15 Education and professional development

15.4 Personal growth and professional development

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Introduction

In this chapter, the twin concepts of personal growth and professional development will be examined. In many ways this is timely since governments worldwide are devising largely regulatory ways of 'driving up' and sustaining the quality of health care that health professionals provide.[1] However, a theme running throughout the discussion here will be that political pressure for what has been termed 'accountability' of the professions has led to a distortion of the means whereby this can be realized, and in the process has created a distancing of the professions not just from politicians but through them from society itself, the members of which are the primary focus for any caring professional.

In contrast to this 'top-down' view of professional accountability, arguments will be presented for an alternative approach—one which provides health professionals with the means whereby they are able to give more clearly an account of what it is that makes them truly professional and through that develop their own professional practice.[2]

The chapter draws on a wide range of literature that is both international and burgeoning. It seems that professional people feel they have something to say—and that they must say it now. Throughout the discussion, the term 'professional' will be used to refer to all those who work in this way within a primary care setting.

The nature of professional practice: what do health care professionals actually do?

The starting point for this discussion is an examination of what health care professionals actually do, that is to address the question: what does it mean to practise professionally?

Society asks certain of its members to provide a particular kind of service for them in a professional manner. To be professional is to act in ways that others cannot, or choose not to act. And professionals are able to do this because they have become, through an extended period of development, members of a community. They have taken on the traditions of a profession. As Carr[3] puts it:

> To 'practise'… is always to act within a tradition, and it is only by submitting to its authority that practitioners can begin to acquire the practical knowledge and standards of excellence by means of which their own practical competence can be judged (pp. 68–9).

Another writer has noted.[4]

> Professionalism … is not just any kind of work … [It] is esoteric, complex and discretionary in character: it requires theoretical knowledge, skill, and judgement that ordinary people do not possess, may not wholly comprehend and cannot readily evaluate … The work they do is believed to be especially important for the well-being of individuals or society at large, having a value so special that money cannot serve as its sole measure … It is the capacity to perform that special kind of work which distinguishes those who are professional from most other workers (p. 200).

Over the past decade or so, many writers have emphasized that professional practice involves dealing with complex, unpredictable situations.[5–7] The kinds of problems that professionals are faced with are often 'indeterminate'—they have no clear or precise solution. It was Schön[5] who coined the term 'the swampy lowlands' to characterize what health professionals only too clearly perceive as their work!

These writers agree that professional practice is located in what some refer to as the 'zone of complexity', where uncertainty is high and agreement low, leading one writer[8] to define professional practice as:

> The exercise of discretion, on behalf of another, in situations of uncertainty.

Now, immediately, this challenges current ideology. Much of today's emphasis on 'quality' in health care assumes that there are clear answers to the problems that patients present. A natural extension of this view is that these 'answers' can be identified, written down, passed on, and 'applied' by health professionals—professionalism by protocol. And if there are no answers at present, then sustained scientific research will eventually find them.

However, the very essence of professional practice is that it involves making judgements. This is not to say that every situation is uncertain—some will be routine. Rather, a professional is required when the situation is not routine, and discretion is required. When one is 'being professional' there are no 'right' answers, only best ones.[7]

Perhaps it is truer to say that professionalism actually begins at the very moment when protocols no longer apply. While some aspects of a professional's practice inevitably entail following protocols, professionalism comes into play precisely at those moments when following the protocol is judged to be inappropriate. These are the moments in which medicine actually happens.[9] Perhaps the high point of professionalism occurs when one decides to take no action or to say nothing in a particular situation. Being professional can often mean choosing to do nothing.

Interestingly (and significantly for this discussion), a recent judicial review[10] in the United Kingdom of a homicide committed by a psychiatric patient (who at the time was being supervised in the community by a psychiatrist) supported this view:

> Each decision made in the care and treatment of a mentally disordered patient involves risk … There are no simple answers. The complexity and the difficulty of the balancing exercise which clinicians have to make daily as the guardians of the patient's health and the public safety, should not be underestimated … Clinicians are often placed in an invidious position forced to choose between options which are not ideal … Even the most eminent can be tested to the utmost of their skill and occasionally fail (p. 2).

With this in mind, it is perhaps encouraging for health professionals in the United Kingdom that the draft proposals by the General Medical Council for revalidation[11] speak of the need for 'a new approach to professionalism … which … recognises the inevitability of error in a judgement-based discipline like medicine' (p. 5).

Schön suggested[5] that there are two contrasting views of professional practice in contemporary thinking. On the one hand, there are those who see professionalism as a technical matter (which he calls a 'technical/rational' view of professionalism) whilst on the other hand, there are those who see professionalism as more like artistry. The 'technical/rational' view holds that medicine is an instrumental act, where there are 'right' answers, and clear solutions to clinical problems:

> It views professional practice as a basic matter of delivering a service to clients through a pre-determined set of clear-cut routines and behaviours … As being able to cut down considerably the risks incurred when professionals make more of their own decisions (ref. 2, pp. 31–2).

The artistry perspective, however, sees this as a deficit view of professional practice:

> Professional practice involves a more complex and less certain 'real world' in which, daily, the professional is involved in making many complex decisions, relying on a mixture of professional judgement, intuition and common sense, and that these activities are not able to be set down in absolute routines, or be made visible in simple terms, and certainly not able to be measured, and which because of this are extremely difficult to teach and to research (ref. 2, p. 32).

The nature of professional knowledge: what enables health professionals to do what they do?

It is now well established[6] that there are different kinds of knowledge. A knowledge of facts—when we 'know' *that* something is the case—is sometimes called 'propositional' knowledge. Skills, on the other hand, require a different kind of knowing, sometimes called 'procedural' knowledge—we know *how* to do something. However, professional judgement— the exercise of discretion in situations of uncertainty—requires yet another kind of knowledge. Epstein describes this in the following way:[12]

> Clinical judgement is based on both explicit and tacit knowledge. Medical decision making … is often presented only as the conscious application to the patient's problem of explicitly defined rules and objectively verifiable data … Seasoned practitioners also apply to their practice a large body of knowledge, skills, values and experiences that are not explicitly stated by or known to them … While explicit elements of practice are taught formally, tacit elements are usually learned during observation and practice. Often, excellent clinicians are less able to articulate what they do than others who observe them (p. 834).

The work of Freidsen, cited earlier,[4] also makes clear that a professional's knowledge base may not always be wholly comprehended or readily evaluated. As others too have remarked,[13] much professional knowledge is 'intuitive', and that in a very real sense health professionals may not always know what they are doing!

Referring back to Aristotle's thinking suggests that the kind of knowledge that enables 'making action' (*poesis*) is what he called *techne* (which we would understand today as 'technical knowledge') but that the kind of knowledge that underpins *praxis* (or professional action) is what he called *phronesis* (which today we might term 'practical wisdom').[3] Here, too, the distinction Schön makes between a 'technical/rational' and an 'artistry' view of professionalism is helpful: *Techne* underpins the 'technical/rational' view whilst *phronesis* and 'artistry' are synonymous.

Modern writers[3,7] have revived the concept of 'practical wisdom' to defend (and to some extent to rescue in a world where professionalism appears to be under threat) the notion of being professional. Carr, for example, writes that practical wisdom is … .

> … a form of reasoning in which choice, deliberation and practical judgement play a crucial role … [It is] a way of resolving those moral dilemmas which occur when different ethically desirable ends entail different, and perhaps incompatible, courses of action' (ref. 3, pp. 70–1).

Following Aristotle, Carr asserts that practical wisdom is 'the supreme intellectual virtue and an indispensable feature of practice' (ref. 3, p. 71), adding that someone who lacks *phronesis* 'may be technically accountable, but can never be morally answerable'. Carr further suggests that, because of this, professional action is not action that can be proved to be correct in some absolute sense but rather is '*reasoned* action that can be defended discursively in argument and justified as morally appropriate to the particular circumstances in which it was taken' (ref. 3, p. 71).

Put this way, 'practice' (i.e. what a health professional does in the course of his or her practice) and 'theory' (i.e. the knowledge that enables a health professional to practise) are not distinct. They are not 'separate' from one another. Theory does not 'inform' practice. Nor is it 'derived from' practice. And theory cannot be 'applied to' practice. Rather, theory and practice are, as Carr puts it, 'mutually constitutive and dialectically related' (ref. 3, p. 50)—you can only understand your practice by appreciating the theory that, *for you*, underpins it, and you can only understand the theory basis of your practice by appreciating its concrete expressions *in your own practice*. This revelation has profound implications not just for how health professionals practice but more particularly for the discussion here concerning how health professionals *learn* to practise.

The nature of professional development: how do health professionals actually learn to do what they do?

Research over the past decade in North America by Davis and his colleagues has clearly shown that health professionals change their practice[14] and improve health care[15] more as a result of informal educational processes than formal ones. More particularly, health professionals learn through holding professional conversations (where they talk professionally about their practice) with respected peers. These are the moments when professional development actually happens.

Other writers confirm this. Lave and Wenger suggest[16] there is a dynamic process here, which involves what they call absorbing and being absorbed into the practice community. Professionals not only learn *from* hearing others talk but crucially they also learn *to* talk. They acquire an understanding of what is appropriate professional thought (and hence action) in particular situations. Put another way, conversation is crucial to professional development.

A study[17] in the United Kingdom of clinical units that were highly acclaimed by hospital-based medical trainees as places to receive good training (and which the trainees saw as providing high quality health care) showed these units to be characterized by:

- a sense of community—feeling that you belonged there;
- a sense of collegiality—feeling that you were a colleague;
- a sense of criticality—feeling that anything that happened there could be openly and honestly discussed.

All of this suggests that professionals learn in and through their everyday clinical work, and as a result of the many, often informal, contacts with their professional colleagues. Professional development is a natural, and naturally occurring, phenomenon. It is the result of becoming a member of a professional community, of acquiring and accepting the traditions of that profession.

There is, of course, a problem here. If health professionals learn largely through informal means, how can society be reassured that what is being learnt is 'correct'? Carr suggests that

> … the authoritative nature of a tradition does not make it immune to criticism. The practical knowledge made available through tradition is not mechanically or passively reproduced: it is constantly being reinterpreted and revised through dialogue and discussion about how to pursue the practical goods which constitute the tradition. It is precisely because it embodies this process of critical reconstruction that a tradition evolves and changes rather than remains static or fixed. When the ethical aims of a practice are officially deemed to be either uncontentious or impervious to rational discussion, the notions of practical knowledge and tradition will tend to be used in a wholly negative way (ref. 3, p. 69).

What Carr is arguing for here is of course professional self-regulation, and he is also challenging the competence of people outside the traditions of a profession to determine a profession's practices. There is, however, a wider implication of what he says. His claim for the right of professionals to regulate their own practice rests on an ideal (and perhaps idealized) view of professionalism—one where there is constant reinterpretation and revision of practice through continued dialogue and discussion. In short, he sees professionals developing their professionalism through what he calls 'the critical reconstruction of practice'.

There is strong support in the wider literature for this. What is termed a 'constructivist' (as compared with an 'instructivist') theory of learning[18] holds that all knowledge is 'socially constructed'. Learning occurs through interactions between people when they attempt to make sense of their experiences, clarify their confusions, and correct their misunderstandings. Indeed, learning is a two-way process: as many teachers know, they often learn through the process of teaching.

In particular, constructivist learning theories are thought to be most significant in developing the kind of knowledge that enables people to deal with complexity and uncertainty. Not just this, but these theories suggest that knowledge is temporary and dynamic, and that some things will remain unknowable.[19]

Support for Carr's view that practice develops through its critical reconstruction also comes from a very practical source. The judicial review cited earlier noted:

> … the importance of clinicians not being so overburdened that they do not have time for mature reflection or to foster appropriately strong links with their teams (ref. 10, p. 3).

However, many health professionals will recognize that this does not always take place. A literature review[20] in the United Kingdom has identified some common features of the failure of many continuing medical education programmes and initiatives to fulfil their potential. These include:

- geographical isolation of health professionals;
- heavy service loads;
- competition with colleagues for inadequate resources;
- lack of time for study;
- CME systems that encourage compliance through external rewards (such as points or payment).

Again, the distinction between a 'technical/rational' and an artistry view of professionalism is helpful. The technical/rational view sees continuing development as 'training'—there are right answers to clinical problems, and health professionals must be told about them. It emphasizes that error is the result of individual failure to follow agreed (and often evidence-based) protocols, and that quality health care can only be achieved through tighter regulations. By contrast, the artistry view is that 'quality' is to be found within professionals, and can only develop when they unearth and explore its basis.

But there is a further and perhaps deeper problem with continuing education, which has already been alluded to here: the kind of knowledge that health professionals need in order to exercise professional judgements is, in part, 'hidden' from them. So how can this be uncovered and developed?

Personal growth and professional development

So far this chapter has shown:

- professional practice involves making judgements in situations of uncertainty;
- this requires practical wisdom;
- which is acquired largely through professional conversations with respected peers.

It has also been noted:

- much contemporary thinking (which is based on a 'technical/rational' view of professionalism) dismisses (or fails to appreciate) any of this;
- and sees the improvement of quality as a need to redress deficits in clinicians' knowledge and skill through remedial training and tighter regulatory frameworks;
- health professionals, however, are often unaware of the nature and enormity of their acquired practical wisdom;
- and may have difficulty explaining (articulating) this to others.

These matters can be resolved by adopting a developmental rather than a regulatory approach that consciously adopts an 'artistry' view of professionalism and assumes that:

> Quality in patient … care is not achieved by decree nor by striving to reach standards set by others … Rather it is achieved by the endless pursuit, by each practitioner, of greater understanding and better practice (ref. 21, p. 181).

On this basis, personal growth and professional development go hand in hand, and these require the appreciation by professionals of the judgements they make in the course of their practice. The thread running through this argument is that professional practice changes when practitioners engage in 'the continuous dialectical reconstruction of knowledge and action' (ref. 3, p. 69)—a process that some writers note involves 'deliberation'.

Deliberation is more than 'reflection' on practice.[2] It is concerned with the critical *construction* of one's practice rather than merely its critical *consideration*. It focuses on 'the contestable *issues* endemic to practising as a professional' (ref. 2, p. 68). As Schwab[22] puts it:

> Deliberation is complex and arduous. It treats both ends and means and must treat them as mutually determining one another. It must try to identify, with respect to both, what facts may be relevant … Deliberation requires consideration of the widest possible alternatives if it is to be most effective (pp. 318–19).

Deliberation is an important concept in any discussion on personal growth and professional development for three reasons. First, it is concerned with practice 'as a whole', rather than just one's own practice—that is with the critical reconsideration of the *traditions* of one's practice. Second, reconstruction fundamentally involves 'building again', and not merely the mechanical or passive reproduction of practice. Third, critical reconstruction involves a perspective beyond current practice (and even its traditions), and takes the professional into the wider consideration of his or her actions. Here not just other people's views on one's practice but also the accumulated views of the profession itself (made available largely through its literature) are taken into account in reconstructing what one does and says.

Conclusions

This chapter has drawn on current literature to develop the themes of personal growth and professional development, which are necessarily interrelated, through an examination of:

- the nature of professional practice;

- the nature of professional knowledge;
- the nature of professional development.

It has shown that professional practice in health care is often 'messy'[5] and deals with complex situations where uncertainty, fallibility and mystery[9] are the norm. This requires practitioners of all professional groups to exercise their judgment,[2] particularly when the working protocol fails to deal with the particularities of the situation that is being presented. Often in practice there are no right answers in some absolute sense,[3] only best ways of acting.[7] The special kind of knowledge that enables professionals to make these judgements has been termed 'practical wisdom',[3] and this is acquired largely through informal conversations with respected peers rather than through formal educational programmes.[14,15] These informal processes occur 'naturally', and professionals engage in them automatically and largely unknowingly.[12,13] There are, however, countervailing forces that prevent them occurring, and 'top-down' interventions (such as many of those being introduced by governments, often linked with tighter regulatory frameworks) appear to be counterproductive.[20]

Out of this discussion has emerged the need for health professionals to engage in the appreciation of their practice,[2] so as to understand more clearly the judgements they make and the wisdom that underpins them. This process has been described as 'deliberation',[2,3] which involves the critical reconstruction of practice.[3]

The concept of 'critical reconstruction' is well supported in the contemporary learning theory literature reflecting a 'social construction' view, which appears particularly appropriate in dealing with the complexity and uncertainty of clinical practice.[18]

Society needs professional people who can make judgements. Anything less is a disservice. It has been argued here that health care professionals' needs are more likely to be met through education than by regulation, and this requires personal growth linked with their professional understanding.

However, governments and some sections of the media have yet to show in their public utterances and policy frameworks that they appreciate the nature of professional practice. Therefore, it is incumbent upon professionals to give a clearer account of their practice and what fundamentally underpins it. Practical ways of achieving this are described elsewhere.[2]

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