who did what, why, when, where and how?" Burke argued that motivational responses emerge when human behaviour is questioned within five primary categories: act, scene, agent, agency and purpose. Burke's "scene" can be expanded to include both time and place and to distinguish between different kinds of agent - one's self as agent and different sorts of "other". This framework forms the *grammar* of motive discourse. In that sense it does involve the imposition or expectation of accounts conforming to a certain structure, but by no means does it dictate their content. The style of the narrative will depend upon the choice of vocabulary and the adoption of a particular rhetoric to tell the "story"; while the entire activity will be even more broadly structured by the context in which the accounting for motives is sought and delivered – "where, how and why is the account being given?" Agent responsibility becomes a prime consideration of motivational statements. Some assessment of responsibility for the commission of an act or the locating of an initiating "cause" is bound to be made. Most motivational narratives will offer or imply variable degrees of positive or negative evaluations about acts and about agents.

These questions comprise elements in the construction of an account which can be seen to form a "motivational narrative" - a story about motives which can be put together to form an analytic framework which can be applied to any communicative event in which such questions of motive arise. Narrative is one of the most enduring and pervasive forms of human communication. It appeals to common perceptions of the passage of time, causality, the consequences of human actions, responsibility and intent. The narrative analytic framework I propose for application to motivational

accounts is presented in Fig.5.1. A "story" about why something has happened or, even, will happen may be offered to varying levels of complexity, depending upon the representational modes at the narrator's disposal and their judgement of the ability of their audience to comprehend that story. Grammar, vocabulary and rhetoric are employed as communicative devices to frame accounts, attributions, blame and responsibility in particular ways.

Fig 5.1. A Framework for the Analysis of Motivational Narratives



As both the accounts and the attributionist traditions have illustrated, more popular forms of motive elicitation are accomplished commonly by blaming, praising, confessing, justifying, excusing, rationalising and so on. Blame, for example, is often used when an act is evaluated negatively, but blaming oneself may be a trigger to empowerment. Taking responsibility can imply a willingness to take control.

There is a need to understand further the process by which motivational accounts might be deemed legitimate or "adequate". Any complete motivational account will address a rationale in which an actor, an act and a scene may be linked by some mechanism; and the rationale produced will depend upon an evaluation of the audience for the statement. Thus accounts about why someone is pursuing a particular educational course must incorporate a sense of agency, of place and of likely outcomes.

This implies the possibility that dialogues about motives might have a certain predictable pattern of question and answer or a natural history to them. Such a view is consistent with what is known about the repetitively structured nature of speech events such as conversation (Coulmas 1981). So the measure of adequacy or legitimacy may require an account to hover near a "threshold of acceptance". Each party to the accounting process participates in negotiating the emergence of acceptable motives - thereby producing a consensus. Anything less than consensus maintains pressure to locate guilt, allocate negligence and attribute blame. For example, a student may be reluctant to reveal their "real reasons" for attending a course if they believe those reasons to be institutionally unacceptable.

Just because motives change does not mean that they are never stable. They do become stabilised when there is generalised understanding or agreement across a community or society of a particular profile for particular actions. In this way the attribution profile becomes institutionalised. We ought not assume that the psychological stability of individuals rests on the degree to which they "internalise" the typical attribution profiles for their society. Their stability may just as much depend upon the individual correctly interpreting a situation as calling for the offering of a particular motive; that is, the recognition of appropriateness, adequacy and legitimacy (Bhatia 1993). In other words, most of us do know how to say the right things at the right time. Institutionalised attribution complexes are stabilised motivational profiles which are generally accepted throughout a community and which permit little flexibility.

This narrative framework has already been employed in secondary research as a means of categorising accounts of health and illness (Iphofen 1996) and the literature on self or personal development (Iphofen 2000). In the former an attempt was made to link accounts with therapeutic outcome, and in the latter to test for typicality in the characterisations employed in personal development. Here I am interested in what students see as legitimate needs and wants and their relevance to themselves and their future goals. This remains exploratory since the framework is untested on "fresh" data (accounts) produced with this analysis in mind. Methodological limitations to this approach are discussed after reporting the analysis.

Effective learning and health care students

Despite the limitations reported in Chapter 4, the investigation of the students' perceptions of their learning styles suggested that some early changes do take place during their course. They begin with fairly classic andragogical intentions - taking responsibility for their own learning and wanting to be autonomous learners - but after a very short time discover some institutional constraints they must face and adjust their expectations downward. What we do not know is if this is a feature of curriculum, organisation or lecturing staff. It would be interesting to find out if this happens in other nursing courses or, indeed, in any other HE courses.

The confrontation of the students with this knowledge and the element of challenge for them to do something about it was in the context of a constructive dialogue about learning. Even students who had previously expressed some dissatisfaction with the module on "study skills" suddenly began to pay attention - they had discovered something which directly affected their ability to learn effectively, something which appeared outside of their own control and which, naturally enough, they resented. While this did produce authentic accounts about learner motives, there remained a problem of recording these interchanges for analysis. To generate something which could be recorded and authentic in that it was in their own words, I asked them to produce a brief written account of why they wanted to nurse (or study radiography) and of their vocational expectations at the start of the course. This was something of a compromise in that it also served diagnostic purposes in identifying any writing difficulties the students might have, and it was also intended to provide a discussion stimulus for their first meeting with their personal supervisor. By this device both students and staff gained commitment to the research exercise.

In any longitudinal research it would be interesting to see how these views changed over time, for present purposes only the initial accounts could be collected, transcribed and analysed using QSR NUD*IST Version 4 computer assisted qualitative data analysis software. (NUD*IST stands for Non-numerical Unstructured Data Indexing Searching and Theorising and was developed by Qualitative Solutions and Research.) The students were informed that the accounts would be analysed in this way and their voluntary assent sought. (Those who did not wish to write too personal an account were given the option of writing more generally about the profession of nursing.) The fact that those accounts were taken seriously and employed as the basis for the work personal supervisors conducted with each of the students provides an important backcloth to their meaning.

For analytic purposes some degree of control over "sociocultural context" is essential. So the context was set here as a short exercise in writing about oneself and a desire, ambition or intention to pursue a career in nursing (or radiography) via a course leading to an academic qualification. The fact that the account was written, short and known to be read by myself and the student's personal supervisor also delimited the account giver's perception of context. A rhetorical analysis was not conducted at this stage - although this would be interesting and productive of linkages to learner motivation, it might be more useful if taken together with some comparative written account by the same student produced for other purposes or even in comparison to a recorded verbal account.

As a fairly flexible means of qualitative data analysis NUD*IST allows for the application of a pre-coded system of categorisation based upon a "tree" structure with roots and branches (or "nodes" termed "parents" and "children" in NUD*IST), and it also allows for generation of new nodes as the data is interrogated. Figure 5.2 shows the initial tree structure as suggested by the Burkean framework. Figure 5.3 shows the emergent framework as typical nodes were created to allow for more specific categories which grew out of the analysis. All documents were transcribed, spell-checked and corrected for ease of reading and report before being imported into NUD*IST. No alterations to grammar or anything that might substantially alter meaning were made. Only one document proved so illegible that only part of it was transcribed and subsequently analysed. The illustrative extracts reproduced below were selected as a "typification" of sets of responses and their NUD*IST identifiers were retained to indicate source and enable their further retrieval if necessary. All interrogations of the qualitative data, their NUD*IST formulae and any cross-tabulations are fully reported in Appendix IV.

Figure 5.2 Initiating Index Tree for Document Analysis

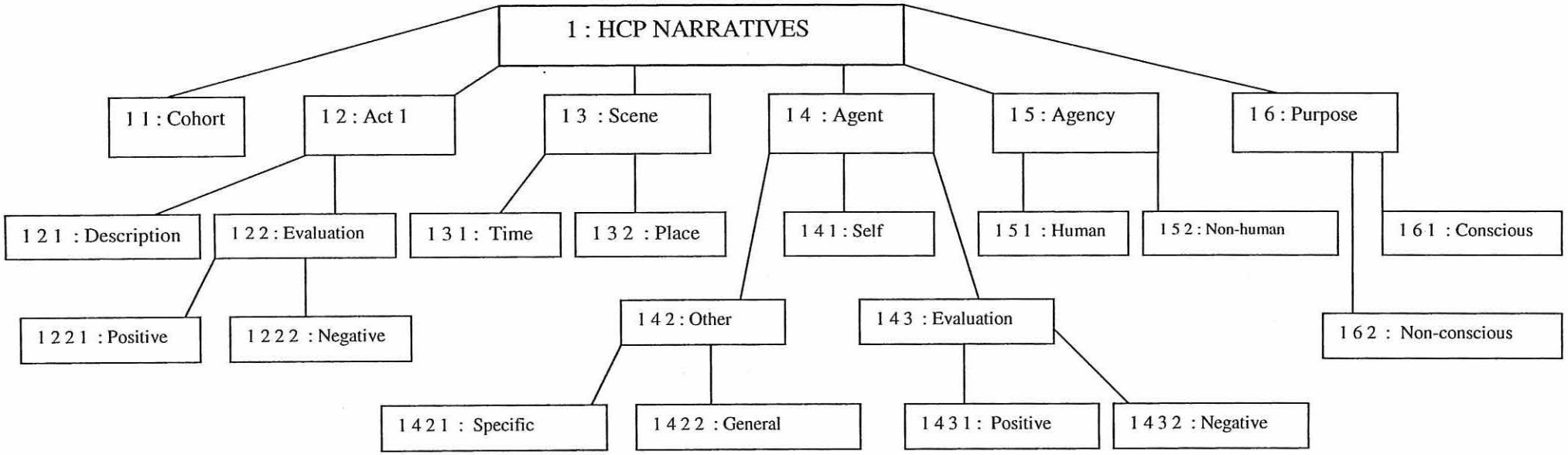
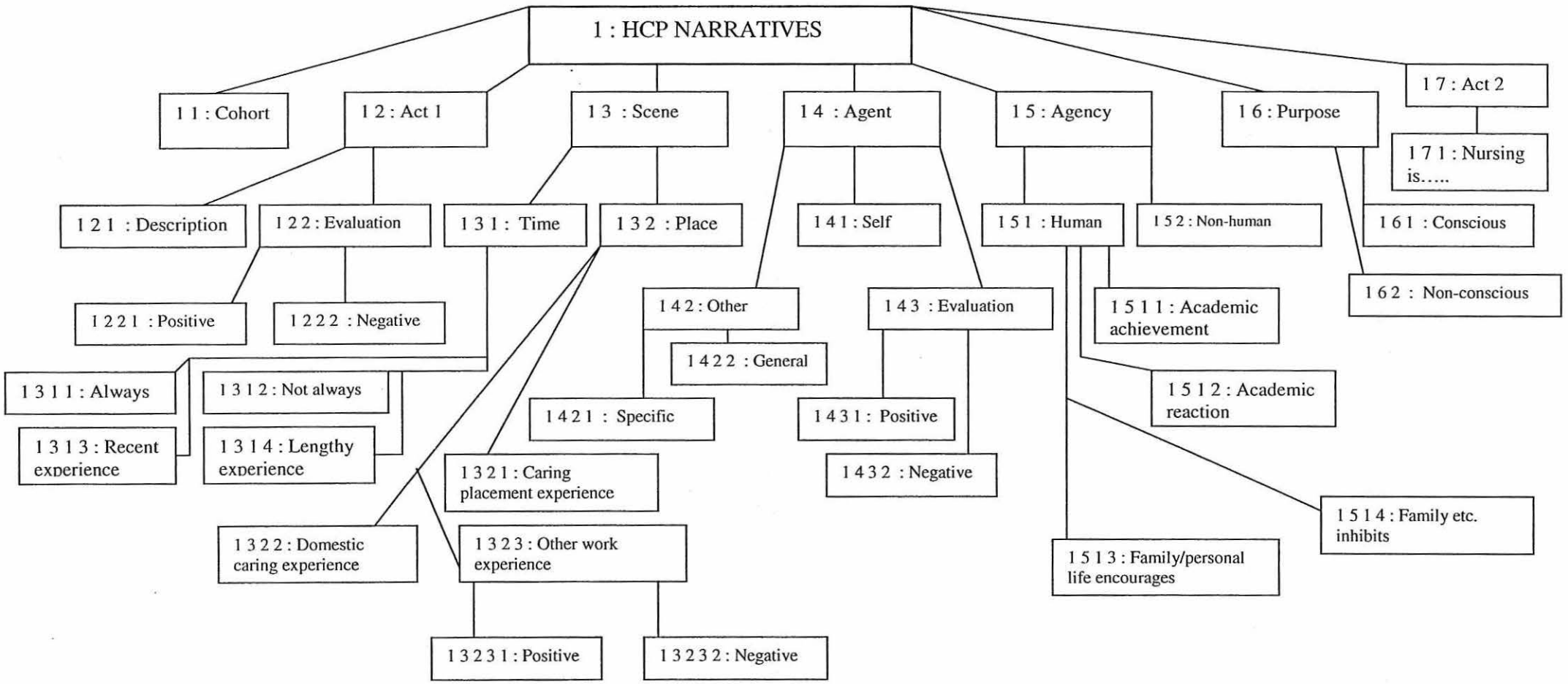


Fig 5.3 Emergent Index Tree from Document Analysis



General impressions

The gloss on by far the majority of these accounts is that of the strongly felt emotional costs and benefits of the students' intended career. There is much expression of the ideal but balanced by realistic awareness of the physical and emotional demands of professional health care. The varied requirements of patients and their families and the need to respect individual wishes and needs is often referred to. The hoped for satisfaction of achieving successful therapeutic outcomes, while dealing properly with unsuccessful outcomes is addressed. Values such as dignity and respect, empathy, patience, trust, confidentiality are frequently espoused as is the importance of good communication skills. Most anticipate working well in a team of competent professionals with a challenging, but interesting and rewarding career structure. A cynic might suspect that the educational recruitment campaign had been highly successful - but the frequency with which the students balanced the idealised vocational imagery with a practical awareness of the mundane aspects of the job might help to discount such a reading. These are not cynical careerists with instrumental attitudes to the imminent educational experience. The excitement of the challenge of learning new skills and new knowledge was anticipated with apprehension but optimism about gaining the foundations for their future career. Most educators would be extremely inspired to have the opportunity of working with students such as these.

Base data

The above impressions and more detailed results reported below were drawn from the analysis of the writings of three cohorts of nursing students and one of radiography students on the Wrexham site. Each cohort is identified by an intake number: 1/95 (34 students), 2/95 (49), 1/96 (40) and 2/95RAD (21 radiography students) - making a total of 144 responses. The precise formulae and tabulations relating to the following data reports are to be found in Appendix IV.

Most (80) made some positive evaluation of the "Act" which brought them to nursing, about a quarter of the responses (37) made negative comments about the Act but of these 22 were balancing both negative and positive evaluations. In other words, they made reference to both the ups and downs of their precipitating experiences. This still leaves 58 accounts which were entirely positive in their evaluations about what made them want to become health care professionals. In terms of testing the framework, it is noteworthy that 64 made no clear evaluative comments about the Act.

Comments about the "Scene" would have to say something about "Time" and/or "Place". A little over a third (53) reported this as a longstanding desire or intention, something they had "always wanted" to do.

195AMDEV

> *Like many other children, or little girls if a relative or a family friend would ask, "What would you like to be Aiwen when you grow up", I would always (say) "A Nurse" without any hesitation.....*
> *We are all called to a certain profession, and my calling lies in the Nursing Profession, above all it is a feeling and a dream that has never faded for twenty-two years.*

195ELIT

> *....I've now accepted, at the beginning of my nursing training, that I have always dreamed of being a nurse - it was always there somewhere, waiting to surface and be nurtured.*

195GSJWJ

> *...to become a qualified nurse was always an ambition that I needed to realise.*

A third (7) of the radiography students reported a similarly longstanding interest in the health professions but none saw this as originally an exclusive desire to become a radiographer.

RAD295RT

> *I want to pursue a career in radiography as I have always wanted to work in a health care profession.*

Thirty-nine did not claim the ambition to have been lifelong, most of these saw it as emerging in their teenage years but others reported it as something new, emerging much more recently as a plan or ambition.

295KIM

> *Initially, when I left school I was uncertain of my career path. After perusing several college prospectus' I decided to enrol on a BTEC Business and finance course. Having now reached HND level in business and finance, I was set to enrol on a degree 'top-up' course in business management, therefore*

completing my education. However during February of this year I began working as a care assistant in a local nursing home for the elderly and mentally ill. To my surprise this role instantly clicked with my personality and I knew that my career path would be that of a nurse.

RAD295DH

Being brought up by a family which has a background of sports and leisure I sometimes think it strange as to why I have chosen the medical field as my profession to be. My father was a sports centre manager, my mother a physical education teacher and my eldest sister a tourism representative. I had always thought I would end up following one of those careers.

Another 21 mention a recent experience as inspirational. Only 14 had had what might be regarded as "lengthy" experience of the kind of caring that nursing or radiography entails. But by far the majority (97) had had some formal caring placement experience:

195AJSS

After working as a care assistant in a nursing home for the past eighteen months, I've come to realise what a satisfying job it is to work in a caring environment. Looking after, and tending to people's everyday needs is rewarding in itself, but I find I am more interested in the clinical procedures, although being able to relate to different individuals and seeing to their welfare is just as important. It is all part and parcel of being able to look after someone reasonably healthy, although infirm, before being able to look after someone who is sick.

195CCKJ

For the past five years I have worked in the community as a carer. This work involved looking after the daily needs of the elderly and disabled and sometimes the terminally ill. I must admit when I very first started working as a carer I used to get very upset and frustrated especially when looking after elderly people. I used to feel that I had nothing to offer them as some of them used to be in a lot of pain, others were very depressed, and some bitter. I used to look at these people and wonder what life was really about. It wasn't until they got to know me and starting trusting in me that I realised these people, even though a lot older, needed the same things as I did. I found it fascinating to hear about their lives, their happy memories and also sad ones. I started

realising that everyone is different and what one person needs is not necessarily what another person needs. We are all individuals and everyone reacts differently to treatment and situations.

196CGSB

...I tried several different working environments, but only when I was in the caring/nursing environment did I feel comfortable and relaxed.

196JEKH

I have had various part-time jobs, some of them caring for elderly people in their own homes and doing this has only served to confirm in my mind that the caring profession was for me.

and 37 mentioned caring experience in their own home or with their family:

195AMDEV

I was very, very close to my maternal grandparents, we all actually lived in the same house. In the end they became like children again Mum, Dad and I had to literally wash, dress and feed them, it was very difficult, sad and at times reduced me to tears while I tried to have empathy with them. This experience only made me stronger in my ambition and dreams, I wanted to care for people like my grandparents who could no longer do things for them selves and were not fortunate enough to have a loving and supporting family to help. Also at the time of my grandparent illness I dreamt of having knowledge to know why they were ill, what were the doctors and nurse giving them in other wards now where they being treated, and how as a family we could best look after them, this knowledge I knew I would have one day if someone would allow me to fulfil my dream.

295RN

There is a strong interest in health care studies in my family, and so enrolling on a nursing course had always been of interest to me. My mother is a radiographer and several of my other relatives are nurses, and whilst being careful not to follow in their footsteps just for the sake of doing so, I saw nursing as an obvious choice.

295SHELLEY

As a child, I had many fears about hospitals, doctors and all things medical. On reflection this was possibly the result of having a mother who was 'nervous' about such things, and who suffered long bouts of 'mysterious' illness. I remember the visits to her private physician with the booming voice, and the huge hypodermic needles which he always inflicted on my poor mother.

RAD295LW

When I was younger I had reason to go to an x-ray department on several occasions. I had all sorts of x-rays done and some scans. As a result I became interested in radiography, and in school I had access to books explaining what the career involved.

Fourteen reported seeking health professional training as a reaction to negative "other" work experiences.

196DACMG

Having spent thirteen years in the motor trade I began to realise that I no longer enjoyed the work that I was doing. It certainly was not a job that I wanted to do up until retirement age. I wanted a career with more reward (not necessarily financial) and a job I could feel proud of.

In fact, twelve had found positive aspects of their other work experience which led them into a caring career.

295SC

I love working with people and this is seen also in my part-time job as a junior hairdresser where I spend my whole day gossiping to the clients!!

RAD295SS

In previous jobs I had enjoyed certain aspects of work which I tried to identify. Once I learned what it was I enjoyed I began to research certain occupations which included these qualities. The job of a Radiographer I believe includes many aspects of what I am looking for in a profession.

Curiously only one individual drew something positive out of negative "other work" experiences.

196HDTMG

In my past working years I have had employment involving meeting, helping and happily communicating with people and work colleagues and also short term employment which was tedious and non-friendly within an office environment. From this experience in the work force, I have realised that practical work involving communication with all levels of people is the work I most enjoy and feel suited to.

The "Agent" responsible for seeking this course of action in the great majority of cases (114) was the student themselves and 101 of these evaluated themselves as a "positive" agent, while 23 also evaluated aspects of themselves as an agent negatively.

195CCKJ

There are many reasons why I want to become a nurse. Firstly I want to be able at the end of my lifetime to look back at my life and know that I made a difference to society and to the world in general. I don't want to be somebody who is really famous, I just want to know that what I do in nursing really counts and helps towards making the world a better place for all. Secondly I want to become a nurse for myself. By this I mean that I want to be able to achieve better things for myself. I want to feel that I have some worth in society and I feel that becoming a nurse will also make me a better person.

295DB

Having come into care work almost accidentally, and with almost no similar experience, I have found it a tremendously worthwhile occupation. However. After an initial few months of finding my feet in the job, I began to recognise a number of limitations to how well I could hope to do the job. These ranged from those I could confront by myself, (such as my initial shock at the violent nature of some of the "challenging behaviour" which merely required me to expand my outlook a bit, and find a way of accepting this, or at least dealing with it normally,) to recognising the almost complete lack of knowledge I had of the causes or reasons for mental handicap/illness, and more importantly, what I could do in the position of "support worker", to improve matters, and how I should go about it.

196SDIT

> *My caring for the sick certificate has proved its worth while as prior to applying for this course I had to help look after my gran. She became very ill very quickly but was not ill enough to receive hospital care. I found it very difficult at first, I suppose because she was close family. I quickly over came this difficulty. At times I thought that nursing wasn't for me and that I wouldn't be able to cope within a hospital situation. I over came this by putting myself in my gran's position, understanding how she was feeling and how I would be feeling if it was me in her position, and exactly how I would want to be treated if I was the patient. Her recovery was made very quickly with great surprise to me but also a great deal of satisfaction knowing that I had at least achieved in helping her back to a healthy life again.*

Forty-three named "other agents specifically" as active in inspiring them, while seven referred more generally to others. The specific agents were mainly family, health professionals who had been caring for them or their family or family members who were health professionals. The "general others" included the influence of the media image of nursing - mentioned surprisingly sparingly and positively in only three accounts. Interestingly only one account reports the "other specific agents" as negative:

295VFM

> *When I think of nursing I think of two different types of Nurses. The older generation seems to be very time orientated. I remember being frightened to death after an operation, when I was young. To be honest it put "me off" nursing. Recently I have been working in Maelor as an Agency Auxiliary and have seen the changes. Nursing seems to be more efficient and caring. This is the type of nursing I want to be involved in.*

It is noteworthy that not one account attributes any "non-human agency" with responsibility for seeking their vocational purpose. This would include any mention of spiritual, supernatural or religious influences. This might of course be inferred as a constraint of context; that is, this essay might not be seen as an appropriate place in which to mention any spiritual calling. It might be interesting to test this possibility by facilitating another setting in which to derive such accounts, and certainly worthy of comparative study. I wonder, for example, if students in say North America would be more likely to disclose non-secular motives, or even if the cultural climate in the UK

has changed to the extent that more recent students would avow such motives or if students in the more distant past would have done so.

Fifteen accounts make mention of human agency, specifically or generally.

196KJ

> *The initial seed was planted in my mind after a consultation with the school Careers officer in the later years of my High School Education at the tender age of 16.*

196SBGT

> *I decided at the age of fifteen that I would like to become a nurse. I don't remember what finally made my mind up. But we had a talk with our school careers officer and nursing was discussed and from then on that was what I wanted to do.*

Twenty five make mention of family members' agency.

195TRSS

> *The nursing profession has always interested me from an early age as that was the career of my father leading me to learn to become aware of what this career entails.*

196CGSB

> *Influences from family members who also work in the nursing profession enhanced my desire to become a trained nurse.*

196DACMG

> *So, influenced to a certain extent by my mother, who was a nursing auxiliary for many years, and by my wife who works with students who have learning difficulties, I began to work my way towards getting the necessary qualifications required for entry onto the Diploma in Nursing course.*

As might be expected a similar amount (22) reported family responsibilities as inhibiting their original career aspirations.

195EWKJ

Following a child care course at college I began to work for the Social Services. This continued for only a short time as I married had children and settled into caring for my family. During this time I had various jobs mainly to suit the family, to fit in with them...

196LW2MG

I applied whilst studying for my "A" Levels in school, and was accepted into the Southern Area college of Nursing Craigaron. N. Ireland. I was a student Nurse there for just under a year, but due to illness in the family I had to have time off.

Only two accounts report family first inhibiting and then encouraging the seeking of a nursing career. Both reported being "held back" by having children.

Sixty one students report favourable views toward academic achievement.

195EWKJ

I left school with few qualifications and if I am honest little ambition.... I recently achieved qualifications which I failed to achieve at school and was surprised by the amount of satisfaction I derived from learning and achieving academic status.

195HIT

Both to assist in my application and also for my own sense of achievement, I undertook a Bachelor of Arts degree with the open university with I completed in 1992.

195TRSS

Since attending college last year and studying the sciences - Health, Biology, Sociology and Psychology my interest has deepened even more so as these are topics that I haven't previously studied but found them very interesting indeed.

196LWMG

This interest arose as I became interested in anatomy and physiology, the human body is a fascinating machine, complex in detail, the more I studied, the more interested in nursing I became. The idea of working with and somehow helping people seemed a very good alternative to the secretarial

work that I was involved with at that time. In 1990, my qualifications were nil, I went on to achieve GCSEs, A levels and a degree in health studies. Now, I am at the stage where I am ready to enter the profession of nursing.

Only 14 reported educational experiences which restricted their ability to enter nursing.

195TRSS

During my years through High School however I was very devoted to swimming spending most of my time training and competing in various competitions which left little for any other interests, including my school work which resulted in me not achieving very good examination results upon leaving school.

196CGSB

On leaving school my academic grades were not high enough to let me apply for the Project 2000 course, so I knew that if I really wanted to fulfil my life-long ambition of becoming a nurse, I would have to improve and continue my studies. This is when I started college and was studying a Diploma in Science and Health Studies.

295NPBW

I had no wish to attempt A-levels as after 2 years of intensive G.C.S.E. courses I really didn't think I could face the same type of education at a higher level.

Clearly one would expect very deliberate conscious purposes to be put forward for seeking to enter this career. Indeed only nine accounts offer a "purpose" which had to be categorised as exclusively "non-conscious". This was only because the respondents expressed their inability to "understand" their motives. All of these, however, could have a high degree of satisfaction inferred from their experiences. The following are the most eloquently expressed:

195LRSS

I started work in a residential home for the elderly... Nursing, I have to say, was not just around the corner - it was MILES AWAY from my thoughts. I settled in and thoroughly enjoyed it. I find it hard to explain just how much I got from the job - the immense pleasure and satisfaction. I smile when I think about - and I feel a smile says it all. I would go home after a twelve hour shift

and relate the day's experiences to my mum and I would beam. Then again I might cry. I was always touched beyond belief. The work was physically hard and sometimes an enormous pull on my emotions. Sometimes I would feel enraged, embittered but NEVER with the residents. I felt so privileged to be helping them in someway to lead a more comfortable life, so privileged to listen to them. I find so often people do not listen, haven't got the inclination or the ability. For me, they were individuals who had unique experiences and so much to give.

195DPKH

Answers are not easy to come by. I just have this tremendous feeling that the good times overtake the bad times even though there seemed to have been more bad times , especially in the last year or so. Yet some days I'd see a patient walk out after he had been with us for some time and all the experiences about this patient, good or bad, suddenly coalesced into one big self-satisfied feeling of pride for oneself, for the team and for the ward. That man came in on a stretcher, half-conscious maybe, in pain, possibly without a limb but after all the time and effort spent on him, was able to walk out. To have participated in this achievement is, short of miraculous, simply wonderful.

As anticipated 86 of the accounts gave clear, conscious purposes. These students give a clear impression of "knowing what they want".

195ACHKH

I want to be part of a profession that promotes good health. Also that helps people who are sick to enable them to get well. When people are dying try to help them die as comfortable as possible and also with dignity. To try and help their families cope with this trauma. Most of all I want to be able to enjoy my training. Then apply the knowledge I have gained with confidence and vigour.

195AJSS

I want to be able to get involved with others when planning a course of action, as well as having the knowledge to perform certain clinical procedures and have the understanding to be able to deal with all sorts of situations that we might come across in any case setting.

195CCKJ

I want also for the world to be a better place and I know this will not happen overnight. I think if I can learn from others and they can learn from me it will be a start of things to come. I hope that what I learn and what I put into practise will benefit myself and others. I hope that in years to come when my children have grown up and had their children that I would have made a small difference in their lives being healthier and better. I feel as part of team working care for all better that eventually this world will be a better place for all. I hope someday that when I look back and need caring for that people will be educated enough to provide the care that I would like to give.

196NJMG

I wanted also to achieve a career that was rewarding, challenging and would give me the opportunity to educate and influence people with my knowledge and to promote better health and quality of life to people so that they can experience long term effects rather than just short term wellbeing. Another reason was to better myself. I wanted a career that would expand and test my knowledge and abilities, aid my chance of promotion, experience various aspects/fields of nursing and above all, be somebody that I could be proud of. ..... Above all I want to learn about people and their lives, be able to advise and care for them to the best of my ability both physically and mentally, be able to better the quality of life to those who need it and last but not least, I believe in treating people how I would like to be treated myself.

295AP

My aim at the moment is to enjoy this course give it everything I have and come out with a mark I am pleased with and that I know I have put everything into it. My thoughts at the moment that I have in my mind about when I qualify are that I would like to work with a small group of people may be as a district nurse or in a hospital caring of people who are unable to do so themselves or making sure people stay fit and healthy giving them advice and knowledge how to look after themselves and stay that way. I want to be someone who is easy to contact and that people feel confident to talk to me about problems or anything that is on their mind, not just someone working in the caring profession in a white uniform working to get people better. I want to be a friend to people, someone who can help.

295DG

> *I want to be a Nurse. I want to be a staff nurse passionately. I want to be a staff Nurse in 'Accident and Emergency' dealing with casualties of various kinds and not only helping to care with treatment for patient however also for relatives of patient, having respect for the other medical and caring professions who can help people when in need by communicating using knowledge and skills to have the interpersonal relationship and attitude to be humanitarians and to have the academically challenging project 2000 course as part of my new chosen career, however knowing that other modules/courses can be done in future years for my progression in my Nursing career.*

Only five radiographers expressed a clear conscious purpose and invariably these were expressed more succinctly:

RAD295HJ

> *I know that it will give me satisfaction in years to come. I realise that the course is very intensive and it will be hard going, but I have set a goal and I aim to achieve it, however hard it seems just to Qualify as a Radiographer and work in the health profession.*

RAD295LRJA

> *After graduation I would like to work for a few years in a local hospital and then maybe move on and work abroad or even join the RAF or the Army and travel in that way.*

RAD295SW

> *I hope that Radiography will give me the opportunity to work in a friendly environment. A career where I can have job satisfaction in helping patients to recovery within the health care team.*

Pattern in the narratives

NUD*IST allows more complex interrogations of the data such as overlaps and interconnections between categories (nodes) and sub-categories which may reveal any systematic patterning in the data.

By testing for common patterns any cohort effects can be identified or ruled out. While all cohorts averaged approximately 50% reporting "positive Act evaluations",

there was a marked proportionate increase over time with each successive cohort making proportionately more "negative" comment about the precipitative experiences - from 12.5% (1/95) through 20% (2/95) (25% for radiographers) to 50% of the 1/96 cohort. This observation might lead one to infer consistent changes in the context - either societal, communal or institutional. Clearly it would be important in research terms to pursue such a pattern over a longer period of time to detect trends and changes in trends. But the awareness of such a cast upon the accounts could be useful to the educator in their treatment of and attitudes towards the cohort as a whole. Perhaps the common observations that tutors often make about the particular characteristics of a cohort can be seen to be supported by data of this nature. Although it remains to be seen how much the teaching staff engage in a self-fulfilling prophecy in this regard.

Other marked observations include:

Fifty per cent of the largest cohort (2/95) stand out as the largest proportion commenting on having "always" wanted to pursue nursing as a career. No other variations in commentary upon "Time" are so marked. Progressively more of each cohort report "caring placement experience" - 56% (1/95), 67% (2/95), 73% (1/96) with the radiography group at 76% (2/95). This is highly likely to be a consequence of a firming up of admissions criteria as recruitment improves. Thus again it may be a reflection of those things the institution values, as represented by the staff conducting admissions interviews. It is also noteworthy that only one of the 1/95 cohort mentions domestic caring experience, while approximately a third of each of the other cohorts mentions such experience.

While a little over half of the first cohort refer to themselves as the initiating "agent", by far the majority of each of the other cohorts do so. More interesting is that specific others are mentioned in similar proportions (approximately one third) by each cohort, all six that mention the influence of "general others" are in the 1/96 cohort. These necessarily include the three accounts that mention the media image of nursing - thus suggesting while the mass communications can influence vocational aspirations it may not be as strong as is sometimes imagined in this profession.

Most of those who refer to family members as "agents" also claim to have "always" wanted to enter their profession (10 as compared to 3 who have "not always" sought the profession), while almost twice as many mentioning family members' "agency"

report their place of vital caring experience to have been domestic rather than a formal placement (13 compared to 7).

Of those who put forward "academic achievement" as a key agency only eleven also make mention of a "consciously purposeful" agency. Similarly of those expressing a "conscious purpose" (27) by far the majority (17) link this to a "caring placement experience" while six refer to a "domestic caring" experience.

Some assurance of consistency in motivational narrative may be found in only three respondents offer both conscious and non-conscious "purpose". Even these may be due to a coding dilemma which is typified by the following text extract:

195AMDEV

> *On one hand I can not honestly think of an answer to the question of why I want to be a Nurse, and on the other there are many, many reasons why I have chosen this wonderful, and of course hard and at times tear(ful) profession.*

Of those who accounted themselves as the "agent" for this act (122), 101 evaluated themselves positively and 44 negatively. But 23 of these evaluated themselves as both positive and negative in certain respects:

RAD295EK

> *At the moment I am starting to understand the intense preparation the radiographer must undertake to become qualified and the range of skills required to ensure a balance is struck between care of the patient and the importance of following correct procedures. I am apprehensive about the depth of physics which must be studied but confident that the hard work has taken me thus for will stand with me.*

295RN

> *I believe that I possess several qualities that are required for the nursing profession such as compassion, patience and understanding. I want to be able to help people to regain their health and to maintain it afterwards. I want to know that I'm being of assistance to someone and that my contribution is valued. After saying this, I realise that my efforts will not always be marvellous. But, I believe nursing has as much to offer me as I will offer it, and I look forward to nursing as a rewarding and fulfilling career.*

Discussion and methodological problems

The possible combinations of pattern in the narrative appear almost endless and data interrogation could go on indefinitely. Limitations on time and space will have to restrict the analysis to the above. What is particularly striking overall about these accounts, which is hard to convey when having to select a few illustrative extracts, is the strong sense of vocation expressed throughout. While many are moral and emotionally expressive, none make reference to any religious or spiritual conviction. Respondents are keen to express their commitment to study and their eagerness to learn how to care. It would be a tragedy if the decline in autonomy inferred from the data in Chapter 4 were matched by a decline in motivation as measured by self-assessed respondent commitment. Such a study was conducted by the BMA and it found that those with a very strong desire to study medicine had dropped by 10% (from 57% to 44%) between entry to and exit from medical school (Wojtas 1995).

This is one thing missing from the present research - the confirmation of the link between authentically produced narratives about learning and the effectiveness of the individual learner. The broader methodological context of this present participative action research with an attempt to incorporate the range of stakeholder influences would preclude a more longitudinal investigation of learner motives and how they might change. Clearly that would require the opportunity to regularly generate and re-visit the learners' accounts throughout the course and afterwards. Moreover the accounts would have to be linked to examination success rates, student destinations and updates of such narratives after some time in professional practice. This, of course, would then be of relevance to the learners' plans for and perceptions of CPD. There is also a methodological problem of measurement reactivity to be overcome: how could regular accounts be produced which were not excessively influenced by the memory of and the act of producing the prior accounts? The most sophisticated experimental design in terms of adjusting for internal and external validity - the Solomon Four Group design - would advocate accounts being produced only by some students at first, others only part-way through the course, yet others only after the end of the course and, for a fourth group, no accounts to be produced at all (Campbell and Stanley 1965). While the comparative analysis of differentially produced accounts would have a great deal of causal significance it precludes any possibility of "using"

the accounts as a means for enhancing learning while the course is ongoing - an objective more in keeping with the participatory spirit of this thesis.

It is also worth noting that in theory the cross-tabulations between cohorts and nodes could be tested for significance by exporting the data into a quantitative data analysis package. While the face sheet data do suggest the possibility of some significances the text units of analysis on which the data is based vary so greatly that the validity of any tests of significance would remain unsafe. I am keen to advocate caution in the quantitative interpretation of qualitatively generated data.

Parallels between the Burkean framework and Knowles' andragogical principles are evident. The narratives clearly contain commentary on why the student perceives themselves to need the knowledge and skills provided (their "need to know"), some observations upon themselves and how they are changing or have changed (their "self concept"), their experiences and how they are relevant to the current learning situation, their readiness to learn (such comments include "relevance", "needs" and why they are doing the course now), and frequently the problems they hope to solve with the knowledge they acquire. Of course, the concept of motivation I am advocating embraces the entire narrative - motivation is the sum total of these "reasons for learning". Any future refinement of the details in the framework could bear this parallel in mind and include codes which test for these elements.

One would expect that the strength of vocational motive evidenced here could sustain the learner through course content the relevance of which is not immediately apparent to the learner. The learner seems certainly convinced of that in these accounts which were generated quite early in the course. But experience suggests that impatience with content still does appear. It would be interesting to discover the stresses and/or the influences productive of impatience, though not necessarily a decline in vocational commitment. This may confound the assumptions in the Dearing Report that skills alone are enough, but by no means is andragogy dismissed. All this may mean is that the educator has to find ways to demonstrate relevance continuously (Iphofen and Poland 1997).

The precise means or mechanisms for employing this kind of additional knowledge about a cohort would require considerable further investigation. Presumably different things would be done with the class than with the individual. More importantly, unlike the learning style research summarised earlier, this material allows a method of understanding and approaching both individuals and the cohort collectively. Practical details in applying the narrative framework include: the difficulty of singling out the main precipitative Act. Strictly there should be a comprehensive analysis for every one of the "many reasons" mentioned by each student. This would make narrative analysis highly complex and unwieldy - hence the popularity of simple checklists and convenient pre-coded taxonomies. To employ the method again I would be inclined to narrow even further the context of the production of the account by refining the question asked to stimulate the production of the account. (For example, in current work on health behaviours I have asked respondents to state an act they engage in which they perceive as "healthy" and another which they perceive as "unhealthy". Thus the straight description is to be generated by them while I have already explicitly evaluated the Acts.)

For the present purposes of focussing upon learning enhancement by identifying key learner motives, there was more than enough for each tutor to work with and to use for sustained early (and ongoing) tutorial relationship. Even the common factors could be employed in collective contexts - thus it can be useful to say "Many of you have always wanted to be...., while for some for you this is a relatively recent ambition - all of you hold the conviction that....."

As with all qualitative data, coding and interpretation remains an area of difficulty. All coding was double checked by another coder, blind to the coding of the first. Any missing codes or disagreements were resolved; often by producing more, rather than less, coded categories. Still many "missing values" remain - thus both coders inferred a great deal of "family support" behind students' motives, but rarely was this contained in an explicit statement.

It is too easy to suggest that the content of such narratives were as anticipated. Once again, these are the accounts of successful applicants, a comparison with unsuccessful applicants might be more revealing of the institutional admission criteria than of

anything "special" about the students. Still there was little need for the students to see their accounts to be merely a re-run of what was presented at admissions interview. They no longer are seeking a place although the account may still be constrained rhetorically by the need to establish a "right" relationship with their tutor - the only other reader of the un-anonymised account. So one might hope for a little more honesty - say about imagined difficulties - than at interview but there may be a tendency to cast the authors with a convincing "worthiness", that they were entitled to the place they now hold. But all writers knew that this was never to be a public statement. Its sociocultural context is that of an exercise as part of a lifelong learning session and to be read privately by two individual lecturers.

It is heartening to read of the compassion, the understanding of the suffering of another and the respect for dignity of the individual that is often expressed in these accounts. It would be tragic if both the institution and the educators lost sight of a personal conviction that rarely has an opportunity for individual expression within the conduct of a course. If ways could be found to re-visit these original aspirations both collectively and individually throughout the educational process, the source of vocational motivation can become a sustaining principle of learning enhancement which helps resist the broader societal pressures - of politics and economics - which were outlined in Chapter 2 and which colour staff perceptions as will be shown in Chapter 6.

Conclusion

When the DfEE conducted research into individual commitment to learning the then Secretary of State's guidance was that: "Individuals must be persuaded that training pays and that they should take responsibility for their own development" (Tremlett and Park 1995: 35). Such an exhortation appears naive, unrealistic, untheoretic, partial, deceptive and biased. Where is the evidence, as far as some individuals are concerned, that training pays? Can and should individuals be persuaded of something that contradicts their experience? How can individuals take responsibility for their own development, if they cannot control those institutions within which (it is assumed) that development must take place? Perhaps individuals are concerned about their own development - it is simply a different view, based on a different set of

values, to those which we (in HE) espouse and who is to say they are wrong? At present such an anticipation of the connection between training and rewarding work appears to hold for most nursing students and for many in health professional education generally, but there is no guarantee that it will remain so in the future.

A "free market" is as impossible in education as it is in the provision of most other public resources. Government funding controls and centralised management has dictated the institutional motives that are regarded as acceptable. Funding justification and administrative requirements have been set up as the dominant stakeholding rationales for higher education. The main participants - students and staff - have had to subordinate their idealised motives to those of the institutional provider. In health professional education in recent years human resource motives have dominated. Trained output or requisite numbers to meet the needs of demographic change and consequent health service demands overshadow any other institutional goals, leaving little time to consider the learned effectiveness of those human resources.

Personal growth and the progress of a discipline are only acceptable motives if secondary to the achievement of qualifications and the accomplishment of rated/credentialised professional development. If individuals are not convinced that credentialism is a primary motive for participation, then they will not participate. If individuals accept the rhetoric of credentialism, then educators will have to live with the possibility that content remains secondary to the instrumental achievement of the necessary qualifications. Higher education has largely surrendered to a government and employer-dominated rhetoric which it has failed to challenge and then wonders why it has problems motivating students! It is this institutionalised attribution complex which may have to change.

Noel Entwistle in his concluding comments to a 1997 SEDA conference on student motivation said "We know how to support high quality learning - but not how to change attitudes, behaviour and institutional contexts." I would contend that we do know how to do all these things, but we do not do it. We all know that the ideals of higher education are fine in an ideal world. But the realities of finance, politics and administration constrain both students and staff to realise that they may not be able to afford the luxury of ideals. The learning dialogue between educators and learners is

the vehicle through which the compromises between the ideal and the real are conducted.

As educators, we are being dishonest both to students and to ourselves if we pretend that the university ideal can be maintained in the face of inhibitory political and economic constraints. Further, we would be being unfair to students if we expected them to hold the highest ideals in the face of the practical need to adopt the most effective learning methods for succeeding in the contemporary higher education system. When students cheat, plagiarise or manipulate the system it is not they who have failed, but us - since we did not or could not resist the encroachment of short-termist, credentialist views of the learning process. If that were never true of university, that the ideals could never have been lived up to in the modern world, then we must say so. If we truly believe in them, in spite of external constraints, then it is important to encourage students to match our ideals through words and deeds.

I would want to re-cast the Secretary of State's earlier statement as follows: "Individuals must find it possible to hold the conviction that learning has rewards and that they can take responsibility for their own development." The learner narratives analysed here reveal that, at least in the early stages of a course, such conviction and willingness to take responsibility exists.

Nevertheless responsibility for learning must be a shared one. The educator necessarily mediates between the learner, the discipline and the institution. The experience of learning and, therefore, the quality of the experience, is conditioned by the educator's mediating role. It is easy to cultivate further cynicism and disenchantment in a cynical and disenchanted world. The challenge is to revitalise the ideals of higher education and the pursuit of knowledge within a discipline - having the courage to admit and defend our learned values. Learner responsibility is a joint accomplishment of learner, educator and institution. If we cannot control the environment than at least we can influence how the learner experiences that environment. Chapter 6 goes on to consider the educator's role in this relationship while Chapter 7 concludes with recommendations for practice emerging from the analyses conducted here, alongside those reported earlier in the thesis.

Reflective Commentary - 5

Planning and Concept Formulation

I felt that there had only been partial success with addressing issues of learning style and method reported in Chapter 4. Something was still missing in my attempt to access the learners' understandings of what constitutes a favourable learning environment. This seemed an opportunity to draw in work I had been doing for many years in formulating a sociological approach to motivation. Motives are clearly vital to effective learning and they seem sure to influence the experience of the learning environment.

The conceptual, theoretical and methodological elements of Chapter 5 represent a highly condensed perspective on an approach to the sociological conception of motivation and was, in one sense, the most difficult section to write. To have explained fully the background to this perspective would have required quite a few more thousand words and would have produced considerable imbalance in the continuity of the thesis. Instead I was summarising an attempt to establish an approach to motivation that I have applied to the experience of health and illness, the stigmatised identity, personal development and adult learning. Even though I have managed to publish some aspects of this work there is resistance to the approach from some sociologists. I did not feel that this thesis was the place to attempt to resolve these issues; instead I used this ongoing project as another vehicle for testing my ideas.

I wanted to get as close as possible to the students' authentically produced motives – not something contrived by a focussed questionnaire, not something produced in awareness of institutionalised prescriptions and certainly not something that was not meaningful from the students' points of view.

I have to admit to "burying" some of the emergent concepts in this approach within the preliminary theoretical discussion for Chapter 5. There is the assumption that motive accounts have a routinely context-specific narrative structure. The morphology of narrative is worthy of much further study and although I favoured the

Burkean framework the possibility that other narrative structures might apply should be considered. Other latent concepts included the idea of the "threshold of acceptance" – in any dialogue what is the boundary for the acceptance of one motive account over another and who determines such a boundary? Similarly the idea that there might be an "institutionalised attribution profile" which influences the stability of motivational narratives is worth investigating. Yet this phase was just one element in my overall project and there was inadequate space or time to pursue it fully. For example, with some thought it might have been possible to fit Knowles' andragogical principles into the narrative framework. Elegance in research design was, however, sacrificed in my concern to generate results that could be of direct use to the enhancement of the learning environment.

Acting

My colleagues readily concurred with discontinuing the learning styles questionnaires. On balance it seemed excessively time consuming given the teaching and learning products it generated. What I needed was to encourage the students to produce their motive-disclosing narratives willingly, to not have them excessively influenced by awareness of institutionalised legitimacies and to have both students and lecturers value the exercise. The idea was to have them write something about their motives very early on in the course and use that exercise to introduce themselves to their personal tutor, while the personal tutor not only gained insight into the student's commitment but also could assess their writing abilities and needs. So I had the data I needed for narrative analysis, the students felt that their views were valued and any writing problems could be identified and dealt with before they became too big a problem for the student. In fact some of my colleagues commented on how useful the exercise was in terms of identifying potential writing problems with some students – since the exercise was conducted in class and spontaneously the students would have found it harder to disguise any deficiencies in their writing ability.

Reflection, Observation and Experience

Admittedly the students groaned when asked to do the exercise, but they had an open-ended session to write the piece and many stayed in the room for some considerable

time as they became absorbed by the task. The apparent cynicism and distancing from any "academic" exercise that goes on as part of the dynamics of a class belies the genuine student underneath. Given my lengthy experience in adult education I suppose I should have known better – what the students say in public is frequently quite different to what they share in private – even with their tutor.

I was genuinely impressed by the conviction displayed in the essays. As I wrote in Chapter 5, they were emotionally charged, insightful and, occasionally, inspired. The requirements of data analysis, even for qualitative research, does a necessary injustice to the richness of the experiences, attitudes and feelings reported. I was immediately concerned with the apparent disenchantment generated by the realities of their subsequent educational experience – whether in the classroom or in placement. I wished I could have found an immediate way to sustain their initial enthusiasm. While this might have happened in the personal relationship between tutor and student, it was not so easily maintained in more public arenas.

Unfortunately since my project was time-limited I moved on to other work, discontinued the "data" collection and I suspect that the writing exercise no longer occurs. In spite of its value this is further evidence of the stress upon staff and the prioritisation of more urgent, if less important, tasks. Their energies and mine could not continually stretch to the maintenance of "good ideas" if those ideas mean more work. Thus the fate of previous good ideas can be explained as a time management problem as much as anything else. Plans to further integrate the curriculum, for shared learning across disciplines, for a research-based community study, for a sustained approach to lifelong learning all fell by the wayside. Even the entry level text book I had gained the contract to write was not supported so I ended up writing it myself with the other sociologist on the staff.

By this stage in this ongoing project it would be fair to say that I had become somewhat disillusioned. Successes were noteworthy but unsustained. But I would not want to give the impression that teaching and organisational quality was particularly poor. Instead I believe that colleagues gained confidence in their own abilities and "did their own thing" with greater assuredness in much the same way that most

university departments operate. That may not be the best way to run health professional education.

Testing Implications

It seemed evident that the key to sustained improvements in the learning environment lies with the permanent staff. If they display cynicism and disenchantment it is easily revealed in their work, in their perceptions of themselves and in their reactions to the students. I had been reading about the concept of the learning organisation and felt that this might be a way forward. How far did this learning environment match the standard criteria being set for the achievement of a learning organisation? Already my personal experience suggested that this was an organisation that did not learn well. Once more I need a vehicle for taking my project into its final phase – a way of ascertaining staff views and concerns. This concept provide a focus for the next stage in the project.

Chapter 6 Facilitating Learning: the Caring Learning Organisation

Introduction

Previous chapters have demonstrated broadly, and in terms of some specifics, the nature and extent of the problems the educators of health care professionals have been faced with in recent years. Incorporation into higher education has led to great organisational and individual upheaval. Earlier accounts within this thesis of the organisational development of the School and the Faculty have been largely descriptive. This chapter considers some of the problems associated with the individual and organisational strategies adopted to confront the demands of such change and reports on the action research interventions aimed at ameliorating some of those problems. The means by which we tried to meet the "idealised" goals that were collaboratively set both for research and for educational development will be examined.

A particular focus is placed here upon the concept of a caring learning organisation and how some of the main organisational and personal dilemmas in contemporary health professional education may be addressed. The aim is to identify obstructions to organisational progress, outline reasons for their existence and suggest ways in which they may be overcome in a move towards a model for evidence based practice in the education of health professionals.

This part of the thesis is based upon the premise that organisations which primarily exist to cultivate caring skills should exhibit a caring ethos and practice caring skills of their own. In the same way, if an organisation exists to fulfil an educational purpose, to encourage others to learn and to learn how to learn, it seems reasonable to expect that it should be able to learn itself. Thus organisations whose primary function is to educate health care professionals to a high standard could be expected to epitomise principles of caring and of learning. My experience, comments made by practitioners and educators together with the primary research and the research literature reported here suggests that some of these organisations have difficulties in caring about learning while their participants (customers/staff/students) are learning about caring.

The typical difficulties which have emerged include occupational insecurity, uncertainty about health service structures, challenge to traditional approaches to care and to learning about care and adaptation to large scale curricula change (Cadman 1997, Hughes 1992, Iphofen and Poland 1997). As has been reported already in this thesis, the strategies adopted to confront the demands of such change include "flattening" of traditional health care educational management hierarchies, more participative curriculum development, student-centred and problem-solving learning, multi-professional and multidisciplinary course delivery and the cultivation of active research cultures within traditionally passive didactic educational settings. Under such pressurised circumstances organisations could be excused for being a little less than caring and not so effective at learning. However, they fail to seek their institutional "missions" if they do not, at least, try to care and to learn. In looking at the nature of uncaring organisational behaviour with reference to certain critical incidents in organisational change, this chapter seeks to suggest some ways in which a learning and caring organisation might be created.

Critical incidents in vignette

Examples of critical incidents which coloured decisions about how to proceed will be offered in vignette form in this chapter. Vignettes are frequently employed in a complementary manner in qualitative research, although no precise definition or procedural guide exists in the literature (Barter and Renold 1999). They are frequently used as exploratory stimuli or "prompts", but they are used here in the "... interpretation of actions and occurrences that allows situational context to be explored and influential variables to be elucidated" (Barter and Renold 1999: 1). In this sense they can be seen as "Stories about individuals, situations and structures which can make reference to important points in the study of perceptions, beliefs and attitudes" (Hughes 1998: 381). Care is needed with the construction and employment of vignettes, even in the context of a multi-method approach (Faia 1979). Consequently these incidents are presented in summary outline form primarily as illustrative of the problems being highlighted. They are drawn from accounts, documents, diaries, memos, letters and reports compiled during the research process.

Varying amounts of documentary evidence is available to support these outlines, but this is not made available here for several reasons. The incidents typically emerged in problematic contexts when either the organisation or individuals were being critically commented upon. There are dangers of perpetuating a malign discourse that is part of the very problem to which this thesis is addressed. The prime justification for their inclusion lies in the problems these vignettes disclose and the principles that they highlight. They are used in the fairly safe knowledge that this thesis as it presently stands will be read by a fairly narrow audience.

These incidents are by no means exhaustive of the events that have influenced the dynamic of organisational progress. It is also to be appreciated that the incidents will have multiple perspectives upon them - from the main protagonists, different management tiers, or outside observers. Necessarily, as presented, they are dependent upon my interpretation as participant researcher. They are presented here in as neutral a manner as possible and hopefully indicate some added justification for the more explicit action research interventions reported.

Caring and learning in organisations

Given the interest in new paradigm management in health services and health professional education it seems odd that there is little literature on the concept of the "caring organisation". I take caring to include caring "about" and caring "for" all participants in an organisation by the showing of value and mutual respect and the meeting of reasonable human requirements. In general terms more humanistic management practices are supposed to have led to commercial, service and industrial structures which make claims for the centrality of human needs, global awareness and sustainable development. The epitome of modern management practice is to balance economics, ethics and ecology (Bennis et al. 1994). In spite of the rhetoric, the vocabulary of modern organisations remains abstract, with dehumanising expressions in which operations are "harnessed" or "critical" and a "distributed enterprise" can reduce ownership costs while maximising "manageability". In fact, proposals to "re-engineer" corporations largely refer to improving the ability of people to communicate with each other - an entirely humane goal. The proponents of re-engineering themselves point out that "Companies are not asset portfolios, but people

working together to invent, make, sell, and provide service" (Hammer and Champy 1993: 25).

More humanistic approaches might be expected of health service organisations, yet they have tended to import wholesale each of the developments made in management theory and practice, albeit at slightly one remove. This has always been because of difficulties associated with the economics of public health provision, the identification of the product or the service and the role of "workers" in health (Georgopolous 1972). Performance indicators in health organisations are necessarily of a highly nebulous and qualitative nature - patient satisfaction, pain, and health are the more notoriously difficult to measure. At least admission, bed occupancy and discharge allow more direct comparisons with, the input/output and unit cost models of hard systems organisational analysis and critical path management planning.

Such an approach was illustrated in the principles of "Good Management" advocated by Sir Roy Griffiths, deputy chairman of Sainsbury's supermarket chain and adviser on the National Health Service to the previous UK Government. He suggested health management needed to establish sound databases to avoid reliance on guess-work and intuition, effective analysis of changing client needs, the setting out of options and priorities and, finally, the ability to make decisions and to act "...there is too much talk, get on with things. Implement and delegate" (Griffiths 1991).

It would be hard to disagree with the informed flexibility that appears to offer sound advice for the management of any organisation. But much is neglected in such advice. Who determines needs, the range of options and priorities? Whose needs are being determined - only clients? What about the workers? Who delegates and who implements? Is action more important than thinking? For example, research on whether organisations which offer caring services can demonstrate in practice their ability to care for their own employees continues to find marked gender differentials. Males are still favoured for grade promotion and managerial opportunities despite structural changes in the health care market and in the work organisation which were supposed to reflect increasingly "woman-friendly" employment trends (Poland et al. 1996).

The transfer of such concepts to higher education is even more problematic. Humanistic institutions such as universities are supposed to seek free thinking, independent research and frank dialogue. Nonetheless, old fashioned managerialism is rampant and expanding in higher education structures. What is, perhaps, ironic is the delay between particular management fashions and their adoption and retention in higher education management. Total Quality Management (TQM) is slightly old hat in management circles now, but higher education is still struggling with the implementation of the concept and tinkering with establishing agencies which might ensure its effective operation. Thus both higher education and health service organisations have been inclined to import the more outdated organisational practices of commercial and industrial organisations whose primary purpose was not to care nor to seek the advancement of learning.

The concept of the learning organisation

The idea of the "learning organisation" goes back to the 1920s and has enjoyed a periodic resurgence throughout the twentieth century. Since the late 1980s the concept has produced renewed excitement and much research and writing, bringing together as it does personal and organisational development with some of the sacred principles of modern management - synergy, communications and quality (Hayes et al. 1988, Pedler et al. 1991). Productivity is no longer to be seen in business organisations as a mechanical issue of input and output, something which is relatively easy to measure in terms of the accounting costs of labour, capital and products. Efficiency (doing things right) is seen to be less important than effectiveness (doing the right things) - "... doing the wrong things less expensively is not much help" (Kanter 1983: 22). As spheres of economic control have moved around the globe manufacturing industry has realised that: "Our ability to learn faster than our competitors may be the only sustainable competitive advantage we have" (Steiger 1994: 265).

Cultivating a learning organisation is about facilitating the learning of all participants in the organisation, bringing together people who are seeking the same objectives and seeking to continually transform the organisation by improving how they achieve that objective (Pedler et al. 1988). "Corporate capability" is seen to be achieved by investing in individual training and development (Critten 1993). Charles Handy

argues that learning organisations are vital in an *Age of Unreason*, ".... a time when the only prediction that will hold true is that no prediction will hold true" (Handy 1989). Handy suggests that learning organisations can meet the demands posed by uncertainty by: permitting questions to be asked and theories tested; drawing on a "proper selfishness" in generating a clarity of role and direction; "reframing" the world and the organisation's place in it; "negative capability" which permits making mistakes as essential to learning with change; and, finally, evidence of "caring" responses which demonstrate trust - only then will people take risks (Handy 1989).

Attempts have been made to distinguish between the learning organisation and the concept of "organisational learning" (Jones and Hendry 1994). The latter is seen as based on the systems concept of "feedback" by which an aggregation of individual learning produces organisational transformation and is primarily found in the work of Argyris and Schon (1978; 1981). Argyris offers the example of "single loop learning" as acting like a thermostat that corrects error in the room temperature - it recognises "too hot" or "too cold" and turns the heating on or off accordingly. "Double loop learning" involves asking questions like: Why am I set at 68 degrees? Why does it matter that I measure heat at all?(Argyris 1982: xii) Sustaining such a distinction seems impossible since many of the principles of organisational learning are subsumed within the characteristics of a learning organisation. These characteristics have been lucidly summarised by Peter Senge (1992):

1) *Cultivating and being informed by a shared vision*: Imagined and desired futures must be envisioned by consensus. The principles and guiding practices by which the organisation attains envisioned futures must be devised and applied.

Incident #1: *The mission statement which I compiled for acceptance by the SNMS was constructed from a series of talks originally given by the Dean and Head of School which he, in turn, had drawn from a retreat in which the entire staff of the School participated. Unfortunately, a single mission statement was not compiled at the time (1992) and when subsequently presented to staff its consensus origins may not have been recognised. Nonetheless, after some modification it was unanimously accepted when presented for ratification in a School Board of Studies meeting in October 1997.*

2) *The construction and dissection of mental models*: There must be free, open, honest, coherent dialogue about attitudes, beliefs and actions. This must include all participants and be conducted without rancour. All workers' views must be respected. Those lowest down the hierarchy are often the first to recognise flaws in systems, services or products. Who would question the vital role of the receptionist in the presentation of a corporate image?

Incident #2: *A group of interested staff worked alongside an SEM to devise the "fast track" pre-registration Bachelor of Nursing, conceived as an access broadening and innovative approach to raising professional and academic standards. The WNB professional adviser was in close contact with all discussions and proposals, via the SEM, throughout the deliberations. There was considerable energy, excitement and interest in the innovation. Just prior to a joint validation submission to the University and the WNB, the professional adviser in an informal meeting withdrew support from some key elements without warning and threatened that validation would be refused unless these criteria were adhered to. The adviser announced that the numbers of students to be admitted were restricted (preventing open transfer from Diploma to Degree course for students performing to required standards); there was a requirement to fulfil the "usual" matriculation requirements for degree entry; the need for "extra" assessments to be completed by degree students was withdrawn; and all Level 3 work in the behavioural sciences was to be completed within 18 months of the start of the course (March 1994). Clearly the conceptual models were not being adequately shared by all involved.*

3) *A sense of personal mastery:* One of the key elements of andragogical learning is that people learn best when they hold an interest in the activity of learning itself, in learning about learning and in the objects of learning (Knowles 1980). So staff development should encourage the organisation's members to learn andragogically and develop in the direction of the goals and purposes they choose for themselves and create the results which they most desire. It requires ensuring that all feedback and monitoring is listened to and respected even if not adopted in the final accomplishment of goals.

Incident #3: *Failing to encourage personal mastery: a secretarial/administrative staff member asked for SNMS to pay her fees for an evening class on databases. The fees were £38. They declined. She attended the course out of interest, paying for herself. The following year SNMS needed someone to set up some databases. A manager remembered that she had done the course and then asked her to do the job, a job that would have cost considerably more to have had an outside consultant. She felt she could not have refused. Her course fee was not reimbursed.*

4) *Team learning*: Integration can be achieved when effective interpersonal communication takes place. Perhaps paradoxically such a devolved, team working system helps to avoid segmentalism. This represents the principle of synergy which refers to the "extra" learning that arises out of individuals working with (or drawing on the work of) others. Synergy is based on the idea that the intelligence and ability of the group is greater than the sum of individual members' talents - the whole is greater than the sum of the parts. "Something more" comes out of the team working together than anything that each one of the individuals possesses or can come up with. Innovation flourishes in team-oriented co-operative environments (Syer 1986, Kanter 1983: 28). Being alert to the signals of successful achievement of objectives is a requirement of team learning. It is argued that the essential qualities of good teamwork include a clear agreed objective, distinct and firm roles for all members of the team, dispensability (no one is vital - the team could continue without you) and trust between members of the team. Of course, for this to work the team has to be of manageable size (10 to 15 members). Anything larger and some of the classic dysfunctions of formal/bureaucratic organisations begin to operate; these include fragmentation, reduced trust, unintended consequences and the displacement of goals (Syer 1986).

Incident #4: *During curriculum development a working party of representatives from subject theme groups was set up with a brief to set an "integrated" (interdisciplinary) unseen exam paper which would substantially be testing a course strand called "The Development of the Individual". They provided a "model" format at their workshop which was largely agreed. They were then to go on to devise the actual exam paper with question and answer guide-lines being fed in from the theme groups (i.e. sociology, psychology and physiology) - as a result of inadequate liaison between the*

Chair of that group and a SEM, the latter seemed to have not been aware that this process was in operation and wanted an opportunity to veto the process. Similarly, inadequate liaison between sociology and physiology representatives and their theme groups led to some dissatisfaction with the question content and format - even though the original brief for the examination had been set by the examinations committee and had formed the basis of the assessment workshop. This is only one of many similar incidents in this period in which the initiating group or manager reversed the decision taken by a properly constituted "working group" which had consulted all relevant colleagues - it occurred with examinations, evaluations, and, most notoriously, with the entire curriculum submission for the periodic re-validation of Diploma and Degree courses - thus setting back the re-validation process by about a year.

5) *Systems thinking:* This entails a way of thinking and talking about systems as a whole (Checkland 1981). The analytic tendencies of most academic disciplines and most professional occupations tends towards thinking in fragmented ways - breaking down processes and situations into their component parts and neglecting interdependencies, collaboration and co-operation. Detailed actions must be keenly examined in the light of the whole system. Holistic approaches are particularly apt in the growing need to understand the connections and overlaps between health and social care. Integrative innovation requires seeing problems as wholes, related to larger wholes "...rather than walling off a piece of experience and preventing it from being touched or affected by any new experience" (Kanter 1983: 27).

Incident #5: *The SNMS employs an administrator (A) who is enthusiastically interested in project management and systems design, but "A" is not a senior manager and there are delicate matters of job description and commensurate pay associated with exploiting "A's talents in this field. So, despite the need for project management throughout the School, "A" is not employed in this capacity. This reflects a situation throughout UWB. There are "experts" everywhere but they are "engaged on other things" and, most certainly, do not receive career credit within the system for applying this expertise "outside" their appointed field.*

In a "systems" view of individual and group development each separate human being is a learning organism. When humans co-operate, or work in concert, they become a

learning organisation. One could read a crude organic metaphor into the implication that the organisation appears to be a living organism in its own right. Clearly it is not the organisation that learns but the individuals who constitute it who learn and who then maintain a structure in which what is learned is remembered and applied.

> "Organisations learn only through individuals who learn. Individual learning does not guarantee organisational learning. But without it no organisational learning occurs."
>
> (Senge 1990)

One important implication of this is the challenge to the "scientific management" idea that organisations need to be divided into thinkers and doers: the thinkers arrange and determine policies, the doers do not need to think but to do as they are told. Passivity amongst employees is challenged. All members of the organisation must be actively involved in organisation development (whether they like it or not!). Learning organisations are anti-elitist, asking for, expecting and valuing everyone's contribution.

The most successful structural mechanism for cultivating organisational learning appears to be the self-managing team with members who are all knowledgeable about all parts of the production process, have special expertise for their own part in the process and treat each subsequent stage in the process as the "customer" for their product. There still have to be clear points of responsibility but not the kind of rigidity found in the past, when even large formal organisations could operate effectively if they had strong and clear leadership and an authority structure commensurate with the organisation's goals. Contemporary organisations have to operate in a much more fluid, competitive and unstable environment. Reductions and restructuring are regular occurrences. Workforces are better educated with higher aspirations and expectations. Organisations can only survive and prosper if they exploit and reward the talents of such demanding human resources. This can only occur if the talents of all throughout the organisation are fully utilised - the focusing of such talents is only possible through smaller work groups.

Learning organisations are not merely better at coping with change, they create it and participate in it - a learning organisation has to be proactive, not just passive and reactive (Gourley 1995). Moreover, a certain vision of the participants is required - they are to be valued, respected, esteemed and listened to. Education spreads throughout all levels of such a work organisation creating pressures for autonomy, flexibility and freedom. Workers cannot be treated or regarded in the same "menial" way; they must be cared about and cared for (Kanter 1983: 56).

Problems in achieving such ends are inevitable: How is a consensus vision constructed? Does it come from the "top" down or is it drawn from all? There are wide variations in participants' abilities to envision or construct mental models. Peeke (1994) argues that it is essential to adopt participative methods in the development of mission statements, that procedures for operationalization are crucial, that broad dimensions of mission need to be agreed with the core of the organisation and institutional change must be linked with the development of a strategic perspective in education management. Given the plurality of educational organisations, he also argues that autonomy is necessary for significant groupings throughout the institution.

Mayo and Lank (1994) offer a schedule which addresses most of these issues and which can be applied to strategic elements in the organisational structure to identify points of strength and vulnerability. They systematically question policy and strategy, leadership, people management processes, information technology, supportive culture, personal learning, team learning, organisational learning and the extent to which learning is demonstrably valued. This schedule is applied to everyone in the organisation to produce a comprehensive rating scale for the whole organisation. Ironically it makes the Teaching Quality Assessment (TQA) exercises of the UK central funding councils look crude and amateurish. So much so that there are reasons to doubt the extent to which universities can even claim to be learning organisations (see Duke 1992).

The achievement of personal mastery could present a challenge to traditional leadership hierarchies and to those individuals who may be low down in the hierarchy. Both, in different ways, depend on the security of a rigid bureaucratic structure. What are the boundaries to the team? Where are the professional and

intellectual *communities* of interest? This can be a problem for academics and health care professionals alike. Who can, do and should we talk to and be influenced by? (Iphofen and Poland 1994) Systems thinking evidently makes a great deal of sense but may be challenging to accomplish. It requires a fairly sophisticated view of organisational workings and the adoption of complex combinations of individual and collective responsibility (O'Connor and McDermott 1997: 220). It is through such a perspective that the workings of teams and individuals become incorporated into the whole organisation. It is not hard to envisage difficulties in applying the concept of the learning organisation to health service organisations and to health professional education. It is such an application that I wish to address next.

Organisational strategies in health services and in the education of health professionals

The quality of worklife (QWL) movement within health services management did introduce principles that resemble the concept of a learning organisation. Some of these translate easily from health services to health professional education. A seminal work by Menzies (1970), for example, pointed to the contradictory organisational goals in educating nurses in a teaching hospital. The primary goals of the hospital could not match the primary goals of the nurse training school. In spite of radical changes in nurse education since then, similar contradictions in goals remain. The concern with targeted recruitment and effective selection processes together with student-centred orientation and developmental practices are intended to improve student retention rates. Funding agencies are keen to operate such principles for the students - applying wastage formulae to lay the responsibility for student retention at the door of the educational institution - but they show no concern to apply it to staff "wastage" in higher education, nor do they see the effect on quality that an obsession with accounting criteria might have.

A concern with job satisfaction is central to total quality management (TQM). Correspondingly, repeated student evaluations are an inevitable consequence of TQA. But how often are staff opinions on job satisfaction sought? It is assumed that they must be satisfied since they chose to make the move from clinical practice into education. Education once was held in higher esteem, rewarded more highly

financially and offered a more conducive working environment. Now many lecturing staff are considering a return to full time practice to avoid the increasing stresses of academic life. Thus although career development planning and advice are assumed to be an essential part of the educational function, inadequate time is given to staff appraisal which has individual development - not just corporate interests - at its heart. TQM is often adopted as a means of securing culture change, part of the process of seeking the consensus gained from a shared vision. It is hard to see how this can be genuinely accomplished merely by top-down information giving, nor by the external or hierarchical "application" of a vision without it emerging from a true dialogue.

With the "flattening" of traditional (educational) management hierarchies gaps are left in previous line management structures. Until the mid-1980s staff knew their places in clearly defined bureaucratic hierarchies. Any flexibility in nursing schools depended on the management style of the Director of Nurse Education. While more participative decision-making strategies in, for example, policy and curriculum development have been encouraged, staff have been initially unfamiliar with the decision making structures in higher education. The immensity of the cultural change in preparing staff to learn how to participate effectively in such structures is something akin to the problem that faced emerging Eastern European democracies.

Job analysis, job specification and alternate work patterns are vital to the QWL movement. Exactly how much flexibility is there in the actual production of work? Workplace culture can be oppressive and inhibit the emergence of flexible working practices. The chances of establishing a HE culture of autonomous professional workers may be more difficult than one might imagine. Student-centred and problem-solving learning are proposed in almost ritual incantations. Yet full learner autonomy has to be curtailed in health care training given the need to licence practice and the concern for public safety which remains in the minds of the educator. Multi-professional and multidisciplinary learning are almost equivalent ritual phrases. But while multi- or inter-disciplinary health care teams operate in clinical practice, there are radical imbalances of power in strategic decision-making. This makes multidisciplinary training unrealistic. Both epistemologically and practically there remain professional territorial boundaries.

Incident #6: *The role of the "specialist" lecturers appointed to work within SNMS was never adequately explained to their colleagues - nor were their colleagues adequately aware of their own responsibilities (and powers) within a HE structure.*

The specialists felt they had been given responsibility without power. So they had frequently to confront problems which were referred to by colleagues and senior education managers as ones of "ownership". They were seen as potentially threatening to the job security of their colleagues - whose fears for the future became focussed on the specialist lecturers and their accomplishments came to be seen as threats to their own control of their elements of the course. The rights and responsibilities which were assumed by the specialist lecturers were not seen as something which their colleagues felt that they too could assume. Thus they were "criticised" for ... "...being involved in everything.." and "...taking too many initiatives" and were excluded from some developments because of their "...tendency to take things over." When the re-validation of the degree course was due, one of the nurse lecturers reported that she was encouraged by a SEM to take a lead in the process "...to prevent the 'ologists from gaining control".

In a similar vein the cultivation of active research cultures within traditionally passive didactic settings sets up many paradoxes. The freedom to generate ideas and methodological procedures is constrained both practically and ideologically. Research requires time and funding, and it is frequently taught in unimaginative, perfunctory ways to those now required to practice it professionally. Moreover, as novice researchers are just starting, the research funding process is becoming increasingly elitist and dirigeist as a consequence of both the implementation of the Culyer recommendations for research funding in the health service and the elitist HE Research Assessment Exercise (RAE) upon which they were modelled. Medical schools with reasonable research performances, but which had not progressed since the last RAE, have had their central funding cut by 10% (Hinde 1997).

Finally, the move from traditional localised ties to service providers and their workforce needs to an internal market (purchaser/provider) requirement created many economic and educational contradictions. How can long term educational planning be

conducted when purchasers may make their "product" judgements in the shorter term? (see Stamps and Duston 1989; Hughes 1992)

Incident #7: *The SNMS has argued for some years that not enough money was being allowed to recruit enough students to ensure adequate labour supply to meet service requirements. In 1997 the EPU asked SNMS to recruit 30 more students a year to meet a labour shortage in nursing staff in two of the North Wales Trusts. Having been forced to cut lecturing and support staff, with inadequate lecture room sizes and with pressure on existing placement opportunities, in the interest of teaching quality the SNMS argued that they could not meet the demand for extra places. Subsequently the EPU simply took the contract to a competitor HE institution which accepted the opportunity for its own economic and political reasons and which has to share its clinical placements with SNMS, leading to pressure on placements which was one of the quality issues SNMS had expressed concern about to EPU.*

Organisational strategies in SNMS

On average in its early years the School had about 1000 FTE students in any one year and 80 teaching staff. A comprehensive statement of strategic intent and direction was drawn up by the HoS in May 1993. While many issues it addressed were dealt with in succeeding years others remain problematic and this document was never systematically employed to establish performance indicators or even less specific measures of achievement. Early teething problems were targeted by University appointed management consultants who produced a report which was viewed critically by senior management and lecturing staff alike (AIMS 1994). The general response was that the Report betrayed a failure to appreciate the culture, traditions and professional demands of health care educators and seemed prepared to sacrifice such a tradition to the urgent requirements of university incorporation. The only elements upon which there seemed general agreement were: removal of an intermediate management tier, enabling senior managers to return to teaching, removal of administrative divisions (such as between pre- and post-registration education), and the encouragement of participation in research activity for all members of teaching staff.

To assess and control the impact of the most recent organisational changes the School set up its own action research project. I took advantage of this opportunity and offered active participation in this project with a view to incorporating its outcomes into the present thesis. A mission statement was drawn up and a performance indicator checklist established with the goal of attempting to measure the extent to which the mission is achieved. Both the mission statement and the performance indicators will be used to assess the degree to which the organisation cares about its members and can learn how best to progress the further development of the organisation. Interim reports linked to the arguments and evidence of this present Chapter have since been made. The work is ongoing and has been delayed as indicated in some of the processes revealed in the preceding vignettes. It is hoped that the work on this evaluation project will culminate in a one day strategic planning meeting of the full School in the year 2000.

Obstacles to caring and learning

For reasons such as those emerging above it seems that health care and health professional education organisations find it hard to practice what they preach. That is, they do not appear to have learned and learned to care. What stops them from achieving these ends is, as Argyris suggests, the difference between espoused theories and theories in practice (Argyris 1993). His first theory-in-practice has four governing values:

1. Achieve your intended purpose.
2. Maximise winning and minimise losing.
3. Suppress negative feelings.
4. Behave according to what you consider rational.

The most prevalent action strategies that follow from this are:

1. Advocate your position.
2. Evaluate the thoughts and actions of others (and your own thoughts and actions).
3. Attribute causes for whatever you are trying to understand.

Such strategies require a degree of openness that is perceived not to exist in SNMS, nor as it happens, in many health service contexts. It might appear to be common sense to care for and value all the participants in an organisation, but old traditions die

hard. Management theorists once believed, in line with scientific management principles, that effective organisations were efficient ones and that efficiency could be accomplished without caring for the humans in the organisation. While human relations and the soft systems theorists have influenced health care management to some extent, paradoxically it is health care organisations that have been slowest to change towards the introduction of caring principles (see Walby et al. 1994).

"Generally speaking we find that people perceive correctly their immediate environment. They know what they are trying to accomplish. ... They are sensitive to the power structure of the organisation, to traditions, and to their own personal goals and welfare.." (Forrester 1971: 272) Of course participants can give sensible reasons for what they are doing, they are trying as hard as they might to solve the problems and are each pursuing policies which are intended to alleviate the difficulties. But it is in the very interaction of these policies that the crises are created: "In other words, the known and intended practices of the organisation are fully sufficient to create the difficulty, regardless of what happens outside the company or in the marketplace." (Forrester 1971: 273)

Argyris suggests how the development of a learning organisation is inhibited by defensive strategies adopted by participants at all levels in the organisation. Defensive routines emerge as a consequence of "single loop learning" - knowledge is turned into an action strategy which has consequences which, in turn, affect the actionable knowledge. But they tend merely to reconfirm existing knowledge unless they are framed by a master program (i.e. broader governing values) which provides the basis for "double-loop learning" and the ability to allow modified actionable knowledge to emerge (Argyris 1982). Single loop learning tells people to "...craft their positions, evaluations, and attributions in ways that inhibit inquiries into them and tests of them with others' logic" (Argyris 1993: 52). The consequences are defensiveness, misunderstanding and self-fulfilling, self-sealing processes.

Menzies (1970) showed how such defensive routines were originally established to protect the nurse from the stresses of the job. Task-oriented work was a way of separating the nurse from the patient, depersonalising both nurse and patient and encouraging a detachment from damaging feelings which inhibit effective clinical

practice. Obsessive and ritualised task performance removes the need to make decisions and redistributes both responsibility and irresponsibility. Ultimately the impact of responsibility is reduced by delegation to superiors and a necessary reduction in the possibilities for personal development.

Menzies also showed how the tasks and emotional difficulties of nursing alone do not account for the level of anxiety and stress associated with the profession. Its social defence system also institutionalises basic psychic defence mechanisms which attempt evasions of anxiety without modifying or reducing it. The defence system produces many inefficiencies in nursing service: it keeps the staff/patient ratio unduly high, it encourages bad nursing practices, it leads to excessive staff turnover, fails to train students adequately for their future nursing roles, has adverse effects on recovery rates, anxiety in nurses heightens the stress of hospitalisation and illness experienced by patients (Menzies 1970).

Her concluding proposition is that "... the success and viability of a social institution are intimately connected with the techniques it uses to contain anxiety. ...(and) .. an understanding of this aspect of the functioning of a social institution is an important diagnostic and therapeutic tool in facilitating social change" (Menzies 1970: 39). It is ironic to note that her proposed solutions included increasing staffing levels to allow adequate training time and establishing a nurse education system which would allow students to train across levels of competence and then be appointed to perform tasks appropriate to their trained level of competence - something only fully accepted in recent Government proposals (DoH 1999). As Menzies pointed out, however, in such a context change becomes another source of anxiety and the need to control continual crisis is held as a threat in terms of the fear of not being able to cope. In this way nursing staff are deprived of opportunities for personal development and the kind of job satisfaction that led them to seek such a vocation in the first place.

Nearly thirty years later similar practices in health management and in professional health education continue to stand in the way of constructing the learning organisation. Scientific management and traditional differences in work culture and practices linger in many areas. Walby and Greenwell (1994) show how the working patterns of nurses and doctors have always differed despite the need for them to

engage in teamwork. Nurses are tied to wards and fixed shifts and breaks. Doctors move between wards, are on call and can take breaks regardless of time. The two professions traditionally bear different relationships to the major management theories. Nursing has been dominated by principles of scientific management, while medicine has always had a structure more likely to fit into soft systems theory. The balance between care, treatment and relationships with patients remains contested in the boundary between medicine and nursing. Junior doctors' roles may be threatened by the extension of nurses' roles. Elsewhere the growth of specialisms in radiography raises questions about the radiologist's role. Physiotherapists too may have to change practices as chiropractic and osteopathy gain state recognised legitimacy.

Traditional power bases in management and in decision-making are slow to erode. In health care management a major area of conflict has long existed between doctors and managers. Managers drive to improve bed occupancy rates, control ward budgets and increase patient throughput. The line of accountability becomes obscured by the distinction between clinical and administrative demands. Devolution of financial accountability is supposed to take decision-making and prioritising of health targets down to the patient level, giving rise to even greater tensions in the workplace. Disputes over who controls treatment, task priorities and mundane duties like cleaning and tidying are inevitable.

Incident #8: *On a few occasions lecturing staff received a note from a junior administrator reminding them to leave the classroom tidy, stop students from consuming drinks and food in class and ensure the windows were closed, the blinds down and all lights off when they leave the room at the end of the day.*

It should not be surprising that such concerns carry over into the education field. Senior academic and management appointments were awarded to people who lacked lengthy HE experience. This in itself need not be a disadvantage except they may bring along the sorts of bad practices from their health services management and professional health education experiences discussed here. Cadman's (1997) plea for leaders who can bridge the cultures of "theory" and "practice" is somewhat symptomatic of this. Much could be gained from the appointment of "new-paradigm

managers" who possess "... individual self-mastery (competence and uniqueness), foster social synergy (flow and connectedness), engender organisational learning (history and development), and engage in sustainable development (information age and living planet)." (Bennis et al. 1994: 7)

Again the present Government appears to be endorsing the search for leadership. They are calling for an inspiring, visionary leadership that will take risks and challenge orthodoxies. "Strong nursing, midwifery and health visiting leadership is needed at every level. It is needed to drive forward interagency and multidisciplinary team working, to improve quality and practice through clinical governance, to lead public health initiatives, to plan and commission services locally through Primary Care Groups and Trusts, and to provide effective management of clinical services and corporate functions" (DoH 1999: 52). It might be harder to find such leaders than is supposed and, in any case, a dependency upon leaders might reverse much of the gains that were hoped for in the move to HE (Iphofen and Fonseca 1997).

While leaders with some fresh ideas and imaginative solutions would be welcome, their inherited culture is not innovative, partly for the following reasons:

- Assumed hierarchies of knowledge and competence linger. There is still a view of the clinical as superior to the 'merely' theoretical, the scientific to the humanistic, the quantitative to the qualitative, the randomised control trial to the survey or ethnographic observation, the medical superior to the caring.

- Educational amalgamation has occurred without much ideological legitimacy. In some quarters conviction and commitment to transfers have been lacking.

- Curriculum content, structure and development is still largely centrally directed by professional bodies. (GMC, UKCC, ENB and WNB - a model now also adapted by emerging national professional bodies in osteopathy and chiropractic.) This varies in rigidity and room for manoeuvre and may presage similar changes throughout the HE curriculum.

- Student-centredness is difficult to apply given the need to train in requisite skills and to meet specific workforce requirements.

- With new dominant sites of caring (in the home and community) the organisation which has to learn gets broadened - possibly uncontrollably - although the appearance of a "learning society" would facilitate less formalised organisational learning structures.

- Accountability remains problematic in light of a more managerially inclined HE system.

Incident #9: *While the formally constituted evaluation process was underway there occurred several blocks to actually getting the organisational evaluation questionnaire circulated to all staff. It was delayed and blocked by Senior Managers on three occasions. This probably accounts for almost nil response rate - it was no longer timely and in the minds of staff.*

- Organisation goals potentially contradict professional requirements. There is pressure to do research without research experience; pressure to maintain skills of clinical practice without adequate time or resources.

Incident #10: *Contradictions in institutional goals: A "fast-track" BA in Nursing Studies was negotiated with the University and WNB. With some imaginative timetabling and curriculum design, it was found possible to run a course for about 20 degree students concurrently with the Project 2000 nursing diploma. The EPU informed Senior Management that "we were not being paid to do that - we were being funded to produce a certain amount of Diploma students". The argument was made that the Welsh Office were getting some extra degree students for the price of diploma students but their view was, simply, they had not asked for degree students! No further detail was provided leaving the assumption to be made that NHS representatives on EPU feared potentially higher labour costs for degree qualified staff and/or that they may prove troublesome by engaging with the system more critically. For whatever*

reason, educational cost effectiveness and widening of access was sacrificed to bureaucratic expediency.

- Finally, can it really be assumed that all this is done in the interests of the patient? Professional educational organisations have other goals which are more immediate to them. Some nurse lecturers, for example, find it hard to admit that they are no longer practitioners of nursing but primarily practitioners of education.

Managers may be inadequately trained to manage such complex structures. In learning organisations, communication cannot just mean the provision of information, it must also mean dialogue. Managers require an ability to discover and establish a vision and its associated values, they have to cultivate the awareness of process problems and not just output concerns, and they are required to balance the interests of other participants in the broader organisation. For example, the diverging goals of meeting the vocational aspirations of the student, the human resource demands of the health service, and the research and teaching expectations of HE have all to be reconciled. Central funding agencies pay for teaching to meet labour power needs, not for research. Excellence in research is a criterion for university success, but unit cost calculations such as staff-student ratios are measures of teaching accomplishment. The chances of meeting either sets of goals are necessarily diminished by such a contradictory logic as too are the opportunities for lecturers to attain career success. The only way to overcome this is to construct an organisation in which the goals to be achieved become a fundamental part of the means for their achievement. What follows are recommendations which might assist this process.

What would a caring learning organisation look like?

Charles Handy suggests that organisational problems emerge from imposing structures which are inappropriate for the culture (Handy 1985). It may be that inherent features of academia make such a caring/learning organisational structure impossible for some types of health care professional. For example, Helga Drummond has suggested that it is hard to gain positive feedback in academia. Activity cycles are long and failure may follow months or even years of intense commitment - "...the lows in management are seldom prolonged or deep... in management there is always

another crisis to take your mind off the last debacle" (Drummond 1991). Indeed some of my colleagues have pointed to the dangers of promoting ex-ward sisters to senior management. Ward sisters may have to adopt a crisis management style to survive in the acute care arena (again see Menzies 1970). If a crisis does not exist in another management context then it may become necessary to create one in order to demonstrate management competence. It may be that a strategically positioned, well-trained and astute organisational developer could institute mechanisms for the cultivation of caring and learning (Welborn 1989). Whether the culture of health professional education can permit or even encourage such a management style is another matter. Indeed, some of the above critical incident vignettes and the obstacles to progress they represent may be understood in this light.

Most of the work looking at caring in education is concerned with curriculum content, with methods for incorporating concepts, techniques and practices into the curriculum (Leininger and Watson 1990). Little is written about whether the experience of education itself is a caring one. This depends upon whether organisations offer a caring pedagogy or andragogy or, even, a "caring curriculum". Drawing on a number of sources (listed below), I would summarise the criteria for a caring learning organisation as follows:

1. *An affiliative attitude:*

Warm, supportive attitude to customers, employees, distributors, suppliers - if something goes wrong it gets sorted out almost regardless of financial considerations. There needs to be mutual trust between participants and the means for identifying and responding to organisational stress must be provided.

2. *Respect for the individuality and difference of others:*

Firms which go to some trouble to protect their workforce (e.g. from redundancy) and offer health schemes or sports and leisure facilities can generate high levels of loyalty and commitment. Difference and disagreement can encourage innovation when bounded by respect. Recruitment should be based on "potential competence" not

merely a narrowly specified range of skills. Responsibility and autonomy provide empowerment which in turn produces a feeling of self-worth.

3. *Open communication:*

Frank acceptance of negative as well as positive aspects of human nature and dialogue within and between groups is necessary. Networks of communication with professional bodies, customers etc. enable participants to remain fully informed of needs and developments within the environment and so that they can respond to change and can innovate within the organisation. Properly negotiated learning outcomes and contracts keep working relationships out in the open and offer the basis for mutual trust in those relationships.

4. *Balance between freedom and order:*

While those in senior management must take executive responsibility, they could fully consult the lower orders before taking key decisions. Participants can work with some independence although accepting some delegation of duties. Contracts must stress a degree of security.

5. *High level of spontaneity, fun and enjoyment:*

People in the organisation should enjoy each other's company and the work activities engaged in. There must be room for imagination and creativity. As with all games, continuous learning opportunities must be offered, these are not mere "pastimes".

6. *Some kind of "transcendental value system":*

There must be an ideology or belief system which provides an overarching framework which drives the organisation forward and permits members to cope with loss and change. A professional caring approach to the tutor-student encounter is essential to such a value system. In-house health audits and health support programmes offer examples of how this might be achieved - yet this is surprisingly rare.

7. *Stimulation, challenge and hope (i.e. prospects):*

The work must offer a challenge which stimulate skills development. Opportunities to engage in career planning so that participants can become can become self-guided professionals and take part in job re-design.

8. *Rewards:*

Benefits and rewards would have to be flexible enough to meet changing personal requirements as the individual and the organisation grows and develops.
(These criteria draw upon Appleton 1990, Cooper and Williams 1994, Halldorsdottir 1990, Newell 1995, Skynner 1983, 1991 and 1996)

I found it noteworthy that these criteria consistently emerged in the specific action research intervention now described - the vision workshop.

The vision workshop: technique and background

As part of the broader process of developing a strategic plan for the School and the establishment of new decision making procedures a decision was taken to adopt a "vision workshop" approach. The technique seemed apt as part of this strategy to assess the organisation's current situation, review and prioritise strengths, weaknesses, opportunities and threats. The technique has been used in similar ways to formulate mission statements which encapsulate institutional goals and to define strategies, programmes and activities that help in the achievement of those goals (Hayhoe 1994).

The vision workshop is a group-based technique for developing a shared plan between several individuals, interest groups or organisations which has been used in a range of health service, educational and private organisational settings (Hancock 1988; Dowrick and Sainsbury 1995). These "interest" groups could be competing stakeholders in a range of ventures whose interests do not necessarily coincide, but who need to relate in some way to the other stakeholders. In our case, as a series of meetings between lecturing staff within SNMS, it can be assumed that the participants were similarly placed in terms of stakeholding, but not necessarily that all individual aspirations were held in common. Thus a degree of openness to a range of possible aspirations had to be assumed.

A vision workshop is not a forum in which decisions can be made since it has no formal place in the organisation's decision-making structure, but it is an opportunity to discuss ideas and issues upon which the decisions staff do eventually participate in taking will be made.

In essence the task involved constructing scenarios of what staff would like things to be like in the ideal working world of nurse education. This was then related to the present situation as perceived by the group and followed by discussion of what is achievable with adequate planning, foresight and appropriate decision making. Put simply we looked at "what could be, what is and what might be" (Mason 1994).

As facilitator, in instructions to the groups I explained that my concern was to try and run the sessions as if I was an outsider to the organisation. I asked participants to try to put aside any specific current agendas they might hold for the time being. Participants were asked to be as open as possible to others' views while respecting the usual expectations of safety and trust that make for effective group work. It was explained that there would be a lot more writing than is normal in group work and that individual's written contributions would be collected at the end of the session. Anonymity was retained, though not confidentiality, since the intention was to make use of our deliberations in improving our collective future.

Each session began with a brainstorm on the theme of what people hoped to accomplish in the session and what their expectations might be. Participants talked of sharing ideas, finding out what others think, enjoyment, pleasure in the company of colleagues, an opportunity to think, reflect and share with others, and the gaining of some agreement on sustaining "first principles". I declared my own interest for my own research and in gaining some insights for the broader organisational evaluation project. Possible risks and threats were discussed briefly.

As a first step to compiling a collective vision, participants were asked to establish their individual visions. This was to be as "ideal" as possible, but also realistic. I facilitated by providing some stimulus material based on my ideal recreational vision. (It seemed essential not to use a work-based vision so as not to "lead" the groups excessively.) Lots of thinking and quiet reflection time was left as participants wrote - discussion was discouraged at this time.

The precise instruction was:

....there is really no reason why work should not be a pleasurable experience. And that is what we need to construct first. A visualisation of our "ideal" work experience. What I would like to do is for each of you to write about your ideal work situation - to characterise the work you would like to be doing - while I talk and suggest some areas you might like to think about. You can write while I talk. Try not to draw on your colleagues or neighbours - don't look at what they write, don't ask them, don't think about what they might think about what you might write - this may take some time since this exercise is the main route for deciding how close our hoped-for futures actually are.

I facilitated by suggesting that participants might begin with aspects of the physical setting - how and when people travel to work, entrances to the building, the nature of the built environment and so on. Then I moved on to the tasks associated with work, to meeting and talking with colleagues, to students, and to the various stages in the working day. All comments were general, nothing specific was said about any of these aspects of the work setting. After a little time the group was left in silence for about twenty minutes until all participants felt they had had enough writing time.

Participants were then asked to look back through their writing and prioritise items by placing a numbered footnote next to the appropriate phrase or sentence. Next these lists were shared as ranked items and grouped as broader categories on acetates. Each broad category was discussed by the group in terms of why they wished to see it as part of their idealised work experience. At this point it became difficult in each of the groups to maintain the "positive" perspective. In the discussion about why particular items were not achieved critical points were made either about systems or management structure (at UWB and School level) or individual lecturer attitudes (unnamed) in general.

Next the group was steered toward addressing what was unchangeable about these problems, looking first at those with which it was perceived that nothing could be done and next at those problems about which there was a perception of potential for change. Possible remedies were then aired in a concluding brainstorm.

Explanation of the outcomes of the vision workshop exercise

The opportunity to attend five workshops was provided in early 1998. Two were held in Bangor, two in Wrexham and one in YGC. In all approximately thirty members of staff attended and the recorded evaluations of the exercise were uniformly positive.

The views set out in categorised lists below are based on the responses of the individuals who participated. More than thirty individuals attended but only those who were able to stay until the end of the session submitted their completed responses (28). These individual responses have been coded to be included within the broad categories which emerged from the collective group discussions (recorded originally on acetate during the initial workshops). Additional categories and items which emerged from the individual responses have been separately indicated (as "IR").

It is difficult to prioritise these lists collectively due to the nature of the emergence of issues in a vision workshop. Prioritisation was however embedded in the instructions given for the individual responses. Individuals were to indicate, in priority order from "1" to "+ n", their preference for an item to be realised. These are indicated by the figures in square brackets; e.g. [1] below. The number of respondents explicitly mentioning that item is indicated in half moon brackets; e.g. (x 5). Respondents are not repeatedly counted as registering within any one item - thus if one respondent mentions something twice it is only counted as one response for that item. But respondents are counted for every separate item they mention.

To illustrate: the first item in the list below was mentioned in the collective group discussion and then backed up explicitly by six respondents, two of whom saw it as "first" in their vision of the ideal work situation, one as third and one as ninth in their list. The second item emerged from the individual responses and was not mentioned explicitly in the workshop itself. However, eight respondents included it in their individual responses, one of whom saw it as first and another as third in their list. Reading that category overall, apart from one respondent, it does look as if most desired an improvement in value and esteem and perceived it to be realisable. "Physical Environment" had to be developed as a separate broad category since it came across in so many of the individual responses. Although this might be viewed as a category which the respondents were led into by the facilitator's initial directions.

The separation of broad categories and individual items must be, to some extent, arbitrary and dependent upon the judgements of the individual researcher conducting the coding. Staff were attempting the describe the "whole" experience, the work setting and situation in its entirety. Some wrote sentences in continuous prose, others short phrases and headings. Items were treated as inclusive when the respondent's intent seemed clear. Others appeared to deserve listing separately. Consequently, any coding must remain, to some degree, artificial. The "collapsing" of categories or items

necessary for coding inevitably detracts from the richness of the individual experience or observation. Necessarily the "authenticity" of the context within which that observation was generated is lost - an unavoidable consequence of research and evaluation.

Categories emerging from the SNMS vision workshops:

Value, Esteem and Rewards:

- all staff and students are valued intellectual capital/assets (x 1[3]; x 2[1]); x 2; x 1[9])
- (IR) students respected and valued as adult learners and treated like adults; acknowledgement that they have relevant knowledge and experience; learning responsibility given to student/taken by student (x 5; x 1[3]; x 2[1])
- recognition of professional competence within the University of Wales, Bangor and within HE generally (value as professional practitioners and as lecturers) (x 3; x 1[3])
- full involvement of part-time and of temporary staff and graduate students
- care with formal titles - no "thems" and "us's" (x 1); (remove fundamental divisions x 1)
- skills and talents of all staff recognised, utilised and rewarded academically and financially (x 3; 1[5])
- equal and mutual respect for the individual demonstrated (being taken seriously) - not just because of position (x 1[11]; x 14; x 1[3])
- financial security, decent salary (keeping up with inflation) and pension (x 1[7]; x 2)
- (IR) personal and positive feedback on progress (x 4; x 1[4])
- (IR) meeting challenges and being able to innovate (x 1)
- (IR) caring students and caring practitioners in an organisation that cares for all its members and shows flexibility, compassion and understanding (x 5)
- (IR) lecturers, students, cleaners... proud to feel part of a valuable organisation (x 1[5])
- (IR) demonstrable contribution to patient care (x 1[2])
- (IR) the freedom to develop, achieve and optimise skills for the future (x 1[3]; x 1[4])
- (IR) recognition for effort (x 1)

Clinical Credibility:

- clinically-informed education and training
- regular engagement in clinical practice (clarification of requirements; one day a week clinical work) (x 2; x 1[5];x 1[3]; x 1[11])
- establishment of professorially-led centre representing best practice in research in clinical practice
- (IR) best university dept. in Wales/UK (x 1[1])
- publish valued work
- ability to work in specialist field - clinical, teaching and research (e.g. specific time dedicated mainly to specialist Branch (x 1))

- minimise the theory/practice gap, (IR) minimise remoteness from clinical areas (x 1[1])
- (IR) high standards in nursing (x 1[1]); having a clear standard in nursing which is being produced (x 1[5])
- (IR) properly organised clinical placement (x 1[4]; x 1[3])
- (IR) properly organised clinical supervision (x 1[5])
- (IR) maintaining clinical work and feeling of remaining a competent practitioner (x 1[5]; x 1[3]; x 1[2]; x 1[1]))
- (IR) maintaining good relationships with Trusts (x1[1])

Research Expertise:
- (IR) development of research expertise (x 2)
- (IR) self choice on conference attendance (x 1)
- (IR) able to do own research, write and publish (x 1; x 1[4]) x 1[1]))
- (IR) a professor with academic credibility to help move us on (x 1[9])
- (IR) a strategy for helping teaching staff to continue developing research skills by working with experienced researchers; taking about research with others (x 1[7]); research related to the teaching tutors actually do (x 1[1]; x 1)
- (IR) completing a further professional qualification (x 1[1])
- (IR) opportunities to share and develop what is already known about R&D (x 1; x 1[3])

Autonomy of time, place and identity:
- appropriate management of time by self and school (having time to consolidate (x 3; x 1[4]; x 1[3]); more space for self (x 1[1]); take time needed to get job done (x 1[8]); better planned working days including mail, clinical teaching, tutorials and scholarship (x1[7]; space and time without guilt for reflection, networking and clinical competence maintenance (x 2; x 1[12]))
- advanced planning of school activities/predictable programmes of activities to permit individual planning for - teaching, teaching prep., clinical practice, placement supervision, research, discussion and "protected" time for individual development (x 2; 1[3])
- to be allowed to say stupid/clever things and clarify thinking
- allow "play"
- (IR) distinction between disciplined and play times and spaces (x 1[3])
- (IR) self-direction (x 1[4];x 2); flexibility to arrange own time (x 2)
- work where necessary to get job done e.g. at home (x 1[9] x 1)
- (IR) time out of teaching to pursue research activities - e.g. summer free of courses (x 2; x 1[8]; x 1[7])
- (IR) staff need to be empowered/ all able to have a voice (x 1[3])
- (IR) less time in office/building (x 1[1])
- (IR) no sense of time - everything going so well you forget about lunch (x 1)
- (IR) flexibility in working day (x 1)
- (IR) one day per week study time (x 1[7])
- (IR) time for personal development (x 1[3]; x 1)
- (IR) feeling free to write and read when mood takes (x 1[7]; x 1)
- (IR) able to travel to meet/discuss with others without feeling guilty for incurring travel costs deemed by others to be "unnecessary" (x 1[5])

Adequate commitment of resources:

- research and development
- adequate resources, quality secretarial/admin. support given pleasantly (x 6; x 1[3]; x 1[9]; x 1[7]; x 1[6])
- skills and time (x 1 [2]; x 1)
- information technology (hardware and software) improved and training to ensure correct use - PowerPoint, e-mail, library searches etc. (x 1[2]; x 1[5]; x 1)
- mundane tasks of administration and control dealt with efficiently by apt personnel
- (IR) adequate staffing levels (x 1)
- (IR) control of own budget (x 1 [5])
- (IR) unimpeded access to regular technical support with specialist expertise - librarian (inter-library loan), IT, videoconferencing, laboratories (x 4; x 2[4]; x 1[2]; x 1[7]; x 1[3])
- (IR) facilities developed for benefit of all students whatever Branch (x 1)
- (IR) all staff to have own office (x 3; x 2[10])
- (IR) up-to-date networked computers (x 3; x 1[3]; x 1[2])
- (IR) buildings open and accessible at all times (x 1)
- (IR) new photocopying machines in working order (x 1[10])
- (IR) ample stationery (x 1[6])

Enhanced sense of unity/community/corporate identity:

- better "social" centres (x 1)
- (IR) canteen for staff and students to avoid "them" and "us" (x 1)
- more involvement with UWB - staff and students appreciate and make use of university facilities, students having opportunity to meet with other students and join activities, joint projects with other departments (x 1[2]; x 1[7]); feeling part of UWB (x 1; x 1[1])
- better involvement with community and with service providers
- bridging of geographical gaps - Bangor, YGC, Wrexham; sense of unity (x 1)
- sharing or disclosing mutual goals, talking to each other, opportunity to discuss problems and so come to understand each other better (x 1[7]; x 1)
- rejoice in difference, acceptance of varying opinions (x 1[2])
- gain information more easily, sharing of information, clear, direct lines of effective communication (x 1[6]; x 3)
- engagement and commitment for common purpose (e.g. power invested in the general interest of the establishment including students (x 1[2])
- (IR) avoid divisions based on academic achievements (x 1)
- (IR) conduct some group analytic work - independent of the course (x 1[4])
- (IR) a positive attitude which encourages new ideas, new ways of doing things and recognises attempts to develop and achieve (x 4)
- (IR) freedom from reactionary moralisations (x 1)
- (IR) attitude of mutual helping and support (x 1); possibly a "buddying" system (x 1[6])
- (IR) group cohesiveness (x 1)
- (IR) honesty, openness and fairness (x 1[6])

Effective organisational development:

- participation/involvement in control and decision-making (x 3)
- joint determination of the future direction of the school (x 2; x 1[7])
- seeking and realising a common purpose - clear objectives and sense of progress (x 1)
- easily discover conflicting agendas (x 1), no fragmentation (x 1)
- a well-run organisation (x 1[5]); speedy, constructive and full feedback from senior management (x 2; x 1[3]); thoughtful and not panicky or reactionary (x 1; x 1[4]); more structured, open sharing of information (x 1[3]; x 1[7]; x 1[8]); control over work and play (x 1[5])
- better management of time and avoidance of timewasting activities (less meetings (x 2); only attend necessary meetings (x 2); keep meetings short (x 1); more disciplined/organised meetings (x 4); not too many irrelevant meetings and action on outcomes (x 1(5); x 1[3])
- equality of opportunity
- (IR) Simple foolproof methods for important procedures e.g. examination procedures, clinical procedures, evaluation (x 1)
- (IR) problems attended to with some sense of urgency (e.g. own budget, sound cards) (x 1[1])
- (IR) change in organisational culture needed (x 1)
- (IR) no one person's opinion allowed to dominate, empowerment (x 2)
- (IR) good marketing of courses (x 1)
- (IR) clear responsibilities for tasks (x 1)
- (IR) opportunity (for staff and students) to criticise the organisation without exaggerated response (x 1)
- (IR) visionary leadership and management (x 1[5])
- (IR) more brokering/networking with relevant outside organisations (x 1[2])

Effective curriculum development:

- genuinely "common" foundation programme
- truly "shared learning" when appropriate (x 1)
- identifiable, discrete units to the curriculum
- (IR) agreement on branch development (x 1)
- (IR) teaching across courses/branches according to expertise (x 1)
- (IR) regular communication with other staff on course planning, curriculum content, general day-to-day activities, innovations - time for development (x 1; x 1[2])
- (IR) clinical staff able to be part of the organisation of modules and deal with inquiries about modules (x 1)
- (IR) opportunity for conceptual development (x 1)
- (IR) more genuinely multidisciplinary approaches (x 1)

Effective pedagogy:

- teaching in rooms appropriate and fit (and fitted out) for purpose
- teaching groups of manageable (small) size (x 3; x 1[2])
- quality contact with students (x 2)
- (IR) students would be supported as much as they feel they need to be and feel confident about approaching tutorial staff (x 1[4])

- (IR) enthusiastic, caring teaching (x 1[4])
- (IR) students attend and on time (x 1)
- (IR) student-led learning (x 1)
- (IR) avoid over assessment of students and excessive marking (x 1;x 1[4])
- (IR) all Branch students have monthly visits when on placement (x 1)
- (IR) staff working as (small) team, meeting regularly, reviewing action, communicating well and building (x 3; x 1[2]; x 1[8])
- (IR) expertise from other University departments utilised (x 1[3])
- (IR) more guided learning (x 1)
- (IR) shorter lecture periods (x 1)
- (IR) an enquiring, intellectually stimulating search for knowledge, not rote learning (x 1)
- (IR) learning contract (x 1[3])
- (IR) attendance not compulsory (x 1)
- (IR) teaching on topics with knowledge and confidence (x 1[8])

(IR) Physical Environment:

- adequate refreshment and relaxation areas for staff and students (x 2 [6]; x 1[7]; x 2; x 1[5]) with "open" areas (x 1)
- tidy, clean and well decorated environment (x 2; x 1[7])
- user-friendly buildings (x 1[4])
- ease of parking (barrier card to avoid need for checking and arguments (x 1[2]; x 1[5])
- tidy, organised, bright, warm office with adequate storage and tutorial space (x 5; x 1[2] x 1[4])
- properly equipped (state-of-the-art) inviting, uncluttered teaching rooms with comfortable seating - sufficient space, heat, lighting, air, AV material and equipment (x 1[3]; x 11; x 1[6]; x 1[9]; x 1[8])
- pleasant outdoor seating area (x 1[11]; x 1)
- squash courts (x 1[7])
- no "Thou shalt not" notices (x 1)
- coffee and eating allowed in classrooms (x 1)
- family photos (x 1)
- safety (x 1)
- doors without security codes which all open the same way (x 1)

Experience:

- enjoyment (x 2; x 1[8])
- mutual esteem
- no-blame culture
- honesty, fairness and openness
- (IR) positive atmosphere (x 1)
- (IR) empathy (x 1)
- (IR) being able to say "no" if uncomfortable about doing something (x 1)
- (IR) ability to make space to think, be interested and engage with others (e.g. staff lunches) (x 1[1]; x 3)
- (IR) minimal stress, calm working environment, less anxiety (x 3)
- (IR) sunny, laughter, fluid & food, smiles, flowers, comfort (x 1)

- (IR) less travel (x 3); cycling distance to work (x 1[7])
- (IR) permission to pursue leisure/diversional tactics (x 1)
- (IR) being able to share knowledge and learn from others (x 1)
- (IR) seeing students become competent practitioners at degree level (x 1[4])
- (IR) regular opportunities for personal support (x 1)
- (IR) more job satisfaction, committed people there because they enjoy their work (x 1[2]; x 3; x 1[9])
- (IR) a positive, stimulating, challenging, motivating environment in which staff feel part of something "special" and visionary, students clamour to study and the outcomes exceed everyone's expectations (x 1[1]; x 2; x 1[2]; x 1[3])
- (IR) friendly, flexible, approachable, encouraging and supportive (x 1[1])
- (IR) a problem-solving perspective, taking staff to higher level of competence, opportunities to learn and set goals (x 2)
- (IR) hospitable, friendly and welcoming environment- e.g. reception, telephone answering (x 3; x 1[10]; x 1[9])
- (IR) being able to function as a university lecturer (x 1[1])

Interpretation of and commentary on vision workshop data

The figures in each broad category constitute the number of individuals mentioning that topic. Individuals might be over-represented across categories since those making most comments are counted more frequently. So no sense of a "strength" of collective feeling can be judged from a frequency count of "respondents per item", nor can intensity of response be inferred from a count of the itemised responses within each broad category. In any case, there are several items which might be considered duplications and some broad categories and specific items are difficult to separate. Others might appear to contradict - without fuller accounts it is hard to reconcile opposing views. The data are inclusive, however, such that nothing contributed by an individual has been omitted.

With all those caveats, the range of ideas and concerns that staff hold and observe is impressive. Trying to address them as an organisational development exercise can pose the classic problem of how to "please all of the people all of the time" although it might be possible with a judicious collapsing of categories that most aspirations could be met. This is discussed later. At the same time, most of the listed broad categories and many of the specific items came up in all of the workshops held, suggesting there is some commonality in the vision to be achieved.

What is particularly striking is how little comment was made about curriculum or pedagogy as against concerns with value and esteem. Perhaps it is in teaching and course design where staff feel most in control, or which they find least problematic and where most of their energies are necessarily focussed. This suggests that the problem areas lie in organisational culture and infrastructure and not in the day-to-day business of educational delivery. It may be the intangibles of the "atmosphere" of the workplace to which we need give some immediate and comprehensive attention.

Even though there had been some leading by the facilitator towards a concern with aspects of the physical environment, this did not emerge as a key concern in the collective discussions. It was mentioned in the individual written submissions by every respondent and seemed vitally linked to making the "experience" of work enjoyable, hospitable, relaxed and friendly. This experiential aspect was connected also to the more visionary comments about standards, values, quality and esteem. This, in fact, was the category which all participants itemised in some detail. Almost all made some comment about the importance of being valued and showing recognition of the values of others - both colleagues and students. Such esteem was seen to be more important as a reward for effort than financial concerns, about which there was remarkably little comment.

Professional credibility was particularly stressed in the area of clinical competence but in a range of different ways. There seemed to be no single recommended way of achieving this. Although some respondents desired recognition via the establishment of a centre of excellence and this was extended into a desire for more research expertise, writing and publishing.

Again, many staff commented on the need for autonomy in controlling their time to allow the flexibility necessary to achieve such professional competence and clinical credibility. This led to a range of comments about provision of and access to basic working resources - stationery, office space and equipment, and, frequently, IT support.

Corporate identity and a sense of belonging to a distinct and supportive community was a more nebulous "resource" which was sought by many participants. But this seemed connected to an efficient, considerate and democratic management structure. The ultimate development of the organisation being dependent upon this - clear planning and no timewasting. In the same way, comments upon curriculum and

pedagogy stressed an efficient, sympathetic approach with small teaching groups being taught the appropriate content within an understanding educational ethos.

The more mundane feature of the physical environment may appear to be trivial but there was a great deal of expressed emotion about such matters. This may be because, if other evidence of value and esteem is lacking, simple recognition of staff's practical requirements in easing some of the burdens of work can demonstrate their worth. Ultimately, the participants desired a warm, friendly, enjoyable experience in their work.

Conclusion: Does the organisation learn and learn to care?

It is not really organisations that learn and care. Individuals are the learners and the carers. If ways can be found to ensure that the system or structure does not inhibit learning and caring, then it is up to individuals to bear their responsibility to do so - if they cannot then there may be a problem in individual characters and abilities rather than the social structure. This is not to imply that individual staff I have contacted to discuss these issues are not learned, open to learning or caring people. But if health care professionals are committed to evidence based practice in health then they should be equally committed to drawing upon the evidence base in the management of health professional education.

One of the reasons all of this matters is to ensure that caring principles are carried over into patient treatment. The SNMS operates as a higher educational organisation which functions to create clinically effective health care professionals. One feature of such effectiveness is that they learn how to care. It could be assumed that caring learning organisations will produce practitioners who are effective carers. The difficulties of demonstrating this connection have been comprehensively considered elsewhere (Jinks 1997) and, in any case, the individual health professional educator has to balance care for the (unknown) patient against care for the (known) student (Leininger and Watson 1990). I am arguing that, regardless of the consequences for patients, there remains an ethical obligation for learning organisations to care about and for their participants.

If the organisation appears uncaring and slow to learn it is largely the fault of structural constraints that prove difficult to overcome. Indeed running through all the caring and healthy organisation qualities discussed above is the need to reconcile two

opposing sets of principles: the freedom to allow independence, spontaneity and creativity, and the discipline of an ordered hierarchy in which the potential for chaos is limited and in which individuals can feel some degree of safety and security while formal organisational goals are achieved. The opportunity to innovate in order to solve problems still runs counter to the stability gained from the upward delegation of responsibility.

There is reason to suspect that the old rigidities of nurse education in particular produced a response to new organisational demands that required the more conscious establishment of alternative (less hierarchical) bureaucratic structures. It is possible that this "very different way of organising professional education" (Champion 1992: 33) was not fully confronted and a clear philosophy linking education and practice established and accepted. Initially there were many prescriptive responses to curriculum and to organisational development requirements (ENB 1989; DLC 1989). Some organisations may have followed these prescriptions fairly rigidly. Deal and Kennedy's (1982: 176) advice on successful change in the corporate culture entails finding champions to act as leaders and, even, false enemies to pose external threats that might strengthen corporate bonds. The artificially competitive culture of both HE and of health care delivery has produced more than enough false enemies while, in such a climate, genuine heroes or heroines are few and far between. In any case, it seems evident that such solutions are anachronistic. New structures of learning, of caring and of learning about caring must be flexible and multi-faceted, able to adjust like any modern organisation to rapid and profound changes in the marketplace for health and for education. The concluding chapter goes on to suggest such policy recommendations, ones which draw on the responses from the workshops and issues raised in the preceding analysis.

Reflective Commentary - 6

Planning from Experience

As a consequence of implementing fundamental changes in the organisational structure of SNMS the first opportunity for progressing my own work came with the establishment of an "evaluation project" designed to judge the success of those constitutional changes. At the suggestion of a colleague the working group set up to implement and evaluate change (of which I was a member) decided to establish performance indicators that would measure our collective progress.

As a Teaching Quality Assessor for the Higher Education Funding Council for Wales, I already had thought through some of these issues and indeed I did this for the workshops that I ran within UWB on the TQA process. So it was relatively easy for me to produce a criterion list and a more condensed form of progress monitoring in a conventional mission statement. Both were agreed within the small working group and successively put to the rest of the staff.

Acting

Obstacles seemed to emerge regularly to impede the implementation of the changes in the decision making structure and both of the above mentioned performance indicators. Attempts to distribute the TQA criterion list in the form of a questionnaire to staff were halted by two different senior managers – even after they had gone through the open democratic process and had been agreed to by the full group. When this did go out as a questionnaire (referred to on pp.179 and 184 – incident # 9) the impetus had been lost, I felt that the staff had become fairly disinterested, so I received a grand total of two replies to the questionnaire. (A similar attempt by me to establish voluntarily a uniform system of course evaluation produced three responses. A "compulsory" system designed and produced by one manager is now in place which staff have made little contribution towards.) Without any particular full staff endorsement, this criterion list is now being formally adopted as the basis for an annual quality audit of the work of the School. (This is reproduced as Appendix V.) Similarly, the delay between the devising of a mission statement and its final

acceptance by SNMS seemed unnecessarily lengthy and I acknowledge that I began to lose some patience. It took two years to get the new decision making structures fully operational (p.176) and even when they were in place staff rarely spoke out at first and meetings tended to be dominated by Research Division lecturers and Senior Management. I appeared to have little control over the outcomes in this "phase" of the study.

Reflection

I believe that I am a fairly resilient person, but I was disheartened by these obstacles and delays. It would serve no useful purpose here to report the character of some of the ways obstacles were presented; it should suffice to say that public displays of emotion were not uncommon. I believe that there were elements of performance measurement that touched some raw nerves. It would be dishonest to say that I hadn't expected them to. On the other hand it would have been even more dishonest not to have tried to implement these measures in a frank and open manner; in a manner consistent with the spirit of this thesis.

Observing

The vignette approach used in Chapter 6 occurred to me as a way of representing more vividly the rather bland prescriptions of the learning organisation literature. These and many more instances not reported here were shared with me by my colleagues and they so often fitted the principles to be found in the literature. This was not a conventional exploitation of the methodology of participant observation. Once more it was opportunistic data retrieval. I made a note of incidents reported to me by my colleagues and then assessed the ways they illustrated various points in the thesis.

Planning and Acting

Given the staff's apparent singular disinterest in the completion of structured questionnaires, I felt that to get at their authentic views upon their work and learning situation would require a much more imaginative approach. I also needed something

that would encourage them to see me as neither threatening nor collusory with management. While reading some of the medical education literature I came across the ideal vehicle – it was a report of a "vision workshop" (a scenario-building exercise) conducted with a multidisciplinary primary health care team in Merseyside. A literature search produced few references to the technique so I telephoned one of the organisers and gained some procedural information together with some information about the outcomes – which were apparently highly successful in integrating a rather disjointed team the members of which held a range of diverse goals and interests. I now needed an opportunity to introduce the approach.

That opportunity came when in a staff meeting on one of the School sites a discussion developed about the future of nursing and the consequences this might have for the future of nurse education. It was an unusually stimulating, enjoyable and open debate. I discussed the vision workshop with the group and the suggestion was made that I be invited to lead such workshops with all the staff. I readily accepted and set up the meetings. Even then a senior manager almost halted the process with the complaint that the first workshop had been about "this organisation" in particular rather than the more generalised discussion that that manager had originally believed they were endorsing.

Nonetheless, I argued my corner successfully and the workshops continued. As a research method I found them particularly engaging since they relied upon my skills as an adult educator – facilitation, encouraging commitment to the exercise, and the ability to focus and sustain the dialogue. The student essays had demonstrated vividly expressed moral concerns. I was concerned to discover how far those moral goals for this sort of professional education can be accomplished if the "structures" do not facilitate it or, worse, obstruct it. So I felt it was important to access the staff's world views – as the main representatives of the "structure" – since just like organisations do not learn as such – those structures only exist in so far as the humans who constitute them continually re-present them.

Observing and Experiencing

While the workshops were easy to conduct, the highly qualitative data they generated required much time-consuming analysis. But the strength of feeling reported about many of the issues vindicated my advocacy of the approach. It did take some time, once again, moving the report through the committee structure and, finally, having the staff request monthly "awayday" meetings in which some of the issues raised could be addressed.

The vignettes helped to demonstrate the distance the organisation was from meeting the basic principles of a caring learning organisation. The vision workshops endorsed that judgement even more. Indeed I am here resisting the strong temptation to report my own difficulties of gaining promotion within the organisation which would accord me some recognition for both the difficulties I have confronted and the developmental achievements I believe that I have accomplished.

Chapter 7 Conclusions and Recommendations: Responding to the Dilemmas of Change

Introduction

The background to and rationale for this work has been change in higher education, change in health service provision and the consequences of these changes for change in the education of health professionals. The work reported in this thesis was taking place in a very specific higher educational setting with its own limitations, constraints and ideals. To some extent these have been put to one side as the more particular problems of the education of health professionals in this setting was being investigated. But any ideals to be realised in health professional education must now be seen to occur within the ideals collaboratively sought by society, communities, health services, government and universities.

The theoretical perspectives which frame this work are derived from a reading and re-reading of a range of ideas and interests on which my own practices as an educator are based and which have informed the direction this work has taken. It must be the fate of all truly effective educators to provide for their own redundancy. At some point their learners have to dispense with their services or they cannot be considered to have learned. The same has to be true of organisational developers, the organisation will only have truly learned when it holds in place the mechanisms for its own positive development and change. What is offered here are some means, which must remain necessarily under continual review, for facilitating effective learning.

This concluding chapter summarises the current status of SNMS as a learning caring organisation, makes some specific observations on context and method, and offers some policy recommendations which apply to School but also, hopefully, to all similar institutions engaged in the production of effective learning experiences for health professionals - maybe for those in all organisations who wish to learn and to care.

Multi-methods participative action research

From my research both in adult residential education and in working to make health professional education reflect a more mature educational perspective I grow more

convinced of how essential it is to conduct pluralist, participatory and reflective research with a proactive and "testing" focus. This multi-method approach is not deliberately triangulated although that need not be ruled out as inappropriate to the kind of work reported here. It does appear difficult to apply triangulation rigorously and systematically in participative research given the need to remain both opportunistic and sensitive to the requirements of the people and the organisation under study (see, for related discussion, Deacon, Bryman and Fenton 1998).

The major asset with participative action research is also its major flaw - there is no one way of doing it. It is a humanistic methodology with a lengthy pedigree of epistemological pluralism and its revitalisation in the 1990s is probably partly a reaction to the political and economic climate of the 1980s. Among the useful practical research devices recommended by writers in this field (see Reason 1994) are included: hidden agenda disclosure, active confrontation, devil's advocacy, co-researcher contracts, accepting chaos and allowing contemplative space. Researchers have to be able to handle its fundamentally "emergent" and introspective nature, but also to be in a position to respond to and, to some extent, have a degree of control over outcomes. There are clearly some topics and some sites wherein this approach is more suitable than others. It appears to work well in the domains of health visiting, pre-natal education, child protection and staff development, with predominantly female co-subjects and in a spirit of collaborative enquiry (Reason 1994). Elsewhere it might be entirely inappropriate. I do feel the approach to be justified and productive in this present setting since it shares many of the characteristics of the above domains and therefore would recommend its future use and development.

As is necessary with this type of research throughout I remained mindful of Martin Hammersley's (1993) warnings about practitioner ethnography and the dangers of insider research. There are also some special problems of conducting adult education research to be aware of which include either excessive domination by the researcher or by self-confident and highly aware students (see Pilsworth and Ruddock 1975, Payne 1990). As I adopted a role that is known in the participant observation literature as a "categorical member" of the community, my main concern was to use this position cautiously and not allow my own views to prejudice the design of the

research instruments nor the outcomes (Denzin 1970: 192). Similarly I attempted not to allow the views and interests of any one set of stakeholders to influence the outcomes.

The model of action research adopted here is, in part, one that has been advocated by Kurt Lewin. Adelman summarised the Lewin model of action research as ".... the discussion of problems followed by group decisions on how to succeed. Action research must include the active participation by those who carry out the work in the exploration of problems that they identify and anticipate" (Adelman 1993: 8). This form of action research suggests ongoing study and observation combined with immediate feedback of results to all participants in a learning dialogue. Dialogue, in this case, also became one of the means for accomplishing effective learning - a way of reconciling the inevitably inegalitarian and possibly paternalistic nature of the tutor/student relationship. There is always a problem for those seen to be in authority - how to teach authoritatively while allowing sufficient self-direction and autonomy to emerge in the student. So the "method" became a "means", suggesting that self-conscious andragogy might be more coherently cultivated when contextualised within an ongoing participative action research project.

But this highlights the potential threats to the validity of the method which lie in its circulatory nature. There may be too many opportunities to influence the direction of results. One might acknowledge that this raises a problem of objectivity without necessarily negating the validity of such research. If research is for the benefit of all stakeholders, then perceived gains have to be estimated, regardless of some methodologically refined abstract concept about the degree of detachment of the observer. Such an approach may approximate what Erich Fromm has called "humanistic radicalism": "... it is not 'objective', if objectivity means theorizing without a passionately held aim which impels and nourishes the process of thinking. But it is exceedingly objective if it means that every step in the process of thinking is based on critically sifted evidence, and furthermore if it takes a critical attitude towards common-sensical premises" (Fromm 1973). I hope to have made my presuppositions clear throughout this thesis and to constantly seek relevance by

looking to the best interests of students and staff first, followed by the benefits to professional health care and, ultimately, society and government.

There must, necessarily, remain an issue of generalisability from any action research based in a specific setting. It is, I suppose, a major methodological limitation of the case study approach and, some have argued, a problem for qualitative or interpretive research in general (Hammersley 1992, Williams 2000). Throughout the thesis I have attempted to clarify the basis upon which general inferences can be made. Evidently broader claims to generalisation are made in this concluding chapter in which specific recommendations for improvements in educational practice are put forward. In the first instance such recommendations must be seen as specific to SNMS and UWB. I would argue that there is some internal inferential validity deriving from the multi-methods approach adopted. In this thesis critiques of the literature pointed to areas worthy of further investigation which were then achieved using a multiplicity of methods which included some basic documentary analysis of semi-official and official documents, an in-course survey or questionnaire employed in analytic and dialogic modes, face-to-face unstructured spontaneous interviews, a record of critical incidents forming the basis for vignettes, semi-formalised written accounts of students' motives for entering nurse education, written and spoken data produced in workshops settings and participant observation in which I adopted the "participant as observer" role. I have argued elsewhere for the value of a single case study approach in qualitative research (Iphofen 1990). In fact, Williams (2000: 215) argues that *moderatum* generalisations (instances of a broader recognisable set of features) are not only possible but inevitable features of interpretive/qualitative research. Williams (2000: 221) goes on to argue that methodological pluralism is one way of adding validity to claims to generality based on such research.

The specific summary recommendations presented in bulleted lists here were drawn from all the above sources within the present series of case studies, together with the additional research sources referenced throughout the Chapter. There are perhaps two ways of assessing external generalisability: practitioners in similar situations might detect some familiarity with the issues and endorse their relevance as matching their own practice experience and/or each of the methods adopted here might be developed

and used (singly or in combination) to assess a commonality of experience by replicating the approach. In this sense these conclusions become "... 'working hypotheses', and hypotheses of this kind take the form of speculative generalisations" (Williams 2000: 212).

Context and method: Who are "the staff"? What is "the organisation"?

One can only counsel caution when defining the objects and persons of study. It is hard, if not impossible to set boundaries to the "system" under study. Indeed that is one of the substantive points I am trying to establish - it is almost impossible to separate the "external" from the "internal" influences on any educational institution. When I have argued that staff and student behaviour and attitude is determined by context I should include: the separate communities and social systems from which each is drawn but which they necessarily bring to the current learning experience, the novel sets of relationships established in that experience, and the broader experience of the social, political and economic influences on the society in which that profession and this particular professional education is being conducted. For example, the staff who are stressed and undervalued are not just stressed and undervalued by their colleagues and students in the classroom and the university - but by their students as clinical (trainee) practitioners, by the settings in which they (as they engage in clinical updating) have to operate and by the awareness of the uncertain futures apparently to be faced by all.

In fact, the neglect of "context" seems to me a serious omission in much research and which can be brought back in in the kind of participative research described here. "Broadly speaking, the context is a consequence of two aspects of research: it is provided partially by the social interaction which occurs in research and partially by the research instruments which are deployed" (Todd 1981: 213). The recognition of these influences provides further justification for participative action research. Alternatives seem flawed precisely in their ignorance of context: "Selecting individuals for research on the basis of a random sampling model involves a process of taking them out of their social context and presuming that they may be treated as equivalent for research purposes" (Todd 1981: 215). While this is not the place to engage such an extensive discussion of the relationship between context and method, it remains part of the methodology of this thesis that context is examined and linked to the emergent data.

As discussed briefly in Chapter 4, some staff will have excluded themselves from the activities reported here, some will not be enacting the mission deliberately, and some will have unexpressed views that are highly influential within the study setting. All research methods remain partial and, in this sense, therefore flawed. My plea is simply that to neglect context is to produce data which has a high potential for inauthenticity and, thereby, neglect some key influence upon the individuals under study.

In trying to understand the broader context of organisation, community and society there have been many sources of ideas and information, most of which were covered in Chapter 2. One key individual has been Robert Greenleaf who has argued convincingly for redeeming the much criticised concepts of "service" and "leadership". In fact, Greenleaf's particular contribution was to combine the two and promote "servant leadership" in which the leader with true authority is seen primarily as a servant to the greater collective interest of the community and society. He condemned educational institutions in particular for obsessions with credentialism and for their implicit denigration of both concepts. His view of the strong educational institution was ".... when all the parties have adequate power for their role; it is weakest where one or more of the elements has too little power, because then somebody has too much and the corrupting influence of power is moving towards the absolute" (Greenleaf 1977: 170). He cautions against the "moral risk in the assumption of virtue, and the extent of coercion in the whole educational process" (Greenleaf 1977: 171). It is these sorts of processes that may inhibit autonomous learning in health care professional students (as well as possibly student of many other disciplines in the present climate) - there remains the confusion between needs and wants, and a power play between the individual learner, the lecturer and the broader policy influences of state and profession and how these are mediated through the educational organisation. Learner autonomy, as well as educator autonomy, may find it hard to break through under such conditions.

Constructs and narratives

In previous research into adult education motives which used a personal construct and repertory grid analysis (Iphofen 1992), I found that the structuring required of the repertory grid lead to a loss of richly meaningful data from the lengthy interaction which took place between researcher and respondent during the collection of the data. I was concerned in this present work to discover a range of means which could be

employed (not only by external researchers) to regularly re-examine the narratives which account for all participants' presence in the organisation. Participant action research leads to a view that all motives are to be treated as valid when seen "in context". It might be wonderful, although rare, to work in an organisation in which everyone shares the same mission. If some are present for less missionary reasons, then knowing that is vital to effective caring and learning. If a secretary is only working in the organisation because the job is essential as a means of economic survival, then that has to be seen as an authentic and valid reason for being there. Such knowledge helps the missionary not to expect the inappropriate from the secretary. Similarly it might help the finance officer to know that the academic has a sense of responsibility which must reconcile allegiances which may be torn between the organisation, their discipline and their profession.

The methodological problem is one of gaining access to such motives. The framework of narrative proposed and applied earlier is an imposed structure, its legitimacy assumed. The research instruments that have been employed here are all different angles on the participants' narratives. They are intended to provoke the elicitation of narrative and thereby gain access to motives. The learning styles questionnaire is highly structured and focussed, the essay a little less so allowing more room for manoeuvre, and the vision workshop hardly at all - in that context both individual and collective narratives could have "gone anywhere". Nonetheless it is possible to suggest that there is always some structure to a story as I argued in Chapter 5. The answers to the questionnaire say something like: "This is the kind of learner I am.". The essays allow more generality but provoke an element of personhood in implicitly asking "Who am I?" but certainly "Why am I here?". The vision workshop allows consideration of "Where I want to be."

There are complications to narrative analysis which were side-stepped to produce the data reported in Chapter 5. When even a simple account about future plans and intentions is given a multiplicity of "precipitating acts" may be reported, described and evaluated. So some of the "acts" referred to were subsumed within the main precipitating act and the qualifying criteria (agent, agency etc.) were taken to apply primarily to that act. To have separated out specific acts from that multiplicity would have require a much more meticulous lexical analysis than was used here. Extra justification for this might derive from the assumption that the account giver cannot be assumed to be as coherent as their lexical constructions might imply (Silverman 1993). Only carefully designed follow-up prompt questions could determine if they really "meant what they said" - a problem for most qualitative research (Kirk and

Miller 1986). I have argued that there is a certain authenticity to narrative analysis since it appears naturalistic. The methodological objective of naturalism remains a primary justification for qualitative research (Erlandson 1993, Grbich 1999, Guba and Lincoln 1985). Future related research would need to continue to consider ways of generating authentic motivational narratives and then employing and re-visiting them throughout a course of study or CPD.

Motivation and rewards

For most people it may be possible to assume a general motivation principle toward the betterment of our lives. More specifically motivation is a function of effort and perceived reward. We may be disinclined to exert much effort if the rewards are not perceived to be great. In fact, the perception of rewards as "small" might make the effort appear relatively more strenuous. For example, the appeal of gambling is dependent upon the requirement of minimal effort on the chance of substantial reward. The health gains to be had from some forms of strenuous exercise may not be perceived to be worth the effort. Some educational qualifications might be perceived as little reward for much effort.

Both rewards and efforts are based upon perceptions and values. Is a diploma worth as much as a degree? Is a "good" degree worth the substantial extra effort than that required for any degree? It all depends upon the estimation of the effort and how that balances against the value of a degree. Thus if the effort put into a degree course is enjoyable and not too damaging in itself, then it may even be engaged in regardless of the sense of value of the outcome. However, if the effort is seen as high relative to the value of a degree, problems in learner motivation can arise. Thus there is danger if the qualification becomes devalued - both in terms of its prestige and its means of access to a valued occupation. A degree can become devalued if standards of achievement fall - if it becomes "easier" to gain the qualification than in the past, or if access is broadened to such an extent that degree qualifications lose any scarcity value. This, of course, may extend into CPD - it becoming essential to engage in not for any extra reward but merely to maintain the status quo.

It is for such reasons that questions have been regularly asked in nurse education about the value of raising educational levels if the resultant qualifications do not lead to better working conditions, higher salaries or more promotion prospects. The reliance on job satisfaction no longer is seen as adequate reward in many service

occupations. A social and economic context in which HE qualifications become the standard professional career entry criteria are as likely to produce a cynical, instrumental attitude toward their accomplishment, particularly in the absence of governmental policies which secure both higher status and higher prestige associated with the profession. This is why the current Government and professional policy proposals set a vital broader context within which to sustain the perceived value of the reward and, as a consequence, the motivation on the part of the learner to succeed.

What follows are sets of recommendations which emerged from the dialogue with students and staff prompted by the engagement with the research reported in the preceding chapters and qualified by the contextual concerns reflected in the literature and discussed throughout.

Recommendations

This study implies that future organisational development in professional health care education needs, in summary, to address the following questions:

What **has** to be done?	What are the pressures, constraints and **demands**?
What does the organisation **want** to do?	What are the personal and institutional **aspirations**?
What **can** be done?	What are the personal and organisational **resources** available to do any of the above?
Where are we going?	What is the institutional **mission**? How can it be formed and maintained from a combination of individual and collective goals?
How do we plan to get there?	What are the means? What **systematic procedures** can be adopted and developed?

There is, of course, a problem of making profound changes to the institutional infrastructure in which this process occurs. An experimental design which involved

radical staff changes has to be ruled out for both pragmatic and ethical reasons; nor is it possible to do much about the centralised funding and course validation arrangements which are strong influences upon class size and course content. This is a particular problem of certain professional health care training courses and the control applied by NHS managers on human resource demands. The connection between employers and higher education is not so clear-cut in non-vocational courses, but nonetheless remains as an influence in the minds of central authorities who allow the economy to condition the educational infrastructure. With such caveats in mind the above questions can be addressed, in turn, by making explicit recommendations about student motives, staff aspirations and the existing context of professional education.

Student motives: encouraging motivation by "using motives to learn"

Attempts should be made to encourage the disclosure of each student's motivational narrative - their reason for wanting to study to become a health professional. Once revealed the organisation must find ways to assist in sustaining and/or modifying the narrative if necessary. In "using motives to learn" attempts have to be made to guard against any simplistic S-R view of motivation and the prioritising of one set of motive categories above another.

For example, the DfEE studies on individual commitment to learn actually used the category of "non-motivated" (Tremlett, Park and Dundon-Smith 1995: 21) - these include non-learners who "preferred to relax" after returning from work, preferred to "spend time with the family", were "too busy" with work to spend time learning or "did not need to learn new things" for work. Other so-called non-motivated learners had, in fact, learned some very practical transferable skills for specific purposes - in other words, had held a short-term learning goal which had been achieved. From the perspective outlined here, students could not be seen as un-motivated to go on learning, they must have motives but it has to be allowed that they may have different motives from the dominant professional or educational ones - the ones we might believe they "should" have from the perspective of our particular value judgements. They are indeed motivated - just to do different things in different ways. Thus the radiography students whose motives were analysed in Chapter 5 showed no abiding passion for the technical content of radiographic knowledge and it is unlikely that both they and many of the nursing students would have sustained their interest in a HCP career that promised no occupational security and a salary which proved impossible to live on.

Indeed it is revealing that many of the mature students prior to joining the course might have been viewed by the DfEE study as "non-participant" and "non-learners" even while they were learning about caring and developing the initial stimuli to the pursuit of training. This approach implies that learning only takes place in institutions, a perspective guaranteed to have the deschoolers turning in their metaphorical and literal graves. People may be learning all the time. Their motives include: to succeed, to get some qualifications, to get a job, to care for the family, to relax and to enjoy life. Continuing non-participants might feel that they have accomplished many of these things - to standards which they have set themselves.

Once on the course apparently "less well motivated" participants ask things like: What's coming up in the exam? What do I really need to know? Is this relevant? They too must be seen as motivated, but toward very clear, short-term goals. In a similar way, course drop-out statistics are employed as a measure of commitment, although the factors behind drop-out can vary widely. Again some researchers regard this as evidence of students becoming "de-motivated" (Purdey and Gale 1988: 45-52).

What is taking place is a change in the institutionalised attribution complex amongst students in higher education and a persistence in the attribution complexes of non-learners which is consistent with a particular sub-cultural view of the value of education. As university educators we might consider "legitimate" motives to include: valuing the university experience; loving the act of learning; and an abiding interest in the topic, subject and/or discipline. In many respects these are the university ideals. We might complain when students do not offer such accounts but even our own university experience may not vindicate such ideal motives. These highest ideals have not always been universally dominant. Perhaps the wealthier classes from the middle ages to the 1960s could afford to promulgate such notions since they did not have to worry too much about having to earn a living afterwards. But lecturers may not always have been so dedicated either to their subject or to the experience of learning - either for part of their student days, or may even have suffered some disenchantment themselves in the contemporary climate. For such reasons the "practical suggestions" offered here should not merely be tricks or devices that "stimulate" students to behave or think in ways idealised by me.

As university educators in professional education we have to decide how to relate our perception of the students' needs with their views about what they want. This means acknowledging the entire complex of motive attributions and placing that in the

context of the available distribution of learning resources. Motives are words which express ideas, aspirations and expectancies. But possessing and advocating such motives to learn is useless without the resources with which learning is done. So it is first necessary to show how to make the best use of the available opportunities and/or to remove any obstacles to learning. This is all part of creating a "conducive learning environment":

- **information and guidance**

Students must be adequately informed about what educational opportunities exist and how best they can make use of them. Expert guidance must be prepared to indicate variation in quality and be specific to the requirements of the individual. Much advice comes from providers at present and so is not independent and impartial. Both paper and people "guides" exist to advertise institutions - to sell themselves. If students find themselves in the wrong institution or wrong course at a later stage, then some of the blame might lie at the doors of the corporate image makers. This seems particularly important in professional health education where, for example, traditional links between education providers and local health services facilitate employment possibilities or when continuing educational opportunities must reflect service needs. Thus, for all its administrative complexities and burdens, independent quality assurance serves a purpose when it ensures accuracy of information for the student recruit.

- **conviction**

All higher education staff must share and exhibit the fact that they care about the goals and ideals of a university education. Cynicism, self-seeking and pessimism more easily cascade "down" an organisation than "up" it although negative attitudes can also undermine from the lower ranks. No successful modern business enterprise lacks a mission statement; nor the means to implement its goals and evaluate its achievement professional educational organisations can learn much from such an approach. It is clear from the research reported here that the "mission" must match the "vision" and ways found periodically to re-visit both to ensure that commitment is maintained and, if it is not, to discover why it might have been undermined.

- **opportunity**

Adequate resources, in the form of time and money are vital and new funding systems are now being considered. But ability is also a vital resource and serious errors are made by admitting students to keep the numbers up without unlocking the

potential that all learners have. Things like opportunities to try out the experience of higher education; improved access to university based on realistic chances for success; increased incentives for adults as learners are ways in which the opportunity may be made a realistic one. Necessarily this has a consequence for the quality of the output. Thus study skills packages like the one reported earlier offer a simple means of enhancing opportunities to succeed. Clearly they need constant updating to ensure relevance to contemporary available learning resources. Keeping up to date, for example, with web-based media requires constant vigilance.

- **perceived net benefit**

When individuals conduct their own personal opportunity-cost analysis, they must calculate that it is worth putting in the effort to pursue higher education. One in five respondents in the DfEE survey did not have a choice - they were required by their employer to attend a course (Tremlett, Park and Dundon-Smith 1995). That counts as a motive, but it does not deliver students with a commitment to learn, rather it produces students with a calculated incentive to achieve the credit of passing the course. If continuing professional development progresses in a similar way, much of the joy of learning is likely to be threatened and there are reasons to suspect that some CPD for HCPs is viewed in this way. The students reporting their motivational narratives in Chapter 5 demonstrated the kind of views that suggest they certainly perceive great personal gains. Such a device could be more than means of reporting but could be used by educators as a stimulus to further learning encouragement and as a focus – a basis for ongoing dialogue.

- **empowerment**

Commitment on the part of both learner and educator is a function of making realistic choices. This is only possible if real alternatives exist. Thus the increasing uniformity of higher education may be disempowering and, therefore, a means for depriving learners and educators alike of taking responsibility for learning. Only if the organisation can respond to the learners' sensed inability to control aspects of their learning environment will learners be encouraged to believe that they can put some direction into their learning. The caring learning approach advocated here relies upon a willingness on the part of educational organisations to do just that. Responsibility for learning accomplishments can only be left with the learner if the organisation does nothing to obstruct – either by not offering adequate information, by failing to express a mission and a vision and so on.

- **quality assurance**

Learners often have a sense of value for money and/or value for the time which they have invested. They will not merely be reassured that what they are getting for their time/money is creditable by a QAA visit and publication of official reports on quality. They make their own judgements of worth based on delivery methods, class sizes, organised and clear curricula, flexibility and variety to cater for individual differences. And they make such judgements on an ongoing basis throughout their course or time spent with the educational organisation. The assurance of quality, therefore, also requires the opportunity for continuing dialogue with providers – not something sought in a crude evaluative response at the end of the course – when it is often too late to do anything about the current learning experience!

(All the above issues are derived from the research reported here and from fuller discussions on each issue in Watts 1990: 74-75, Tremlett and Park 1995: 15-20, and Uden 1994: 28-35.)

We can and ought to have as much control over these resource factors as possible. Not all are equally controllable. My own and my colleagues' attempts to develop the learning environment revealed in the "reflective commentaries" that form part of this thesis show just how difficult that can be. And institutionalised provision will still be used by students for their own purposes - whatever we hold to be the "real reasons" or even the "best reasons" for doing it. Ideally we seek congruence between the motives of the individual student and those of the institutional provider. Students who find themselves in institutions that espouse the same motives as they do will have really found their "place".

Cultivating motivational congruence in a responsive environment

In the dialogue about learning, students and lecturers often pass off responsibility to each other. Given the need to confront the constraints on higher education together, the responsibility for learning must also be shared. As lecturers we could choose to deride motives which come low down on our own priority list or we could choose to use those motives along with our own in a dialogue about the learning experience. To put it colloquially - to understand where we are each "coming from".

Cultivating such a "responsive environment" cannot merely mean the imposition of an integrative curriculum or an andragogical pedagogy. Teaching Quality Assessment

refers to "enhancing the quality of the learning experience" and we can do this by engaging in a discourse with the student that includes consideration of the following topics:

- **clarifying the reward structure**

It must be made clear what is to be gained from the successful completion of the course. What can be achieved and what is the value of such achievement? If degree qualifications are devalued, we must be prepared to discuss this. Other motives for engaging the course might then be seen as more important. But it is not hard to see how student destination information would enhance the motivation of those students whose accounts would be vindicated of they could see themselves in similar destinations in a few years' time. Clearly, if employment prospects were in decline such rewards would not be on offer – but it is hard to imagine such a scenario in the health care professions in at least the foreseeable future.

- **sharing success tricks**

Learners can be encouraged by discovering practices successfully adopted by those they emulate. Those who succeed well in assessment procedures, for example, can share their mechanisms and methods for success. My own most successful system for exam success was a revision syndicate for exams: working with others to predict likely questions, to rehearse acceptable answers and to co-operatively produce revision notes. It sounds very instrumental - but it worked and enhanced my enjoyment of the learning experience considerably. There are times when an instrumental rationality is an acceptable part of the learning experience. Many of my colleagues involved both in the delivery of the study skills package and in the learning styles stage of the study found themselves sharing such "tricks" frequently. Indeed conversation with many educationists leads me to suspect this to be an accepted part of the successful tutorial and mentoring relationship.

- **identifying and addressing practical needs**

Learners' needs are frequently practical - such as how to write a good assignment, how to conduct an information retrieval search effectively, how to make seminars work, how to use a piece of equipment and so on. Modelling, description, over-the-shoulder work and systematic instruction can be employed in a concerted manner to suit most learners' individual needs. Most teachers identify this as good practice - but may balk at employing this in higher education due to lack of time or the belief that, at this level, there are few practical solutions to these sorts of

problems. Just recently discussions have opened in SNMS about the possibility of post-registration students on CPD courses sharing in the lifelong learning/study skills package outlined in Chapter 3. My own experience of delivering advice on assignment writing to post-registration students suggests that failing to resolve such apparently trivial needs can get in the way of the main purpose of CPD – the further acquisition of knowledge and skills that enable the learner to enhance their own practice. This, of course, was the point made by the research conducted by my post-registration colleagues and reported in Chapter 4.

- **practical andragogy**

The principles of andragogy are generally valued but, regardless of the reservations about andragogy outlined earlier, it would be a contradiction in terms to impose autonomy upon learners who were not ready for it. This can even happen with mature students. It may be that with some topics and with some learners, autonomy and responsibility for learning will take time to cultivate. I learned this for the first time in my first full time lecturing post in an adult residential college near Edinburgh. Given the nature of Scottish higher education at the time, students expected – even demanded – straightforward lecture sessions. They resisted interactive sessions, participative shared learning and workshops of any kind. If students want didactic teaching at first then it might be appropriate to meet that need in the short term, even if it counters an institutional mission or the educators' own valued educational principles. This present work and the research on learning styles reported earlier confirms this. Students on clinical courses do feel vulnerable if their essential skills practice and knowledge is not adequate before their initial placement experience. There is a problem of balancing cognitive growth with behavioural modification that was discussed earlier (in Chapter 3). But recovery from being "thrown in at the deep end" in clinical practice is not guaranteed. It is essentially andragogous to permit learners to judge when they are ready to be autonomous.

- **matching rhetoric**

Educators need persuasive rationales for action. Learners need to be convinced of the "good reasons" for learning a particular thing or behaving in a particular manner - this cannot be taken on faith. Nor can this be done by the crude employment of, for example, an appropriate student sub-cultural vocabulary - this might appear contrived, soon gets outdated and the educator anachronised. Often students bring their own highly persuasive rationales as the narratives in Chapter 5 demonstrate. These can form the basis for a broadening rhetoric that, if openly shared, could

become adopted by those students with less personally convincing rationales. Such an approach might be particularly effective in vocational education.

- **responding to variations in learning styles**

Even though there is reason to doubt the effectiveness of the formal employment of learning styles within curricula as indicated in Chapters 3 and 4, learners still hold notions about their own "best ways of working". The discovery of these can be facilitated by personal experiment. Learning work can be turned into leisure by the appropriate use of working time and by judicious time management. Most successful learners manage time by use of simple rewards and by the sense of control derived from choosing one's personal "best time to work". Once again in spite of the methodological limitations, the work on learning styles with post-registration students reported in Chapter 4 suggests an interest in the "process" of learning that can become a vehicle for increased skills with the "content" of learning.

- **disclosure - sharing vulnerabilities**

We have to be prepared to discuss exams we have failed or lecturers we didn't like - or lecturers who didn't like us! The fear and conditions of failure must be confronted. The usual reasons for lack of success should not be buried since the individuals most at risk will be the ones most likely to suffer. Once aired these possibilities can be addressed. The students' fears disclosed in their motivational narratives in Chapter 5 (as well as the vulnerabilities of staff revealed in the vision workshops in Chapter 6) offer possible means for accomplishing this.

- **display - pride in competencies**

At the same time we should encourage apt immodesty as a means of boosting confidence. If we can be prepared to reveal being good at something, students will see this as acceptable pride. It also enhances co-operative learning in that students can share in each other's collective expertise. Indeed a concern to develop a culture of which the staff themselves can display pride frequently emerged in the items reported from the vision workshops in Chapter 6.

- **success and failure biographies**

Phrases like "I can do that!" and "That sounds just like me" are reflections upon the modelling of career biographies, as is the observation that someone worse off than oneself succeeded. Mature students are particularly encouraged by the news that it is never to late to learn and to gain qualifications and career success. By this

means their aspirations can be encouraged and are seen as eminently achievable. Once again the narratives in Chapter 5 gave evidence of this, as did the meta-narratives of others' encouraging experiences that they reported occasionally in their essays.

- **pedagogical content**

Last but not least is the encouragement of commitment by the employment of known successful ways of teaching one's discipline. It does assume that the content alone may not be enough to stimulate interest and commitment. If delivered in an interesting or exciting way, the learners' attitudes toward the content can change. We need imaginative introductions to courses and innovative, alternative forms of curricula which produce students who are excited into sharing our vocabularies of motive, our reasons for learning - our "idealised" judgements about how the intellect can and should be developed. We need to be equally imaginative about assessment and attendance – those more bureaucratic concerns of the learning environment which can be obstacles to learning, but which are also, at root, the source of legitimacy for the existence of the educational organisation in the first place. Without this justification the argument for returning the "training" of health professionals to the practice setting would be hard to defeat. And it is something still aired occasionally by health service managers and government health ministers alike.

All of the above suggestions were compositely drawn from the action research reported here, the relevant literature sources reported and commented upon throughout this thesis and from reflections upon my own experience and the reported experiences of colleagues. In some senses they are motivational narratives which offer ideas about some practical "mechanisms" for constructing successful learning environments. They imply means by which people can take responsibility for their own learning and thereby enhance their individual commitment (Uden 1994:13). They are suggestions that might help reduce anxiety and boost confidence. Quite apart from the constraints of politics and economy, encouraging discourse about such issues helps create the "conducive environment" that I hope we are all looking for.

Staff aspirations

Ways must be found for doing the same with more permanent members of the organisation. The evidence of the work reported in Chapter 6 suggests that positive, goal-oriented narratives should be allowed or encouraged to emerge within the staff and the institution must find ways of working with them. In this way an institution can

become more than just a collectivity of roles (the sociological definition). It becomes a combination of narratives or "reasons for the roles" that combine in particular, hopefully successful, ways. Devices for encouraging the emergence of narratives could include the vision workshop detailed in Chapter 6, which might allow such motives to be re-visited on regular occasions in an attempt to discover the approximation to the "ideal".

It is not so much the actual content of a mission statement that is important. While the mission statement becomes a focus for a transcendental value system, what matters more is the construction and re-construction of the mission that permits such values to be reformed and re-stated. People do not constantly refer to their mission in the ordinary course of affairs, they need special opportunities to do it. Sometimes this is accomplished in informal corridor discussions but other more routinised institutional opportunities are needed if the process and outcomes are to be taken seriously.

In this respect the participants in the construction of an institutional narrative might avoid any of the temptations to build and/or perpetuate a malign discourse. This can undermine all attempts at progress contained in the mission and in the vision. It is not just gossip that can be destructive of individuals as well as institutions, but malign discourse is much more insidious and pervasive. It cultivates a cynicism for procedures seeing them, perhaps, as suiting bureaucratic demands that are far from the hearts and minds of teachers and students. It sabotages attempts to demonstrate mutual trust and mutual respect. It constructs a facade of cynicism that can fundamentally undermine the best hopes of an institution.

The problem then becomes one of finding ways to inhibit a malign discourse. This does not mean stopping or preventing gossip or rumour-mongering. Those things, rightly or wrongly, are routine in modern social intercourse. They appear particularly inevitable in complex organisations and certainly members do gain some pleasure and potential kudos in being the bearer of little known pieces of information. Problems arise when nothing is offered as an alternative. Management silence perpetuates the discourse, even allowing it to become more malign as motives are guessed at without ever being aired and challenged.

It is clear that an organisation inhabited with professional carers is not necessarily exempt from this process. It is why "sacred space" (Wright and Sayre-Adams 1999) has to be offered as a retreat from the stress. What might help even more is regular

retreat time being allowed within the organisational routine which is something more than the ephemeral escape offered by the annual vacation. Instead of being absent and distant such a retreat allows individuals to remain in the organisation and trying better to understand it.

Policy and action recommendations drawn from the vision workshops

By collapsing the disparate individual items emerging from the workshops reported in Chapter 6 into coherent broader categories it might be possible to construct a consensus vision - one to which most members of the organisation might subscribe and which would represent the ideal work setting. Some items that were mentioned by only one respondent might also be seen as problematic by many, so items of detail could be listed for attention within each broad topic category. This consensus list could then be presented via the normal democratic process for decisions about implementation and application. While I would hope the method could be applied in any organisation (educational or otherwise), I do not, of course, expect the content to be necessarily held in common elsewhere – another limitation to the generalisability of these case studies.

It is important not to see this list as critical in any negative sense. The comments were generated in a positive light - with a view to the "ideal" and so many of these things may already have been happening or under way. Indeed others might have been put in place since the workshops were conducted even as a consequence of ideas emerging in the workshops. The organisation and the individuals who constitute it have been, necessarily, developing professionally and collectively.

Nonetheless these are clearly strongly held views about what makes for the ideal work setting and staff expectations are such that these items need to be continually addressed. Difficulties may arise over those issues which appear contradictory (such as "respect for difference" while "seeking common purpose") others may, in practice, be unachievable (such as the desire to build a "sense of community" and a social "centre" in spite of geographically split working sites). But attempting to reconcile such apparent contradictions is one of the major tasks of continuing organisational development. In procedural terms it might be useful, first, to identify areas of responsibility for action, next assess which elements of the vision are already in place and, then, which of them still need to be implemented. There may be a view that some issues have already been rectified or that no disagreement exists. These could be

endorsed by senior management directly. Others could be put up for debate as part of the decision making machinery of the School in order to assess how achievable they might be.

The remedies proposed by the staff to overcoming obstacles to achieving the desired aims included more positive talking opportunities, a sharing of aims and aspirations, a bringing into the open of desires, hopes, wishes, ambitions, values, philosophies, and frustrations. As a step in this direction the following more specific suggestions can be offered:

1) Drawing on the general statements in the vision workshops could allow the organisation to achieve some consensus on general philosophy and principles, perhaps in the form of an expanded mission statement. Staff might disagree more on what are seen as the appropriate means for achieving those ideals and, possibly, what is realistic.

2) Any disagreements about means for achieving the mission might be resolved by a full staff seminar or "awayday", led by senior management, expressing views about achievements, prospects and challenges. It would be particularly timely to do this in light of the Government and UKCC's new proposals for nurse education. Given the views expressed above it would be vital that this was not dominated by senior management but run as a one-day workshop/conference allowing all staff the opportunity to express opinion. A means for allowing the organisation's ethos to be formulated and stated more fully would be a positive outcome to be sought from such an event. It would provide a natural sequel to the original vision workshop exercise. (As I write the first of such planned "awaydays" has taken place and more are planned for the future.)

3) Many of the more detailed and specific items could be assessed for achievement as part of the annual evaluation rotation soon to be implemented as a consequence of actions within the School's Quality and Evaluation Board.

4) As many staff as possible should be included, perhaps by a delegation and rotation of responsibilities, in the evaluation of the organisation's goal achievements.

5) Proposals for and any oversight of initiatives in organisational development need to be maintained by the appropriate body within the School's decision-making structure.

The above recommendations are designed to implement a process of "collective thinking". Activities such as vision workshops or the long term scenario planning now adopted by the most successful multinational corporations implicated in the global economy are examples of collective thinking. Ways have to be found for how such "...collaborative thought can lead to co-ordinated action" (Jaworski 1998: 109). And dialogue is frequently advocated as the key to this; dialogue in both the form and the content of professional education. While recent policy recommendations have emphasised the importance of leadership in this process (DoH 1999) it is vital that the right kind of leadership is advocated. Only when the leadership fosters and participates in dialogue can co-ordinated action take place: "The conventional view of leadership emphasises positional power and conspicuous accomplishment. But true leadership is about creating a domain in which we continually learn and become more capable of participating in our unfolding future" (Jaworski 1998: 182).

The vision workshops were an attempt to revitalise a consensus view of the future. Since only half of the staff attended, the consensus might not be as fully established as one would hope for. So the question remains how to establish this in an ongoing way in the future. The concept of an institutionalised attribution complex introduced in Chapter 5 needs to be understood and utilised - but it must be flexible and adaptable to be realistic as well as idealistic, to adjust to external constraints while never losing sight of the aspirations of members of the organisation. This represents one way of establishing a philosophy of mutual respect and a set of mutual support systems. In addition there would have to continue to be acceptable and supportive procedures for circulating information, making decisions, putting together teams to act in research and in educational development, and the careful setting of roles for team members. The evidence of the vision workshops also suggests a need to confront problems of staff insecurity, their perceived vulnerability and their lack of confidence about an ability to engage some tasks. Finally, there is need to also confront any problems of role conflict in the inevitable mix of roles that comes from rapid and complex professional development. Staff have to be lecturers, practitioners and researchers, as well as, as they have always been, managers, counsellors and mentors.

The apparent contradiction and dilemmas witnessed in educational organisation as this research progressed are only parallels (and, partly, consequences of) similar

dilemmas in the health service that this education system was established to supply. Public health gain, patient and practitioner empowerment, clinical effectiveness and service efficiency become incompatible objectives when pushed to extremes. In their policy origins they "... appear as a series of disconnected initiatives, arising from inherently conflicting ideologies" (Duggan 1995: 31). In the same way pragmatics demands attempts to reconcile such dilemmas. For each individual in the organisation the problem becomes how to balance and so prioritise pressures from the university, from health funding agencies, NHS, central government, professional bodies, students, and colleagues with one's own professional and career ambitions.

Professional education within universities

Nolan and Nolan (1997b) came to the conclusion that the uncritical acceptance of andragogical principles and the drive to self-direction is inappropriate in the early stages of nurse education. They advocate a model of co-operative learning in which a "friendly, caring and fallible" teacher takes the lead in directing the student's learning and gradually facilitates self-direction in the student. The research reported here in Chapter 4 suggests that students start with high expectations of self-direction and come to realise that it is harder to achieve than they expect. There is no evidence that they are contented with this decline in their expectations nor is there any evidence that this is achieved "co-operatively". However, the analysis of their narratives in Chapter 5 supplies further evidence of the strength of vocational commitment that will sustain them through a range of learning adversities, whether in classroom or practice placement. Nolan and Nolan (1997b) suggest that a comprehensive core curriculum and pedagogic philosophy needs to be agreed by consensus across all teaching staff so that the correct balance in self- and teacher-direction can be achieved. The staff views collated in Chapter 6 demonstrate that such a caring learning organisation can be achieved and the vision workshop offers a means for achieving it.

Overall this research gives an indication of how vital it is to continually review the change in the student (i.e. their movement toward becoming effective learners) in the context of change in the profession of nursing and the health service generally. Learners may possess learning styles but they are liable to change through the process of learning. It might be that such adaptation is more likely to occur with health care professionals since the range of influences and learning situations they need to experience, and the various participants they will meet in them, will have quite a variety of influences upon them. Thus it would seem unwise to identify the learners'

styles, assume it to be fixed and then devise a course of study to suit such styles. Instead it might be more appropriate to set up the usual range of health care learning situations in which both individual and collective adjustments to learning styles could be made in a way which allowed the "testing" for an appropriate style facilitated by educators who were aware of the full range of possibilities.

It does seem that the ability to be more reflective and self-directive as a learner increases as the student moves through their training and into practice and so mechanisms to support this ought to be available within the educational setting. Some such mechanisms can be formal (such as journals and portfolios) but others must be more informal and embedded into the entire system - and not just found in the intimate tutor/student relationship. This means that the philosophy of the curriculum and of the School should match the vocational philosophy of the profession. That is:

1) If health care is to be holistic and client-centred, then education must be holistic and learner-centred.

2) If practice is to be evidence-based, then so should educational practice and gaps between theory and practice must be closed. Theory must not be merely abstract, and evidence must address problems identified in practice.

3) If patients are to be empowered to make their own health care choices, then student learning must be facilitated, the learner empowered and an inflexible didacticism ruled out.

4) Reflection cannot be merely "in" practice, it must be "on" or "about" practice - and this includes reflection on learning as well as health care practices.

Although it is uncomfortable, it may be vital to address the issue of whether the university is an appropriate place in which to conduct professional training. "If the sole object in view is to train reasonably successful lawyers, doctors, administrators, engineers, or technicians of any kind, there is no reason for burdening the university with the task. History has repeatedly shown that this can be done on the job or in separate training schools" (Hutchins 1968: 109). In the thirty years since Hutchins argued the place of the university in the anticipated "learning society" of the twenty first century, and in which he also anticipated the diminishing influences of "politics,

economics, technology and the social order" (Hutchins 1968: 3) on such institutions of liberal democratic education for all, it seems hardly fair to indicate how far wrong he has turned out to be. In the UK all of higher education seeks to justify itself precisely in terms of its contribution to politics, economics, technology and the social order. The separation of professional education from such institutions is clearly highly unlikely, in fact they provide continued justification for their funding. The question then remains only how to do both – to train and to educate; and what principles must be balanced between professional requirements and the university ideal?

This is the even broader "context" within this work is offered: the need to understand the role of a university in light of contemporary pressures. This is not the place to consider the pertinent issues fully, but it is vital to see the pressures from which the questions raised in this thesis had to be addressed. As a consequence of the general direction government policy has taken (more recently in the Dearing, the Kennedy and the Fryer Reports) higher education has been increasingly subjected to "the hegemony of instrumental reason, the dominance of questions of means over all other questions" (Blake et al. 1998: 6). The quality of the university experience cannot be reduced to measures of customer satisfaction (Blake et al. 1998: 44-7), the nature of the wants and needs of the individual, of society and how the two become mutually beneficial is far more complex than the simplistic performance indicators of quality and, thereby, of effectiveness, will allow.

The university must be a focus for resources of knowledge and intellect that inspire, convert aspiration into realistic achievement and permit the kind of personal and social transformations that are vital to fulfilling the individual and the collective potential of a society. It is only through co-operation between learner and educator and between both these and the institution that such learning is conducted effectively. It is in this light that this work is offered. My personal research "mission" is to be seen as an attempt to accomplish these university goals in the context of health professional education and training.

Conclusion

This Chapter has drawn together the different threads to the thesis, indicated the implications of this work for future practice and made explicit policy and analysis recommendations for the education and training of health care professionals. There is now a need to find an opportunity within the inevitable imminent changes to

curriculum to make use of these recommendations as part of the natural process of organisational development. This might be accomplished by maintaining an ongoing participative action research project which attunes members of the organisation to change based on evidence and to regular evaluations of the success of the institutional mission.

As with all action research, the initial incentive for the study was composite - a combination of concerns about behavioural science teaching, about the nature of learning in general, about the particular problems of learning for health care professionals, all against a background of massive change. So action research is necessarily emergent, reflexive and reflective. It also means the work cannot be conceived as finite. A particular stage in the evolution of health care professional education has been reached, but the consequences of this early phase will take some time to filter through to the patient experience. Meanwhile, the CPD of those educated in this early phase is picking up pace and the changes in health service provision and in higher education which frame this study are far from slowing down.

As this thesis was being written up a review of the structures and processes of NHS funded nursing midwifery and health visiting education had already been initiated. The UKCC Peach Commission (UKCC 1999) reported and in general it endorsed recommendations already made in the Government policy statements outlined in Chapter 2. These include workforce expansion and improved strategic workforce planning, additional training places to remedy reductions made between 1992 and 1994, and a national recruitment campaign. While a more flexible career and training structure is anticipated, so too is a strengthened relationship between NHS and education providers. The Department of Health is likely to adopt a more active role and the Government says that it wants: "... to give a kick-start to more multi-professional learning and teaching and to ensure the systematic sharing and spreading of good practice; and more effective and accountable stewardship for the NHS's massive investment in education" (DoH 1999: 28). This policy emphasises the importance of a strong link between lifelong professional education and the complex and rapidly changing needs of patients. A clearer system of flexible career pathways is desired "...to ensure that practice development, education and research are joined-up, and a framework is provided for post-registration education and continuing professional development" (DoH 1999: 28).

Both students and staff in health professional education will necessarily continue to have multiple agendas with varying priorities. They will not match each other precisely and they will change over time. But an underlying principle of this thesis has been that dialogue is the essence of effective learning. It is a means for reconciling the inevitably inegalitarian and paternalistic nature of the tutor/student relationship as well as the inevitable hierarchies of educational organisation. Dialogue must be open allowing the appropriate reflection on practice, both in professional practice and in learning about professional practice. The Government has recognised that the health services require "... a modern, responsive workforce of well-motivated, well-trained professionals equipped to respond to the challenge of change" (DoH 1999: 13) but this will not happen so long as this workforce is constrained by structures that limit development and innovation (DoH 1999: 7). While external pressures will inevitably influence course content and curriculum strategy, they must not be allowed to influence the professional educator's "style". So long as that is demonstrably effective and efficient.

In many respects, effective learning requires effective communications skills. A good learner is one who can manipulate their environment to facilitate their own learning. There is little any one individual can do to alter the entire context of learning during their own individual experience of the process. Politics, economics, professional culture and collective aspirations are all influencing that context in evolutionary or, very occasionally, revolutionary ways. The effective learner responds to that context in the best possible way - it is rarely possible to change the environment, but one can change how one responds to it

Effective learning also implies lifelong learning. Knowledge and information in health care grows steadily, organisations and systems are under the pressure of continuing change. Any health professional that considers their learning to be "complete" will never be adequately prepared for contemporary care work. Yet there is a contradiction in aspects of this policy that has to do with the inevitability of setting limits upon self-direction in the caring professions. The vehemence with which this policy is advocated sits uneasily with the recommendations about professional educational flexibility. Clearly some boundaries are set by legal and ethical responsibilities. More problematic are the organisational pragmatics of applying new knowledge or practice changes in settings notoriously resistant to change. Any real innovations in health professional education will have to be matched by an openness in health service organisations - it would be interesting to see vision workshops operating routinely in an acute general hospital.

Such an approach would have the organisation match an attitude to learning implicit in CPD. For both the lifelong learning organisation and the lifelong learning individual there is no final "point of arrival", learning requires humility and the expectation that learning goes on indefinitely. The best educators recognise the inevitability of learning while teaching.

At the time of writing the conclusion to this thesis, and with wholesale changes in the form and content of nurse education once again imminent, it is worth remembering that one of the stimuli to this research was a recognition of the problems arising from administrative incorporation and amalgamation without ideological legitimacy. Discrete nursing and radiography schools with their own traditions and which were geographically separated were forced to become one new institution. Midwifery education saw itself as continually subordinated to nursing, while the survival of radiography education locally remained perilous. At the same time these disparate groups were entering a not exactly friendly HE environment with threatening and destabilising changes of its own. None of this was designed to enhance participants' conviction and commitment to the institution. It is vital that these lessons are learned.

There are inherent contradictions in attempting to accomplish potentially diverging goals. There are divergences to meeting the vocational aspirations of the student, the human resource (labour power) demands of the health service, and the research and teaching expectations of HE. These interests ought to coincide, but there is no inevitability that they do so. This is about establishing a symmetry between the theories espoused and the theories in practice (Argyris 1993). In the radical organisational change which has been experienced on incorporation into higher education by most nursing and midwifery schools across the UK common difficulties have emerged as outlined at the start of this thesis (Cadman 1997).

A classic study from the organisational analysis literature seems entirely appropriate to understanding the experiences of SNMS. Burns and Stalker (1966) draw a distinction between "mechanistic" systems which are effective in times of order and stability and "organic" systems which are more effective in times of rapid change. Mechanistic systems are rigidly hierarchical, with vertical - "information up, decisions down" - communication processes and responsibilities carefully controlled. Organic systems in contrast require flexibility and initiative from individuals for the organisation's goals to be furthered. In this case communication is more about consultation than command, solving problems through bringing together all those who

have knowledge and expertise. In unstable conditions with massive changes in both market and products this represents a more efficient organisational system allowing adaptation to changing circumstances. This has clearly been the case for nurse education. The markets (in the form of new health and education systems) have changed out of all recognition and continue to do so, while the product (a qualified health care professional) is still demanded although no one can give a precise specification for what the new version of this product needs to be. Nurse educators have had to accommodate such uncertainties while attempting to operate in an emerging organic structure which still retains elements of its mechanistic history. In addition organic systems do impose greater demands on individuals - requiring greater commitments to their goals, the continual learning of new skills and involvement in new areas of work which require them to move beyond their original competencies.

By and large it has long been recognised that strategies of defence and resistance - natural responses to frustration and anxiety - have been adopted in the face of difficulties in reconciling such dilemmas (Menzies 1970). A frequently cited example is the sacrifice of the systematic rigour required for independent research into client needs with the ad hoc construction of patient satisfaction questionnaires by variably qualified ward staff in order to meet the more immediate needs of organisational audit. Such dilemmas pose real difficulties for the study of organisational caring and learning in health care settings. Undoubtedly the individual members of health care and health professional education organisations do care and can learn, there is much less evidence that the organisations can do so (Newell 1995, Welborn 1989).

At the same time the structure of SNMS is, I believe, more finely honed that it was when this research began. Naturally I hope that the participative action oriented research reported here played some part in that honing. There is undoubtedly a need for a comprehensive and visible statement of strategic intent and direction which is used systematically to establish performance indicators and so re-visited periodically. Perhaps more importantly it should be reviewed by all staff regularly and be so flexible as to be easily updateable to accord with changes in the broader economic, political and social climate. It is also to be hoped that certain aspects of the research on which this thesis is based which have come to fruition in the form of reports and recommendations and which are now under consideration by Senior Management

should soon be in operation within the School. It seems that the organisation has now learned much about how to learn. The inevitable large-scale changes that we will soon have to confront can now be managed in a manner that is constructive for all members of the School and for the University as a whole.

Reflective Commentary - 7

A Final Reflection

Chapter 7 was necessarily the most prescriptive part of the thesis. In it I was trying to bring together the conclusions reached and recommendations to be drawn from each of the preceding phases of the project. I came to these views after drawing upon my prior experience, modifying that in relation to the experiences of working in this specific institution, recording the views of students and staff (from evaluations and the explicit methods reported earlier in the thesis) and bringing those into focus in relation to the specific suggestions made here. I drew also upon specific recommendations made in the literature on student motivation to refine the detail within my own suggestions.

I have come to the conclusion that there is very little that lecturers can do about the motives of students which don't match the professional and educational ideals they wish to espouse. To accomplish this would imply a fairly comprehensive control of all aspects of higher education. Students - even in vocational courses - "use" institutions; some do it more sincerely than others. To prevent that it would be necessary to employ some either highly sophisticated or highly authoritarian systems. In the end their perceptions of their needs and their wants are likely to override even the educators' experienced judgements about their true needs. We may take some comfort in the knowledge that this is even worse in non-professional/vocational courses where students may be taking optional modules merely to make up a course.

I have also concluded that something can be done about those students who are obsessed by assessment and "just want to pass". This can be done by using all opportunities for a dialogue with students about the nature of the learning process - this is vital for continuing professional development too. This accounts for my emphasis upon the importance of dialogue. Information and discussion about the staff's own ideals and the constraints that they have to face, helps students to have a more realistic understanding of the broader institutional pressures which produce a course designed and assessed in a particular way. I have found in the past that sharing such concerns treats the student as an intelligent and worthy accomplice.

When my external examiners engaged in the common practice of asking "What's your big idea?", I was, nonetheless, surprised by the question. Did they have to ask? Wasn't it obvious? Or did they just want to hear me express it in my own words? This is one of the problems with the Viva experience – one is constantly thinking that the examiners appear not to have read the thesis, or not to have read it as carefully as one might have hoped. The more I thought about it, the harder it became to express my one "big idea". In fact, I suppose there are many "little ideas" – the big idea lies in what might happen if all the little ideas were put together. I know that I am trying to say that in times of rapid and stressful change, the nature and the content of the dialogue that members of the organisation have with each other can become a sustaining force. It constitutes the ethos of the institution since it empowers practically and spiritually. If we can talk together in this way about these things, we can collectively confront the challenges that we meet and move together through them. Moreover, we can come to a collective understanding of what health care professional education can achieve in the context of the higher educational institution. It seems to me now that "caring" is an essential part of that process. In fact, Peter Jarvis has expressed its importance most eloquently: "What is called for, is an approach to learning that enables people to recall their own experiences of being cared for, and their experiences of caring for others, and realising that the world would be a better place - irrespective of either social structures or structural change - if individuals living within whatever structures that exist do so out of concern for the Other" (Jarvis 1997: 171).

In observing that response, and while remaining mindful of the difficulties of generalising from the specific studies reported here, I would hope that there are plenty of spin-offs for other professional educational settings and institutions too. I would not want to argue that this approach is exclusively necessary for health professional education. It could be of interest to all learners in higher education. Again one would need to contextualise fully the learning environment. Perhaps a different ethos is essential in other professions – shouldn't an aesthetic experience be part of the architect's education; shouldn't the symbolism, puzzles and enigmas of mathematics pervade the mathematician's learning situation; and shouldn't the musician's environment be imbued with rhythm and melody?

My interest in learning was clearly drawing on my interest in other issues. I could not write about the connection between learner motives and effective learning without incorporating a particularly sociological view upon motivation that I wanted to advocate. In the same way, my work in the sociology of health was raising concerns about what is actually meant by "holism" and the extent to which it is implemented. Thus one of the obsessions of research culture is the measurement problem – of course I am concerned with that but more concerned about "adding value", and "making a difference" (both phrases are acknowledged to be dangerously voguish since Government reports repeatedly bear such titles). When I think back to the learning styles approach – I realise that this is why I have turned out to be so critical of crude "quantitativism". It does seem to me that the vision workshop and the facilitation of narrative opportunities do represent more authentic ways of generating the appropriate forms of reflection upon learning and teaching – whether or not distinct "styles" get revealed – and of generating the awareness of the full context (institutional, social, cultural, political and economic) within which learning occurs. These contextual influences necessarily vary according to one's position in the organisation. Different participants hold different "stakes" in the enterprise. Mutual awareness of the participants' varied interests is stimulated by dialogue – therein lie both the diagnostic and therapeutic benefits of reflection. It is not enough to say that dialogue and reflection must/should occur – it is necessary to be clear about how that dialogue or reflection can be framed. What should be the substance of the dialogue? What constitutes appropriate content of the reflection? (see p.103.para 2.) This is what I am trying to accomplish in the specific recommendations that were offered here.

By now I was well aware that motivation and environment together contribute to effective learning. But I wanted to avoid any prescriptive rationale (p.62) Such as – "You ought to be deciding things for yourself." There is a danger of abrogating share in the responsibility for learning – the context is mediated by the educators.

Coaching leads to "finding things out" not just "learning things" (p.64). But this does not mean that coaching is always superior to training. Getting the balance right between the two is one example of how dialogue between educator and learner can be accomplished. Thus dialogue is part of the way in which responsibility for learning is

shared between educator and educated. For me now it is vital to take into account all the "elements" of effective learning – andragogy and/or pedagogy, the 'stages' in a learning cycle, the possible range of learning 'styles' available and the degree of autonomy or self-direction that might be allowed or sought depending upon context. And by "context" I mean that different students in different learning situations learning different substantive content will have different learning needs. The role of the educator as mediator (between student and context) then becomes one of ensuring that the correct mix or combination of learning opportunities are provided for the learner. Again dialogue becomes the vehicle through which this can be accomplished. If learning aims are sought secretively or mysteriously then the educator assumes the role of patron – claiming to know what is "best" for the student without the student's conscious compliance.

Ford's Motivational Systems Theory discussed in Chapter 3 shows how complex the combination of elements which go into effective learning actually are. The factors which constitute motivation and those that make up a responsive environment are many and dynamic; and they are likely to be in continuous change. All the more reason to reject research measures which are artificial snapshots of a highly complex process (cf. Jarvis' modification of the Kolb model in Jarvis et al. 1998, Ch.6). Action research, as I have argued, must be part of and responsive to that change process. But herein lie some potential dilemmas. This argument leads to the conclusion that effective learning cannot be fixed and cannot be dependent upon stimuli that are external to the learner. So why bother creating a "caring learning organisation" at all?

Added to this, while I am an advocate of critical reflection as a primary contributor to effective learning, Covey argues convincingly that learning must become habituated to be truly effective. He claims that learner motives (the combination of knowledge, skills and attitudes) should be habitual. My mistake was in treating "habit" as necessarily an "unthinking" process. We can habitually do things and habitually think about what it is we have done or are doing. My own practice experience in my part-time clinical hypnosis work demonstrates this possibility. After initial consultation and preliminary treatment, some of my "stopping smoking" clients report lighting up a cigarette and observing the whole process as if in slow motion.

They have begun to address the habit. There is no reason that this could not occur with other "learning experiences" – a thought-full habituation. Indeed, one error I made in my reaction to the Viva examination was to engage in the defence of my thesis while sometimes forgetting that I was still "learning". Having to defend a thesis should not mean that one stands "accused" of something. While the assessment may be a trial, that should not be literal. Something I always tell my students is that I regard all assessment as formative. There is little point in awarding marks without making marks on the paper which the student has sight of in order to remedy any errors and to make progress. It shows mutual respect – for what the student produced, and for the educator's requirement to assess. To treat assessment as summative with no formative element is to resort to the very instrumental rationality I condemn – at least if that is the sole purpose of the educational experience. I was in danger of losing sight of the habits of attitude, knowledge and skill that have enabled me to learn in the past. Evidently learning is routinely accomplished with and through others – more especially through significant others. That is what a Viva has come to mean to me. And it became a way of demonstrating my thesis in very practical and personal terms.

This is, of course, why I came to see why the creation of a caring learning organisation is necessary. Caring is both the topic and the resource for the educated health professional. If it was not both the topic and resource for the health professional educator then the habit of learning caring could be in danger of being lost. One might argue that all learning organisations should be caring and, in such a case, that might be a valid moral standpoint. But in this case it is vital to the lifelong education of a caring health professional.

The organisation is not an "external stimulus" to the learning experience. It is part and parcel of it. So although my adult residential college students could get on whatever the institution, those institutions actually facilitated by, at the very least, not obstructing the students' progress. If health professional educational organisations do not get it right, they are in danger of producing well-educated but "uncaring" health professionals. On the other hand, if "efficiency" gains dominance over effectiveness, it could be possible to "train" effective carers who might not need to be particularly effective learners - I suppose that takes me back to the initial reflections

about whether it matters to, say, have a caring nurse that I addressed in the first chapter. Competent caring requires that the professional knows what they are doing and why – so caring cannot be divorced from learning completely. The particular clinical skills of the nurse (as my colleagues frequently tell me) require communicative competence. That is not something that can be done in an unthinking (if caring) way. If the patient does not receive the message that they are being cared for, then other technical patient handling skills will not be so effective. This means that the construction of a caring ethos is vital to the context within which all health organisations operate.

I could not have set out in this thesis to "prove" this point about caring. The concept is too nebulous and the proof far too complex to achieve. This is why the last stage of this thesis is highly prescriptive. It reflects my own musing (again prompted in the early years of my work by my nurse education colleagues) upon whether a university is the right place for nurse education. There are dilemmas associated with the demands of any professional training and how that fits the ideals of university education. It also reflects my growing awareness of how sustaining narratives are co-constructed in both educational and therapeutic settings. Some of the content of any such discourse suggested here is based on my twenty-eight years' experience of mature students, what appeared to work in resolving their anxieties and maintaining or improving their motivation. It is also based on the things my colleagues told me and disclosed in the workshops reported here. To some extent these comments endorsed my prior experience, but they also raised concerns that surprised me. I had not expected staff to express such a concern with being valued, respected and held in some esteem. It was evident that they did feel a lack in this respect and that this was partly due to the imposition of unrealistic expectations from the "many masters" they serve. How can one fulfil the many demands of the educational institution (teaching, administration, research and pastoral care); of the nursing and educational professional associations (ethics, standards, CPD); of colleagues throughout the health care system (clinical competence, update)? The maintenance of professional credibility – as an educator and clinician – requires some considerable effort and may, of course, prove impossible to sustain comprehensively. Even proposing to address these issues raises a sensed vulnerability. Without addressing them resolution is unlikely and continued stress and crisis becomes inevitable.

In such a climate I came to see that the organisation, its administration and its resources easily become a focus of attack. The "malign discourse" I wrote of is beguiling because it appears to serve a cathartic function; yet it merely perpetuates sensed grievances. That discourse in particular requires an intervention, endorsed by senior management, which shows awareness of the pressures of the job and proposes ways of moving forward in a process of collective thinking. In this way pressure for change is no longer something merely visited upon staff by senior management as representatives of external interest groups. Instead it can become something that all participants in the organisation confront together.

This concern with the content and nature of dialogue led me to find out more about a new organisation aimed at stressed health care professionals - the Sacred Space Foundation. Pressures are so great that no sacred space is to be found in or near work. One has to "retreat" to it. Interestingly at the first conference run by that organisation that I attended a medical colleague from UWB was leading a workshop and it was an interest I did not know he had – in fact, he told me that experience had suggested he keep slightly quiet about it amongst his medical colleagues. I have since become a sponsor of that organisation since its goals seem so vital and are inadequately addressed within the formal institutional structures of health care and health professional education that have been examined here.

In my private hypnotherapeutic practice clients have sacred space with me – but I need them to be able to reproduce it in their home, work and/or leisure environments. Similarly I would hope that during their time with me at least some of my students find a certain sacred space within the learning experience. On continuing reflection I realised that what I had in mind for the caring learning organisation is something like what has been achieved by the best of the "free" schools, such as Summerhill, or even throughout the Steiner Waldorf education movement. So I wonder now if there is any way it might be possible to create a sacred space closer to the work setting (or even within it). But the research obsession would lead one to a measurement problem again – how much sacred space is needed and for how long? This might lead to the inevitable process of quantification. It is a bit like going to church to pray and asking people how many prayers they prayed, or how many services they attended – instead of asking how they felt in that prayer or service and what happened to them that made

a difference to their life? In the same way anatomical dissection reveals little about what it means to be a human being.

Thus I have submitted my PhD thesis, but I still wonder if it will make a difference to anyone or how much of difference it will make. The thesis is a consequence of the vital dialogue I have striven to advocate and, now complete, I hope it forms part of the means for the continuation of that dialogue. What I want to know is if the thesis will have meaningful consequence. Perhaps I should not ask that about the thesis itself – rather about the process of doing the work which culminated in the thesis and all those I came across, and influenced or who influenced me along the way. Perhaps the thesis as object should be less important (even if more "measurable") than the thesis-writer and his colleagues as subjects.

This reflective commentary should make it clear what have I learned and how have I changed as a consequence of this work. The prescriptions in Chapter 7 have become part of the substance of the dialogue that I have with my students. I now know without doubt that the intellectual journey should be a trip of imagination and creativity – more than likely in the path of an esteemed leader or leaders. And when I consider the reasons for the successes and failures of the various projects reported here, I have certainly changed my views about how collaboration can operate effectively. Collaboration may help produce the caring learning organisation, but without effective leadership there can be no useful collaboration. In any future work of this nature I would stress the establishment of suitable leadership principles well before any arrangement for collaboration.

My leaders have predominantly been the writers referred to in the substantive text presented here – given the fact that the student here was a late middle-aged, professional educator who could only conduct the research on a part-time basis and had to largely self-supervise. In this respect, despite being of necessity an unconventional thesis and despite its imperfections, I hope this work to offer something of a model to colleagues similarly attempting to accomplish a PhD part-time. Occasional facilitation of the task by educational managers, who may be leaders from time to time, is essential but the bounds of conventional educational bureaucracy more often than not hinders rather than helps this process. Reflecting

upon their roles as learners and as educators seems vital for all those in potential leadership positions throughout our communities: the family physician, the school teacher, the policeman, social worker, university lecturer, local business people, and, of course, the nurse, the midwife and the health visitor.

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Appendix I Thesis Dissemination

Since the work contained in this thesis has been developing over a period of time some of the material reported has been based upon, disseminated or published in a variety of different arenas. These are listed below with comments upon authorship.

Material contained in **Chapter 2** has been drawn upon, presented and/or published in the following ways:
Bellis, I. (1996) *Stress amongst nurse lecturers as a consequence of organisational and curricula change*, unpublished MPhil Thesis, University of Wales, Bangor. [This work was supervised by R. Iphofen. The work is referenced in Chapter 2 but none of it has been reproduced in that Chapter. Supervising this work offered further insight into the contextual issues being addressed.]

Iphofen, R. and Merchant, M. (1993) "The Skill Mix Study - Acting on Research Findings" (The Gwynedd Development in Nursing Project) presentation to nurses in the acute unit at Ysbyty Gwynedd. [M. Merchant was Chief Administrative Nursing Officer for the Gwynedd Health Authority at the time – this was a jointly planned collaborative presentation.]

Iphofen, R. and Fonseca, J. (1997) "Spare a thought for the 'ologists", *Sociology and Nurse Education Network*, March, Issue 11: 2-4. [R. Iphofen was first author on this piece which was originally written in response to a leader in the Nursing Times. J.Fonseca contributed some additional comments and observations.]

Iphofen, R. and Poland, F. (1997) "Professional Empowerment and Teaching Sociology to Health Care Professionals", *Teaching Sociology*, (an Official Journal of the American Sociological Association) Vol.25, January: 44-56. [R.Iphofen was first author on this piece. It was intended for a "themed" issue on sociology in the health professions. The issue did not materialise. F.Poland provided additional comments and observations and the piece was revised five times by R.Iphofen after referees' and editors' comments.]

Iphofen, R. (1998) "Sociology in Health Professional Education" *ISA World Congress of Sociology*, Montreal, July. [R.Iphofen was sole author of this paper as an invited panellist to the Congress.]

Ideas discussed in **Chapter 3** were initially formulated in papers such as:
Iphofen, R. (1994) "Ideals and Realities: Compromising the Vision of Open Learning", Invited paper at *International Conference on Educational and Cultural Barriers to Open and Distance Learning: A European Perspective*, University of Sheffield, Flexible Learning Unit, 15-17 June. [Sole author as invited speaker.]

Bundy, C., Iphofen, R. & Poland , F. (1994) "Tutorials and Seminars in Nurse Education", a one day workshop at Colwyn Bay - EHE funded, 23 October. [Jointly facilitated and led workshops.]

Iphofen, R. (1995) "Developing and Applying Learning Outcomes in Nurse Education", *Wales Access Unit, HE-CATS Learning Outcomes Project,* Workshop & Presentation, Aberystwyth, 27 February. [Invited presenter – subsequent to consultations with R.Iphofen sought by the Director of this Project.]

Concepts, collaborative work and action research contained in **Chapter 4** were developed and reported in:

Iphofen, R. (1995) "Lifelong Learning - Study Skills for Health Care Professionals", Workshop and Research Report, Medical Institute, Wrexham. [Workshop was organised by R.Iphofen and final report was produced by R.Iphofen after contributions from participants and facilitators attending the workshop.]

Iphofen, R. (1995) "Supervising Research Students", University of Wales, Bangor, Staff Development Workshop. [Presented on invitation.]

... and published in ....

Iphofen, R., Poland, F., Hesketh, J., and Wright, M. (1996) "Lifelong Learning in the Health Care Curriculum", *Capability* (Also in *Case Studies* - the on-line World Wide Web journal for "Higher Education for Capability") November 2(2) URL= http://www.lmu.ac.uk/hec/journal/2-2.htm [Lead author was R.Iphofen with some minor additions from other contributers.]

Iphofen, R. (1996) "Typifying the Untypical: Characterising Mature Students for Nurse Educationalists", *Adults Learning*, Vol.7: 236-238. [Sole author.]

Iphofen, R., Lavelle, M. & Patterson, P. (1997) "On Reflection", *Adults Learning* Vol.8, No.10, pp.267-69. [Final piece put together by R.Iphofen on the basis of writings and observations by collaborators.]

Although the student motives data and analysis is reported here for the first time, the conceptual and theoretical work on which **Chapter 5** is based has been developed in:

Iphofen, R. (1996) " 'Why Me? Why Them?' Understanding Motives, Blame And Responsibility In Health And Illness", in Fazey, J. (ed.) *Realising Academic Potential, Collected Papers in Health Studies.* Vol. I, Part 2. Bangor: University of Wales. [Sole author.]

Iphofen, R. (1996) "Why Me? Blame and accountability in health & illness", Paper at *British Sociological Association Medical Sociology Group Conference*, Edinburgh, Sep. [Sole presenter.]

Iphofen, R. (1996) "Aspiration and Inspiration: Student Motives in Adult Residential Colleges", *Studies in the Education of Adults*, Vol.28, No.1, April, pp.65-87. [Sole author, based upon MSc Dissertation research.]

Iphofen, R. (1997) "Understanding Motives in Learning: Mature Students and Learner Responsibility", Staff and Educational Development Association Conference, *Encouraging Student Motivation*, Plymouth (April) [Sole presenter.]

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Iphofen, R. (1998) "Strong words, strong minds, strong bodies: an analysis of the narrative structure of affirmatory metaphors in personal development programs", paper delivered at BSA annual conference on Making Sense of the Body, Edinburgh, April and to be published in Watson, N. et al. (2000) *Reframing The Body* (Volume II), London: Macmillan. (forthcoming) [Sole author.]

Iphofen, R. (1999) *A Framework for the Narrative Analysis of Health and Illness*, poster presentation at BMA/BMJ Conference on "Narrative Based Medicine", London, 12th November. [Sole author.]

Three other papers related to the work in Chapter 5 are in preparation for publication: one on "levels of explanation in sociology" and another on "the concept of motivation in sociology" another on "responsibility for health".

Although detailed vision workshop data is reported here for the first time, much of the the conceptual and theoretical work behind **Chapter 6** was reported in:

Iphofen, R. (1997) "Caring about Learning while Learning about Caring: Coping with Organisational and Curricula Change in Health Professional Education", Paper presented at the *British Sociological Association Medical Sociology Group Conference*, York (Sep.) [Sole presenter.]

A paper based on this chapter is to be published by a North American publication - the *Journal of Allied Health*, July 2000. [Sole author.]

Material in **Chapter 7** has appeared in some of the previous publications mentioned above and in internal policy documents which have gone before the relevant decision-making boards within SNMS.

Appendix II Chronology of Events

18.11.92	Letter from Research Division Lecturer to all Faculty staff - encouraging collaborative involvement in research tenders
May 1993	Head of School asks for contributions to Faculty Strategy and Quality Assurance Document he is writing.
May 1993	Research Division staff ask for: better networking (intra-UWB, regional, national etc.) more "open" meetings with liberal/frank discussion research skills workshops to be set up publications ideas workshops research seminars outline research strategy for SNMS and "profile" research funding strategy
June 1993	Research Division meeting notes: inadequate support for independent research and conference attendance in "study leave" policy; "health studies" to be taken as central strategic topic focus; suggestions advanced for curriculum modularisation; suggestions for changing decision-making structure of SNMS; research seminars - problems of fees and expenses for visitors.
June 1993	Meeting between Research Division and Gwynedd CANO discussed: need to market the skills of the Research Division through the Trusts and the Health Authority; need to enhance the research experience of clinical staff; need for adequate resources to do the job; pressures on time.
July 1993	Research Division meeting: need for all staff to gain teaching qualifications; suggest organising staff into interest/theme groups which reflect specialist research interests and which should be reflected in teaching; suggestions made for modularisation and draft protocols to be developed and proposed to lecturing staff; proposals made for re-structuring decision-making and lines of communication in SNMS.
16.8.93	"Academic Support Group" (ASG) established - regular confidential strategy meetings with Senior Management take place throughout 1993, 1994 until 1995. Issues raised: establishment of "fast track" degree in nursing; secretarial support at Wrexham site; need to establish Boards of Studies; modularisation;

	need for course management teams to be established; need for "new blood" in staff and in management; inefficiency/incompetence of existing pre-reg. exam board; problem of staff attitude to 'ologies - poor mock exams.
October 1993	Research Division meeting notes: need for formally constituted Research Board of Studies; need for formal research training programme; need to develop postgraduate supervisors; need for thesis supervisory committees; Faculty postgraduate committee representation; more time for research.
27.10.93	Full statement of ASG activities and contributions for Senior Management Team (SMT)
Feb. 1994	Meeting with Director of NHS R&D Wales - requests for reduction in number of meetings and better workload distribution to enable more research time (excessive teaching required).
May 1994	ASG suggests: research skills and interests audit of staff; more collaborative research proposals; need for long term research strategy; research funding opportunities database to be set up; research skills training to be provided for staff.
8.6.94	ASG awaydays to plan R&D strategy.
17.11.94	ASG meet with Senior Management. Issues raised: status and integrity of Research Division; curriculum development ongoing to Levels 2 & 3; workload re-distribution (excessive teaching); financial/resources barriers; new decision-making structures not altering perceived hierarchy; staff failing to adhere to systems/procedure; some staff reluctance to change; needs for a TQA system; need to integrate teaching and research for all staff; more staff development opportunities;
March 1995	Research Division Lecturer in Psychology leaves.
March 1995	ASG meeting suggests: employing staff development for degree teaching skills; a peer review/ teaching assessment system; improvement of internal TQA system;

	holding staff "exit" interviews; research training course for health professionals; need for adequate resources stressed again; lack of research division staff time for R&D.
April 1995	ASG meeting records need to: develop research strategy; develop postgraduate supervisory expertise; liaise with staff development on above; secure divisional representation on Faculty Board; suggest start using ASG for Level 3 teaching & research training.
April 1995	Memo to Head of School stressing need to establish management system for Research Division after imminent departure of Professor and Senior Lecturer.
May 1995	Professor of Health Studies leaves.
July 1995	Senior Lecturer in Nursing Research leaves.
July 1995	Remaining Lecturer in Psychology seconded to Psychology Dept.
October 1995	ASG statement to Senior Management raising: continued shortage of research expertise; difficulties of getting existing staff to upgrade research activity; low visibility of health studies research in Faculty and UWB; lack of policy on staff research development; inadequate resourcing (routine admin. stopping research progress).
October 1995	Letter to VC - includes above but also: staff under-equipped to teach at degree level; inhibitory hierarchical administrative structure in SNMS.
November 1996	Proposal to UWB Research Committee to establish IMSCaR
25.11.97	Letter from Head of School to IMSCaR Director - seeking details for moving forward together. No direct response, minimal liaison occurring until Professor in Nursing takes up appointment - April 1999.
26.1.98	Seminars/presentations about IMSCaR for Faculty of Health Studies members.

Appendix III: Student Nurses' Views About the Project 2000 Course

This questionnaire is designed to obtain your views of the Project 2000 course. There are no right or wrong answers and it is not a test. No names are required and your answers will be totally confidential.

The questionnaire consists of 48 statements about the way in which a Project 2000 course could be organised. Please read each statement and decide whether or not you think the course **should** be organised in that way. Indicate the extent to which you agree with each statement by placing a **circle** around the number which best reflects your opinion. Use the following scale:

I strongly agree with this statement	: circle number 5
I agree with this statement	: circle number 4
I neither agree nor disagree with this statement	: circle number 3
I disagree with this statement	: circle number 2
I strongly disagree with this statement	: circle number 1

		strongly agree				strongly disagree
1	The teaching-learning process should involve the student discovering things for him/herself.	5	4	3	2	1
2	Students should be free to speak their minds and express their opinions.	5	4	3	2	1
3	Each student should attend the same sessions.	5	4	3	2	1
4	Ideas, theories, procedures etc should be presented by tutors as facts, as the only way of doing things.	5	4	3	2	1
5	The aims of the course should be decided by the students, based on issues they feel are important.	5	4	3	2	1
6	A large number of different learning methods should be used	5	4	3	2	1
7	Tutors should evaluate the course by the extent to which the students find the course helpful	5	4	3	2	1
8	Students should be able to form real friendships with tutors.	5	4	3	2	1

		strongly agree				strongly disagree
9	Issues to do with values, emotions, and feelings should be avoided.	5	4	3	2	1
10	The course should be based on a pre-planned content and aims.	5	4	3	2	1
11	The order in which topics are learned should be determined by the students themselves.	5	4	3	2	1
12	The course should be controlled by the tutors.	5	4	3	2	1
13	At any one time, whilst in college, all of the students on the course should be doing the same thing.	5	4	3	2	1
14	The teaching-learning process should involve tutors giving the facts and students learning them.	5	4	3	2	1
15	Different learning methods should be used to suit the needs of differing students.	5	4	3	2	1
16	The tutors should evaluate the course by the extent to which the students successfully learn the laid-down content.	5	4	3	2	1
17	The tutors should present ideas, theories, procedures etc as open to interpretation.	5	4	3	2	1
18	The tutors should be willing to admit their own uncertainties, weaknesses and problems.	5	4	3	2	1
19	There should be plenty of opportunity to explore and discuss values, feelings and emotions relevant to the course.	5	4	3	2	1
20	There should be very little variety in the learning methods used on the course.	5	4	3	2	1
21	Both students and tutors should have an equal say in the way in which the course is run.	5	4	3	2	1

		strongly agree				strongly disagree
22	At any one time, whilst in college, students on the course might be doing different things.	5	4	3	2	1
23	There should be little trust or support developed in the group as a whole.	5	4	3	2	1
24	The order in which things are learned should vary according to the needs of individual students.	5	4	3	2	1
25	Students should have very little say in deciding what is taught on the course.	5	4	3	2	1
26	The tutors should evaluate the course according to the feelings of the students.	5	4	3	2	1
27	The emphasis of the course should be on presenting firm and clear conclusions of thinking and research.	5	4	3	2	1
28	Students should be discouraged from openly expressing their emotions.	5	4	3	2	1
29	The course should be run on a co-operative basis between students and tutors.	5	4	3	2	1
30	The sequence, or order in which things are taught should be decided by tutors before the course begins.	5	4	3	2	1
31	The content of the course should not be decided in advance but should develop during the course itself.	5	4	3	2	1
32	Tutors should evaluate the effectiveness of the course by the extent to which students learn specific knowledge and skills.	5	4	3	2	1
33	The emphasis of the course should be on the generation of knowledge rather than just passing on facts.	5	4	3	2	1
34	The tutors should make all the decisions about the way the course is to be run.	5	4	3	2	1
35	Tutors should stress that to many problems there is 'no right answer'.	5	4	3	2	1

		strongly agree				strongly disagree
36	The tutors should quite often discuss their out-of-work lives and activities with the students.	5	4	3	2	1
37	Tutors should stick to their own favourite learning methods and use these whenever possible.	5	4	3	2	1
38	Emotional issues should be brought out into the open and discussed.	5	4	3	2	1
39	Tutors should avoid talking about their own thoughts, feelings and emotions.	5	4	3	2	1
40	Each student should go through exactly the same sequence of learning.	5	4	3	2	1
41	The relationship between students and tutors should be formal, based largely on position and status.	5	4	3	2	1
42	Tutors should never discuss their own problems with students.	5	4	3	2	1
43	Students should be able to 'do their own thing' if they wish.	5	4	3	2	1
44	Fact, ideas, and theories should be presented, given to students by tutors.	5	4	3	2	1
45	Tutors should treat the student as friends and equals.	5	4	3	2	1
46	Students should give little respect to each other's views and opinions.	5	4	3	2	1
47	Tutors should not really care what happens to students.	5	4	3	2	1
48	There should be a good spirit of co-operation and teamwork on the course.	5	4	3	2	1

To complete the questionnaire there are a few questions about yourself. Please answer each question by placing a √ in the relevant box or by writing your answer in the space provided:

How old are you?

17-18
19-20
21-25
26-30
31-40
40+

What is your gender?

Male
Female

What is the **highest** level of qualification you have gained so far? Please _ the box which best describes the qualifications you have. If you are unsure please describe your qualifications in the space provided.

'O' Level/ GCSE or equivalent

'A' Level or equivalent

Diploma or equivalent

Degree or equivalent

Higher Degree

Other (please describe below)

How long has it been since you last engaged in formal study? Please _ the appropriate box.

Less than a year

Between one year and five years

More than five years

Please describe briefly below the type of learning you have undertaken since leaving school. If you have come to the course straight from school please _ this box

Have you been involved in Self Directed Learning in the last five years?

Yes

No

Which branch programme have you elected to take? Please write your response below.

THANK YOU FOR YOUR TIME AND EFFORT

Appendix IV: Interrogating the Data in NUD*IST

The following are the questions asked of the essay data in NUD*IST and the formulae and node codes required for the data to be elicited. The terms used refer to Boolean or Collating operators which instruct the software to draw out the relevant text units and compile reports indicating counts of responses and the relevantly coded units from the original source. Some Negations and Restrictions were applied but no Contextual Operators since the "text units" to be analysed were based upon paragraph markers in the original documents and paragraph sizes varied considerably. There seemed no particular gain from re-transcribing the documents to apply comparable text units since the main analytic concern in this project was with content and not style. The project is saved on computer file under the heading "Student Motives" and all index searches and rawfiles can be made available for re-test or further study.

How many evaluated the Act positively?
Node count at (1 2 2 1) = 80
How many evaluated the Act negatively?
Node count at (1 2 2 2) = 37
How many were both positive and negative in their evaluations?
Intersect (1 2 2 1)(1 2 2 2) = 22
How many had "always" wanted to do this?
Node count at (1 3 1 1) = 53
How many radiographers had "always" wanted to do this?
Intersect (1 1 4)(1 3 1 1) = 7
Coding check: any coded at both "always" and "not always"?
Intersect (1 3 1 1)(1 3 1 2) = 0
How many say "not always"?
Node count at (1 3 1 2) = 39
How many mention a recent experience?
Node count at (1 3 1 3) = 21
How many mention a lengthy experience?
Node count at (1 3 1 4) = 14
How many had formal caring placement experience?
Node count at (1 3 2 1) = 97
How many had caring experience at home?
Node count at (1 3 2 2) = 37
How many had positive other work experience which encouraged?
Node count at (1 3 2 3 1) = 12
How many had negative other work experiences?
Node count at (1 3 2 3 2) = 14
How many are both positive and negative about "other work experience"?
Intersect (1 3 2 3 1)(1 3 2 3 2) = 1
How many saw themselves as responsible Agent?
Node count at (1 4 1) = 114
How many evaluate themselves as Agent positively?
Intersect (1 4 1)(1 4 3 1) = 101
How many evaluated themselves as Agent both positively and negatively?

Intersect (1 4 1)(1 4 3 1)(1 4 3 2) = 23

How many named specific other agents?

Node count at (1 4 2 1) = 43

How many mentioned general others?

Node count at (1 4 2 2) = 6

How many non-human agency?

Node count at (1 5 2) = 0

How many generally mention human agency?

Node count at (1 5 1) = 15

How many encouraged by family?

Node count at (1 5 1 3) = 25

How many discouraged?

Node count at (1 5 1 4) = 22

Check for family both encouraging and inhibiting.

Intersect (1 5 1 3)(1 5 1 4) = 2

Do academic/school experiences encourage?

Node count at (1 5 1 1) = 61

Do academic/school experiences inhibit?

Node count at (1 5 1 2) = 14

How many expressed "non-conscious purpose" ?

Node count at (1 6 2) = 10

How many are solely "non-conscious"?

Less (1 6 2)(1 6 1) = 9

How many are clear/conscious in purpose?

Node count at (1 6 1) = 86

Any difference in the radiographers?

Intersect (1 1 4)(1 6 1) = 5

Tests for cohort effects:

Matrix Node: (I 20) //Index Searches/Index Search211
Operator: INTERSECT
Definition: Search for (VECTOR INTERSECT (1 2 2 1) (1 1)). No restriction
Rows: (1 2 2) /HCP Narratives/Act 1/Evaluation
Columns: (1 1) /HCP Narratives/Cohort
Data: Number of documents coded

Evaluation	195N	295N	196N	295R
Positive	15	25	26	13

Matrix Node: (I 22) //Index Searches/Index Search213
Operator: INTERSECT
Definition: Search for (VECTOR INTERSECT (1 2 2 2) (1 1)). No restriction
Rows: (1 2 2) /HCP Narratives/Act 1/Evaluation
Columns: (1 1) /HCP Narratives/Cohort
Data: Number of documents coded

Evaluation	195N	295N	196N	295R
Negative	4	8	20	5

Matrix Node: (I 23) //Index Searches/Index Search214
Operator: INTERSECT
Definition: Search for (MATRIX INTERSECT (1 3 1) (1 1)). No restriction
Rows: (1 3 1) /HCP Narratives/Scene/Time
Columns: (1 1) /HCP Narratives/Cohort
Data: Number of documents coded

Time	195N	295N	196N	295R
Always	9	23	13	7
Not always	9	12	13	4
Recent expe~	11	3	4	2
Lengthy exp~	4	3	4	3

Matrix Node: (I 24) //Index Searches/Index Search215
Operator: INTERSECT
Definition: Search for (VECTOR INTERSECT (1 3 2 1) (1 1)). No restriction
Rows: (1 3 2) /HCP Narratives/Scene/Place
Columns: (1 1) /HCP Narratives/Cohort
Data: Number of documents coded

Place	195N	295N	196N	295R
Caring Plac~	19 (56%)	33 (67%)	29 (73%)	16 (76%)

Matrix Node: (I 25) //Index Searches/Index Search216
Operator: INTERSECT
Definition: Search for (VECTOR INTERSECT (1 3 2 2) (1 1)). No restriction
Rows: (1 3 2) /HCP Narratives/Scene/Place
Columns: (1 1) /HCP Narratives/Cohort
Data: Number of documents coded

Place	195N	295N	196N	295R
Domestic ex~	1	14	13	8

Matrix Node: (I 27) //Index Searches/Index Search218
Operator: INTERSECT
Definition: Search for (VECTOR INTERSECT (1 4 1) (1 1)). No restriction
Rows: (1 4) /HCP Narratives/Agent
Columns: (1 1) /HCP Narratives/Cohort
Data: Number of documents coded

Agent	195N	295N	196N	295R
Self	19	41	39	15

Matrix Node: (I 28) //Index Searches/Index Search219
Operator: INTERSECT
Definition: Search for (MATRIX INTERSECT (1 4 2) (1 1)). No restriction
Rows: (1 4 2) /HCP Narratives/Agent/Other
Columns: (1 1) /HCP Narratives/Cohort
Data: Number of documents coded

Other	195N	295N	196N	295R
Specific	9	14	13	7
General	0	0	6	0

Matrix Node: (I 29) //Index Searches/Index Search220
Operator: INTERSECT
Definition: Search for (MATRIX INTERSECT (1 5 1) (1 1)). No restriction
Rows: (1 5 1) /HCP Narratives/Agency/Human
Columns: (1 1) /HCP Narratives/Cohort
Data: Number of documents coded

Human	195N	295N	196N	295R
Academic ac~	12	19	24	6
Academic re~	3	3	5	3
Family or p~	3	6	9	7
Family or p~	6	7	9	0

When do they typically offer "agent as self AND negative" - any patterns there?

Matrix Node: (I 37) //Index Searches/Index Search228
Operator: INTERSECT
Definition: Search for (VECTOR INTERSECT (1 4 1) (1 4 3)). No restriction
Rows: (1 4) /HCP Narratives/Agent
Columns: (1 4 3) /HCP Narratives/Agent/Evaluation
Data: Number of documents coded

Agent	Positive	Negative
Self	101	44

How many claim not to know why (162) but offer clear if plural reasons (161)?

(I 33) //Index Searches/Index Search224
*** Definition:
Search for (INTERSECT (1 6 1) (1 6 2)). No restriction - 3 documents.

Do those with specific purposes (161) link these to any direct experiences (1321 + 1313)?

Matrix Node: (I 34) //Index Searches/Index Search225
Operator: INTERSECT
Definition: Search for (MATRIX INTERSECT (1 6) (1 3 2)). No restriction
Rows: (1 6) /HCP Narratives/Purpose
Columns: (1 3 2) /HCP Narratives/Scene/Place
Data: Number of documents coded

Purpose	Caring Plac~	Domestic ex~	Other work ~
Conscious	17	6	2
Non-conscio~	1	1	0

Any connection between family members' agency and "time" or "place"?

Matrix Node: (I 30) //Index Searches/Index Search221
Operator: INTERSECT
Definition: Search for (VECTOR INTERSECT (1 5 1 3) (1 3 1)). No restriction
Rows: (1 5 1) /HCP Narratives/Agency/Human
Columns: (1 3 1) /HCP Narratives/Scene/Time
Data: Number of documents coded

Human	Always	Not always	Recent expe~	Lengthy exp~
Family or p~	10	3	0	2

Matrix Node: (I 31) //Index Searches/Index Search222
Operator: INTERSECT
Definition: Search for (VECTOR INTERSECT (1 5 1 3) (1 3 2)). No restriction
Rows: (1 5 1) /HCP Narratives/Agency/Human
Columns: (1 3 2) /HCP Narratives/Scene/Place
Data: Number of documents coded

Human	Caring Placement	Domestic experience	Other work experience
Family or p~	7	13	0

Any connection between human agent and agency?

Matrix Node: (I 32) //Index Searches/Index Search223
Operator: INTERSECT
Definition: Search for (MATRIX INTERSECT (1 5 1) (1 6)). No restriction
Rows: (1 5 1) /HCP Narratives/Agency/Human
Columns: (1 6) /HCP Narratives/Purpose
Data: Number of documents coded

Human	Conscious	Non-conscious
Academic achievement~	11	1
Academic reaction	0	2
Family or parent encouragement	1	0
Family or parent inhibits ~	3	2

Appendix V : Annual Quality Audit Workplan

DATE: 26/03/99 **RESPONSE REQUIRED BY: any date**

UNIVERSITY OF WALES, BANGOR
SCHOOL OF NURSING, MIDWIFERY AND HEALTH STUDIES

Quality and Evaluation Sub-Board

Contact: Ron Iphofen

In accordance with its remit the Q&E Sub-Board has established the following annual review of the School's activities. Each topic area will be reviewed in the month indicated and action co-ordinated by the identified member of staff.

Your comments on each of the following areas of concern are invited. Please send your comments to the staff member with responsibility for that area.

If we receive no response on any particular item, we will assume that you perceive there to be no problems with the School's activities in that area. The Sub-Board will still review each topic and make recommendations to the full Board of Studies if necessary.

You may, of course, make comments about any of these areas at other times as well.

Link to:
Month
Named Staff
Topic areas

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Review period: January

Topic: New Courses and Validation/Re-validation of existing courses

Action: Named Member of Staff

Proposals for new courses and course validation.
Making proposals for a new course
Level: Pre-reg Module
Post-reg Module
First Degree Course
Masters Course

Making changes to existing courses.
Making changes to -
Pre-reg Modules

Post-reg Modules
First Degree Courses/Modules
Masters Courses/Modules

Re-validation of existing courses:
Re-validation of -
Pre-reg Modules
Post-reg Modules
First Degree Courses/Modules
Masters Courses/Modules

Credit Accumulation and Transfer

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Review period: February

Topic: Monitoring of Student Progression

Action: Named Member of Staff

Student Admissions
Application process for ....
diploma courses
post-reg modules
degree courses
taught Masters
research studentships
upgrading from MPhil to PhD
Interviewing and selection
bi-lingual arrangements
multicultural arrangements

Student Induction
Registration
Students Union

Student Progression
(a) Intake analysis
Named courses
.....
.....
(b) Student records (proforma/protocols)
Named courses
.....
.....
(c) Cohort analysis and non-completion
Named courses
.....
.....
(d) Results analysis

Named courses
.....
.....
(e) Student destination statistics
Named courses
.....
.....

Student Attendance
Monitoring systems
Attendance Records

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Review period: March

Topic: Organisation and Management

Action: Named Member of Staff

Committee Structure
UWB Committees
Staff Representation
Student Representation
External Representation
Faculty Board
Staff Representation
Student Representation
External Representation
Board of Studies
Staff Representation
Student Representation
External Representation
Sub-board on ..... etc.
Staff Representation
Student Representation
External Representation
P2K Diploma Course Committee
Staff Representation
Student Representation
External Representation
BSc Course Committee
Staff Representation
Student Representation
External Representation
BA Course Committee
Staff Representation
Student Representation
External Representation
MSc Course Committee
Staff Representation

Student Representation
External Representation
MPhil/PhD Supervisory Arrangements
Staff Representation
Student Representation
External Representation

Co-ordinators:
Modules.....
Courses.....
Postgraduate research.....

Timetabling

Practice placements
(a) Pre-registration
nursing
non-nursing (?)
(b) Post-registration
nursing
non-nursing (?)

Managerial and administrative responsibilities:
(a) Consultative procedures
(b) Participative procedures
(c) Contractual obligations
(d) Document control (e.g. consistency in dating, numbering, cross-referencing, identification of source, minuting conventions, bi-lingual arrangements)
(e) Purchasing decisions
(f) Budgetary control
(g) Long-term policy and planning (e.g. Mission Statements; curriculum development - e.g. hotlinks to central UK bodies)
(h) Office management and support systems

Clinical Links
Link Tutor Schemes
R&D Links

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Review period: April

Topic: Assessment and Mentoring Systems

Action: Named Member of Staff

Examinations and Assessment Systems
Named Courses:
Diploma in Nursing Studies
BA

BSc
Post-Reg Modules
Graduate Transferable Skills Modules

Grading/marking schemes
Named courses.....

External examining and moderation
(a) Approval of external examiners' appointment
(b) Action on informal comments
(c) Written reports
(d) List of current examiners
(e) List of past examiners

Mentors and assessors
Placement mentors
Clinical Specialists

Internal moderation procedures
second/double marking

Bi-lingual arrangements
multicultural arrangements

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Review period: May

Topic: Communications processes and the dissemination of information

Action: Named Member of Staff

Course information for students:
(a) Institutional directories
(the Bangor "profile" folder; facilities; amenities; support systems)
(b) Course directories/outlines or prospectuses
(c) Preliminary course guides/notes for students
Guidance notes on referencing
.....plagiarism
.....writing etc
(d) Study guides/handouts related to individual teaching sessions
(e) Principles for marking formally assessed coursework
(f) Grading schemes
Named courses.....
(g) Supervisory guidelines
(h) Bi-lingual arrangements

Informing students on progress:
(a) Feedback on work produced during course
(b) Feedback on formally-assessed work

Student feedback to staff (student evaluations):

(a) On course as a whole
Named courses.....

(b) On specific modules
Named modules....

(c) On teachers and their teaching methods
Anonymised (?) comments....?

Communications systems

(a) Networking
(b) General Information to Staff
(c) General Information to Students
(d) Minutes from all "public" meetings

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Review period: June

Topic: Formal Supervisory Arrangements and Pastoral Care

Action: Named Member of Staff

Tutorial/Academic Supervision

Arrangements for each named course.....
..... including research students
Review of student progress
Supervisory guidelines
bi-lingual arrangements
multicultural arrangements

Appeals procedures:

(a) For students on taught courses
(b) For research students
(c) staff grievance procedures
(d) complaints about staff

Welfare

Counselling
Financial Hardship

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Review period: July

Topic: Staff Development

Action: Named Member of Staff

Staff Training (Full/part time)

Induction

Formal Training Provision
Mentoring

Staff appraisal (UWB and School)
Performance Monitoring
Peer review

Staff development opportunities:
(a) Improving teaching effectiveness
(b) Improving research competence
(c) Improving administrative and managerial skills
(d) Improving clinical competence

Promotion of good practice in teaching, research and administration
(a) teaching (e.g. methods, curricula, assessment)
(b) research (e.g. research design, grant capture)
(c) the administration and management of your own work
(d) the maintenance of clinical competence and update.

Promotion of innovation in teaching, research and systems management

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Review period: September

Topic: The physical environment, amenities and facilities

Action: Named Member of Staff

Buildings
(a) notices and signposts
(b) room space, sizes and furniture
(c) the use of rooms
(d) use of and access to nearby facilities
(e) facilities for eating and drinking
(f) cleanliness
(g) parking
(h) reception

Library and Information Services
Opening Hours
Book return
Placement/out of hours borrowing
NHS library facilities
Reciprocal arrangements

Audio-visual Arrangements

Teaching Equipment
Student Accommodation

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Review period: October

Topic: Staff profile

Action: Named Member of Staff

Named Staff

(full/part-time)
..... educational qualifications
clinical qualifications
educational experience
clinical experience
research interests
research experience
languages

Work load distribution (!!)

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Review period: November

Topic: Research Activities

Action: Named Member of Staff

Research Student Supervision
Admissions Process
Named Staff Supervising Students
Review of student progress
Supervisory guidelines
External examining and moderation
Senior Postgraduate Tutor
MPhil/PhD Supervisory Arrangements
Staff Representation
Student Representation
External Representation
Project Management

Funding Proposal Submissions

Ethics Committees Submissions