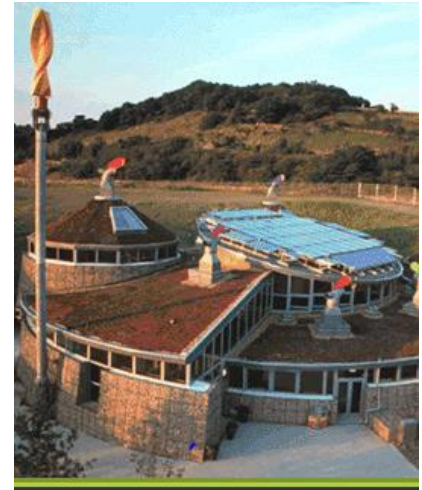


Practice development is practitioner development

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None of us should really be here today, because in a way it is ludicrous that we should need to have practice development conferences at all. Practice development shouldn't be something different and special. Everything we do, as practitioners, managers and academics should be concerned with practice development - it should be at the core of our being. Especially academics.

I can see no reason or justification whatsoever for academics in a practice-based discipline other than the development of practice. And I hope to show this morning that this does not mean teaching. For me, practice development has nothing to do with the mug and jug theory of education - you know, the students are the mugs and I come along with my jug of knowledge and top them up. This has also been called the 'top down' or shower model of education. I want to argue that practice development requires a 'bottom up', or what I like to think of as a 'bidet' model.

I've taken an active interest in practice development for a number of years. I was involved in the original Kings Fund Nursing Development Unit initiative in the early '90s, and in a number of Practice Development Units since. My previous job title even had the words 'practice development' in it, but it wasn't until I came to think about this paper that I first seriously asked myself the question: 'What is practice?'. And the more I thought about it, the more I realised what a good question it was.

Of course, the word has two spellings (unless you're American) and a number of meanings. Spelt with a 'C', as it is in the title of this conference, it is a *noun*. When we talk about the practice (with a 'C') of nursing or the practice of medicine, we are referring to a thing, in this case, an institution, a profession or a general way of doing things. When we talk about a medical practice (also with a 'C'), we are sometimes referring to a building, sometimes to the group of people who operate out of that building, and sometimes to their agreed way of working. Practice development means to improve or develop the institution or profession of nursing, medicine and so on. A practice (with a 'C') development unit is therefore concerned with developing this thing that we call professional practice. The outcome of practice development (with a 'C') is a better *thing*, either an entire profession or a group of clearly identified individuals within that profession.

Then, of course, there is practise with an 'S'. Practise with an 'S' is a *verb*. To practise is to do something in a certain way. Practise development means to improve or develop what we

do as professional practitioners. The outcome of practise development (with an ‘S’) is better *action*.

Perhaps I’m being pedantic here, but I only realised when I was thinking about this paper that I rarely distinguish between the two. It was only then that it occurred to me that I had been misrepresenting myself and what I do for almost my entire career. Although my previous job title said that I was a Reader in practice development with a ‘C’, I actually had little interest in developing the profession of nursing or the general principles by which nurses work. For me, practice development with a ‘C’ is largely a matter of policy and politics. I suddenly realised that my interest is, in fact, in practise development with an ‘S’. I want to influence directly what individual nurses *do* rather than generally what nursing *is*.

But to say that practise with an ‘S’ is what we *do* is only half the story. Why is it that we refer to *all* doctors as medical practitioners, to *all* lawyers as legal practitioners, to *some* nurses as nursing practitioners, but *never* to postal delivery practitioners or bricklaying practitioners? You might argue that it is something to do with belonging to a profession, but that only begs the question of why medicine is regarded as a profession whilst bricklaying isn’t. Clearly, not all doing is practise and not all doers are practitioners. There has to be something more.

Some years ago, I wrote about the distinction between nurse technicians and nurse practitioners. They *can* be seen as two stages in the development of the nurse, but they are also two modes of working. Nurse technicians adhere to the technical rationality model of nursing, and their modus operandi can be summed up by the following definition:

Nursing is a science and the application of knowledge *from* that science *to* the practice of nursing. (Andrews & Roy 1996, my italics)

This technical rationality model assumes a hierarchy in which knowledge and theory inform practice in a one-way flow. Nurse technicians are concerned with what we might call ‘the appliance of science’, with the scientifically proven ‘best’ intervention for each nursing problem. Perhaps I was being less than charitable when I described this technical approach to nursing:

almost as a branch of engineering, and the goal of nursing knowledge and theory as finding the most efficient and effective ways of carrying out nursing procedures. (Rolfe 1996)

Well, perhaps, and yet I continue to find the same sentiments echoed in the rhetoric of evidence-based practice, which appears to have as one of its goals the search for the holy grail of the most efficient and effective generalisable intervention for each generalised nursing problem. This can lead to some disturbing trends. For example, in my own field of psychiatric nursing, cognitive behaviour therapy has been found in RCTs to be the most effective and cost efficient nursing treatment for depression. This has been interpreted (quite wrongly, I believe) by some nurses to mean that all depressed patients should be offered CBT, almost regardless of who they are as individuals. Physicians have treated the disease rather than the patient for very many years; indeed, the medical model is predicated on the idea that it is the disease rather than the patient that responds to medication. If the patient presents with signs and symptoms of depression, she will probably be prescribed the drug

that has been found in clinical trials to be the most effective treatment for her general condition. I am concerned that nursing is heading the same way.

In contrast to these nurse technicians, nurse practitioners are concerned with individual solutions to individual problems. They approach each clinical encounter as though it is unique, and seek out the best intervention for that particular patient in that particular situation, regardless of what the textbook might tell us is the 'gold standard' intervention. The technician's solution lies *outside* of the situation and can usually be found in a book or journal, whereas the practitioner's solution lies in the situation itself.

In a certain sense, then, the technician's intervention is mindless, since all the decision-making is done beforehand; theory and practice are separate and self-contained, and the technician (as Andrews and Roy said above) merely applies knowledge *from science to practice*. The practitioner's intervention, on the other hand, is mindful; the theory is to be found in the practice itself. As Carr and Kemmis note:

A 'practice', then, is not some kind of thoughtless behaviour which exists separately from 'theory' and to which it can be 'applied' ... The twin assumptions that all 'theory' is non-practical and all practice is non-theoretical are, therefore, entirely misguided. (Carr & Kemmis 1986)

We can perhaps see, then, why architecture is regarded as a practice whilst bricklaying is not. The architect enters into a relationship with her work; the design of the building evolves in response to what Schön refers to as a 'reflective conversation with the situation' *as she works*. Knowledge is consciously extracted from the practice situation and is immediately fed back into it. The bricklayer, on the other hand, merely *applies* the theories of the architect and need give no thought at all to what she is doing as she is doing it. Indeed, the mark of a good bricklayer is that she is able to do the job without thinking about it, just as the mark of a good typist is that she doesn't have to think about where each key is on the keyboard, and the good driver doesn't have to think about when to change gear.

Similarly, nurses and doctors who act automatically, simply applying external theory or clinical procedures in an unconscious or mindless way could not, at least by my definition, be described as practitioners; they are technicians. Practitioners, on the other hand, need more than this global generalisable knowledge. The philosopher Hans-Georg Gadamer tells us that:

Once science has provided doctors with the general laws, causal mechanisms and principles, they must still discover *what is the right thing to do in each particular case*, and this is something which hardly seems to be predictable or knowable in advance. (Gadamer 1996, my italics)

Whilst the technician requires only a body of general knowledge which she applies to all relevant cases, the practitioner's knowledge is somehow embedded in the practice situation itself. This amalgam of action and knowledge as intrinsic components of the same act is sometimes referred to as *praxis*, and for the sake of clarity, I'll use that term from now on to refer to practise (with an 'S').

I'd now like to think for a while about the development of praxis. Clearly, we firstly need to differentiate between *technical* development and *praxis* development. When a bricklayer

goes on a course to learn a new method of laying bricks, she is developing her technical ability; her technique. Similarly, when a nurse goes on a course to learn how to give IV injections, she is also developing her technique.

In my opinion, this is not praxis development. She has merely learnt a new technique which, in time, she will perform mindlessly, perfectly and without conscious thought. I should perhaps make it clear that I don't wish to denigrate such courses. All practitioners need a grounding in technical knowledge and skills. But such courses merely make the student a better technician. Not all education and training is praxis development. However, if, as part of the course, she is asked to consider the problems of giving IV injections in *individual* cases, for example to a *particular* child with a needle phobia or to a *particular* woman with a compromised circulatory system, she will have started to develop her praxis.

I should make it clear that I am talking about individual cases here. Going on a course to learn how to work with 'the needle phobic patient' is technical development, not praxis development. Technical development is concerned with the *global* application of a (usually evidence-based) technique. The knowledge-base is public, it lies outside of the situation to which it is applied. Praxis development is concerned with unique individual instances. There is no global, universal, public knowledge base concerning how to give an IV injection to Mrs Jones; the knowledge base lies within the clinical encounter itself. The knowledge is *part of* the clinical encounter. It does not exist until the encounter takes place.

Perhaps it is becoming apparent, then, that praxis entails an understanding of each individual patient in each individual situation and in somehow creating knowledge from the encounter. This notion of the true focus of praxis being the individual clinical encounter can be seen in a wide variety of definitions of nursing over the past thirty years:

It is one of the tasks of the professional nurse to perceive and respond to the human being in 'the patient' and to assist the ill human being in responding to the human being who is 'the nurse'. (Travelbee 1971)

Nursing is concerned with how this particular man, with his particular history, experiences being labelled with this general diagnosis and being admitted, discharged, and living out his life with his condition as he views it in-his-world. (Paterson & Zderad 1976)

[Nursing is] a social activity, an interactive process between individuals, the nurse and the patient. (Chapman 1979)

Nursing involves seeing the recipient as a holistic being, and using this view to meet his or her individual needs through meaningful interaction. (Pearson 1988)

Nursing consists of interactions between unique individuals, with unique experiences, and it always takes place in unique situations. (Sarvimaki 1988)

Nursing is ... carried out within relationships; it is, in essence, a special form of relating. (Kirby 1995)

Praxis development, then, is concerned largely with learning better and more effective ways of engaging with individual patients. Praxis development is about building therapeutic relationships through which individual understanding is possible. And interestingly, we can see that it is not necessarily the relationship *per se* that is therapeutic, but rather the knowledge that is revealed to us through the relationship about ourselves, our patients, and how we might improve our interactions. It is, as Gadamer told us earlier, about discovering what is the right thing to do in each particular case.

Here, then, is the dilemma that lies at the heart of praxis development. If praxis has no public knowledge-base, how can it be taught? Well, the simple answer is that, in my opinion, it can't. We can teach technique because there is a body of public knowledge that can be transmitted from teacher to student, but praxis is, in a very real sense, made up on the spot. Whereas the knowledge-base for technique is applied *to* the nursing encounter, the knowledge-base of praxis is generated *from* the encounter.

Praxis can't be taught, and yet it *can* be learnt, and the most obvious and effective way is *directly* from the encounter itself. Unfortunately, however, the knowledge base of praxis is usually lost to us. We interact with a patient, something therapeutic happens, and we move on to the next patient. Now, of course, the technician knows exactly what has happened because it is carefully planned in advance. The technician deliberately intervenes in the way that research findings tell her to, even though the intervention itself might be *performed* mindlessly. For example, although the bricklayer might build an entire wall without having to think about what she is doing, she will have consulted the architect's plans in advance, and will know exactly what she has to do and how she has to do it. Similarly, although the nurse technician might give an IV injection without thinking too much about what she is doing, she will know in advance from her textbooks precisely how and why it is to be given.

For the practitioner, the textbook is of little use. With praxis, the practitioner has no idea what to expect; the intervention cannot be planned in advance, and prior theorising will not help. However, the intervention *itself* will be performed in a fully conscious mindful way. For example, the architect might have no idea in advance how a particular brief will be translated into a completed design for a building, and the creative ideas will often only arise during the act of drawing.

Schön, you will recall, refers to this process as a 'reflective conversation with the situation', and gives extensive examples of this from a number of disciplines throughout Part Two of his book *The Reflective Practitioner*. He sums up as follows:

In a practitioner's reflective conversation with a situation that he presents as unique and uncertain, he functions as an agent/experiment. Through his transaction with the situation, he shapes it and makes himself part of it. Hence, the sense he makes of the situation must include his own contribution to it. Yet he recognises that the situation, having a life of its own distinct from his intentions, may foil his projects and reveal new meanings. (Schön 1983)

Once she is immersed in the practise situation, the chances are that any prior thinking and planning will prove useless. Thus, although the architect is not able to approach a new project with a fully-formed theory of how she might respond to it, the act of *making* the drawing will be a fully conscious and mindful process.

Similarly, the nurse practitioner who is about to give an IV injection to a needle-phobic child will be unable to plan her intervention because she will have no idea in advance what to expect from the clinical encounter. In Schön's words, the situation has a life of its own. Knowledge about the situation can only come from the intervention itself, from the therapeutic relationship that the practitioner quickly forms on meeting the child. The problem, then, is how the practitioner is to learn from these clinical encounters; that is, how is she to develop as a practitioner.

Let's just think for a moment about the knowledge that the practitioner needs to access in order to develop her praxis. We have already seen that each clinical encounter generates its own body of experiential and personal knowledge about that encounter and about the participants who are engaged in it. There is a real danger that this knowledge will just evaporate into the ether as the nurse practitioner moves on to her next patient and the patient after that, so that by the end of the day she will have nothing tangible to show for her day's work. Experience is not the same thing as experiential knowledge; we all know nurses who have years of experience but who have learnt nothing from it.

Now, to some extent, that doesn't matter, since much of this knowledge is unique to the situation it was generated from and can't be employed elsewhere. However, some aspects of this experiential knowledge relate to the *people* involved rather than to the *situation*. It is knowledge about the patient, and perhaps more importantly, about the practitioner herself. This knowledge is important: it might not be *generalisable* either to the population as a whole or to a theory; but it is nevertheless *transferable* to other similar encounters.

But there is another type of knowledge embedded in the clinical encounter that is even more important for the practitioner to gain access to. This is knowledge about the *process* of praxis, knowledge about *how* the practitioner responds to the situation. As Schön says of practitioners:

Stimulated by surprise, they turn thought back on action and on the knowing which is implicit in action. They may ask themselves, for example, "What features do I notice when I recognise this thing? What are the criteria by which I make this judgement? What procedures am I enacting when I perform this skill? How am I framing the problem that I am trying to solve?" (Schön 1983)

The practitioner not only thinks about her action, but about *how* she knows. We can see, then, that praxis development is really concerned with *practitioner* development. In order to develop as a practitioner, the nurse must firstly reflect on *what* she has learnt about her patient and about herself from the clinical encounter, and secondly, she must reflect on *how* she conducted the encounter: how she theorised about the situation; how she recognised certain elements of the situation; what hypotheses she constructed; how she tested them; how she subsequently modified her interventions; and so on. Praxis development is concerned primarily with the practitioner learning about *herself* and the way she works as a unique individual.

I have so far resisted using the word 'reflection', but we really can't get much further without it. What I have referred to as practise with an 'S' or praxis is, of course, no more and no less than what Schön called reflection-in-action. For Schön, reflection-in-action, reflecting on what and how we practise as we are doing it, is what all practitioners should be aspiring to. This is not, however, what most nurses are referring to when they talk about reflective

practice. When they cite Schön as one of the key writers on reflection, they are usually referring to reflection-*on*-action, reflection after and away from the practice situation. Interestingly, Schön is hardly concerned at all with reflection-*on*-action, and when he does mention it, it is in the very specific context of reflecting on reflection-*in*-action. Reflection-*on*-action is therefore not just any old reflection. For Schön, reflection-*on*-action is retrospective contemplation of the practitioner's reflection-*in*-action. It is, if you like, a meta-reflection. In Schön's terminology, then, reflection-*in*-action is praxis and reflection-*on*-action is praxis development.

Since it is the focus of this conference, I will end with a few words about enhancing the *environment* for praxis development. Well, clearly, praxis development happens in the practise setting alongside patients and other practitioners. It is concerned with relationships and reflection, and seen from this perspective, praxis development is dependent mainly on the psycho-social environment. Most important is a permissive psychological climate. Praxis entails experimenting in practice, and that entails at least the possibility of mistakes being made. It goes without saying, then, that praxis development can only happen in a climate that encourages risk-taking and learning from mistakes.

Linked to this is the need for a practicum. A practicum *can* be a physical space, for example, a skills laboratory or a practice suite. But it is far more than a physical space - it is an attitude towards practise, an attitude of acceptance that there are no preordained right answers to any given clinical problem, nor that existing professional knowledge will necessarily solve those problems. A practicum also includes a human resource, which Schön referred to as a 'coach', but what in nursing is more often called a mentor. The role of the practicum coach is not to instruct but to facilitate, by which I mean, to help with the psychological and emotional effects of doing praxis: feelings of uncertainty; fear of failure; loss of control and loss of confidence. A practicum can be a scary place for practitioners and technicians who are accustomed to feeling in control of their clinical practice. And finally, praxis demands the time, space and resources to reflect on praxis: protected time, a comfortable and private space, and perhaps a clinical supervisor.

Praxis development can and must happen anywhere, regardless of the physical environment. Sometimes it happens *despite* the physical environment. But it can never happen unless a great deal of thought is given to the psychological, social and emotional setting in which it takes place.

I'll leave you with another quote from Gadamer and a recommendation that you get hold of his book:

I would consider it a great advantage if we were all to be more aware of the important distinction between scientific medicine and the art of healing. The distinction is ultimately that between a knowledge of things in general and the concrete application of this knowledge to particular cases ... Clearly it is only the first, knowledge in general, which can actually be learnt, while the other must gradually ripen through experience and the development of one's own powers of judgement. (Gadamer 1996)

Practise development is practitioner development and practitioners need to be nurtured if they are to grow.