gary rolfe, melanie jasper and dawn freshwater

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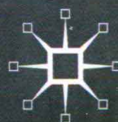
generating knowledge for care

2nd edition



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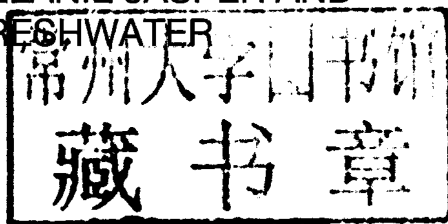
GARY ROLFE, MELANIE JASPER AND
DAWN FRESHWATER



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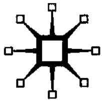

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Preface

The changing face of professional practice and education

The decade since the publication of the first edition of this book has witnessed unprecedented changes to the ways in which healthcare professions in the UK work to provide care to patients. Factors such as the global economic costs of health care, European working time regulations which affected, in particular, junior doctors' hours, and the growth of professional regulation have all changed the dynamics of practice within which all practitioners work. There has been increasing recognition of the independent roles that experienced practitioners in all fields of health care can play in taking both accountability and responsibility for healthcare assessment, diagnosis, care package planning and delivery, moving many functions from the sphere of medical practice to other recognized professional practitioners. This has resulted in the development of consultant roles in all healthcare professions, and has seen a huge increase in the number of specialist practitioners. The global economic crisis occurring as we were revising this book has resulted in threats of huge reductions to public spending in the coming years, putting extra strain on the UK NHS's already creaking budgetary controls. In short, spending on healthcare has to be reined in.

These developments in the healthcare agenda have been accompanied by changes in the ways that healthcare professionals are trained and educated. Some disciplines such as nursing are now firmly embedded in the university sector, while other emerging professional groups such as paramedics are just beginning to engage with higher education at pre-qualification level. Indeed, a workforce educated at least to degree level is usually regarded as one of the defining features of a profession. Clearly, healthcare practice and healthcare education are essential partners, and neither can flourish without the other.

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For example, we have recently witnessed the growth in power and influence of notions of evidence-based practice (EBP) as the key to decision-making in healthcare. The evidence-based practice movement began as an educational initiative, and has built its success on a symbiotic relationship between the universities as promoters of the theoretical ideas which underpin it and as suppliers of evidence for practice, and the healthcare professions who maintain a constant demand for that evidence. However, the rise of EBP in the health professions can also be partly attributed to the type of knowledge that it promotes. Newly emerging professions and academic disciplines often rely heavily on traditional ideas about what constitutes good practice and sound scholarship, and this usually results in a very technical approach to practice based on 'hard' scientific evidence. As a result, EPB is usually regarded as the dominant discourse and the default mode of practice for most healthcare professions.

It is in the face of this growth in technical practice based on hard scientific evidence that we are attempting to justify and promote practice based primarily on reflection on and in our own practice. It is probably fair to say that reflection, both as a way of practicing and as an approach to learning, has forged a somewhat ambivalent relationship both with the emerging healthcare professions and with their developing partnership with higher education. On the one hand, interest in reflection both as a way of learning and as a way of practicing has often emerged at the point at which the professions first begin seriously to address their academic standing. Reflection, then, is promoted by some academics as an innovative learning strategy for exploring professional knowledge. On the other hand, the type of knowledge that serious and critical reflection produces is sometimes seen as directly challenging, and even contradicting, the type of knowledge that is valued most highly in universities and practice areas, which favour those types of knowledge to be found at the top of the hierarchies for evidence-based practice. In fact, the evidence-based paradigm challenges or even dismisses many of the concepts that we believe to be essential for the development of critical reflective practice and the creation of experiential knowledge and theory for practice. We are therefore concerned that the strides that have been taken in raising the profile of independent practitioners and their capacity to provide individualized care based on expertise and experience will be eroded in favour of protocol and procedurally driven care measured against governmental targets which tell us nothing of the experience of patients or the true outcomes of care delivery.

Hence, our motivation in revising this book has been to continue to promote the centrality of critical reflection as key to experienced and expert professional practice. We propose that reflective learning is *the* way of life for committed professional healthcare practitioners who are always striving to give the best and most appropriate possible care. This involves not only the development of an individual knowledge and skills base, but also the growth of confidence to challenge some of the taken-for-granted assumptions endemic in healthcare and the empowerment to champion what is right rather than what is dictated.

The coming of age of reflective practice

As well as structural, political and professional changes in most health and social care disciplines, the past 10 years has also seen the growth and development of reflection as a way of doing practice and education. When we wrote the first edition of this book, reflecting on our own practice was still a relatively novel way of thinking about and learning from what we do as healthcare professionals. Arguably, of course, the notion of reflection can be traced back at least 2,500 years to Socrates' assertion that 'the unexamined life is not worth living', but its modern application to professional learning and practice probably dates from Donald Schön's book *The Reflective Practitioner*, published in 1983.

As with individuals, the growth and development of academic ideas and practices progresses in stages. Seen in this light, reflective practice could be regarded as a somewhat unruly and challenging 18-year-old when we published the first edition of our book in 2001. In the intervening years, that teenager has matured into a thoughtful and (perhaps) rather staid and conforming young adult.

As a rebellious youth searching for its own identity while at the same time challenging the established 'unexamined life' of nursing and healthcare practice, the academic discipline of reflection produced a flurry of publications during the 1990s, including many of the seminal works still being cited today. However, as Thomas Kuhn (1996) pointed out, most scientific revolutions or paradigm shifts are relatively short-lived and are followed by periods of 'normal science' where the shift in focus or perception is consolidated and embedded. That has certainly been the case with reflective practice, where the flood of challenging and radical publications of the 1990s has given way to

a steady trickle of more conservative texts which largely restate and establish reflection as a mainstream practice.

These developmental changes have had three implications for our book. First, while we have restructured and largely rewritten the vast majority of the text, many of the seminal references continue to be of relevance and can still be found in the second edition. Reflective practice might have grown up, but it is still very much influenced by its childhood and adolescence. Second, like most young adults, reflective practice has 'left home' and is growing in influence in disciplines and professions across the entire spectrum of health and social care practice and education. For this reason, we have widened our scope and modified the title of our book to *Critical Reflection in Practice*. Third, our target readership has grown up and matured alongside the development of reflective practice. Many of those who might have found the first edition of our book useful in their undergraduate education and early years of professional practice are now senior practitioners who also teach, supervise and mentor their colleagues. While the second edition continues to be of relevance to beginning and novice reflective practitioners, we have made a deliberate effort to ensure that it will also be of use to senior practitioners in health and social care in relation to their own higher education and to the education and development of their colleagues.

Finally, we would like to briefly restate our guiding principle as outlined in the preface of the first edition. As before, we have tried to write a book that is not simply *about* reflection but which employs a reflective methodology. We have therefore retained the three strategies of using real-life case studies to illustrate our points, of encouraging you to take 'reflective moments' to think about your own experiences, and of offering suggestions for further reading. To repeat the claim we made in the first edition, if this book teaches anything, it teaches how you might best learn for yourself.

GARY ROLFE
MELANIE JASPER

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1

Critical reflection and the emergence of professional knowledge

Melanie Jasper and Gary Rolfe

Introduction

No one involved in professional practice and education in health and social care could have failed to notice the inexorable rise of evidence-based practice over the past decade. As the health and social care disciplines strive to become accepted as bona fide professions with all that entails, there is a perceived demand for practice to be based on firm evidence and for evidence to be based on good science. Evidence-based practice is therefore often taken to mean *research*-based practice, and research is taken to mean experimental or quasi-experimental empirical studies. In this chapter, we will outline the challenges posed by the knowledge demands of the emerging healthcare professions and examine how these have shaped our thoughts about the need for a critical approach to reflection. We will argue that critical reflection can make an important contribution to the evidence-base for practice, but more importantly, that it can reflexively influence practice in its own right.

More specifically, our aims for this chapter are:

1. to help you to think about the professional constraints and pressures that determine the way you practice;
2. to encourage you to think about the ways in which you reflect on your practice as part of your everyday life;

3. to explore the ways that you might avoid reflecting on difficult'or uncomfortable issue; and
4. to begin to think more critically about yourself and your practice.

Reflective moment

Think carefully about our aims for Chapter 1. Now think about your own practice and how these aims might contribute towards developing it. For example, what initial steps might you take in order to become a more critical reflector?

Based on our aims above, identify and write down some of your own aims, both in terms of what you hope to know and what you hope to be able to do after reading Chapter 1. We will return to these at the end of the chapter.

Developing professionalization in healthcare

The past decade has seen changes to ways in which the multitude of health and social care occupations are regulated in the UK, with increasing emphasis on public protection and risk reduction. The three regulatory bodies concerned with all healthcare professionals except medicine, the Health Professions Council (HPC), the Nursing and Midwifery Council (NMC) and the General Social Care Council (GSCC) (the latter with separate bodies for Wales, Scotland and Northern Ireland) were established from their predecessors in 2001, provide far more emphasis on professional accountability and behaviours through codes of conduct, standards and ethics for registrants than previously. All councils are charged with setting standards for entry to a professional register, for approving programmes for education and training, for maintaining a register of practitioners and for taking action against registrants who are not meeting their standards of practice. The Health Professions Council alone now has over 200,000 registrants on its active register, regulating 14 professions in 2009, but with at least four more professions likely to come under its remit in the next five years. In addition, there are moves to incorporate healthcare practices previously considered to be 'alternative' such as acupuncture, medical herbalists and traditional Chinese medicine practitioners. The NMC has around 680,000 registrants.

The scope of activity of the Councils ensures that expanded areas of professional practice are initially regulated in the same ways as entry to the professions. For instance, programmes leading to independent and supplementary prescribing by nurses, midwives, pharmacists, and some other allied health professions such as physiotherapists and radiographers must be approved by the NMC and/or HPC, dependent on the profession involved. A recent exploration of higher levels of practice by the NMC takes the stance that what is regarded by many as advanced practice bears no additional risk to the public than the basic notion of competence to practice, and at that time declined to set standards for advanced practice *per se*. However, a change of leadership at the NMC has resulted in a declared intention to re-open this debate, especially in light of increasing changes to the ways in which doctors work, and the resultant impact on the work of specialist and consultant nurses. The protection of the public is of paramount importance in the work of all the regulatory bodies, and at a time when there is growing criticism of standards of practice within the NHS, it is the responsibility of the professions to ensure that whatever role the practitioner is performing, it is being performed in compliance with the standards and codes of practice expected. Similarly, the HPC has not indicated any intention to consider registration beyond competence to practice on registration. All Councils do set standards for continuing professional development and require evidence of this for periodic re-registration, but this attests only to the standards required by all practitioners and does not differentiate further levels of practice in any way.

Yet, surely, the public must have expectations of practitioners who have been qualified for a long time, or indeed hold titles such as 'Consultant', 'Advanced Nurse Practitioner', or 'Specialist', even if the professional bodies do not. At the very least, every practitioner is expected to ensure that they practice to the latest (and best) evidence available, to keep themselves abreast and skilled in the latest treatments and techniques available and to practice within the Codes of Conduct published by their respective professional bodies. How would a member of the public be able to judge that a practitioner does indeed measure up to their expectations?

Reflective moment

Think about the last time you or one of your family used the services of a registered healthcare practitioner. How did you know that they

were competent to practice? What evidence did you have that allowed you to draw that conclusion? What would give you confidence in their professionalism, over and above such things as certificates on the wall, titles, uniforms or name badges?

The increasing professionalization and regulation of healthcare professions is aimed to increase public confidence in them following such cases of professional misconduct as Harold Shipman, Beverley Allitt, the Bristol Paediatric Heart Surgery and retained body parts incidents. The end result is expected to be greater patient safety, but there is no evidence available to demonstrate that this is indeed the case – it is an assumption arising from tighter legislative control. It is, in fact, hard to see how better patient care arises from imposing more regulation on practitioners; indeed, it is the central tenet of this book that better patient care will only result from enabling all practitioners to be critically reflective within their practice environment.

Becoming critical

It is primarily this challenge to find ways of promoting better patient care that prompted us to write a book about what we call critical reflection. In the preface to the first edition to this book we described critical reflection as 'using the reflective process to look systematically and rigorously at our own practice' (Rolfe et al., 2001). We might have added that critical reflection also uses the reflective process reflexively to look systematically and rigorously at itself. In distinguishing between *critical* reflection and other ways of reflecting, we recognize that reflection is a natural human activity. We all reflect and we do it often: many of us reflect silently to ourselves while walking home from work; we reflect at home with our families when we tell them about our day; we reflect in the car and in the bath; we even reflect in our dreams. Some of us write down our reflections in diaries or in on-line 'blogs'. Socrates is reported to have said that the unexamined life is not worth living. We would argue that the unexamined life is simply not feasible, and that unexamined practice can be both dangerous and unprofessional.

However, this book is not concerned merely with the day-to-day reflection that seems to be an intrinsic part of human experience. Indeed, such unstructured and unfocussed musings are not likely to

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