

# **An Analysis of Contemporary Issues for Leaders in Healthcare Education: Achieving Praxis and Closing the Theory Practice Divide**

Mr. Philip T. Beckwith  
Senior Lecturer  
Department of Health Care Practice  
Faculty of Health and Social Sciences  
University of Bedfordshire  
Bedfordshire, United Kingdom

## **Abstract**

In his executive summary of the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, Frances (2013) insists that "a list should be drawn up of all the qualities generally considered necessary for a good and effective leader. This in turn could inform a list of competencies a leader would be expected to have" (Frances, 2013, p108). While Frances does not specify educational leaders in his report, they are fundamental in the development of the future workforce through role modelling of the much hailed '6 C's' and therefore impact the patient experience (AACN, 2012; Frances, 2013).

In this paper I will address the dilemmas faced by educational leaders engaged in healthcare education. One such dilemma is academic drift or the valuing and greater uptake of academic practices at the expense of vocational qualifications and practices (Edwards and Miller, 2008 p36). Another dilemma is the move from vocational to academic training, and then forward to a degree threshold profession due to various political drivers, in professions such as operating department practice (ODP). Other dilemmas that will be addressed include the paradigm shift created by change management strategies that employ the vocationally trained clinical assessors to support students enrolled in degree level study (Hauxwell, 2010).

*"No pedagogy which is truly liberating can remain distant from the oppressed by treating them as unfortunates and by presenting for their emulation models from among the oppressors. The oppressed must be their own example in the struggle for their redemption."* (Freire, 1972, p. 54).

It could be argued that Freire was predicting the plight of the vocationally trained educator, who, whilst unable to access higher education themselves are therefore being suppressed. These practitioners struggle to support the new pedagogy and the students engaged with it. One concrete example of this suppression is the Diploma of Higher Education in Operating Department Practice (Dip HE (ODP)) in its current mode of delivery. This mode requires that forty percent of the programme is comprised of theory instruction which is delivered within a university setting. The remaining sixty percent of the programme is comprised of clinical practice within

partner hospitals. The oppressed vocationally trained educator is now expected to support the student engaged with the BSc (Hons) Operating Department Practice with no or minimal continuing professional development to support this progression (CODP, 2006). This situation creates the academic drift and alienates the vocationally trained educator (Edwards and Miller, 2008).

### **Issues dominating current provision of operating department practice in higher education (HE)**

Operating Department Practice (ODP), a fledgling profession with its academic underpinnings, has quickly metamorphosed from vocational education to higher education in approximately ten years (CODP, 2010). In the traditional academic world, the expectation is that lecturers hold a first degree and Senior Lecturers a Master's or PhD. In contrast the lecturers employed to deliver the first Dip HE (ODP) predominately held only a vocational award (City & Guilds 752 or National Vocational Qualification (NVQ) level III (ODP). Therefore ODP lecturer credibility in the academic world was (and to some extent still is) a concern.

The move from Further Education to Higher Education has also impacted the students. It had long been assumed that the NVQ Level III (ODP) created a 'dumbing down' affect by virtue of both a narrowing of the curriculum and the reliance of assessment driven practices. This assumption was compounded by the aspirations of '*students*' moving on to higher education, which was seen as having more esteem and prestige than '*trainees*' entering employment via the vocational route. The tension between teaching for academic progression and teaching for occupational purposes also materialised with some lecturers expressing concerns about the vocational validity of their programmes (James and Biesta, 2007).

The entry requirements for the NVQ III were five General Certificates of Secondary Education (GCSE's) or an equivalent at grade C or above to include Maths and English. When moving towards Higher Education it was decided at the national level, that the entry requirements should remain the same despite calls for levels to be raised to three A Levels at grade C or above. This decision was made to comply with the Department of Health's (DoH) policy of open access and the joint validation processes (CODP, 2006). Higher education minister, Margaret Hodge, suggested lowering the entry-level qualifications at level three from three to two A levels when speaking at the education and skills committee in December 2001; however this reduction had been rejected (THE, 2001). A simple change management tool such as the SWOT analysis first described by Albert Humphrey (2005) would have identified the students accessing higher education without any level 3 qualifications as both a Weaknesses and a Threat. Ms Hodge also confirmed that the government had asked the Qualifications and Curriculum Authority (QCA) to look at a range of professional qualifications to see if they could be accredited as higher education-level qualifications (THE, 2001). This review by the QCA became one of the political drivers leading to the move from vocational to academic training.

### **Leading while being led**

A move from vocational to academic training is clearly a paradigm shift in delivery needs and requires managed change, otherwise a structured approach to transitioning

individuals, teams, and organizations from a current state to a desired future state (Filicetti, 2007). Managing change is not necessarily a new concept as Abraham Lincoln, although dead for 125 years, still inspires people with his leadership strategies. He advocated that one should "...lead while being led, giving a subordinate the correct perception that they were, in many ways, leading not I (Lincoln)" (Basler, 1946). This was the stratagem for the introduction of the NVQ training system implemented by the UK government of the 1990s. This juxtaposition between changing service needs and the workforce preparation started in 1970 with the Lewin report. However, ODP training within England and Wales was wholly funded by the government through the Strategic Health Authorities. Commissioning, and therefore funding and structure, was driven by various government initiatives (DoH, 1970; NHS Management Executive, 1989; DoH, 2008). The Department of Health (DoH) led the transition of ODPs from assistants to practitioners by requiring that practitioners engage with a voluntary register, held by the Association of Operating Department Practitioners. Which in turn transitioned into statutory registration with the Health Professions Council (HPC). This transition required meeting eleven criteria, one of which was the demonstration of a profession-specific body of knowledge (Bevan and Smith, 2003). This body of knowledge was enhanced through research and publication generated by the move from vocational training through further education to academic study in higher educational institutions (King, 2003).

### **Are we leading or are we being led?**

Professor Darzi, in his paper *High Quality Care for All*, states that "A clear focus on improving the quality of NHS education and training is essential and the system will be reformed in partnership with the professions" (DoH, 2008). In 2009 this consultation occurred between the DoH and the CODP with the consensus being that operating department practice should move to an all degree profession (CODP, 2010). As with the move from vocational to academic education with the introduction of the Dip HE (ODP), the move from Dip HE to BSc (Hons) risks becoming an unmanaged process due to praxis. Tony Wilson describes praxis as "doing something, and then only afterwards, finding out why you did it" (New Order, 1983). This can be seen in the current introduction of the BSc (Hons) ODP as a spasmodic structureless process. Educators' involvement with this praxis changes and shapes the world of education (Lindeman 1944: pp103).

Efforts to reduce the effects of praxis and the theory practice divide require adult education to be perceived as 'education for use' and requires a structured approach (Lindeman 1944: pp103). This approach could be the formalisation of education leadership. After all, leadership qualities are not inherent but are a product of appropriate education programmes (Cunningham & Kitson, 2000; Kouzes & Posner, 2007). Therefore, when undertaking these changes to the world of education, the implementation of sound models of change must be applied.

### **Management of change in operating department practice within higher education**

Although there are many ways in which change can be categorised, a useful model is Ackerman's three modes of change: developmental, transitional and transformational (Ackerman, 1983). She explains that developmental change may be planned or

emergent and enhances or corrects current aspects of an organisation; this may well require focusing on the improvement of a skill or process.

Ackerman (1983) further explains that transitional change conversely seeks to achieve a known desired state that is disposed from the one that currently exists. This type of change is episodic and planned and is the basis of much of the current organisational change literature originated in the work of Lewin (Kanter, 1983; Nadler & Tushman, 1989). Lewin (1951) described change as a three-stage process involving the unfreezing of the existing organisational equilibrium, followed by the moving to a new position, and finally refreezing in a new equilibrium position.

Schein (1987) expanded upon these three stages. He advocated that unfreezing also involves the disconfirmation of expectations that could lead to the creation of guilt or anxiety; and this further instills the provision of psychological safety that may convert anxiety into motivation to change. In the moving to a new position he suggested that this can be achieved through cognitive restructuring, often by identifying with a new role model or mentor in conjunction with searching the environment for new relevant information. During the refreezing stage Schein concludes that refreezing occurs when the new point of view is integrated into the total personality and concept of oneself, coupled with the development of significant relationships (Schein, 1987).

### **What mode are we in?**

"We Teach as We Are Taught?" this quote from the Dutch sociologist Timmerman whose 2003 paper 'The Impact of Personal and Professional (Teaching) Experiences on Teacher Educators' Conceptions of Teaching, describes educators' current conceptions of teaching in the context of their own professional and personal socialization. Timmerman further suggest that educators have been teaching either formally or informally before entering the role of the teacher / educator, and that all teacher educators have memories as students, Timmerman (2003). This becomes apparent when investigating the delivery of work based education, the NVQ III trained mentor has their comfort zone well and truly embedded in mode 2 delivery of education.

*"Mode 2 knowledge production is characterised by being produced in the context of application—it has to be 'performative' in a contemporary situation where the sources of supply and demand for different forms of specialised knowledge are diverse and where the market process defines contexts of application. Furthermore, it is heterogeneous in terms of the skills deployed, transdisciplinary in the sense that it cuts across conventional disciplinary structures, and is located in a multiplicity and diversity of sites."*

(Gibbons et al, 1994 pp 56-61).

It could also be argued that Mode 2 knowledge production can be characterised by learning outcomes that are performance and discipline-related, with the pedagogy becoming more experiential and situationally specific, and whose content derives from work requirements rather than 'subjects' or disciplines. A paradigm shift occurred in 2002 away from Mode 2 knowledge production to Mode 1 learning. ODP education was moving from the NVQ level III and into Higher Educations' Dip HE. The educational leaders in clinical practice persisted in teaching as they had been

taught, however, in Mode 1 knowledge production, there is a requirement for university education to foster evidence based higher order thinking and a more philosophic approach aimed at increasing the facilitation of lifelong learning (Coffield & Williamson, 1997). To further complicate this transition, the validation process for a Dip He (ODP) programme is far from straight forward. The national curriculum document, written by the College of Operating Department Practitioners and the Health Care Professions Council (HCPC), provides the Standards of Proficiency with a further requirement that the programme is compliant with both the Quality Assurance Agency's Benchmark statement for ODP and HCPC's Standards of Education Training (CODP, 2006; QAA, 2004; HPC, 2005). These drivers for change inform the move from vocational to academic education and from mode 2 to mode 1 learning.

### **Freezing out the mentors**

It has been established that there was at this time a paradigm shift in pedagogy from mode 2 to mode 1 knowledge production. At this point a Lewinian unfreezing would appear to have taken place, Schein (1987) suggested that disconfirmation of expectations could lead to the creation of guilt or anxiety. This concept of guilt or anxiety will be explored, but first one must confront the new position of mode 1 learning and its place in Lewin's model of change.

This new position began in 2002 with the move from further to higher education (CODP, 2006). Schein (1987) suggested that moving to this new position encourages learners to search the environment for new relevant information and to identify with a new role model or mentor. This is certainly the case for the practice educator who has moved into this new role of supporting the student within the higher education setting. With this dramatic shift in expectations, what support is available for these educators and how is this provided?

Hauxwell (2010) elaborates and suggests that overall there is no substantive reference in the professional bodies' guidance or the current literature for providing support for learners in the clinical setting. Further he muses that similarly, there are no references to this in other Allied Health Professions (AHP's) registered with the HCPC. Lewin's model (1951) would now inform a refreezing stage, when Schein (1987) intimates that refreezing occurs when the new point of view is integrated into the total personality, and concept of one's self, coupled with the development of significant relationships can be extrapolated to the relationship between the student, practice educator and the HE institution. (Lewin, 1951., Schein, 1987., Hauxwell, 2010). This 'refreezing' stage occurred in 2009 when it was identified that ODP should move to a degree profession resulting in the BSc (Hons) Operating Department Practice (CODP, 2010). As previously stated, it was Professor Darzi's (2008) vision that quality education and training would be reformed in partnership with the professions. Therefore who is to lead this metamorphosis in practice education from the diploma to a BSc (Hons)?

## Who or what is an educational leader in healthcare education?

Who is to lead this metamorphosis in practice education from diploma to BSc (Hons)? Under the present structure we have the practice educator who is a many faceted individual. The practice educator's responsibilities range from accountability for the supervision and assessment in learning to implementing leadership. The practice educator provides leadership as a specialist clinician and also in the supervision of preregistration and postregistration students. It could be argued that there is no need for leadership in the clinical practice environment as one practitioner stated "leadership is just something Darzi dreamed up", (not cited). However, the advanced or specialist practitioners are experts in their field and in the clinical interventions they undertake. The role of the advanced or specialist practitioner is defined both by the **Scottish Government (2003)** and **Humphreys et al (2007)** as having four distinctive roles, these being *expert practice, research, education, and leadership*. But again when evaluating educational leadership provided by advanced or specialist practitioners in the practice setting, there is no evidence that the qualities of leadership are inherent (Cunningham & Kitson, 2000; Kouzes & Posner, 2007). It could be argued that educational leadership is a product of altruistic intent.

The French philosopher Auguste Comte first used the word altruism in 1851 and defined it as '*self-sacrifice for the benefit of other*', (**Comte, 1856**). There is the belief that the educational leader evolves through altruism, acting as a role model and displaying the traits required of a professional practitioner (Winch and Gingell, 1999). This educational leader may be didactic or progressive but nonetheless appreciates the power of learning and its place in the students' educational experience (**Winch & Gingell, 1999**). However, learners quickly 'catch on' to mentors' personal characteristics, inadequacies and insecurities which may influence assessment outcomes, also known as 'toxic mentoring' (**Gray & Smith, 2000; Gopee, 2008**).

As alluded to previously, Schein (1987) suggested that disconfirmation of expectations during the 'moving to a new position stage' could lead the clinical educator to experience guilt, anxiety, or the feeling of being 'out of their depth' which may lead to the mentor's reluctance to fail a student. It could be argued that one such cause would be the clinical educator's lack of confidence in their own academic strength. **Duffy's (2004)** study addressed this issue in depth examining how student nurses passed clinical assessments without demonstrating sufficient competence. The study concludes that mentors did not wish 'to be the person who ended a student's career', (Duffy, 2004). **Skingley et al (2007:28)** asserted that this is an issue that is still largely overlooked. Hauxwell (2010) describes how these educational leaders are in fact the 'gatekeepers' to the profession stating that: "The legal and professional repercussions of poor 'gate keeping' are now more visible since the profession achieved statutory registration". With statutory registration comes the responsibility for gate keeping the ODP profession. Who is to be the gate keeper? Clinical leaders or managers?

The professional and government bodies use the terms clinical specialist and leader interchangeably. Some assert that leadership is performed by a person who sets a new direction or has a vision for an individual or group and uses management tools or directs resources according to principles and values that have already been established (Marquis & Huston, 2009). This juxtaposition between leadership and management is

illustrated by what is created when you have leadership without management or management without leadership (Marquis and Huston, 2009).

## **Conclusion**

The discussion by Quinn and Hughes (2007) of the intrinsic influences surrounding the educational leader and the supportive learning environment, suggests that students will enter the learning environment with personalised levels of motivation and confidence. Hauxwell (2010) further suggests that the student has raised expectations of the professional and life-related skills that they are encountering. It is noteworthy that these educational leaders are predominately altruistic and have little understanding of the power they have over the students' progress thus leaving to chance that the educator had good educational experiences which can by 'osmosis' be transferred to the student (Hauxwell, 2010). Educational leaders, as opposed to clinical managers, need to be identified and sound change management models applied to prevent the ODP profession from tumbling into the abyss that awaits it. This will require resources in the way of funding and the training required to develop this group of practitioners, and whilst at the time of writing this paper the government have ring fenced health from public sector cuts,

"The government should rethink ring fencing funds for health and international development, consider appointing a "minister of the deficit", and do more to explain the need for a debate on which services should be cut, PricewaterhouseCoopers will recommend today".

(PricewaterhouseCoopers, 2010)

This warning from 2010 is still relevant as evidence by to the present climate as it is unsure whether the resources will be made available, and therefore what the future holds for the profession and the delivery of patient care. The need for continuing professional development of the educational leaders in practice is a service need and not a 'bolt-on' as reinforced by Frances (2013):

"The commissioning landscape has now changed, with the introduction of the national NHS Commissioning Board, its regional offices and clinical commissioning groups. However, the essential tenets required of the commissioning process may not have changed. The experience of Stafford shows an urgent need to rebalance and refocus commissioning into an exercise designed to procure fundamental and enhanced standards of service for patients as well as to identify the nature of the service to be provided. However, none of this will turn a theory of effective commissioning or monitoring into practice unless commissioners are recognisable public bodies, visibly acting on behalf of the public they serve and with a sufficient infrastructure of technical support. Effective local commissioning can only work with effective local

monitoring. And that cannot be done without knowledgeable and skilled local personnel engaging with an informed public."

(Frances, 2013)

So, as a profession are we leading or are we being led?

## **References**

Ackerman, L. (1986), "Development, transition or transformation: The question of change in organizations", *OD Practitioner*, 18(4), pp.1-8.

American Association of Colleges of Nursing (2012), "The Impact of Education on Nursing Practice", <http://www.aacn.nche.edu/media-relations/EdImpact.pdf>, (Accessed 29/09/2013).

Basler, R. (1946), "Abraham Lincoln: His Speeches and Writings", World Publishing Co., New York.

Bevan, D., Smith, M. (2003), "AODP Business: It has begun", *Journal of Operating Department Practice*. Lewes: Association of Operating Department Practitioners.

Coffield, F., & Williamson, B. (eds) (1997), "Repositioning Higher Education. Open University Press, Buckingham, UK.

College of Operating Department Practice (2006), "Diploma of Higher Education Operating Department Practice Curriculum Document". Wilmslow: College of Operating Department Practice.

Cunningham, G. and Kitson, A. (2000), "An evaluation of the RCN Clinical Leadership Development Programme", *Nursing Standard*, (part 1) 15 (12): 34-37 (part 2) 15 (13): pp. 34-40.

Department of Health and Social Security, Welsh Office, Central Health Services Council. (1970), "The Organisation and Staffing of Operating Departments". London : HMSO. (The Lewin Report.)

Department of Health. (2008), "High Quality Care For All", London : HMSO. (The Darzi Report.)

Edwards, R., Miller, K. (2008), "Academic Drift in Vocational Qualifications? Explorations through the Lens of Literacy", *Journal of vocational education and training* 60 2, pp.123-31.

Filicetti, J. (2007), "Project Management Dictionary", Canada: PM Hunt.

Frances, R (2013), "Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: Executive summary", London: The Stationary Office pp. 108.



- Freire, P. (1972), "Pedagogy of the Oppressed", London: Penguin.
- Gibbons, M., Limoges, C., Nowotny, H., Schwartzman, S., Scott, P., and Trow, M. (1994), "The New Production Of Knowledge: The Dynamics Of Science And Research In Contemporary Societies", London: Sage.
- Hauxwell, J. (2010), "Learning in theatre: a critical commentary from experience", London: The Journal of Operating Department Practice. pp.12-14.
- Health Professions Council (2008), "Standards of proficiency Operating Department Practice", London: Health Professions Council.
- Health Professions Council (2009), "Standards of education and training", London: Health Professions Council.
- Humphrey, A.S. (2005), "SWOT Analysis", (Available at <http://www.businessballs.com/swotanalysisfreetemplate.htm>). [Accessed 29/09/2013]
- James, D. and Biesta, G. (2007), "Improving Learning Cultures in Further Education", London: Routledge.
- Kanter, R. (1983), "The change masters: Innovations for productivity in the American corporation", New York: Simon and Schuster.
- King, R. (2003), "Comment: Agenda for Change", Lewes: Association of Operating Department Practitioners.
- Lewin, K. (1951). "Field Theory in Social Science", New York: Harper and Row.
- Kouzes, M. and Posner, B. (2007), "The Leadership Challenge", 4th ed. New York: Jossey-Bass.
- Lindemann, E. (1944), "Symptomatology and management of acute grief", American Journal of Psychiatry, Vol 103.
- Marquis, B. L. & Huston, C.J. (2009), "Leadership Roles and Management Functions in Nursing: Theory and Application", 6th ed, Philadelphia: Wolters Kluwer/Lippincott, Williams & Wilkins
- Nadler, D., Tushman, M. (1989), "Organizational Frame Bending: Principles for Managing Reorientation", The Academy of Management Executive, (3). pp. 194-204.
- New Order. (1983), "New Order: Play At Home", London: Channel 4 Episode dated 31 March 1983.
- NHS Management Executive. (1989), "The Management and Utilisation of Operating Departments", London: VFM Unit. (The Bevan Report.)

PricewaterhouseCoopers (2010), "NHS funding should not be ring fenced, says citizens' jury", [Available at] <http://www.guardian.co.uk/business/2010/aug/10/pricewaterhousecoopers-spending-cuts-deficit-research> (Accessed 29/09/2013).

Quality Assurance Agency (2004), "Quality Assurance Agency's Benchmark statement for ODP", London: Quality Assurance Agency.

Quinn, F. and Hughes, S. (2007), "Quinn's principles and practices of nurse education", 5th edition, Cheltenham: Nelson Thornes.

Times Higher Education (2001), "Ministers sidestep poor to hit target", London: Times Higher Education, Vol (12).

Timmerman, G. (2003), "We Teach as We Are Taught? The Impact of Personal and Professional (Teaching) Experiences on Teacher Educators' Conceptions of Teaching", *International Journal of Interdisciplinary Social Sciences*, Volume 3, Issue 5, pp.173-178.