

The use of imagination in professional education to enable learning about disadvantaged clients

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Abstract

Professional education is delivered equally on campus and in practice placements but until lately, theories of learning and teaching in higher education have focused mainly on processing text-based forms of knowledge. Even more recently introduced learning methods such as reflection and problem or enquiry based learning do not fully address the complex and often challenging learning needs of student health and social care professionals as they face the reality of everyday professional practice (Hall 2001). Working in a practice placement requires students to be able to make sense of the chaotic events going on around them that frequently evoke emotional responses, and challenge the individual's value and belief systems, which can lead to a changed outlook on life (Howard 2002). This means that the type of learning, which occurs in practice settings, is often implicit in nature and the knowledge gained is likely to be tacit making it difficult to share with others. However, what is learnt implicitly both within the placement and campus will have a significant impact on later practice and therefore we need a mechanism to 'unlock' this tacit knowledge.

In this paper we propose that creative methods of learning such as developing the use of imagination may have more direct application in bringing into the public domain previous implicit learning experiences. As a means of exploring this issue we present our recent research (Hart *et al.* 2001), which assessed how qualified and pre-qualified midwives are educationally prepared to work with disadvantaged women, an area of crucial importance, and one that is personally and professionally challenging. From the findings of this research we created a learning model which can be used by lecturers or practice educators either in the campus or practice settings. We conclude the paper with a discussion evaluating its fitness for enabling students to learn about disadvantaged clients.

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Introduction

In this paper we propose that theories of learning and teaching in higher education are often related to campus based episodes and until the recent introduction of learning methods such as reflection and problem or enquiry based learning, were heavily focused on processing text-based forms of knowledge. Even these recently introduced methods do not fully address the complex and often challenging learning needs of student health and social care professionals as they face the reality of everyday practice (Hall 2001).

We believe that current learning and teaching methods do not fully prepare students for learning in preparation for professional practice which requires students to be able to make sense of the often chaotic events going on around them in the practice placements which form half of their course. Working in practice placements frequently evokes emotional responses that challenge the individual's value and belief systems, and which often leads to a changed outlook on life (Howard 2002). The type of learning that occurs in practice settings is often, although not exclusively, non-formal and implicit in nature and the knowledge gained is likely to be at least partly tacit, and therefore difficult to articulate and share with others. In our experience, students often value placement learning more highly than campus based learning and yet more needs to be done to draw it out, reflect on it and link it with other knowledge; and this may be more easily accomplished in campus based sessions.

Fox (1997) asserts that implicit learning occurs in the nursing practice environment where 'the stimuli are rich and complex and the acquisition of knowledge is characterized by the absence of both conscious awareness and explicit strategies for learning' (1997, p. 460). What is learnt implicitly both within the practice and classroom setting will have a significant impact on that individual's later practice. We need a mechanism to 'unlock' this tacit knowledge in order to reveal potentially prejudicial thinking and to help students understand events in the practice arena, and their reactions to them. Different disciplines within health and social care are at different stages of this. For example, social work

training has addressed social inequality and prejudice to a far greater degree than has nursing and midwifery, and has incorporated this goal into its mainstream curriculum (Hart *et al.* 2003).

In this article we propose the use of imagination as a way of unlocking tacit knowledge, enabling empathy and allowing learners to rehearse sensitive scenarios privately. This way we anticipate that students, the professional practitioners of the future, will begin the process of developing critical self-reflection. This is a prerequisite to the development of critical action taking into account their sense of self and their potentiality for action within society, a transformatory process akin to the 'critical being' described by Barnett (1997), following Mezirow (1991).

As a means of exploring some of these issues we draw on our recent research, which assessed how midwives are educationally prepared to work with disadvantaged women, an area of crucial importance but one that can be personally and professionally challenging. We touch on the difficulties of doing education research in this area but maintain our belief in the importance of trying to design research that goes beyond what is being taught and examining the impact of what is learned in the delivery of health care itself.

In order to strengthen our argument for the type of transformatory learning in professional education described above, we briefly explain the origins of our learning model designed to promote equality. The model derives from the concept of using imagination as a process to enable midwives to work more effectively with disadvantaged women, and was developed as a practical response to the challenges posed by the research described below. The education theories that shaped the development of the module are explored and we offer our reflections on using the model in the classroom. We conclude the article with a discussion evaluating the learning model's appropriateness for promoting the goal of health equality and then consider future development and research.

The research

The research project 'Addressing Inequalities in Health: New Directions in Midwifery Education

and Practice' (Hart *et al.* 2001) was commissioned by the professional body responsible for training nurses, midwives and health visitors in England, in response to concerns about 'inequalities in health'. At that time many central government policy initiatives had begun to focus on this issue. The specific brief for this two-year project was to investigate the preparation of midwives to deliver effective care to disadvantaged clients.

Research aims and design

The research aims were to

Undertake an extensive literature review of the provision of midwifery care to minority or disadvantaged women, with regard to historical, social and political contexts in relation to concepts such as 'impairment', 'prejudice' and 'discrimination'.

Analyse and evaluate midwifery curricula learning outcomes, teaching and assessment methods in relation to the care provided to minority and disadvantaged groups.

Evaluate the appropriateness of stated learning outcomes in relation to the skills and abilities that midwives need to assess and provide for women from a range of minority or disadvantaged groups.

Advise the (English National) Board on ways in which educational preparation could most effectively enable the assessment, provision and evaluation of the maternity needs of all women (Hart *et al.* 2001, p. 10).

Methodology

The research design comprised two components: a national questionnaire study of curriculum content, and three case studies in different locations. The locations were selected using deprivation indices and represented a geographical spread across England. One case study was undertaken in an inner city location within the south-east with a high level of socio-economic deprivation and a large, diverse ethnic minority population. Another case study was in an affluent area of central England, albeit with pockets of deprivation. The third was located in the north of England, in an area of high socio-economic

deprivation. The case studies researched the experiences and perspectives of midwifery students, lecturers and practice educators, service managers, health advocates, midwives and their clients, using the methods described below.

National survey of pre- and post registration midwifery education

Every midwifery department in England was invited to complete a pre-registration and post-registration postal questionnaire recording the curriculum aspiration with regard to preparing midwives to meet the needs of 'disadvantaged' women.

A sample of curriculum documents from nine institutions (including the three case study sites) was analysed to triangulate the data received from the questionnaires.

Case study sites

Focus group discussions with midwifery students

Semi-structured interviews with midwifery students, midwifery tutors, midwives mentoring students, midwifery service managers, service users, maternity link workers and health advocates.

Observation of campus and placement based teaching

Relating what happened in the different contexts of curriculum planning, educational delivery and practice realities was methodologically challenging, and unsurprisingly is rarely tackled in educational research. We acknowledge that influences on learning go deeper than what occurs directly in the classroom and in practice, and we recognized early on that we could not establish any conclusive causal relationships between what occurred in each of these spheres in our case studies.

Research findings

Our research approach enabled us to explore the kinds of issues that came up in each of the different contexts and how they might impact on each other. This was most easily established at the level of

examining the relationship between curriculum planning and educational delivery. We found a gap between the aspirations of the curriculum and its delivery. There was no obvious connection between students receiving input on a particular topic, and then being able to practice in an anti-discriminatory or anti-oppressive way in relation to that area.

For example, although inequalities issues were on the curriculum in each of the case studies, they were rarely a compulsory part of the assessment. We also observed that prejudicial thinking, displayed by teachers and students in both classroom and placement teaching situations, often went unchallenged.

Service users reported that issues of attitudes and communication were the most important aspects of effective midwifery care; their wish for respect was paramount. We felt that whilst attitudes and communication must be addressed, the student also needs to understand the social and cultural context of the clients' lives. Even if it were possible for a student to learn about every disadvantaged group, current teaching and learning methods meant that they might not be able to use this knowledge in practical way. The student's own assumptions, beliefs and past experiences will determine how they interpret the factual knowledge and construct the personal knowledge that they use to inform their communication and decision making in the placement setting. Traditional methods of teaching and learning in higher education rarely address these complexities. Not only is it necessary to enable students to think about how the knowledge they use in practice was formed but also how they can equip themselves to deal with the complexities involved in providing health care to the diversity of client groups within their case load.

In answer to these challenges we developed a new learning model, which we and other health and social care lecturers have subsequently used in our teaching (Hart *et al.* 2003). The idea is that, whilst it is impossible to address all the complexities involved in providing health care to diverse client groups, certain components can be described against which teachers, practitioners and students, can personally evaluate their practice and think about how they might seek to improve their own ability to imagine the impact of inequalities and hence work towards

promoting equality in health care through engaging with and *enabling* diverse client groups, rather than just feeling that they had 'learnt about' particular groups.

The learning model for developing an 'inequalities imagination'

In our research study we explored how, within the context of contemporary British midwifery, the range of possible applications of the concept of 'disadvantage' was so wide that it could be argued that almost every pregnant woman has an aspect of her identity which could be identified as 'disadvantaged' (Hart *et al.* 2001). Our model encourages practitioners and students to be aware of broad definitions of 'disadvantage' and related concepts such as ethnicity and gender. However, in order to focus the analysis, the possible characteristics or experiences of people that might contribute to their being classified as 'disadvantaged' can be divided into the following five categories:

- 1 Mental or physical impairment.
- 2 Particular characteristics which have historically led to individuals experiencing prejudice and discrimination (e.g. ethnicity, gender, etc.).
- 3 Clients who experience prejudice.
- 4 Clients who experience discrimination.
- 5 Clients living in relative material poverty.

Categories (1) and (2) could be said to be primarily related to the person (internal locus), whilst categories (3) and (4) are concerned with the manner in which other individuals and institutions relate to individuals in categories (1) and (2). Category (5) could be consequential to any of the other four. For certain individuals all five categories may be applicable to their health care provision.

In parallel with developing this broad operational definition of disadvantage, we used Campinha-Bacote's (1999) model of cultural competence as a starting point for developing a model specific to our own work. We wanted to construct a model that expressed what our students needed to learn in order to engage with the client's experience of inequality in order to promote equality. We realized that because of the diversity of the client group, their individual needs and associated structural

inequalities, a model was needed which focused on the pragmatic question of how practice could actually be improved. Campinha-Bacote's model was redesigned because, although it enhanced practitioners' awareness of their own part in addressing individual clients' needs, it focused on cultural competence and did not fully address the wider definition of disadvantage argued for above. Also we wanted to redesign the model as a diagnostic tool to help students identify areas in which they could improve their abilities and commit themselves to specific action. In this redesign, three of the five original components of Campinha-Bacote's model, cultural desire, awareness and skill were renamed to reflect the broader definition of disadvantage. We reordered the diagrammatic representation of these components to better reflect the notion that equalities desire incorporated all the others, which could not be addressed without a genuine attempt to value and respect the client. Two new components, equalities analysis and action were added to encourage students to think about challenging structural inequality. At the centre is an unbounded area entitled 'developing an inequalities imagination' which appears at odds to with the notion of promoting equality, which is the goal of using the model. However, the concept with its emphasis on inequality represents our belief that a model focused on equality might divert the student from recognizing the need to fully engage with the client's experience at an empathetic and personal level. Thinking about and acting to alleviate inequality can be personally challenging and defences may come into play in order to deflect this challenge (Hart and Freeman, in press). Hence the focus must remain on the process of using imagination to empathise with the clients' experience of inequality rather than on the less personally challenging concept of promoting equality.

The components of our model are summarized in Fig. 1. Our description of the model starts with (Equalities) desire, which is to us the most important component. This is represented as the will to develop competence which is based on 'caring which begins in the heart and not the mouth' (Campinha-Bacote 1999, p. 205). This is a significant part of the process of developing an 'inequalities imagination'.

Without this essential ingredient the use of other parts of the model may result in 'politically correct' behaviour alone, rather than a genuine attempt to value and respect clients as people and to demonstrate a commitment to reducing inequalities. (Equalities) awareness is constituted by the deliberate attempt to look beyond one's immediate circumstances and gain a deeper awareness of self in relation to others. This involves examining the self and exposing one's biases and prejudices. As in Campinha-Bacote's model (Campinha-Bacote 2003), we see (Cultural) knowledge as the process of seeking and obtaining a sound educational foundation for understanding the world view of others, as well as the acquisition of knowledge about epidemiological, biological and psychosocial aspects specific to the client or client group. Similarly (Equalities) skill is employed to engage with each client in an open and honest way to obtain personal information in order to undertake assessment and plan appropriate care. (Cultural) encounter depends on continued exposure to a diverse range of clients, which enables the continual improvement of equalities skills together with a renewed opportunity to examine one's (Equalities) awareness/perspective. As Campinha-Bacote points out, engaging in such encounters can be difficult and uncomfortable at times as indeed we have found in our own research in this area (Hart *et al.* 2001). Continued encounters may not be possible for some practitioners, depending on their geographical location, which may lead to loss of skills. However Campinha-Bacote (2003) reminds us that cultural encounters include more than just face-to-face encounters.

A further component, which we have introduced into the model, is that of (Equalities) analysis which represents the development of a questioning approach to the social construction of disadvantage and its relationship to the ways in which the structure of health and social care delivery systems reinforce inequalities. The final component that completes our model is (Equalities) action. This incorporates the notion that a student, lecturer, practice educator, practitioner or service manager engages in actual activity which should lead to challenging inequalities, although use of the model does not prescribe in which component this action

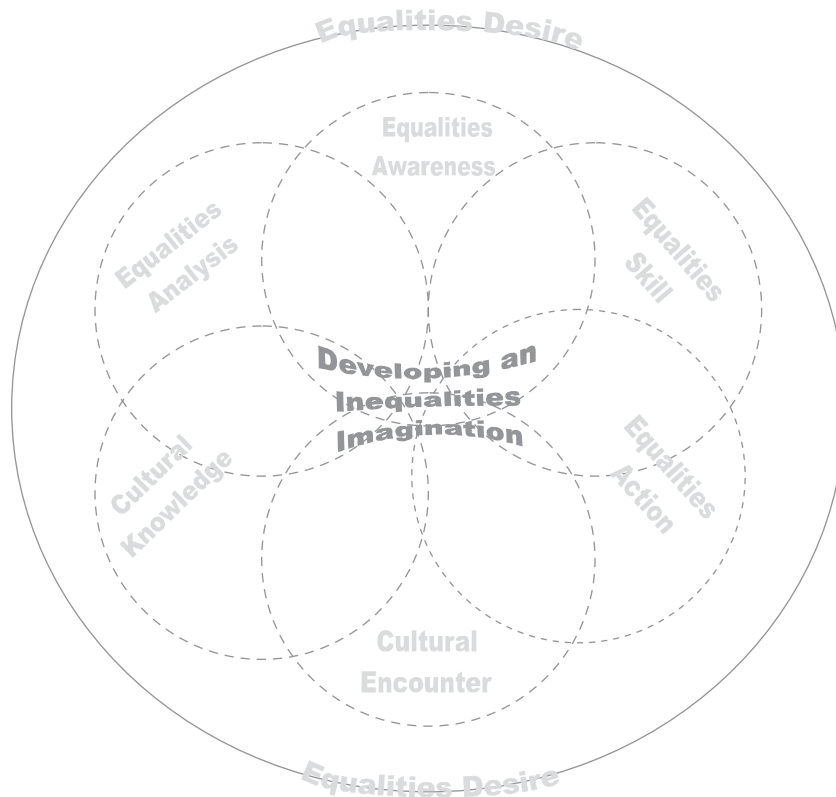


Fig. 1 Adapted from 'A model and instrument for addressing cultural competence in health care'. Campinha-Bacote (1999).

should occur. Our practice and teaching experience suggests that how the individual components of the model are operationalized by different students and practitioners leads to lively debates, as well as to individuals setting their own goals for self-development.

Our model then encompasses biological, psychological and sociological dimensions across cognitive and affective domains in order to describe the components necessary in the development of an 'inequalities imagination'. However, following Campinha-Bacote (1999) we also stress that we see the model as a striving towards an understanding of the client's experience of inequality rather than expecting that it is possible for an individual to have fully understood it. We emphasize here development rather than accomplishment because no matter how experienced practitioners become, the client's uniqueness together with the practitioner's own personal experiences requires them to constantly re-evaluate their thinking and behaviour. However,

the greater the expertise in the component parts the greater and more expansive does the understanding of the potential inequality faced by the client become. Furthermore, individuals may develop expertise in the different components of the model at different rates, hence the unbounded area of development within the centre. It implies thinking beyond a very limited sense of individualized care (what the individual client says she wants or needs) to a much more analytic and creative approach that recognizes both the structural and individual factors that determine and define needs in contemporary society. In order to be successful this skilled activity requires understanding of self in relation to others, the use of empathy and sensitivity and an appropriate knowledge base.

The use of imagination to enable learning about disadvantaged clients

We chose to use the concept of 'imagination', a process under used in traditional modes of learning

(Mulligan 1992), in order to describe the means whereby practitioners are encouraged to bring to mind previous situations and to consider how they might have acted differently. The process is akin to reflection as it involves thinking about a situation that happened in the past but it can also help students create and work with mental images of what has not yet been experienced; a concept not often used in reflection sessions (Hall 2001). However when working with images based on recalled situations, some aspects of the original situation may remain at a subconscious level, meaning that the user is not fully aware of their effect on their thinking and behaviour (Hall 2001). Therefore it is important to try to make explicit as many aspects of the recalled situations as possible in order to expose, explore and guide current thinking and action. Building on the product of the explored situations the practitioner can use imagination to rehearse future behaviours privately without risk before exposure to real life situations.

Imagination allows us to become someone else for a time, to see things from perspectives other than our own and therefore it can be used as a means of developing empathy (Mulligan 1992 : 185). However some practitioners may already feel empathy with a certain client group because they believe themselves to be members of the group, for example many health professionals are single parents. Although they may have this one aspect in common with the client, other personal circumstances will be different and the use of imagination can help the practitioner to recognize the implication of these differences.

Used in this way, the notion of 'imagination' allows students to harness creative resourcefulness in unique situations, and it implies a loosening up of thinking.

The case for a holistic approach to learning

In our research we discovered that in learning about inequalities it is imperative that appropriate methods of teaching are promoted which reflect a holistic approach to learning, incorporating knowing, feeling and doing in order to develop students' 'inequalities imagination'. Most of what we do, think, feel and believe is learned through a variety of sources and

will impact on what and how we learn next (Hall 2001). Much of campus based learning and teaching focuses on the acquisition of factual knowledge and although other learning methods such as reflection and problem based learning are used for practice based subjects, learning about self and emotional responses may remain implicit. Similarly in the placement, learning is often informal as the nature of the experience is unpredictable and the pace of clinical decision making leaves little time for reflection on the learning taking place.

Whilst it is recognized that holistic learning is necessary, for practice within the caring professions, learning is often falsely divided between 'knowing that' (propositional knowledge) and 'knowing how' (practical knowledge) (Ryle 1949). This encourages the perception of a divide between intelligent thought and action.

Eraut *et al.* (1998) has suggested 'personal knowledge' as a rather different contrast to propositional knowledge; and defines personal knowledge as the knowledge that people bring to practical situations which enables them to think and perform. Such personal knowledge includes both propositional knowledge (text-based material and rules and procedures), which they have personalized through their previous use of it in practical situations and knowledge constructed through reflection and experience, as well as practical skills and unprocessed memories of episodes (Eraut 1998 : 4). He also stresses that normally several relevant areas of knowledge are used together in an integrated manner, and that such integration relies on previous learning from experience.

Barnett (1997) redefines the dimensions of higher (university) level learning to include not just knowledge but also self and the world. In this definition, the role of emotion, which has traditionally been ignored as a part of learning in higher education, is acknowledged. Emotion is a key component in constructivist, reflective learning and part of the process of becoming the 'critical being' described by him. Barnett's notion of the development of the 'critical being' as an aspiration of higher education means that students reflect critically on knowledge but also develop their powers of critical self-reflection and critical action taking into account their sense of

self and their potentiality for action within society. The recognition of others and self as sources of knowledge through personal reflection is the key to this type of learning. This process results in the production of knowledge that is similar to Eraut's (1998) definition of personal knowledge.

But how can this transformative learning be managed within the curriculum? So far it has received scant attention from educational theorists and lecturers within higher education (Brockbank & McGill 1998). Our empirical research, as well as our teaching and learning experiences in this area demonstrate how hard it is for lecturers and practice educators to work effectively with personal knowledge. This is because personal knowledge consists of deeply held views, which require the teacher to become a learner and challenge their own prejudicial thinking and to develop the skills to challenge that of the students appropriately (Hart and Freeman, in press). It requires the teacher to sensitively facilitate learners to explore complex and potentially painful emotions experienced within the learning environment. It is no wonder that teachers find these kinds of activity difficult as they potentially raise anxiety levels and personal defences in both themselves and the learners. Developing these skills in health care professionals will not only enhance client and patient care but should also increase the practitioner's confidence when working in multidisciplinary teams. In short, it should give individual practitioners more of an understanding of how they have arrived at their particular perspective.

Goleman's (1998 : 317) definition of emotional intelligence is that it 'refers to the capacity for recognizing our own feelings and those of others, for motivating ourselves and for managing emotions well in ourselves and in our relationships'. These abilities are complementary to those of academic intelligence but for the purpose of the learning required in practice in inequalities, emotional intelligence is the key. For students to undertake this type of learning they need some internal motivation, and learning must be deep (see Marton 1975) rather than superficial, similar to the notion of equalities desire described in our model.

Thus students need the help and encouragement of teachers on campus and in the practice placement

in order to change their learning styles according to the goal or context of the learning (Miller *et al.* 1994). Transformative learning is more likely to occur when there is a relationship of trust between teacher and learner. Teachers need to be comfortable with handling emotion and, although many teachers in professional fields do feel comfortable with the student centred learning approach proposed by Rogers (1983), our study confirms Miller *et al.*'s (1994) conclusion that they find it hard to challenge students, even in reflective learning sessions (Hart *et al.* 2001) As we suggested, teachers themselves may have a considerable amount of personal learning to do before they can begin to help students with this.

A variety of campus based learning opportunities, particularly those with an experiential base, such as responding to material presented through video clips, role play and simulation of frequently encountered practice situations, enhance the students' learning potential. However, the practice placement arena, where the students have the opportunity to make sense of what they have learnt in the classroom, to consolidate their learning and to create their personal knowledge using actual practice situations, is central to learning about issues of inequality. Given the pace of service delivery it is difficult for practice educators to have time to explore these issues in the placement setting. Once back in the classroom, innovative methods such as exercises in guided imagery, see Tuyn (1994), can be used to tap experiential memories to stimulate discussion, enable their exploration at a conceptual level and help create possibilities for new action. The desired outcome is to help the students identify with learning both intellectually and emotionally, recognizing the effect it may have on their way of doing things and make them aware of the potential for advocating it to others (see Steinaker & Bell 1979).

The learning model in use

Following our research project we have used this model in campus based sessions for pre and post qualification nursing and midwifery students, counselling students and student teachers of health care students. We start by describing how it came

about and then outline the individual components giving examples of our own experiences. In doing this, we act as role models to encourage students to share their experiences relating to the different components. This activity stimulates peer group discussion about experiences in and outside the placement setting and offers an opportunity for participants to support, question or challenge individual perspectives. Each student is given a copy of the diagram (see Fig. 1) and asked to think about their experiences and actually draw on the model their current position in relation to their personal perceptions of their own status in relation to each component.

Each of us has delivered the session in a slightly different way. The content and delivery is planned taking into account the academic level of the course, the timing of the session within the course and the amount of practice experience of the student. The following section gives a broad overview of how we use the model within a campus based session.

Description of the use of the model to enabling learning

It is important to establish basic ground rules early on in the session and we ask that anything discussed should remain confidential to the group and that any of us can choose to opt out for a while. We try to establish rapport and explain that although people, including ourselves, find it hard to challenge each others' beliefs we will try to facilitate this process in a sensitive way. We ask the students to pair up and tell each other about their practice area, identifying any issues relating to inequalities in health emerging from there. We ask them to play close attention to how they feel when they talk about these inequalities issues. Are they concerned about them, if so, how and why? For many students, this process enables them to engage immediately with critical reflection on their own emotional responses.

Issues raised by the students are mapped onto the formal sociological and/or political economy debates, exploring the different theoretical explanations of the inequalities they have raised from their practice areas. If time allows, policy directives and debates can be brought in at this point. In addition

to this propositional knowledge students are encouraged to talk about their emotional responses. Sometimes students touch on practical knowledge, for example sharing information about how to access committees in the work-place which facilitate the raising of inequalities issues. We encourage students to see themselves as agents of change no matter how small that change might be and give them examples of small changes that they might make. Sometimes they feel able only to talk about the inequalities between professional groups – especially between nurses and doctors identifying themselves as personally disadvantaged. Psychosocial explanations can be brought in here to encourage them to explore why they are keen to focus on inequalities in relation to themselves rather than to clients. The concept of professional defences can be shared at this point. We use techniques such as imagining themselves on their own shoulder in order to gain a different perspective and cognitive puzzles and word games to demonstrate conditioned responses thereby helping students to loosen up their thinking. Again, this facilitates the development of personalized knowledge through engaging critically with personal emotions and responses as part of learning within higher education.

We then introduce the model describing the components and sharing with them some of our own level of function in each component. We map this on the diagram by marking the point on a copy of the model in each of the components that represents our current level of ability in that component. This can be used as a reference point against which later development can be measured. We emphasize the 'becoming' aspect of the model, and explain that we all have different strengths and weaknesses and the important part is to strive towards improving.

The students are then invited to share the anonymized details of a more specific client, or a practice situation they have been in, that they would like us to think through together in relation to the model. It is sometimes necessary to suggest to other students that they can ask questions but refrain from offering advice to the student until later in the session. This is to avoid other students hijacking the session and closing down the reflective thinking process. The following is a description of a post

qualification (nurse) student's experience in one of our sessions in which the actual details have been radically changed in order to preserve anonymity.

The post registration student is a community nurse and she says that the session so far has made her worry about the way she has acted with a client and she'd like to explore it with us. 'Please don't criticise me too much though', she asks. I [Angie Hart] try to reassure her by saying that we all have experiences where we are not too happy with our own performances and tell her that I am pleased she feels able to share her difficulties with us. I remind the group about confidentiality. She describes her client as an elderly Pakistani man who speaks English very poorly; his wife is similarly ill and 'difficult to communicate with'. The nurse reflects on a recent visit to him. I noted to myself that she did not mention arranging for an interpreter to accompany her on the visit, however, she did describe banging on a neighbour's door to establish whether the neighbour's bi-lingual teenager was in. Unfortunately she was not, and so the nurse proceeded with her visit without interpretation. Her client is diabetic and asthmatic and the nurse feels he needs a stairlift. The client is also very confused about his medication and she thinks that he does not take his preventative steroids, nor his insulin, as regularly as he should. After the visit, she rang the client's GP twice to leave a message and he did not return her call. She says she feels helpless to change the situation.

One of the other nurses in the group rather forcefully attempts to come in with some advice at this point. I ask that he hold fire and suggest that we explore the first nurse's experience with this client in relation to our model. The first nurse is keen to do this, and so she talks us through each of the components, thinking aloud about how competent she feels in each of the sections. For example, she says that she thinks she has equalities desire, but is feeling guilty now that she realizes how little she has done for this client. Another nurse in the group mentions encouragingly that the very fact that she is talking with us about the client means that she cares. The first nurse also reflects how her lack of equalities skill is partially related to her lack of cultural encounters. Most of her clients are white British, as is she, and

she tells us that she does not know where to start when she works with a client who is from a different cultural background than hers. This leads into a general discussion of what constitutes cultural difference and the difficulties individual nurses have with different people. One nurse mentions the 'white working class weirdos' she works with. I challenge her use of language here, and another nurse says she is shocked by what this nurse had said. I suggest that the accusation of 'weirdness' is often about our feeling uncomfortable with difference.

Returning to the client, the first nurse and colleagues spend some time working on equalities analysis and equalities action. When discussing equalities analysis, I ask them to think about this specific situation in relation to the inequalities map on the board. The relevance of structural explanations such as institutionalized racism are tentatively offered as potentially relevant by other students, and one nurse attempts to apply a Marxist interpretation of racism to this case situation. This leads to a discussion about the nature of institutionalized racism and whether indeed the concept can be usefully applied in this case.

Exploring 'equalities action' not only enables these post qualification students to personalize the knowledge they have gained in the session, but also encourages them to think about what they can do to improve client care. Some basic issues such as knowledge of and use of interpreting services were raised here, as was the issue of challenging authority and generating innovative ways to engage the disinterested GP. Much discussion was about how much of a patient advocate the nurse should be. By the end of the session the nurse who shared her experience had a written plan of action. It included using e-mail to write to the GP with her concerns, setting up another appointment to see her client accompanied by an interpreter, and using the Internet herself to explore the availability of leaflets for asthma and diabetes in the patient's language.

Having explored the use of the model in a specific situation, the students are asked to think about where they place themselves in a general sense in relation to the model. They are then asked to fill in a copy of the model in which the imagination boundaries are omitted so they can create their own.

As mentioned previously, we undertake this activity first and explain how our own perspectives have shifted over the past few years.

Students are asked to think about and write down on Post-it notes three things they will do, within a specific time limit which they determine. We also do this and the notes are displayed so everyone can look at them. Students are invited to share some of their thoughts with the class and many do. For post qualification students, most of their commitments relate to engaging on committees, challenging other staff members. Because of the power dynamics involved in being a pre qualification student, these students find the equalities action issues more challenging, and they often limit their aspirations to gaining cultural knowledge, encounter or equalities awareness and/or skills. Developing in-depth knowledge of local services, benefits and/or community groups for specific disadvantaged clients is a popular commitment cited. If the students are particularly despondent about their perceived inability to effect change, we sometimes invite them to imagine how they might behave if they were a ward sister, or even Trust Chief Executive. This generally lightens the mood and frees them up to think about issues from a different perspective.

Discussion

Informal and formal student evaluation confirms that students appear to respond well to our attempts to share with them our experiences of the difficulties in developing our own 'inequalities imagination'.

Brocklebank & McGill (1998) suggest that the qualities needed by lecturers who want to help students to make a paradigm shift into learning relating 'knowledge, self and action in the world' are:

- 1 Realness or genuineness: a willingness to be a person, to be and live the feelings and thoughts of the moment and share this with the learner.
- 2 Prizing acceptance and the trust of the learner: a belief that the other person is fundamentally trustworthy.
- 3 Empathic understanding: which is communicated to the learner (1998, p. 47).

These qualities require a high degree of emotional intelligence and lecturers and practice educators in

health care may need to undertake further training in dealing with their own and others' emotions in order to facilitate this type of transformatory learning.

It is clear that this learning challenges traditional views of teaching and learning in higher education and although the nature of the content of the learning constitutes an extreme example of the need for a different type of learning, some authors suggest that the principles underpinning it should be an aspiration for all higher education (see Harvey & Knight 1996; Barnett 1997, 2000). For us the challenge is not just the centrality of emotion in this type of learning, but also the imperative to access and make explicit, the implicit learning that occurs both in campus based and practice settings. Furthermore, we expect the learners to act upon these insights both in terms of their understanding of their own learning processes but also in terms of the impact on their professional practice.

To facilitate the move into action we adopted the idea of the use of imagination as a way of unlocking tacit knowledge, enabling empathy and allowing the learners to rehearse sensitive scenarios in a supportive environment. We believed that this latter would enable learners to be freed from the anxiety of using new behaviours for the first time in the real life practice setting.

Our use of imagination in helping students imagine what they could do differently is akin to the final stage in the cycle of reflection. Many lecturers and practice educators in health care already use reflection as a learning tool and are skilled in enabling students to describe what happened in a practice based scenario. The use of imagination offers a way of helping teachers conduct the final stage to the reflection process, that of imagining how the practitioner could do something differently.

But even if the facilitation is skilled how does this learning experience relate to the rest of the course and what impact might it have on the students' learning career?

Some of the favourable feedback received from students with whom we have used the model may reflect our conscious efforts to minimize the power dynamics between lecturers and students in the campus setting (see above – Brocklebank & McGill 1998, p. 47). We both try to be honest about our own

feelings in relation to inequalities and to engage with the group in an empathic way. However, we recognize that students need to be seen to perform, and engaging with our model is a key way for them to gain our approval in the classroom. On the other hand, most of our use of the model has been on one-off sessions, and the students have seen us more as visitors rather than as lecturers with authority over them. And perhaps because of this, they have not lacked the confidence to criticise the learning model constructively.

Increasing student numbers, reducing resources and the increasing use of learning technologies in the higher education sector may reduce opportunities for small group work, which is essential to facilitate this type of learning. Apart from the resource issues, the move to modularization with an attendant compartmentalization of knowledge can inhibit the introduction of more holistic ways of learning. Fortunately, in our own higher education institution there is a will to support learning methods that enhance the development of professional knowledge in its broadest sense and a recognition that learners need to be offered a mix of learning opportunities.

Conclusion

We are committed to the potential transformatory power of what we are hoping to achieve in trying to enable learners to become aware of their own thinking and feeling processes. We believe that increasing learners' awareness of their frameworks for understanding will help them to realise when they might limit thought, value feeling, and action. (see Harvey & Knight 1996). This type of learning experience seems key to Barnett's (1997) notion of a 'critical being', which in his view, should be the aspiration of a higher education system but also in our view to the development of a professional practitioner.

However, at present we are unable to assess whether the use of our learning model facilitates transformatory learning. In order to do so, we would have to formally capture changes in students' attitudes and behaviours and establish a conclusive causal link between them and the use of the model. Our understanding of how different knowledge bases and

learning opportunities coconstruct experience suggests that such a project would be complex.

Despite these caveats, analysis of our experience of using the model as a learning tool with pre qualification nurses, midwives and counsellors enables us to establish the students' propensity for change and personal growth. We also believe that the use of imagination as a way of unlocking tacit knowledge, enabling empathy and allowing the learners to rehearse sensitive scenarios in a supportive environment at least offers a way of helping teachers conduct the final stage to the reflection process, that of determining how the practitioner could do something differently in the future.

Whilst this article describes the use of the model with pre and post qualification nursing and midwifery students, student teachers in health care and counsellors, we have yet to test out the model with medical and social care students. However, we believe that to use the model with multiprofessional groups in campus or practice based settings will add a further dimension to both our and the students' learning.

NB The term 'teacher' is used to refer to a generic group comprising of lecturers (in higher education) and practice educators (in practice placement).

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