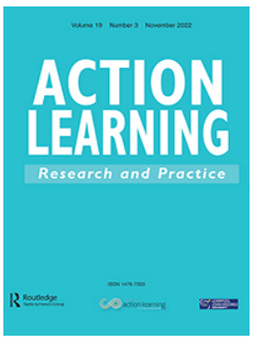

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Action learning and healthcare: affinities and challenges

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Action learning has been used in healthcare settings to bring about changes to how services are delivered, to help individuals to develop their knowledge and skills, including leadership development, and to enable the development of collective abilities and communities of practice. It is evident that there are some positive elements in the healthcare environment that support the processes of action learning – what we might call affinities between the environment and these processes. However, those who have practised action learning in these environments also know that difficulties and disablers can arise, to derail or block the processes – what we might, perhaps optimistically, call challenges.

This paper is based on our experiences as facilitators of action learning in healthcare, and also social care. Each of us independently identified the main affinities we had experienced and the main challenges we had encountered in our work with action learning in different organisations in health and social care. They were collected together and themes were identified. We then reflected on the themes and, in some cases, built on them. The purpose of the paper is to share the learning from our experience, and to encourage others who are using action learning in these environments to consider how best to use the affinities and how best to monitor for and, where necessary, tackle the challenges.

Affinities

A common theme we independently identified is that the concept of reflective practice is integrated within health and social care education as well as practice, with an emphasis on critical analysis of 'incidents', actions taken, key learning and takeaways for staff/team. Professional education for clinical professions emphasises reflective practice and in some cases includes action learning – although this is evidently implemented with variable success (see Maddison and Strang 2018; Willis 2014). Professional bodies in health and social care, such as the Royal College of Nursing and the Chartered Society of Physiotherapy, promote action learning as part of continuous professional development.

Professional supervision is also an integral part of health and social care practice: this means not only supervision by line management but also reviewing and reflecting on professional practice and obtaining feedback from peers. Healthcare staff often bring this experience to the action learning group, showing curiosity and an ability to explore options to support other action learning members. The use of reflective practice as part of professional and personal development has a harmony with the reflection that

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is part of action learning. Discussion in action learning sets, by providing time and space for reflection in relation to current work challenges, and also career direction and work/life balance issues, can be welcomed by participants. However, some of the challenges we note below may run counter to this affinity.

A second common theme we identified was that the increasing emphasis in healthcare on working in multi-professional teams can foster a more democratic way of working, which contrasts with the previous (and in some places still present) inter-professional pecking-orders, especially in relation to interactions between medical and non-medical clinical staff and between professionals and managers. Working in multi-disciplinary teams means that staff are accustomed to talking through problems and issues with one another, and this can provide good preparation for work in action learning sets – even though these team discussions may not take the same form as the questioning and reflecting dialogue of an action learning set. Likewise where staff have been involved in cross-functional process mapping as part of service improvement projects. Team processes such as 'hand-over meetings' and sharing case notes, mean that group learning is practised as a matter of course in the workplace, and this too can be a good foundation for the action learning set members to engage in collaborative learning and reflections, and to learn from each other. The involvement of members of different professional groups is also identified, below, as a challenge of using action learning in healthcare, but in some settings, a foundation for positive practice has been established by the use of multi-disciplinary teams.

Critical action learning, with its interest in understanding the workings of power and influence in organisations, is perhaps particularly relevant to understanding how to bring about change. With its focus on issues of cross- organisational and professional working, anti- discriminatory practice, and social and emotional intelligence, critical action learning has a good alignment with health and social care professional practice.

An affinity for action learning is linked to a shared interest in improving patient care and, often, in mutual support of colleagues. This means that staff – or at least the majority of them – are willing to work together to tackle problems that get in the way of providing good patient care, or that make life difficult for colleagues. When it is obvious that a change or service improvement is necessary, action learning can seem very relevant and be welcomed, as it provides scope to do things differently from the outset.

The democratic nature of the action learning set can at first seem counter-cultural to some groups within healthcare settings, which still defer to an expert medical model: that is the belief there is an answer and generally it will be diagnosed by someone more senior, or with more experience. However, this may be both a challenge and an opportunity: those who are willing to participate in action learning can very quickly realise a sense of liberation and relief. Participation can lead to a re-awakening of personal enthusiasm and energy (often in mid-career) for tired (and sometimes cynical) clinical professionals.

One of us noted the willingness by health and social care staff to engage readily and to voice their own views and feelings in the action learning set, once the place of the set as a safe and confidential learning space has been established:

> I am often struck by the open conversations, including showing vulnerability, with little or no concern for personal reputation or official affiliations. This may not be unique to health care staff but this 'readiness' does contribute significantly to creating a sense of security and

> acceptance in the group, enabling it to become 'the container that helps transform incoherent and unconscious perceptions into coherent thought.' (Nitsun 1996, 123)

In summary, the main affinities we noted between action learning and healthcare, based on our own experiences were: the common use of reflective practice in healthcare work and in professional development; the increasing use of multi-disciplinary teams to provide patient care and to analyse problems; the value of critical action learning in analysing change in complex healthcare contexts; the common interest among healthcare staff in improving patient care; the potentially liberating and energising effect of practising action learning; and the willingness of staff to voice their views and feelings, once the set has been established as a safe and confidential space.

However, as we will see in the next section of this paper, some of these affinities are affected by certain challenges of using action learning in healthcare.

Challenges

A challenge experienced by all five of us concerns workload and other demands on the time and energy of participants in action learning. The pressure of work can make it difficult for healthcare staff to feel they have the time to spend talking and listening in an action learning set, rather than taking immediate action to achieve results. The constant pressure on professional and managerial staff to deliver healthcare – exacerbated by the Covid pandemic, but preceding it – combined with staffing shortages and a crisis-ridden culture, can mean that taking time to participate in action learning appears a luxury, not a priority. There is the related discomfort associated with listening and talking rather than 'getting things done'. Many clinicians, in particular, feel guilty in relation to anything that takes them away from direct patient care. Where taking time out for personal and professional development is perceived to be a luxury, this can lead to sporadic attendance in sets. When participants have struggled to attend the full action learning session, or have been called away at short notice, this can affect the dynamics of the action learning set.

A related challenge concerns having sufficient time and effort allocated to prepare and plan the action learning programme. This can mean that the set-up process is rushed and ill-thought-through in terms of organisation and personal objectives. In addition, insufficient time may be allocated for the evaluation of the programme. Both for internal NHS programmes and for those associated with an HE institution, the emphasis often appears to be on signing off an action learning-based project and moving on to what comes next.

A second challenge encountered by some of us concerned the nature of the issues raised by members of the action learning set. Some of the problems raised have origins that are systemic in nature and beyond the personal influence of members of the set. Organisational constraints can get in the way of appropriate actions to address the root causes of the problems. Rigg (2011) argues persuasively that action learning can help participants develop systemic leadership abilities, and she gives examples of projects that have used action learning to address wicked, cross-organisational problems in health and social care, but the success of such projects depends in part on the composition of the group, the authority of its members and the support available to it from the wider organisational environment. Without authority and support, systemic problems

can appear beyond the influence of the group and its members. Practically, unless the action learning programme has been established as part of a wider organisational change strategy, with the support of executives of sufficient influence to address systemic issues, learning and action may need to be focused on the individual level rather than organisational level.

Systemic problems can give rise at the individual level to issues of low morale, work fatigue, anxiety and well-being: these may be raised in the action learning set, particularly as the set becomes accepted as a safe and confidential space for discussion. Revans described hospitals as 'institutions cradled in anxiety' (1982, 263–264), a characterisation undoubtedly applicable not only to hospitals but to all healthcare organisations, particularly when under the pressures of high levels of demand and low levels of resourcing, and especially when they are in the throes of the top-down reorganisation of structures and systems to which the NHS is regularly subjected. These psychological and emotional issues may be very relevant for participants, and can give rise to challenging conversations. While colleagues in the set may offer sympathy and emotional support, it can be difficult and stressful for an individual to discuss issues and develop positive plans of action. Members may find some relief in sharing their problems with the group and feeling understood and supported, but in situations of unremitting pressure, or during a slow reorganisation where individual jobs may change in ways yet undefined, it can be very difficult for people to decide on what actions they can take, and little may change between the meetings of the group.

A third challenge experienced by more than one of us concerns communications between the members of the range of professions found in healthcare organisations. Different professional groups can have quite different perceptions of issues and problems and how they might be addressed. Of course, this can be positive, but it can also lead to conflict and argument, particularly in the early stages of an action learning set forming as a group. Power dynamics can emerge in mixed professional groupings (for example in the relationships between orthopaedic surgeons and physiotherapists, or between psychiatrists and clinical psychologists) and each profession will have a different perspective. In such cases, members may be reluctant to be completely honest, where it is believed that 'not-knowing' is a compromise of professional identity. This can be overcome by drawing sets from a single profession, but using profession-specific groupings does dilute the power of learning with others and the benefit of encountering alternative perceptions of problems and issues. There is often great value in organising multi-disciplinary action learning sets around purpose, and using skilful facilitation to manage the challenges that can arise.

Part of the clinical culture of healthcare is to defer to expertise, and this runs counter to the values of equality, free exchange and questioning that are at the heart of action learning. This clinical culture – seen in a professional insistence on seeking expert answers to problems – is also reflected in the didactic and course-based nature of much of the education provided in HE institutions for clinical professionals. HE staff associated with such programmes are often resistant to the different approach to learning that action learning embodies, and this transmits to some graduates of these programmes.

Finally, one of us identified as a challenge a tendency by those who commission or organise programmes to regard action learning as merely a technique – an instrumental means of pursuing the latest service change initiative, which is often originated nationally,

rather than as a developmental opportunity at both individual and organisational levels. Pedler, Burgoyne, and Brook (2005) have described the ethos of action learning as 'optimistic, humanistic, engaging, but also pragmatic and sceptical, suspicious of canonical ideas (and the experts who trade in them)' (62). An emphasis on action learning as purely a method, rather than also as an ethos, risks failing to make the best use of its potential for individual and collective development (Edmonstone 2018).

These challenges – high workloads, the systemic nature of some problems, the personal and psychological nature of some issues raised, communication across professional boundaries, a tendency to defer to expertise, and the use of action learning as a technique rather than also as an ethos – do not inevitably arise with every application of action learning in healthcare, but some of them are relatively common. Although we have experienced them in working in healthcare organisations or with healthcare professionals, it seems likely that they may also apply in other settings, particularly perhaps in complex organisational settings.

Conclusions

Action learning has a long history of application in healthcare, and a starting point for this paper was the thought that there were certain factors in the professional and organisational environments of healthcare that were positive towards action learning processes and which encouraged their practice – which we have called 'affinities'. Of course, this thought was followed almost immediately by the reflection that action learning in healthcare is not all plain sailing, and that it is prone to certain challenges.

In this paper, we have pooled our collective experience of these affinities and challenges, in the hope that these reflections will be useful to others who are using – or planning to use – action learning in this environment.

It seems likely that different patterns of affinities and challenges will apply to each attempt to arrange and implement action learning. In planning for, and in supporting, action learning in healthcare, the question is whether we can gain an understanding of the pattern in that particular setting, help participants make the most of the affinities and benefits, and help them to manage the challenges.

Disclosure statement

No potential conflict of interest was reported by the author(s).

References

Edmonstone, J. 2018. *Action Learning in Health and Social Care*. Boca Raton, FL: CRC.

Maddison, C., and G. Strang. 2018. "Do Action Learning Sets Facilitate Collaborative, Deliberative Learning?: A Focus Group Evaluation of Graduate Entry Pre-Registration (GEN) Students' Experience." *Nurse Education in Practice* 28: 285–291.

Nitsun, M. 1996. *The Anti-group: Destructive Forces in the Group and Their Creative Potential*. London: Routledge.

Pedler, M., J. Burgoyne, and C. Brook. 2005. "What Has Action Learning Learned to Become?" *Action Learning: Research and Practice* 2 (1): 49–68.

Revans, R. W. 1982. *The Origins and Growth of Action Learning*. Bromley: Chartwell-Bratt.

Rigg, C. 2011. "Systemic Action and Learning in Public Services." *Action Learning: Research and Practice* 8 (1): 15–26.
Willis, S. 2014. "Student Paramedics' Perceptions of Action Learning: A Mixed-Method Study." *Journal of Paramedic Practice* 6 (12): 626–632.