Nurse Education Today 34 (2014) 1179–1183

Contents lists available at ScienceDirect

Nurse Education Today

journal homepage: www.elsevier.com/nedt

Rethinking reflective education: What would Dewey have done?

Gary Rolfe

College of Human and Health Sciences, Swansea University, Singleton Park, Swansea SA3 8PP, UK

ARTICLE INFO

Article history:
Received 13 November 2013
Received in revised form 5 March 2014
Accepted 11 March 2014

Keywords:
Reflection
Reflective practice
Education
Scholarship

SUMMARY

Reflective practice has largely failed to live up to its promise of offering a radical critique of technical rationality and of ushering in a new philosophy of nursing practice and education. I argue in this paper that the failure lies not with the idea of reflective practice itself, but with the way in which it has been misunderstood, misinterpreted and misapplied by managers, theorists, educators and practitioners over the past two decades. I suggest that if reflective practice is to offer a credible alternative to the current technical–rational evidence-based approach to nursing, then it needs to rediscover its radical origins in the work of John Dewey and Donald Schön. In particular, nurses need to look beyond their current fixation with reflection-on-action and engage fully with Schön's notion of the reflective practitioner who reflects in action through on-the-spot experimentation and hypothesis testing. Finally, the implications of this radical approach to reflective practice are developed in relation to the practice of nursing, education and scholarship, where they are applied to the challenge of resolving what Rittel and Webber refer to as 'wicked problems'.

Introduction

It is now more than a decade since I made the following observation:

> Reflective practice was originally conceived as a radical critique of technical rationality, and was based on the premise that knowledge generated by practitioners reflecting on their own experiences is of at least equal value to knowledge derived by academics from empirical research. However, experiential knowledge from reflection-on-action now finds itself at the bottom of the hierarchy of evidence on which to base practice, and reflection has become just another technical tool.
>
> [(Rolfe, 2002, p.21)]

My prescription for the problem was a return to the roots from which the modern idea of reflective practice originated, in particular the work of John Dewey, Carl Rogers, Paulo Freire and Donald Schön. However, it appears that little progress has been made, and whilst it could be argued that Schön's work was the catalyst for the reflective nursing practice movement and continues to exert a huge influence, I would suggest that it has largely been misunderstood and misapplied. In particular, when Schön writes about what he calls the reflective practitioner, he is not referring to either the idea or the process that has come to be known as reflective practice in nursing and other health care disciplines. Schön is not referring to the retrospective contemplation of practice, not suggesting that we write about our practice, and is not advocating models or frameworks to structure our reflection. For Schön, reflective practice is something that we *do*, not something that we sit down afterwards and think about. Reflective practice means reflection *in* practice, or what he more usually refers to as reflection-in-action. What he calls reflection-on-action, which appears to have seized the imagination of nurses and other health care practitioners, hardly warrants a mention in either of his two seminal books.

The problem for nursing, which I attempted to highlight back in 2002, is that there is nothing in the idea of reflection-on-action that offers a credible challenge to the dominant technical–rational paradigm of evidence-based practice. That is to say, if we regard reflection simply as a way of generating knowledge about our practice by thinking about it retrospectively, then that knowledge will always find itself at the very bottom of the hierarchy of evidence alongside personal experience and unsubstantiated belief. So long as the dominant model of health care demands that practice should be determined by research-based evidence, preferably derived from quantitative data, then experiential knowledge will never be taken seriously.

This paper will offer a radical reappraisal of reflection and reflective practice in an attempt to establish it on a firmer footing. The word radical derives from the Latin *radix*, meaning roots. Taking a radical view of reflection therefore means exploring its origins, and its modern-day use originates in the work of John Dewey from the early years of the 20th century. On the face of it, Dewey's ideas appear far from radical. Dewey uses the words 'reflection' and 'thinking' more or less interchangeably, which is perhaps why reflection is often regarded as little more than thinking about our experiences. However, Dewey was a pragmatist philosopher and a practical educator, and his notion of *thinking* is intricately connected to *doing*. For Dewey, reflection is not simply having an experience and then going home to think about it. On the contrary, thinking is an active process that involves forming hypotheses and trying them out here and now in the real

http://dx.doi.org/10.1016/j.nedt.2014.03.006
0260-6917/

world. Thinking or reflection is therefore a form of experimentation. We cannot reflect in an armchair; refection can only take place in practice; reflection, in Dewey's words, involves:

> Doing something overtly to bring about the anticipated result, and thereby testing the hypothesis.
>
> [(Dewey, 1916, p.115)]

It might seem odd to think of reflection as a way of *doing* rather than as a way of thinking. However, Dewey's description of reflection is more or less identical to what Schön would later refer to as reflection-in-action or simply as reflective practice, which he described as 'a reflective conversation with the situation' (Schön, 1983, p.163). Reflective practitioners reflect on-the-spot, in the here-and-now, and the products of their reflections are immediately put into practice in a continuous and spontaneous interplay between thinking and doing, in which ideas are formulated, tested and revised.

Practice: Wicked Problems and On-The-Spot Experimenting

It might be argued that this is an outmoded approach to practice in the age of evidence-based nursing, and that nurses no longer need to engage in a reflective conversation with every situation they find themselves in; that they simply need to apply the best evidence from research. Schön referred to the application of research-based theory to practice as technical rationality, where university-based technologists generate knowledge for practice-based technicians to apply. Technical rationality is a useful model for practice when situations are simple and straightforward and where the same solution can be expected to work in every instance. For example, if a patient presents with the signs and symptoms of a chest infection, then the treatment intervention and the care pathway will be the same in almost every case. In these situations, there is a standard procedure, usually based on best evidence from research that is more or less guaranteed to work. However, many situations that we encounter as practitioners are not easy to diagnose and, once diagnosed, not simple to treat. Many include complex physical, psychological, social and personal interactions, and many do not have straightforward solutions, if indeed they have solutions at all. And even when they do, it is not always easy to specify if and when the problem has been resolved.

In the 1960s Rittel and Webber coined the term 'wicked problems' to refer to these complex, multifactorial situations. These problems are wicked in the sense that they resist and defy our attempts to formulate, tackle and resolve them, and stand in contrast to 'tame problems' which can be solved simply by the application of a technical–rational standard procedure based on best evidence. Rittel and Webber (1973) were writing about problems in the field of social planning, but Conklin (2006) generalised the idea of a wicked problem to other disciplines. For Conklin, a wicked problem cannot be fully understood until after we attempt to solve it, we will never know for certain if and when it has been resolved, and there is rarely a 'right' solution which is acceptable to all of the stakeholders. Furthermore, wicked problems are, by definition, unique and we only get one attempt at tackling them. They are not amenable to off-the-shelf evidence-based solutions and our experience from dealing with similar problems in the past will be of limited value. Whereas reflection-on-action after the event might help us to pinpoint where we went wrong on this occasion, it will not help us to deal with future wicked problems.

Whilst some of the issues that nurses are called upon to deal with in their everyday practice are simple, straightforward and relatively 'tame', many fit the above description of wicked problems. For example, nurses are sometimes called upon to comfort a bereaved friend or relative of a deceased patient. The solution to the problem of how best to respond will not be found in a text book. Different people will react differently to different approaches and the nurse will not know how effective any particular intervention is likely to be until after she has attempted it. The nurse has only one shot at getting it right and her previous experiences with other bereaved individuals will be of only limited value in this unique situation. And, of course, there is no definitive point at which the nurse can feel satisfied that the problem has been fully resolved.

Reflective practice, in Dewey and Schön's sense of experimenting-in-action, is our best hope in dealing with the kinds of wicked problems which nurses and other health care practitioners are increasingly faced with in an ever more complex and demanding health service in which our relationships to technology, treatments and service users are being constantly challenged and redefined. Therefore, in order to respond effectively to wicked problems, practitioners need to reconsider their relationships with academics, researchers and service users. The traditional technical–rational model is based on a hierarchical relationship in which technologists hand down their prescriptions for best practice to technicians, who then apply them to objects in the material world. If the technologists are civil engineers and the technicians are constructing a bridge, then the technical–rational model ensures that the bridge will be properly designed and built. If the technologists are bio scientists and the technicians are pharmacists, the technical–rational model will ensure that the medications are safe and effective. And for some of the more technical procedures that health care practitioners are called on to perform, the evidence-based technical–rational model ensures the delivery of good and consistent care. That is to say, the technical–rational model works well for tame problems which have a clearly defined outcome and a standard procedure which can be mapped out in a care pathway.

However, I would suggest that many of the problems we are faced with as nurses are of the wicked type for which no amount of theory or research evide;nce can ever prepare us. In order to address these challenging wicked problems, nurses must become their own theorists and researchers by generating hypotheses and testing them out on-the-spot in the form of practice interventions. As Schön tells us:

> When someone reflects-in-action, he becomes a researcher in the practice context. He is not dependent on the categories of established theory and technique, but constructs a new theory of the unique case … Because his experimenting is a kind of action, implementation is built into his inquiry. Thus reflection-in-action can proceed, even in situations of uncertainty or uniqueness, because it is not bound by the dichotomies of technical rationality.
>
> [(Schön, 1983, pp. 68–9)]

Rittel and Webber (1973) argued that the crucial relationship for dealing with wicked problems is that between the planner and clientele (or in our case, practitioner and service user) that will lead to a joint decision to try a particular course of action. However, it is important to remember that wicked problems involve multiple stakeholders, each with their own values and criteria for what counts as a 'good enough' resolution, so rather than entering into a one-way hierarchical relationship between the technologist and technician, the practitioner must form partnerships with service users and other stakeholders based on mutual respect and trust. The practitioner and service user must reflect-in-action together by generating and testing ideas and theories and arriving at a solution that is jointly agreed and accepted.

Clearly, this is easier to achieve in some settings and circumstances than others. In my own field of mental health nursing, such therapeutic partnerships are not uncommon. Patients are often actively involved in their own treatment programmes, and interventions such as cognitive behavioural therapy depend for their success on a therapeutic liaison in which the patient takes the lead in identifying the problem, formulating the treatment plan and evaluating the outcome. The therapeutic encounter takes the form of a puzzle which the nurse, patient and others address together by experimenting-in-action with different interventions. In other areas of practice such as intensive care nursing, options and opportunities will be more limited. In line with current thinking