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Facilitating affective elements in learning - In a palliative care context

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ABSTRACT

The aim of this study was to explore ways clinical supervisors facilitate the learning of the affective elements of professional competence in a clinical palliative care environment. The secondary aim was to advocate for and raise awareness of the importance of the affective domain in medical education.

A clinical palliative care learning environment has been reported to be emotionally challenging. The affective and transformative learning processes taking place requires special support. However, little is known about how clinical supervisors facilitate this learning processes. A qualitative, explorative study was designed to capture supervisors' perceptions of their supervision using semi-structured interviews. Six experienced clinical supervisors working within a palliative care context were recruited using convenience sampling. Data were analyzed using inductive content analysis. The affective elements were viewed as essential for learning, clinical supervision, and professional competency. Supervisors use a variety of different ways of facilitation. Four main themes were identified; building a relationship, creating space for learning, creating a pedagogical environment, and Mirroring.

1. Introduction

Even though the interest in the affective elements, which includes feelings, emotions, values, beliefs, empathy, compassion, and emotional intelligence, in the life of healthcare professionals, as well as students, has increased during the past decade (Granek et al., 2017a,b; McConnel and Eva, 2015). Palliative care as a clinical environment is still known to be emotionally demanding for medical and healthcare students, as well as for practicing professionals, as they daily face high levels of suffering (Vargas Mota et al., 2016). Students in this context understand that they will likely meet dying people and their loved ones in the midst of existential crisis (Sand and Strang, 2014) and are apprehensive of how they will be able to handle these emotionally tricky situations. The affective learning process of critical thinking and self-questioning can be emotionally uncomfortable and anxiety-inducing (Brien et al., 2008). The imminence of death in a palliative care context forces student to confront their own values, beliefs, and previous experiences of death. This can lead to resistance, which in turn might hurt learning and teaching activities (Brien et al., 2008). As there is still limited research available touching upon facilitation of the affective learning process within palliative care. This study was designed to explore this phenomenon.

1.1. Background

The affective domain is very present in the activities of the healthcare environment but has remained as a relatively unrecognized phenomenon, as the nursing curriculums seem to remain relatively skill-based due to the very specific need to evaluate, ensure, and maintain standards (Meretoja et al., 2016). However, from a patient perspective, it has been reported that patients place a high value on empathy in therapeutic relationships, and compassion is considered an essential element in the quality of care (Sinclair et al., 2017). From an organizational perspective, professional values are directly related to the quality of care (Weis and Schank, 2002), and the affective domain is considered to be one of the dimensions of professional competence (Eppstein and Hundert, 2002; Cowan et al., 2006). From an educational perspective, all learning environments include an essential emotional element (Isba and Boor, 2011). Although it is not explicitly understood how students learn about the emotional toll of practice since only a few studies have focused on the topic (Dwyer and Hunter Revell, 2015; Brien et al., 2008).

1.1.1. Educational reforms

The Swedish higher education system was reformed in 2007 after the influences of Bologna process. In the wake of the Bologna process,

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outcomes-based education (OBE) has gained a strong foothold within university curriculums. Whilst enabling the standards needed for becoming compatible, the explicit purpose of reforming the educational systems with the aim of regional convergence, OBE has been critiqued for failing to address the affective elements of professionalism including; ethics, attitudes, emotions, values, having unresolved issues with the definition of humanism, accountability, and altruism (Cowan et al., 2006; Bolander-Laksov et al., 2010). Additionally, OBE is critiqued for providing a simplistic solution to a complex expert clinical practice and aspects of the learning process (Harden, 2002). Even though the focus should be on the design of a teaching and learning system, not on the student as a 'person'" (Biggs and Tang, 2011). Currently, the undergraduate nursing programme in Sweden lasts three years and is comprised of 180 credits, and the palliative care course takes place towards the end of the education. Teaching and learning activities in undergraduate nursing curriculums are designed to develop a professional identity as well as professional competence. These learning activities take place within both formal and informal learning contexts. Clinical training is seen as taking place within the informal learning context of medical education workplaces. The learning is seen as situated learning in the context or in a similar context where the learner needs to apply the knowledge, skills, and attitudes as a health care professional (Dornan et al., 2011). Dornan (2012) defines medical education workplace as: "any place where patients, learners, and practitioners come together for the conjoint purpose of providing medical care and learning" (Teunissen and Wilkinson, 2011). In this study, learning is viewed as situated within the context of a palliative workplace learning environment and involving cognitive, psychomotor and affective domains (Bloom and Krathwol, 1956).

1.1.2. Perspectives on learning

This study comprises a constructivist perspective on learning, recognizing constructivism to hold many different learning theories, with both abstract and applied approaches. In this study, learners are seen as active agents in their own learning, processing and linking new information into already pre-existing knowledge and understanding. This, in turn, enables deep, meaningful learning to take place (Mann et al., 2011). However, a reported gap exists between how students are taught to identify and manage the emotional challenges within the affective domain in clinical practice context, and the reality they face when transitioning to the practice (Dwyer and Hunter Revell, 2015). In clinical palliative care, the nursing educators and clinical supervisors must consider the emotional impact context has on the learning process (Brien et al., 2008). The supervisor has an important influence on learning. Specially to enhance the student's sense of belonging, which is a prerequisite for clinical learning (Levett-Jones and Lathlean, 2008). Learning in this study is considered as competence development from the three learning dimensions; the content, incentive, and environment (Illeris, 2009). In addition, four types of learning; cumulative; assimilative; accommodative; and transformative (Illeris, 2009) are explained focusing on the transformative learning (Mezirow, 2009; Swanwick, 2013). Concepts of reflection and the multiple approaches to understanding (Gardner, 2009) are explored in this study. This study adapts Bloom and Krathwol, 1956 theory of the three domains of learning; cognitive domain, psychomotor domain, and affective domain. The cognitive domain deals with knowledge and how we acquire and process it. The psychomotor domain deals with manual skills. The affective domain deals with feelings, emotions, values, beliefs, empathy, compassion, and emotional intelligence. Knowledge of all three domains is essential for full professional development and socialization into the profession (Cowan et al., 2006). However, medical education has traditionally focused on the cognitive and psychomotor domains which can lead to a hidden curriculum and tacit knowledge development in the area of the affective domain. Additionally, the affective domain is considered to be one of the dimensions of professional competence (Eppstein and Hundert, 2002; Cowan et al., 2006).

1.1.3. Three dimensions of competence development

According to Illeris (2009), the tension field of competence development involves three dimensions of learning; the content, incentive and environment. The content dimension is involved with abilities and meaning construction, and the development of functionality in the challenges of practical life. It includes knowledge, skills, meaning, attitudes, values, ways of behavior, and methods. The incentive dimension functions to secure the learner's mental balance by creating sensibility. It comprises feelings, emotions, motivation and volition. The integration dimension builds and provides external interaction socializing the individual to the community in the form of participation and communication (Illeris, 2004, 2009). This tension field holds two learning metaphors; the horizontal acquisition, which can be seen as a monological view on human cognition and action, and the interaction process – a dialogical participation metaphor where learning is seen as an interactive process taking place in a social and cultural context (Sfard, 1998; Paavola and Hakkarainen, 2005; Illeris, 2009; Isba and Boor, 2011).

Illeris (2009) outlines four types of learning; cumulative; assimilative; accommodative; and transformative. According to his theory, all learning has to do with some previous knowledge, understanding, or experience in the form of what he calls mental schemes or mental patterns. The cumulative learning takes place when learning is mechanical and is new in nature. Assimilative learning takes place when a new element is added to an already existing pattern or scheme. Accommodative learning takes place when a mental scheme or pattern is not readily available. This leads to a feeling of not understanding, and one has to break down a previous mental scheme to link the new learning into. However, the last type of learning – transformative, involves all of the previous types of learning and "is characterized by simultaneous restructuring of a whole cluster of schemes and patterns, and typically occurs as a result of situation caused by challenges experienced as urgent and avoidable, making it necessary to change oneself in order to get any further" (Illeris, 2009).

1.1.4. Transformative learning

Transformative learning can be understood as a social process, where a new frame of reference or revised interpretation of the meaning of the lived experience is constructed and internalized (Swanwick, 2013). Reflection is seen as a key concept in transformative learning (Boud and Walker, 2006) as it is an affective, intellectual activity leading to new understanding. In a palliative care context, students have voiced the concern of how they will be able to handle emotionally difficult situations and expressed feelings of fear and insecurity before their clinical training. At the end of life care, the imminence of death forces students to confront their own values, beliefs, and previous experiences of death (Brien et al., 2008). This affective learning process, including critical thinking and self-questioning, is emotionally uncomfortable and anxiety-inducing. It can lead to resistance which can create a barrier to learning and should be considered in learning and teaching activities (Brien et al., 2008). The student's frame of reference, to describe a person's way of knowing, might need to be shifted and changed in a transformative learning process (Illeris, 2009., Mezirow, 2009). The prerequisites for critical reflection to take place are freedom, equality, and empowerment so that the learner will be able to fully engage with the assessment of the content, process or premises of the efforts to interpret and give meaning to an experience (Mezirow, 2009; Swanwick, 2013). Critical reflection includes both cognitive and affective elements of learning and takes into consideration the moral and ethical criteria, the learning content, and the process and acknowledges the learning context (Kneebone and Nestel, 2011; Driessen et al., 2009). It is important that clinical supervisors are sensitive to the impact of this process possibly amplifying the fears, apprehension and have educational strategies to facilitate the empowerment and development of the nursing students' professional identity by fostering authentic communication in a safe and trusting environment