



Review

Ethical experiential learning in medical, nursing and allied health education: A narrative review☆☆☆☆☆☆



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ABSTRACT

Students enrolled in medical, nursing and health science programs often participate in experiential learning in their practical classes. Experiential learning includes peer physical examination and peer-assisted learning where students practise clinical skills on each other.

Objectives: To identify effective strategies that enable ethical experiential learning for health students during practical classes.

Design: A narrative review of the literature.

Data Sources: Pubmed, Cinahl and Scopus databases were searched because they include most of the health education journals where relevant articles would be published.

Review Methods: A data extraction framework was developed to extract information from the included papers. Data were entered into a fillable form in Google Docs. Findings from identified studies were extracted to a series of tables (e.g. strategies for fostering ethical conduct; facilitators and barriers to peer-assisted learning). Themes were identified from these findings through a process of line by line coding and organisation of codes into descriptive themes using a constant comparative method. Finally understandings and hypotheses of relevance to our research question were generated from the descriptive themes.

Results: A total of 35 articles were retrieved that met the inclusion criteria. A total of 13 strategies for ethical experiential learning were identified and one evaluation was reported. The most frequently reported strategies were gaining written informed consent from students, providing information about the benefits of experiential learning and what to expect in practical classes, and facilitating discussions in class about potential issues. Contexts that facilitated participation in experiential learning included allowing students to choose their own groups, making participation voluntary, and providing adequate supervision, feedback and encouragement.

Conclusion: A total of 13 strategies for ethical experiential learning were identified in the literature. A formal process for written consent was evaluated as effective; the effectiveness of other strategies remains to be determined. A comprehensive framework that integrates all recommendations from the literature is needed to guide future research and practise of ethical experiential learning in health courses.

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1. Introduction

Students enrolled in medical, nursing and health science programs often participate in experiential learning in their practical classes (Braunack-Mayer, 2001; Wearn et al., 2008). Experiential learning

involves students acting as models in class demonstrations of practical techniques, and peer-assisted learning where students work in pairs or small groups to practise skills such as taking client/patient histories, and peer physical examination such as taking blood pressures, performing functional movement assessments, and practising

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treatment techniques. Demand for such learning is increasing because there are diminishing opportunities for large numbers of students to learn 'at the bedside'. Experiential learning, or learning by doing or by experience, was described by Dewey (1963) who argued that educational possibilities arose from ordinary life experience provided they were 'intelligently directed' by educators who guided students through a series of carefully-designed experiences to stimulate new observations, judgements and reflections. Importantly, during experiential learning students need to be personally engaged for learning to take place. To enhance student engagement experiences need to be as close to real life as possible so that students see their relevance, become curious, and take charge of their own learning (Boud and Miller, 1997). Student engagement in learning can be diminished when they feel uncomfortable or confronted by the learning context such as might occur when they are required to remove their clothing (Patton, 2014).

Cultivating the kind of behaviours and attitudes required for ethical healthcare practice needs to be embedded across students' educational journey and often begins during students' earliest experiences in practical classes. According to Rouse (2007), embodied action, which includes bodily dispositions or habits, can be sustained over time because it is inculcated in the continuing dispositions or habits of individual agents. The benefits of experiential learning are well documented in the literature and include developing the level of clinical competence required before practising on real patients (Bindless, 1998), and developing 'respect for, and sensitivity to, patients' needs and wishes' by acting as models (Braunack-Mayer, 2001). Students report that undertaking patient roles facilitates their development of empathy with patients' perspectives as they experience, for example, what it feels like to undress in front of, and be examined by, a comparative stranger (Wearn et al., 2008). The development of students' empathic capabilities is congruent with current identification of person-centred care as a core graduate capability of health practitioner education. Student models are also considered to be a good substitute for real patients (Koehler and McMenamin, 2014) and provide opportunities for students to practise on a variety of body types and work with a range of personalities.

Experiential learning may expose students to a range of risks and challenges that may not have been explicitly disclosed to them. Participating in experiential learning can involve students removing part of their clothing, physical touch or disclosure of personal information. Students may feel uncomfortable about being partially undressed or touched by other students. As an example of potential risk, practising treatment techniques exposes students who do not need a particular treatment to the risk of injury from the inappropriateness of the treatment and from the student's low level of expertise and lack of experience. From the authors' experience, the inherent challenges associated with experiential learning have been exacerbated in recent years by the keenness of students to video record segments of practical sessions and demonstrations, often without participants' consent, for review at a later date. Such activities also expose teachers and institutions to the risk of potential litigation for failure to ensure their students' wellbeing.

In any experiential learning environment there may be vulnerable groups of students or students with particular learning needs. Students may also feel pressured to participate (Marley, 2009). When considering the risk of harm to students posed by experiential learning activities, such activities are often categorised as those that include non-invasive or invasive procedures, with the implication that non-invasive activities carry a lower risk for students and university communities. However, all experiential learning activities, whether they are invasive or not, have the potential to cause physical and/or emotional harm to students. Students may be confronted, upset or challenged by participation in any experiential learning activity and their ability to learn from the experience may be adversely affected (Patton, 2014). This risk to students' wellbeing and ability to learn raises a range of ethical issues for

university teachers who choose to implement experiential learning activities, including:

- the importance of 'free and informed consent' (Braunack-Mayer, 2001) and privacy issues arising when students are required to remove part of their clothing, to be physically touched, or to disclose personal information;
- students' safety when inexperienced students practise complex techniques that require high levels of psychomotor development to be performed safely on each other. Authors of a 2016 study on the risks of teaching cervical manipulation in masters programs, stated: 'Practicing skills with fellow students is encouraged but an important safety policy or a risk benefit analysis in most educational programmes does not appear to be present' (Pool et al., 2016);
- peer identification of health conditions that warrant further investigation. A study in a New Zealand medical school reported incidence rates of up to 23% per year for conditions warranting further investigation encountered as part of early clinical skills learning (Wearn et al., 2016);
- Cultural sensitivities, with perceived pressures to take part in experiential learning activities. According to Marley (2009), 'even if consent for peer physical examination is sought ... non-consenting students are immediately apparent to their colleagues, creating peer pressure to participate. The emotionally vulnerable are the most likely to accede to this and the most likely to be distressed'; and
- recording photographs, video or audio without consent, particularly where these are subsequently shared on social media.

Despite the acknowledged benefits and widespread pedagogical practice of using students as models in health programs in universities across Australia there has been a growing concern about ethical issues in experiential learning in medical education since the 1990s (Braunack-Mayer, 2001). These ethical concerns are also evident in the nursing (Hilton and Barrett, 2009), physiotherapy (Delany and Frawley, 2012) and health science literature (Hendry, 2013). Hendry's literature review (Hendry, 2013) identified a number of ethical concerns including feelings of 'coercion, embarrassment, and perceptions of a lack of consideration for cultural and religious beliefs'. Other authors report such issues as failing to obtain informed consent from students (Wearn and Bhoopatkar, 2006) and not having a procedure for dealing with incidental findings of possible conditions requiring referral (Wearn et al., 2016). A review of relevant experiential learning literature located only one example of a formal, documented policy addressing ethical experiential learning practise in an Australian medical school (Koehler and Schafer, 2014). Current approaches governing ethical experiential learning in most clinical skills classes are ad hoc with health schools and/or teachers often developing in-house rules to guide experiential learning practices. This has led to recent calls for a national policy for peer physical examination to ensure students' safety and wellbeing, and for a framework for ethical experiential learning in practical classes to be embedded in all levels of curriculum design (http://www.griffith.edu.au/_data/assets/pdf_file/0004/437350/Curriculum-Design-Learning-Objectives-and-Outcomes.pdf, n.d.).

The aim of this study was to identify effective strategies that enable ethical experiential learning for health students during practical classes. A narrative review of the medical and health sciences literature was conducted to collect and summarise all available evidence relating to the following research question:

- What strategies are effective in enabling ethical experiential learning in clinical skills classes when health students act as models?

2. Method

A narrative review of the medical and health science literature was conducted to 'shed light on a relatively unexplored topic area'

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