Research Article

Creating a Dynamic of Engagement: Emotions and Professionalism in Health Education

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Abstract

This article explores how professional health education might be more specifically informed by theoretical and empirical literature relevant to student engagement. The distinctive circumstances students find themselves in are explored in relation to the different cultural arenas in which they learn, the competing value systems they navigate and the different forms of pedagogy they encounter. Becoming a member of a health profession is discussed as a moral endeavour, conducted in uncertain and liminal spaces filled with possibility and risk. Yet - to paraphrase Couldry (2000) - the conditions of both academia and practice, and of students’ personal lives, can serve to limit the type of selves, the kind of health professionals, they can become. Those conditions, as lived, understood and interpreted by students themselves, must be the subject of deeper inquiry if we are to promote conditions that fully develop and fulfil their agentic, social and dynamic potential. Finally, the role of identity formation within health practice and education is discussed, drawing on Giddens’ (1991) reflexive project of the self. Ways to promote more dynamic forms of engagement, through lived experiences and across departmental, disciplinary and organisational boundaries, are offered and discussed.

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Introduction

I ask her for my result, ‘1.1’, the nurse says, with no trace of emotion in her voice. I try hard not to cry, but panic and despair get the better of me. I choke on my tears. Crying involves a lot of breathing at the best of times; with respiratory illness, it is downright difficult. I sob quietly, bitterly, the way defeated people cry. I lament my helplessness, my body’s betrayal. I can’t do it. I can’t breathe properly. I cannot breathe. All those hours at the gym, kickboxing classes, strength training, runs – all to no avail. My illness is stronger than my body, stronger than my will. I’ve lost 300 precious millilitres of lung function over the past three months. The equivalent of what a healthy person would lose over a decade. I look at the nurse. She stands there, stony but for her slight impatience. Now I’m crying and can’t do the other tests. I’m spoiling her day, getting her behind schedule. I collect myself; ask her for a glass of water. A sulky hand presents me with a dripping paper cup. She doesn’t look at me or say anything. I am alone.

I later reflect on the encounter with the nurse. What sort of training has made her able to stand there, saying nothing, offering no word of comfort or distraction? Does she do this every day, to all her patients? Does she feel anything but annoyance towards me? Is this exchange sanctioned by the National Health Service? Does she think of me as a person? I can’t ask her these questions. She probably won’t even remember me. I know I failed the unwritten law of the medical world, where everything is impersonal, where news of deterioration and terminal illness are to be met with dry eyes and a steady gaze. And within this world, my human failure will be held against me, while her failure to be human does not even have a name (Havi Carel, 2008, 38-39).

In her book ‘Illness: Art of Living’, Havi Carel describes numerous encounters with health professionals, some of whom she felt stood with her in her darkest moments and others who seemed unable to do so.

Her graphic account and search for answers reflects the current soul-searching in healthcare, following systemic failings in parts of the UK. Like Carel, I am interested in how the education of health professionals influences those encounters. I am less certain of it as a cause of the lack of human connection, and find myself wondering if it is possible that the nurse she describes did not know what to do, or thought her response was the correct one, or for some reason believed that doing nothing was better than doing the wrong thing. Was she in some way incapable of a spontaneous or caring response, due to ‘burnout’ (Felton, 1998) or some other stress-related problem, or in some other way estranged from her caring work?

It is undeniable that many problems exist among the healthcare workforce yet my own daily encounters with healthcare students of all professions and grades tell me that the great majority are resourceful, intelligent and kind people. What’s more, I see them fully engaging in an explicitly moral endeavour, seeking to improve the lives of
those for whom they care. Tronto’s (1993, 127) four ethical elements of care – attentiveness, responsibility, competence and responsiveness – are alive in our conversations, and apparent in their academic work and in accounts from practice.

Healthcare embodies both realities, and urgently requires an explanation that goes beyond the simple dichotomy of good/bad person or functioning/failing system, so beloved by policy makers and headline writers. Sontag (1991) and Frank (2013), like Carel (2008), share their experiences of living with illness through storytelling. Frank (2013, 193) asks how those telling their stories resist pessimism and sustain hope. The question is equally pertinent to those working in healthcare. The purpose of this article is to seek to understand how education can contribute to a health service prepared to look in both directions; to believe that cold and even inhumane acts are carried out by perfectly well ‘trained’ professional members of the healthcare workforce, and simultaneously to believe in the basic humanity and ethical commitment to care of the great majority. It is my contention here that reconciling and integrating these seemingly incompatible truths is fundamental to the future contribution of education to health practice.

The article begins by showing how practical and intellectual domains are intertwined; in structurally complicated, gendered, physically and emotionally demanding, externally regulated health education. Student engagement, with care practice and with academic work, is discussed in light of research as a fragile and contingent phenomenon. I draw on Giddens’ (1991) work to explore how education might more directly develop and support a more reflexive form of engagement with health practice, concluding that emotional engagement with others is central to the work of healthcare and therefore to healthcare education.

**Being a healthcare student**

Professional healthcare education is, by any measure, hard work. It combines the same academic demands as any other undergraduate or post-graduate degree with regular, assessed work placements. These require that students not only negotiate and cope with long journeys and irregular hours, and become part of new teams, but that they work in various ways with people who need care and treatment. They need to ‘know’ things: to be up to date with the latest research evidence and clinical information, to understand
the implications of signs and symptoms, laws and policies, and to recall and connect complex pieces of information. But they also need to ‘be’ in certain ways: for example, respectful and effective communicators, able to place others’ needs at the centre of their care; to understand them as part of a wider system, such as a family or community; to be prepared to advocate on their part, and to be present for them emotionally and practically. Acquiring ‘skills’ is often a preoccupation, whether physical, technological or interpersonal, as situated work-based learning also requires a considerable amount of ‘doing’.

Discussed less often are the embodied and social forms of learning that healthcare practice entails. Help and support is frequently given by people managing illnesses or disability, to the health professional. These reciprocal relationships are where care is made manifest. It is only possible, other than in very particular circumstances, to work with someone with their permission, their feedback, help and guidance, and their expertise. Without such mutuality the education of health professionals could not take place. Health students need to be sensitive to the health, safety and wellbeing of others, while simultaneously trying to perform technical procedures or form a complex judgement.

This space, at once intimate and common, is where professional selves are formed and performed. Biesta’s (1994) description of ‘practical intersubjectivity’ is helpful in understanding the way care interactions (can) affirm each other, through shared endeavours and a mutual commitment – for example, to rehabilitation regimes or pain management. The intersubjective arena is less well explored in health education as a site of ethical development; the more dominant ‘values-based education’ is the subject of much interest currently. The latter relies on the inculcation (and proposed measurement) of individual ‘qualities’, leading to the current ‘six Cs’ of the National Health Service: compassion, courage, competence, care, communication, commitment.  

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3 http://www.england.nhs.uk/nursingvision/
Increasingly critiques of the attempt to elicit or ‘measure’ such qualities are being made however; for example Smajdor (2013:2) questions whether the concept of compassion is definable, much less quantifiable, asking (after Bradshaw, 2009) if by offering incentives to demonstrate compassion, we will find ourselves experiencing a ‘McDonaldisation’ of care.

Unlike most of their peers in higher education, sooner or later, health students will see people die, in both expected and unexpected circumstances. They will also see people live, with conditions and in ways they cannot imagine wanting to live themselves. Inevitably they will witness prejudice and injustice and many will be subjected to both during the course of carrying out their caring work. All will experience at first hand a variety of team and organisational cultures, and unfortunately may encounter bullying behaviours, or see the effects of inadequate resources, or an externally / managerially driven preoccupation with achieving targets. They may, or may not, be supported in their emotional work to understand power relationships in a highly gendered workforce, and to resist exploitation and what Browne and Braun (2008) call the devaluation of healthcare work.

Unlike the reality shock Kramer (1974) described, in her landmark study of attrition and burn out among newly qualified nurses, today’s students are likely to be all too aware of healthcare’s shortcomings, cognitively if not yet affectively. In the past newspaper reports tended to be forgotten over time, but social media has enabled light to be shone into the darkest corners. Covert filming leaves no doubt that cruelty and abuse continue to be heaped upon voiceless, vulnerable people.4 Shocking events are preserved for perpetuity in grainy YouTube clips, circulated, commented on, and re-circulated via Facebook and Twitter.

These, then, are the distinctive educational circumstances that health students find themselves in; moving between the many different cultural arenas of practice and academia, navigating their way through competing value systems, coming to know themselves as novice health professionals through intimate emotional and practical ‘bodywork’, with all its unspoken mores (Twigg, 2000). Simultaneously they manage

4 See, for example, You Tube clips of abuse at Winterbourne View, Bristol [http://www.youtube.com/watch?v=subMgyJOK8&feature=kp](http://www.youtube.com/watch?v=subMgyJOK8&feature=kp)
different types of assessments to prove themselves - to their mentors, educators, future employers and education commissioners - as worthy colleagues and fellow professional registrants. Uncertainty is a common feature of health education, the amount of change within a single programme leaving many feeling little confidence in the eventual outcome. So there is a liminal quality to the student years: full of possibility and fraught with risk, not quite like other students and not quite a professional, engaged in the moral endeavour of care yet all too often confronted with its dark side.

**Challenges to engagement in health education**

The complexities at stake for health education remain under-explored in the literature. While there are important messages from research into student engagement more generally, the ways in which these might be applied or adapted to health students’ engagement is as yet unclear. The unique dual attachment of health students to practice and to academia offers an opportunity to reflect on their overarching goal to become a health professional.

Recommendations from numerous inquiry reports, notably Francis (2013), foreground the importance of voice, respect across disciplines, responsibility, accountability and most centrally, the preparedness to stand against the crowd to say something is wrong. Yet when Levett-Jones and Lathlean (2007) researched student nurses’ placement learning, they found a sense of belonging to the nursing team to be pivotal to feeling able to learn. While this reflects the work of Kember, Lee and Li (2001) with part-time students, it reflects a high (if understandable) level of social need.

Bryson (2014, 11) helpfully expands and complicates the idea of belonging with affiliating and feeling integrated, going on to suggest that as long as points of engagement exist – which may be intellectual, social, geographical or career-focused – then students tend to build more and stronger attachments over time. Some of his own research participants found blocks of work placement to disrupt earlier forms of engagement, even coming to ‘hate’ university (Bryson and Hardy, 2014, 38). The ‘hot action’ of work, described by Beckett and Hager (2002, 20), resulted in the more passive forms of classroom-based learning seeming to be a waste of time and frustrating, as students wanted to get back into the more exciting world of work.
All these studies support Mann’s (2008) thesis that an absence of feeling actively engaged - feeling distant from learning, socially or intellectually - is an isolating and largely negative experience, highly associated with drop-out. Certain groups remain more vulnerable to dropping out of higher education; men, mature students and those from low income families or with financial problems were found by Rose-Adams (2013) to be particularly so. In health programmes, male students begin in a minority and reflect national trends of dropping out in higher proportions (Mulholland, Anionwu, Atkins, Tappern and Franks, 2008; Wintrup, Wakefield and James, 2013). Students from certain black and minority ethnic groups are not achieving the expected grades or first class degrees when compared with white and other ethnic groups (Stevenson, 2012). Reasons for this persistent attainment gap are the subject of much debate.

As a result of successful recruitment strategies, health professions reflect these experienced and diverse groups of students in significant numbers and it is likely that widening access targets, expressed by the Office for Fair Access (OFFA) ⁵ are met in many universities in large part by health programmes. However the combination of intensive, demanding programmes and greater diversity means dropout is often higher than more traditional programmes of study. In research with Foundation degree students we found this to be associated with financial problems and family issues. More flexible, modular programme designs also led to the loss of cohort and social support and eventually to loneliness (Wintrup, James, Humphris and Bryson, 2012). Without a shared cohort schedule, seemingly minor problems, such as a timetabling mistake, could be experienced as rejecting and personal. Many reported feeling unable to express difficulties, in case these were seen as personal inadequacies, yet we heard too how once voiced, problems were resolved quickly and trust rebuilt: ‘We felt bewildered at the beginning. And then we all started realising that actually we had voices’ (Wintrup et al., 2012, 180). A mentor’s praise kept one student from dropping out: ‘If I hadn’t had those two placements, and with that recommendation from the (professional) in that school […] I would have given up by now’ (Wintrup et al., 2012, 177).

In a study of graduates we found care practice, and the goal of a career in healthcare, to be a strong motivator; the familiar, rewarding relationships of care work

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⁵ http://www.offa.org.uk/access-agreements/
were found to be nurturing in ways not present in the University, which was often negatively associated with anxiety, fear of failure and a sense of hurdles to be overcome (Wintrup, Wakefield and James, 2013).

So our own and others’ research into student engagement in health education reveals it to be fraught with potential: for rewarding and reciprocal caring relationships, membership and belonging, a desired professional career and stimulating experiences. At the same time these possibilities have to compete with the more involved lives and commitments of mature and diverse groups of learners, the social and practical disruptions of work placements, a continual need for adaptation and adjustment across and between practical and academic settings, and exposure to the various public and politicised cultures of healthcare provision.

So, professional healthcare education is distinctive and complex. But rather than see that as a reason for going no further, I want to explore the pedagogic implications of such an embedded and contextually dependent form of learning. To structure this exploration, I make use of Giddens’ (1991, 53) concept of self-identity. Healthcare education can be viewed as a unique project of the self, started long before university, unfolding over time and oriented towards the development of an anticipated future self – for my purposes, the good health professional. In Giddens’ thesis, the development of a stable sense of identity comes from a carefully woven narrative that explains the past and anticipates the future, is constant over time and capable of integrating external events and exerting influence over them:

..the self is not a passive entity, determined by external influences; in forging their self-identities, no matter how local their specific contexts of action, individuals contribute to and directly promote social influences that are global in their consequences and implications (Giddens, 1991, 2).

Conceptualised in this way, the complex and multifarious types of learning in healthcare can be seen as opportunities to prompt new and stretching reformulations of a sense of oneself. Equally the need to integrate experiences and to maintain a sense of identity introduce the likelihood of reformulations of events to protect one’s sense of self - as a good person, or to explain past events in ways that make sense, and feel comfortable. How able we each are at any given point to reflect on the aspects of
ourselves we feel less comfortable with, or less proud of, will depend on both interior and exterior landscapes. In Giddens’ sense, and taking Havi Carel’s (2008) account as it stands, the unresponsive nurse will (like Carel herself) have reflected on the event, whether deeply or not, and most probably found a way to integrate it into her ‘careful biographical narrative’ (Giddens, 1991, 54).

The pedagogic implications of placing the reflexive understanding of self as central to health education, means revisiting how we conceptualise and construct that education; currently the students’ projects of the self, their constant sense of themselves, is variously assaulted and bombarded with new information about who they are and how they came to be where they are now (Giddens, 1991). Carel’s account – at once eloquent, moving and quite damning – offers a piece of information that may be hard to hear, but that needs to be recognised as a singularly powerful source of learning. It is easy to imagine how we might find ways to reject or nullify her central message, or to reject and demonise the nurse she describes. Yet to educators, both sets of individual experiences are equally important, if we are to better understand how to contribute through education to a more emotionally engaged, yet emotionally resilient, workforce.

**Examples of integrative activities**

Ashwin, Abbas and McLean (2014) in a study of quality in higher education focus on teaching as pivotal to developing in students a transformative relationship with knowledge. They describe teaching that *makes demands* of students and asks them to engage with difficult knowledge, as capable of transforming the student’s sense of who they are and what their engagement with the world is. What, though, is the transformative, ‘difficult knowledge’ educators need to help health students engage with? There is much that is difficult in terms of content and some that is difficult in terms of implication, and some that is simply hard to learn and absorb. But there is also difficult *self-knowledge*, provoked by care practice with its imperfect settings, unpredictability, unsettling encounters and finite resources – which is unique to those whose very sense of themselves is intimately bound up with being a ‘good’ health professional.
There are lessons to learn from research. The frustration expressed by Bryson’s (2014) student on returning to university after a work placement is easy to identify with - yet time to engage in inquiry, reflection and sense making is precious too. Sharp, artificial divisions between ‘theory’ and ‘practice’ are unhelpful and unnecessary, and serve to reinforce the idea of separate worlds. Intellectually stretching education wherever it takes place has to do its work of ‘making demands’ on students: to describe, analyse, question and to challenge the broader forces shaping health provision.

In failing to make explicit the purposeful and dynamic relationship between the interior-personal and the exterior-political, education itself becomes disaffecting. A health student who struggles to arrange a smooth discharge for someone who is terminally ill is puzzled by continual delays and the lack of support, feeling inadequate when things go wrong. Left to make sense of such an experience – or worse, being blamed for a lack of success - the students’ sense of self and the kind of professional she is becoming is at risk of dislocation with the self that has, for whatever reason, provided such an inferior standard of care. Isolating experiences such as this require educators and mentors to be helping students to reject the dichotomies of good/bad, and to engage more broadly with the difficult knowledge of health systems and cultures.

Of course the student may need no help to look beyond the immediate experience, to discover that there simply is no suitable system in place, and in doing so feel incensed and moved to seek others’ views, to lobby for or even to develop a better system. In doing so, her sense of self is reinforced as capable and agentic and she is likely to realise the need for communal and collective action if things are to improve.

The idea of transformational and dynamic engagement with difficult knowledge offers health education ways of exploring, with students, the ways in which their care practice can ‘directly promote social influences that are global in their consequences’ (Giddens, 1991, 2). The differentiating forces discussed by Couldry (2000, 130) ‘cut across boundaries, multiply options for cultural allegiance, and disrupt the effectiveness of centralised forms of address’, offering health education ideas for connection and engagement outside the restrictive domains of professions and organisations.

These connections might include working together across disciplines and outside of health programmes, in societies and special interest groups (for example, in societies,
charitable work and special interest groups 6) in ways that inform their sense of themselves as part of a larger workforce.

Social media offers new perspectives on familiar issues, within the same organisation or internationally, across disciplinary and academic boundaries, and on the basis of shared interests. A recent conversation between an academic and a group of students showed how students not only discovered the role of the military in developing prostheses but also learned of the political critique of such developments. 7

Project work that supports the work of a hospital ward or community team need not be carried out as formal placement, but can change the lives of students and people using services. Both develop allegiances and shared commitments to change, and in so doing have both personal and societal implications. A gardening project is one such example; 8 students learn about activism from activists, rather than through a lecture. Students’ own activism and political engagement is another form of activity that can help them explain and challenge their practice in ways that create connections with people not otherwise involved with health education.

Interdisciplinary ‘Schwartz rounds’ 9 are becoming an everyday feature of some hospital settings, in which anyone affected by a recent clinical event can share feelings and concerns. The powerful learning that takes place is deeply personal, communal and can be seen to have broader ramifications across organisations and beyond.

Such examples do not offer a single formula for change and are not intended to do so. Rather they show ways in which less ‘formal’ education – that involves instruction, monitoring, inculcation - can lead to more learning; about themselves, others and about the situations in which healthcare takes place.

6 See, for example, the Interdisciplinary Critical Care Programme http://www.sotonccp.org/overview/faculty
9 http://www.kingsfund.org.uk/projects/schwartz-center-rounds
Conclusion

It is difficult to know, other than anecdotally or in small-scale research, the effects on the students’ learning of these interesting new allegiances. Might any of these new forms of connectedness and allegiance within, across and outside of healthcare speak to Carel’s nurse? It is possible, likely even, that she would not have been changed by an education that exposed her to shared work with peers, people using services or disabled, politicised academics. Yet she might have been - and even the possibility is worth exploring and researching if we are to learn how to educate for emotional and intellectual engagement.

If we surmise, because it is more productive to do so, that her goal that day was not to plummet a person already coping with a serious illness, into a deeply lonely place, or to find herself written about and discussed at various conferences and even in this article, then it is necessary to ask just what might have helped her to join Carel (2008) in coping with the frightening and despairing moment of the test result.

If we imagine her as a student, with her carefully maintained biography of the good nurse, we would want her to have opportunities to ask someone – without being judged - what to do if a person falls apart in front of you, when you do not really understand the implications of their disorder or their test results, or when you have a long list of appointments to get through and fear you will be blamed for late running or for causing complaints. We would want her to know that by simply being beside someone in their pain and grief, by letting go for a moment of the need to be in control of appointments, she will not fail in her broader duties or need for efficiency. She will not fall apart herself, or be out of her depth, or be seen to be overstepping a boundary, or be unable to regain control of her day.

We would want her to learn, as Colley (2006) reminds us, that there is no single ‘correct’ response in caring work and she may get it wrong again, but that should she need to take a little longer than planned when giving someone distressing news, she is not failing – even when the clinic over-runs. We would want her to know, when she works out that appointments are not long enough, or staff not plentiful enough, or environments not conducive enough, or test results too frightening to be coped with alone, that we - her educators and mentors, her managers, healthcare commissioners,
regulators and inspectors - will stand beside her when she starts realising that she too has a voice.

References


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