SIXTH EDITION

BECOMING A REFLECTIVE PRACTITIONER

EDITED BY
CHRISTOPHER JOHNS

WILEY Blackwell

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CONTENTS

PREFACE

Reflective practice *matters*. It matters because it opens a gateway for practitioners' to learn and grow towards realising their potential and their visions of practice as a lived reality. A reflective practitioner is someone who lives reflection naturally within everyday practice. It is a mindful way to practice whereby the practitioner pays attention within the unfolding experience, mindful of responding most appropriately in tune with their vision. It is a process of self-realisation. Rolling Thunder describes this as 'seeking and knowing one's own identity' [Boyd 1974:7].

Reflective practitioners learn through reflection on experience. In this way, the practitioner gains insights that inform future experiences within a reflexively spiral of being and becoming. I assume that the practitioner's practice matters to them and that values and vision are important. Hence realising one's vision of practice as a lived reality must be the aim of every practitioner who takes themselves seriously. Recipients of service deserve nothing less.

The emphasis of this book is on *becoming* a reflective practitioner. Becoming is a journey. No matter the practitioner's level of experience or status. It commences with the first reflection on experience. In the uncertainty and uniqueness of everyday practice, practitioners face situations that often feel chaotic. As Salzberg notes (2002:76)

> No matter how much we want it to otherwise. The truth is that we are not in control of the unfolding of our experience. We can affect and influence and impact what happens, but we can't wake up in the morning and decide what we will encounter and feel and be confronted by during the day.

The experience becomes less chaotic as the practitioner becomes more able to ride with chaos rather than be thrown by it. Such learning isn't complex or difficult. Yet it does take commitment and discipline to learn in this way.

The spin-offs are great. We become more effective, more purposeful, more motivated and satisfied, more in control of ourselves and our practice. Our lives become richer with meaning, purpose and expertise. We become more satisfied and committed. For these reasons, reflection has become a normal learning approach within the professional curriculum and, as such, demands serious consideration.

I wrote against a background of social unrest following the death of George Floyd in May 2020, and the resurgence of Black Lives Matter into the social consciousness as a consequence. His death is a wake-up call for all people to be critically reflective of their own attitudes to ethnic minority peoples, most notably health care practitioners who espouse person-centred nursing. Hence *reflective practice matters* as the key to enable practitioners towards cultural safety to become aware, examine, understand and shift their attitudes to ensure peoples of all races feel culturally safe. Becoming culturally safe that must be a key aspect of person-centred practice. It is a massive challenge given the deeply embodied racism that most white people would deny and yet is reflected subconsciously in most aspects of daily life. Why is it that black people are ten times more likely to be stopped and searched than white people? [BBC News 8th July 2020].

The book is also set against an environmental background of climate change as a result of the way the planet has been exploited for economic growth. In response to the environmental crisis, there must be a radical shift in consciousness towards living in harmony with the planet resulting in healthier lives. Failure to do so will simply be extinction. Evidence is all about us. Take, for example, Covid 19. As such, practitioners, no matter what discipline, but perhaps especially health and social care practitioners, should reflect on their practice set against this background of creating healthier lives for themselves and for those they work with and care for. It is the *bigger* picture. It is our individual and collective responsibility to practice in harmony with the planet. It is a tough ask given the world we live in but, as Rolling Thunder (1974:7) notes –

> mankind's strength and ultimate survival depend not upon an ability to manipulate and control, but upon an ability to harmonize with nature as an integral part of the system of life.

My approach to 'Becoming a Reflective Practitioner' ever since the first edition published in 2000, is to create a reflective text to engage and dialogue with its readers. As such, I use many stories and dialogue to illuminate ideas and give examples of reflective writing. This approach illustrates the reflective process and what the writer seeks to realise in their practice. Hence, the text is also a text on realising person-centred practice.

My inquiry into the nature of reflective practise commenced in 1989, resulting in an understanding of guided reflection (Johns 1998) that has been continuously reflected on for its rigor, coherence and utility as presented throughout this book.

The book is designed to guide both student and registered practitioners at any level of professional learning, along with their guides, teachers, and managers, to become reflective practitioners, not just clinical practitioners but also educators, managers, and most significantly, leaders able to enable others to grow and fulfil their potential. Although the book's background is healthcare, it is a resource for all professionals who aspire to offer a service to people.

Health care, no matter what discipline, is fundamentally concerned with the relationship between the practitioner and the person receiving health care to meet the person's health needs, whatever they may be. Nothing about this relationship can be assumed to be certain or predictable. Everything is an interpretation depending on context. As such, the practitioner's response to the patient is perceptive, seeking to understand the patient's experience and needs to inform an appropriate and effective response. This is the essence of person-centred health care that is unless the patient is viewed as an object to do things to. Then the patient is no more than of technical interest. Disembodied. Education and practice must radically shift to ways of learning and knowing that nurture person-centred health care rather than skid along the technical surface of things. We need to create opportunity to learn through experience to reveal the very depth of professional artistry. This is the way of reflective practice. And yet, if we are not *alert,* reflective practice too can skid along the surface of things. Most importantly, approach the book with a sense of play and curiosity to see where it takes you. Most of all, reflective practice is about YOU and nothing can be more interesting.

Like previous editions, this sixth edition has been extensively revised and reorganised to comprehensively guide students, practitioners, managers, and their guides across disciplines *no matter their level of experience* to learn through reflection on experience to become a reflective practitioner. I have looked back through previous editions and associated books (Johns 2002, Johns 2010, Johns and Freshwater 2005), reading and reflecting again on these published narratives resulting from my guidance of practitioners within the guided reflection. Some narratives are republished because they tell such vital stories of becoming a reflective practitioner. New guest authors give wider perspectives on reflective practice, including contributions from international authors.

Chapters

The book is organised in two parts. Part 1 is written by myself with the exception of Chapters 12 and 13 jointly written with Otter Rose. Part 2 is written by contributors who offer the reader wider perspectives on reflection and reflective practice.

Part 1

In Chapter 1, I envisage reflection. Reflective practice is at risk of being a cliché with its multiple interpretations that begs the question 'what exactly is reflection and reflective practice'? How can we know it and apply it certain of its validity?' If known, it can be applied with prediction and control, so everyone knows what it is. However, things are not that simple. Reflective practice will always be interpreted in different ways according to the interpreter's perception and intentions. I give a brief overview of reflective theories that I have dialogued with over time and which, to a varying extent, have influenced my own conception of reflective practice. In describing reflection, I view learning as a movement through understanding, empowerment and transformation. At each level, insights can be gleaned.

I explore vision as fundamental to reflection. Vision sets out what the practitioner is striving towards. Vision sets up creative tension, the dynamic learning moment within reflection between vision and an understanding of our current reality. In understanding this tension, the practitioner can work towards resolving it so the vision can be more realised. Barriers that constrain are identified and worked towards overcoming. Without vision, reflection has no real meaning except perhaps as a superficial problem-solving tool. As such, reflection is always an exploration of values that constitute vision and the assumptions and attitudes that support realising the vision as a lived reality.

In Chapter 2, I set out the Six dialogical movements that structure the reflective learning process that is systematically explored through succeeding chapters. I set out the *reflective attitude* comprised of a number of attributes the practitioner needs to cultivate to engage reflection to gain maximum benefit. One of these attributes is developing *bringing the mind home*. Bringing the mind home helps to prepare the practitioner to be fully present within--the-moment, whether in clinical practice or reflecting on experience.

In Chapter 3, I explore the first dialogical movement concerned with paying attention to a particular experience with the intention to write or portray a description of that experience. This expression is the raw data reflection. Paying attention immediately cuts across the taken for granted nature of much of experience and habitual practice. Over time, through paying attention, the practitioner becomes increasingly self-aware, leading to mindfulness where nothing is taken for granted and the whole span of practice is an inquiry. I advocate keeping a reflective journal to write descriptions that becomes an ongoing and unfolding reflective record of experience.

In Chapter 4, I explore reflection using the Model for Structured Reflection [MSR]. The MSR has been significantly revised from previous editions and is easy to apply. From feedback, I get the impression that many people think that simply using the MSR *is* reflective practice. Worse, they view a model of reflection as a prescription. It isn't! It is a heuristic, a means to an end towards gaining insight. I urge readers to dwell with the MSR, to feel the depth of the cues rather than view it superficially and skid along the surface of reflection. If so, reflection loses its vitality.

In Chapter 5, I explore insight. Insights are the learning accrued through reflection. They are described as embodied learning because they change the person in some way so that they now view and respond to the world differently, however slight. They are not necessarily easy

to identify because of their embodied nature. Insights are initially tentative and held loosely. They are most often acknowledged reflexively through subsequent experiences.

In Chapter 6, I explore the third dialogical movement between the practitioner's tentative insights and informing literature whereby relevant information from whatever source is accessed, critiqued, juxtaposed with insights and assimilated into personal knowing. I show how theory can be explored as theoretical mapping enabling practitioners to position themselves within the theory and plot movement towards a more desirable position.

The second part of this chapter is devoted to the fourth dialogical movement, the dialogue between the practitioner with a guide and peers. Guidance opens a learning space where the practitioner can share their experiences and insights, inviting the guide to offer their own perspectives. As a result of this dialogue, new insights emerge, deepened, and co-created. Guidance radically shifts the relationship between student and teacher and, as such, has profound implications for curriculum as explored in later chapters.

In Chapter 7, I explore the fifth dialogical movement as weaving insights into threads and patterns represented in reflexive narrative form. The word 'narrative' has seeped into everyday speak. I wonder, have we moved beyond the technical rational to value experience and anecdote reflected in this seepage? Or is *narrative* simply a word to reflect 'the story' or 'vision'. Whatever, it does suggest a valuing of context and subjectivity; that people are not machines. People are human and that experience is human and unique. And that no matter the difficulty, learning through reflection is dynamic. Narrative is creative. The practitioner has a license to construct narrative in ways that best express their reflexive learning and journey, for example, through poetry, art, metaphor and images. It cannot be prescribed even though academic institutions will nevertheless impose criteria about how it should be expressed.

In Chapter 8, I apply the model for structured reflection to my description of being with Peggy one morning at the Day Hospice. I apply the MSR in a systematic way to illustrate my use and understanding of each cue and as an exemplar to readers.

In Chapter 9, I set out my narrative of 'patients I do not give a therapy to' written as a series of prose poems about different patients who share the fact I did not give them a physical therapy, challenging myself about my role and the concept of therapy.

In Chapter 10, I explore the sixth dialogical movement as the dialogue between the text and its audience. In doing so, I emphasise that the text is more than simply an account of the practitioner's journey. It offers an audience a focus for their own reflection and learning. The practitioner invites the audience to dialogue with an intent to stir the audience to draw and act on their own insights. With this idea in mind, the practitioner writes in a way to engage the audience and open this reflective space. Audience can be readers or listeners through performing the narrative.

In Chapter 11, I explore the idea of performing narrative to an audience in contrast with an audience reading a narrative. I give an example of how one practitioner converted her written assignment into a play 'Musical chairs' that was performed at a reflective practise conference.

In Chapter 12, I set out the performance narrative 'people are not numbers to crunch'. It was written from my perspective as a partner to witness Otter's experience of undergoing an angiogram. It exposes issues which reflect an unsatisfactory level of care, notably that nursing staff do not introduce themselves and treat Otter as if she is an object and myself as an outsider beyond their gaze. The performance is set against a CQC report of care at this particular hospital. Otter's graphic storyboard of this experience can be accessed on the Wiley Blackwell website.

In Chapter 13, I explore with Otter how art and storyboard offer as a particular visual approach to reflection and narrative that may offer an alternative to language approaches and hence may benefit visual reflectors. Breaking narrative into visual scenes, like poetry, aids the revelation of insights. Poetry and art are expressive forms that open up the neglected right brain moving away from rational thought to nurture imagination, perception and ul-

timately intuition. We use Otter's storyboard of bullying in the workplace. We know from experience that many practitioners will relate to this because bullying is endemic within the workplace. Storyboard's visual storyboard is easy to relate to, opening a clearing for practitioners to explore their own experience of being bullied and how such pernicious behaviour can be confronted.

In Chapter 14, I contemplate the reflective curriculum. It is fascinating to look back at the previous editions to see this chapter's reflexive development. It is the most vital chapter because health discipline curriculum is entrenched in a technical rational modus where reflection is viewed as just another teaching technique. If this is the case, then much of the benefit of reflective practice is lost. The reflective curriculum views professional artistry and identity as its education aim, and reflective practice as its primary approach, re-orientating theory to inform this process. In other words, it turns the traditional relationship between practice and theory on its head. Easier said than done. I imagine how two teachers with differing teaching approaches explore teaching nursing students about stroke. John takes a theory--driven approach typical of a dominant technical rational approach. Jane takes a reflective approach that embraces performance and with it, cross-discipline teaching. At Bedfordshire, I involved drama and dance teachers as co-supervisors for reflexive narrative doctoral students. Their involvement opened up the performance potential as a profound learning space. Performance engages and empowers people. It is an embodied learning that is necessary for practice disciplines where the body has to learn rather than the mind simply think.

Developing post-registration reflective curriculum is illustrated through two courses; one as part of a 'top-up' degree and one as a total masters degree in leadership.

Much of the reflective practice taught in Universities is by people who are not reflective. As a consequence, they adopt technical rational approaches to teaching reflection that are inadequate. The whole book is itself a treatise on the need to create reflective learning environments if we are to practice reflective practice critically rather than as a superficial problem--solving exercise. Of course, it has value even at that level if it enables practitioners to pause and reflect on what they are doing in terms of best practice. But much of what we do and the way we think about what we do is culturally prescribed, And so, the reflective teacher, like the reflective practitioner, must pierce this cultural veil to understand and shift the norms that govern teaching of teachers if the value of reflective practice to develop professional artistry is greater than a technical rational approach to do reflection.

In Chapter 15, I explore how reflective academic writing can be meaningfully graded from a professional artistry perspective in contrast with a technical rational perspective. I argue that the focus of all reflective examination should primarily focus on the insights the practitioner draws from reflection, not on the reflective process itself. I use Jill's reflective assignment on touch and the environment to invite readers to grade and reflect on how they graded.

Chapters 16 and 17 are illuminations of guiding nursing students in dedicated guided reflection sessions. The two situations: 'Michelle finding a woman upset about her breast biopsy' and 'Hank's complaint' are real situations shared in guided reflection. As you might expect, guiding the first year group is more directed, whilst guiding the third year group is more open. The chapters illuminate the use of theoretical mapping, the way can be fed into the dialogue between guides and students.

Chapter 18 is a narrative of guiding of Trudy within the context of her clinical practice whilst also undergoing the Becoming a reflective and effective practitioner programme set out in Chapter 14. The narrative reveals how a particular experience is unfolds over six guided reflection sessions leading to profound insights. Of particular note is the richness of Trudy's reflective description imbibed with MSR cues.

Chapter 19 reveals Sally's narrative 'a small voice in a big arena' which was written as her conflict management assignment on the MSc Leadership in healthcare degree. It reflects how conflict is an everyday occurrence for many practitioners and hence a common focus for

reflection. Her effort to respond to conflict from her vision of leadership heightens the conflict tension dramatically revealing the struggle to realize her vision of leadership as a lived reality within a transactional healthcare organization.

Chapter 20 sets out the Learning Organizations inspired by the work of Senge (1990) concerned with creating an environment in which reflective practitioners work collectively towards realising their vision of practice as a lived. This is exemplified through the Burford NDU Model of nursing: caring in practice. This model consists of four reflective systems set against the background of the Learning Organization. Two systems concerned with implementing the vision through reflective cues and communication are explored.

In Chapter 21, I set out 'A system to live and ensure quality' through developing clinical audit, standards of care, and group guided reflection that each foster reflection, personal mastery and team learning.

'A system to enable practitioners to develop personal mastery towards realizing their vision of practice' is the focus of Chapter 22. Within healthcare organizations guided reflection is usually termed clinical supervision that comes with a political agenda to essentially safeguard the public. Hence a tension exists between its regulatory and developmental intentions. Susan's narrative, completed as an assignment on the MSc Leadership in Healthcare degree, gives focus on instigating clinical supervision as an element of leadership against the background of developing the Learning Organization.

Part 2

Awakenings [Chapter 23] reveals how arduous reflection can be for some practitioners, such as Aileen, in despair about her nursing predicament. As she quotes '*There is much truth that learning through experience is arduous work'*. For Aileen reflection was a rope to pull her out of her despair but her hands are slipping. The rope is hard to grasp. And what is it pulling her into?

In Chapter 24, Gerald Remy reflects on his leadership two years after completing the MSc Leadership in healthcare degree. Gerald, like Susan and Sally noted in earlier chapters, undertook the MSc Leadership in Healthcare degree. He was part of a learning community of 10 aspiring health care leaders. I emphasise community for a number of reasons. Firstly, from a leadership perspective, creating community is fundamental for any leader to create. Secondly, I believe that learning through community whereby others in a similar aspiring boat are available to each other through a period of time [in this case, 28 months] enhances learning through reflection. Community creates the condition for dialogue for a group of people learning towards similar goals. This idea permeates through many of the chapters in the book and reinforces the need for guides to be themselves leaders and skilled at guiding others to learn through reflection. Indeed this ability to guide learning in others is a prime quality of leadership.

Thirdly, is whether learning can be sustained without guidance, especially in a hostile culture that puts constant pressure on the practitioner to conform to organisational norms that are previously learnt ways of being. The ability to sustain learning, against the grain, so to speak, is reflected in the extent reflection has become inculcated within the practitioner's community rather than an individual thing. Gerald suggests he has achieved that to some extent, although it remains precarious as he continues to hold creative tension. Of course, in terms of the efficacy of reflective learning, this issue of sustained learning at the depth of is of vital concern, that reinforced the necessity of first, a clear understanding the nature of reality [organisational norms that govern everyday ways of relating], and secondly, being able to detach self from the anxiety of transgressing these norms. Living this tension is akin to playing a subversive and dangerous game of survival where guidance is vital.

Gerald's narrative gives a dimension on expressing learning through metaphor. Gerald, like all NHS staff have been socialised into the transactional culture that governs health care organisations. Hence the idea of being a servant-leader or a transformational leader is immediately at odds with this culture. It begs the question – 'how can one come to appreciate and separate self from this culture whilst being immersed within it where one's every action has been socialised towards being transactional from either a subordinate or managerial perspective'. Gerald used the metaphor of David and Goliath to see and work with this tension. If the tension is not addressed then learning is limited and yet one can see how difficult it is to unlearn learnt ways of knowing [embodiment] to begin to respond differently and without coercive fear.

Fifthly, Gerald highlights the significance of one's background in shaping the person. To become a leader from a servant-leader or transformational perspective required Gerald to look back at his upbringing in order to understand how his background influences who he is now and who he seeks to become. He recognises the tension between a Goliath within and a David within and the need to vanquish his Goliath through his David. Anybody learning through reflection will need to consider their background- perhaps using the influences grid [How does my background influence the way I respond within this particular situation/experience?].

Chapter 25 offers a teacher of teachers' perspective on reflective teaching. In particular it highlights how a 'reflective mindset' results in challenging previous ways of teaching that had been viewed as successful. The reflective teacher seeks to give responsibility to the students to find their own way with minimal guidance. Not easy to do when you think you know the best way, but it opens to door for the teacher to learn and be challenged through post-exercise dialogue. Adenike also explores the culture of the classroom, highlighting the difficulty teachers face with issues such as control and emotions.

Chapter 26 offers a Canadian perspective on reflective teaching using the MSR and stimulating reflection through constructed narratives. Arlene lifts to the surface the dynamic nature of reflective teaching offering new perspectives on learning through reflection for both guides and students.

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CHAPTER 1

Envisaging Reflective Practice

Christopher Johns

Sitting in the train the other day a woman hobbles on. Finds a seat to put her leg up. She says to her mate 'They just don't care anymore. She didn't look properly at my foot. She wasn't interested. Told me it was probably a corn. Wasn't listening to me. Told her the pain was in me' eel. In the end she said 'Your 10 minutes are up got to see someone else'.

Her mate rolls her eyes 'Bloody awful ain't it, chiropody on the NHS'.

The woman's comments suggest her care was unsatisfactory. You might accept her word that the chiropodist wasn't listening to her and ponder the reason for that. Had the chiropodist's practice become routine requiring little thought and engagement with the patient? The bottom line is that every professional, no matter what discipline, must take responsibility for ensuring the most effective and desirable practice. This requires practitioners not only to be reflective after the event but more significantly, to have the ability to reflect within the practice to ensure best practice. This is the stance of the reflective practitioner.

Professional Artistry

Before exploring the nature of reflection, it is necessary to consider the type of knowing it generates, what I term professional artistry stemming from Schön's description as the 'kinds of competence practitioners sometimes display in unique, uncertain, and conflicted situations of practice' (Schön 1987, p. 22). Adding to Schön's description 'set against a background of realizing one's vision'.

Every experience is unique. It cannot be determined. We may have many similar experiences that serve to inform our interpretation and response. There can be no prescriptive solutions. As such, practice is largely intuitive, drawing on our tacit knowing. By tacit, I mean knowing that is not easily articulated. We can only know our practice through reflection as something lived rather than as something theoretical. Take the example of caring. Frank (2002, p. 13) writes:

> Caring is one of those activities that people know only when they are involved in it. From within, and only from within, caring makes sense. To try and explain care leads to the circularity expressed in statements such as 'caring for this person requires doing this, and I do this because I care for this person'. Philosophy teaches that, for some activities, there is only practice.

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It follows that if we accept Frank's position, we can only know caring from within caring – the professional artistry perspective. Caring cannot be known as a technical or abstract thing. The practitioner knows self as caring only within the moment.

King and Appleton (1997) and Cioffi (1997) endorse the significance of intuition within decision making and action following their reviews of the literature and rhetoric on intuition. They note that reflection accesses, values, and develops intuitive processes.

Aristotle drew a distinction between practical wisdom and theoretical wisdom. Practical wisdom does not result in knowledge that is determinate and universal; indeed, it does not result in propositional knowledge at all but in discriminations and actions.

Technical rationality (or evidence-based practice) has been claimed as necessary for nursing's disciplinary knowledge base because it can be observed and verified (Kikuchi 1992). Historically, professions such as nursing have accepted the superiority of technical rationality over tacit or intuitive knowing (Schön 1983, 1987). Yet, a technical rational mentality is likely to lead to stereotyping, fitting the patient to the theory rather than using the theory to inform the situation. This mentality inevitably leads the practitioner to fit the person to the theory, thus reducing the patient/client to some object and the practitioner to the status of a technician carrying out a prescription irrespective of the person's humanness.

In an educational and organisational culture dominated by a technical rational approach, the idea of writing spontaneous, subjective, and creative descriptions as a basis for reflection and gaining insight may seem to go against the grain. A technical rational approach gives dominance to theory and objective facts rather than subjective opinions and feelings. Indeed, feelings may be denigrated as unprofessional and stories as mere anecdotes with little learning potential. From this perspective, reflective practice is likely to be adapted to fit this dominant culture rather than see the potential for reflection to transform both educational and organisational culture.

Since the Briggs Report (DHSS 1972) emphasised that nursing should be a research-based profession, nursing has endeavoured to respond to this challenge. However, the general understanding of what 'research based' means has followed an empirical pathway reflecting a dominant agenda to explain and predict practice. This agenda has been pursued by nurse academics seeking academic recognition that nursing is a valid science within university settings. Whilst abstract knowledge has an important role in informing practice, it certainly cannot predict and control, at least not without reducing the patient and nurses to the status of objects to be manipulated like pawns in a chess game. The consequence of this position in nursing has been the repression of other forms of knowing that has perpetuated the oppression of nurses of their clinical nursing knowledge (Street 1992). Has it improved in the past 20 years? I see no evidence to support that. We who plough the professional artistry field reap a poor reward in academic acclaim. Professional artistry is subjective and contextual, yet is often denigrated as a lesser form of knowing, even dismissed as 'mere anecdote' by those who inhabit the hard high ground of technical rationality. People get locked into a paradigmatic view of knowledge and become intolerant of other claims because such claims fail the technical rationality injunction as to what counts as truth.

It is unimaginable for any healthcare practitioner to face clinical practice with a technical rational mindset simply because each clinical moment is a unique human-human encounter. Yet, unfortunately, the reality is otherwise. As a consequence, healthcare practitioners become technicians and patients objects.

Reflection

A good place to start is a quote from Wheatley and Kellner-Rogers (1996, p. 69): 'Life is playful and life plays with us. The future cannot be determined. It can only be experienced as it is occurring. Life doesn't know what it will be until it notices what it has just become'. I like these words because they are playful. Reflection is playful and is the gateway to knowing life as it is occurring and knowing life as it has just become.

Reflection is a process of self-inquiry towards self-realisation, however, that might be expressed. It enables practitioners to learn reflexively through their everyday experiences. Experience is a rich learning opportunity when we pay critical attention to it. As O'Donohue (1997, p. 26) writes:

> 'Everything that happens to you has the potential to deepen you'. This potential is actuated through reflection as a self-inquiry into experience to find meaning, gain insight and prompt action that will deepen you.

Learning is expressed as insights. Insights are focused towards realising the practitioner's vision of the desirable practice. Reflection moves the practitioner away from an uncritical, pre-reflective state of being where aspects of the practice were not questioned but simply taken for granted (Cox et al. 1991).

The words *reflection* and *reflective practice* are often used glibly in everyday discourse as if reflection is simply a normal way of thinking about something that has happened and which requires little skill or guidance. Smyth (1992, p. 285) writes:

> Reflection can mean all things to all people . . . it is used as a kind of umbrella or canopy term to signify something that is good or desirable . . . everybody has his or her own (usually undisclosed) interpretation of what reflection means, and this interpretation is used as the basis for trumpeting the virtues of reflection in a way that makes it sound as virtuous as motherhood.

Smyth's words are both salutary and provocative. They remind us to be careful about grasping reflection in any casual or authoritative way. The Compact Oxford English Dictionary 3e defines 'reflect' as:

- throw back heat, light, sound without absorbing it,
- (of a mirror or shiny surface) show an image of,
- represent in a realistic or appropriate way,
- bring about a good or bad impression of someone or something (on),
- think deeply or carefully about.

Hence reflection can be viewed as a mirror to see images or impressions of self *thrown back* in the context of the particular situation. It is thinking deeply about the way the practitioner responded and reasons for that response in light of what they were trying to achieve. It is *self-judgmental* – did I do good or bad? It is a *wake up call* because so much of practice is non-reflective, merely a matter of habit and automatic response.

Next time you are at work, ask yourself some questions.

- 'Why am I responding as I am?'
- 'Am I being effective?'
- 'Could I respond in different, perhaps more effective ways?'
- 'Am I responding in tune with my vision of practice?'

Sensible questions the responsible practitioner should naturally ponder as they go about their practice and to reflect on later. These questions open the doorway to self-inquiry. As a consequence, the practitioner becomes more sensitive to their practice. They step along the reflective road.

A Brief View of Reflective Theories

Imagine the practitioner's cry – 'tell me what reflection is so I can do it!' However, it is not as simple as that. It is more complex than simply applying a technique, although on the surface, it might seem that a prescription is just what is required. Indeed, many practitioners and

educators may misguidedly view it as such. If so, reflection becomes a task to be done rather than something meaningful and transformative.

When I first explored reflective theories, I discovered the work of Schön (1983, 1987), Boud et al. (1985), Boyd and Fales (1983), Gibbs (1988), and Mezirow (1981). It is not my intention to review these theories in any depth. The reader is directed to the primary sources to explore these theorists more deeply and explore more recent ideas.

All models of reflection should be viewed through a sceptical lens. Rather like the skilled craftsman, the practitioner will choose the tool that is most helpful. Models are not prescriptions for reflection. They must always be viewed as a heuristic, as a means to an end. In a technical rational society, reflective models are likely to be grasped as authoritative. The risk, from this perspective, is that practitioners will fit their experience to the model of reflection rather than use the model creatively to guide them to gain insight. It is easy to get wrapped up in the technology of reflection, especially in a learning culture dominated by technical rationality. It is a Western technological addiction (Rinpoche 1992).

Boyd and Fales (1983)

These authors write: 'We define reflection as the process of creating and clarifying the meaning of experience (present or past) in terms of self (self in relation to self and self in relation to the world). The outcome of the process is changed conceptual perspective. The experience that is explored and examined to create meaning focuses around or embodies a concern of central importance to the self'. (p. 101)

From their research with counsellors, they extrapolate reflection through six components (p. 106):

1. A sense of inner discomfort.
2. Identification or clarification of the concern.
3. Openness to new information from internal and external sources, with ability to observe and take in from a variety of perspectives, and a setting aside of an immediate need for closure.
4. Resolution, expressed as 'integration' , 'coming together', 'acceptance of reality', and 'creative synthesis'.
5. Establishing a continuity of self with past, present, and future.
6. Deciding whether to act on the outcome of the reflective process.

In relation to stage 6, they note 'the new insight or changed perspective is analyzed in terms of its operational feasibility involving the practitioner's sense of rightness, values and potential acceptance by others'. (p. 112).

I generally agree that reflection is triggered by 'inner discomfort' for practitioners when first engaging reflection. However, as the practitioner becomes more mindful, then all experience, not just 'inner discomfort' becomes available for reflection. I equate the idea of changed conceptual perspective with insight (see Chapters 4 and 5).

Boud et al. (1985)

These authors posit reflection as moving through three key stages:

- returning to experience
- attending to feelings
  - utilising positive feelings
  - removing obstructing feelings

- re-evaluating experience
  - re-examining experience in the light of the learner's intent
  - associating new knowledge with that which is already possessed
  - integrating this new knowledge into the learner's conceptual framework
  - appropriation of this knowledge into the learner's repertoire of behaviour

Appropriation is akin to gaining insight; that the practitioner has changed through the reflective process, that when faced with a similar situation, they will respond differently. This differs from Boyd and Fales's approach in that the practitioner makes a choice whether to respond differently in light of learning. Boyd and Fales (1983, p. 112) write: 'The need to test one's self-changes [insights] against the mirror of others is an essential component of all growth'. These words emphasise that all individual learning must be set within its context.

Gibbs (1988)

Gibbs offers a practical reflective circle moving through six stages suggesting that each stage is important to inform the next stage ultimately resulting in an action plan for responding in future similar situations.

1. Description (of the situation).
2. Feelings (what were you thinking and feeling).
3. Evaluation (what was good and bad about the experience).
4. Analysis (what sense can you make of the situation).
5. Conclusion (what else could you have done).
6. Action plan (if it arose again what would you do).

Mezirow (1981)

Mezirow viewed reflection as a process leading to emancipatory action. He posited a depth of reflection through seven levels of reflectivity spanning from consciousness, the way we might think about something, to critical consciousness where we pay attention and scrutinise our thinking processes. Thinking is inherently problematic. Hence our thinking is a focus for reflection. Hence I need to think differently to perceive the situation differently, and in doing so, to unearth those assumptions that govern thinking. If reflection is viewed merely as problem solving, and we used the same thinking to solve the problem that caused the problem, then we wouldn't get very far. Our solutions would quickly break down. Mezirow (1981, p. 6) conceptualised the outcome of reflection as *perspective transformation*:

> The process of becoming critically aware of how and why the structure of psycho-cultural assumptions has come to constrain the way we see ourselves and our relationships, reconstituting this structure to permit a more inclusive and discriminating integration of experience and acting upon these new understandings.

Mezirow's focus on understanding assumptions takes reflection into what is generally regarded as a 'critical' domain. The focus on emancipatory action is to rewrite one's own and collective assumptions to govern a more satisfactory state of affairs, however, that might be framed. Not easy stuff for the humble practitioner to grasp as Smith (2011, p. 212) acknowledges:

> Despite widespread and long standing commitment to the notion of critical reflection across the health and social care professions, it can be difficult to assimilate into teaching because the language is complex, and the same terminology is used in different ways in different contexts so carries different nuances.

Balancing the Winds

The above theories all stem from a rational Western cognitive tradition reflected in the words, ideas, and language used. Put another way, they all come from one direction or wind. My exploration of Buddhism and Native American lore gave me wider perspectives and different winds (Johns 2005). It is not enough to 'know' reflection. It is deeper than that – it is about developing mindfulness and wisdom, something beyond rational thinking that is not easily defined. Goldstein (2002, p. 89) notes:

> Mindfulness is the quality of mind that notices what is present without judgment, without interference. It is like a mirror that clearly reflects what comes before it.

Thus mindfulness is a heightened state of awareness. It is being aware moment by moment of things and the world around us, of our body, our feelings and thoughts, and ourselves in relationship with others. Wheatley and Kellner-Rogers (1996, p. 26) write:

> The more present and aware we are as individuals and as organisations, the more choices we create. As awareness increases, we can engage with more possibilities. We are no longer held prisoner by habits, unexamined thoughts, or information we effuse to look at.

Miller offers a vivid description of being mindful of the world around him (1964, p. 27):

> Nothing was too petty to escape my attention, seeing the everyday things in this new light I was transfixed. The moment you give close attention to anything, even a blade of grass, it becomes mysterious, awesome, indescribably magnified world in itself.

Through paying attention to their experiences and reflection, practitioners *naturally* become more aware of themselves and their practice. Reflection is a way to connect with all things, gain respect and inner strength, and realise one's vision as reflected in the idea of *bimadisiwin*. Jones and Jones (1996, p. 47) write:

> Bimadisiwin is a conscious decision to become. It is time to think about what you want to be. The dance cannot be danced until you envision the dance, rehearse its movements and understand your part. It is demanding for every step needs an effort in becoming one with the vision. It takes discipline, hard work and time. It is freeing, for it frees the spirit. It releases you to become as you believe you must.

Such words stir the imagination. Bimadisiwin is reflection. It is a ritual dance of becoming. Listen to the drum!

Believe in the vision of you
Practice the vision
Become the vision

Spectrum of Reflective Practices

Reflective practices span a number of approaches (Figure 1.1) characterised by three developing themes:

- From *doing* reflection towards *being* reflective.
- From a technical rational to a professional artistry perspective.
- An increasing criticality.

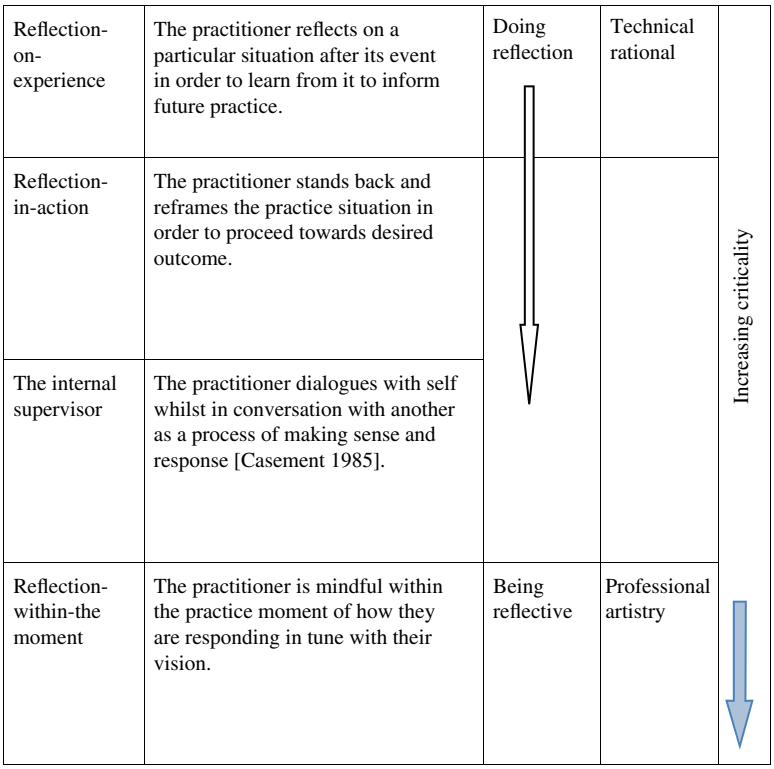

FIGURE 1.1 Typology of reflective practices.

Doing reflection reflects an epistemological approach, as if reflection is a tool or device. *Being* reflective reflects an ontological approach concerned more with 'who I am' rather than 'what I do'. It is pertinent to note that all the theories I briefly noted all focus on reflection, not reflective practice. Bulman et al. (2012), in their investigation of student and teacher perspectives on reflective practice, revealed that a focus on being rather than doing was significant. The ontological approach subsumes the epistemological, as if the way we think about and do things must involve us who are to think about things in the first place. Doing reflection reflects a technical rational approach, whereas being reflective reflects a professional artistry approach. Criticality reflects the depth of inquiry into the background that frames experience.

Reflection-on-experience

When people refer to reflection, they usually refer to reflection-on-experience. Indeed, most theories of reflection are based on this idea of looking back on an experience after the event with learning intent.

Reflection-in-action

Schön (1983, 1987) distinguished reflection-*on-action* with reflection-*in-action* as a way of thinking about a situation whilst engaged within it, in order to reframe it as necessary to overcome some impediment. The practitioner naturally adjusts to minor interruptions within the smooth flow of experience because the body has embodied knowing. However, the

practitioner is sometimes faced with situations that require the practitioner to stop and reframe the situation in order to proceed. This requires a shift in thinking and contemplating new ways of responding. As such, it is problem solving yet recognising that old ways of thinking are inadequate. Reflection is the practitioner's unique encounter and conversation with a situation through which, as Schön (1983, p. 163) puts it, 'he shapes it and makes himself part of it'.

Schön (1987) drew on exemplars from music and architecture, situations of engagement with inanimate forms. His example of counselling is taken from the classroom not from clinical practice. The classroom is a much easier place to freeze and reframe situations in contrast with a clinical practice grounded within the unfolding human encounter. It is easy to misunderstand reflection-in-action as merely thinking about something whilst doing it.

Schön (1983) responded to the idea that reflection interferes with action. He acknowledges the difficulty of 'being in the firing line' when the practitioner must respond quickly and intuitively. However, I make a distinction between cognitive thinking and embodied thinking based on the body's tacit knowing. Hence the quick intuitive response is an example of embodied thinking – the body knows how to respond. Subsequent reflection on the experience, as with all reflection on experience, feeds tacit knowing and the intuitive response even if the practitioner does not recognise it as such. As Schön concluded (1983, p. 281), 'there is nothing in reflection, then, which leads necessarily to paralysis of action'. Perhaps when reflection has not been embodied, as for novice reflective practitioners, an attempt to reflect--in-action can seem to interfere with action as if cognitive thinking gets in the way of intuitive thinking and response.

The Internal Supervisor

Casement (1985) coined the expression the 'internal supervisor' as a continuous dialogue the practitioner has with themself in response to the unfolding situation – 'what is going on here', 'how am I responding', etc. The practitioner is also mindful of intent – 'what am I trying to achieve?' It is a more dynamic form of reflection-in-action.

Reflection-within-the-moment

Reflection-within-the-moment is akin to Schön's reflection-in-action but not as a problem--solving approach but as a way of being. It is being mindful of the way they are responding within each unfolding moment in tune with their vision of the practice. This ability may seem a lot to ask within the turmoil of everyday practice. Yet through dedicated reflection-on--experience, it can become a natural posture. It is being a reflective practitioner.

Christopher Johns Conception of Reflective Practice

Reflective practice is 'Being mindful of self, either within or after experience, as if a mirror in which the practitioner can view and focus self within the context of a particular experience, in order to confront, understand, and become empowered towards holding and resolving the creative tension between one's vision of desirable practice and one's actual practice, to gain insight within a reflexive spiral towards realising one's vision of practice as a lived reality'.

Creative Tension

Senge (1990, p. 142) describes creative tension as 'The juxtaposition of vision (what we want) and a clear picture of current reality (where we are relative to what we want) generates what is termed "creative tension"'. Thus the learning potential of reflection is revealing, understanding, and working towards resolving the creative tension between one's vision of practice and one's actual practice as revealed and understood through reflection on experience. Ryan (2013, p. 145) describes such learning as 'treating self as a subject in relation to others and the contextual conditions of study or work'. The emphasis on 'others and the contextual conditions' reflects how practice is strongly influenced by such factors that need to be understood and shaped towards realising the most effective care.

Vision

To hold creative tension, it is necessary for the practitioner to have a vision of practice, however, tentative that might be. *It follows that reflection is also a reflexive inquiry into vision that becomes a moveable feast like shifting goalposts.* A vision gives direction and purpose to practice. It shapes one's attitude. It is constructed from a set of values that are ideally developed with colleagues so that everybody pulls in the same direction. Holding a personal vision is essential to contributing to a shared vision. As Senge writes (1990, p. 231), 'If people don't have their own vision all they can do is "sign up" for someone else's. The result is compliance, never commitment'. Holding a vision fosters commitment and motivation simply because practice has more meaning. Whilst this may seem straightforward, it may not be easy. In reality, practitioners are often at a loss to say what their vision is as if practice is concerned with 'what I do' rather than 'what I value'. Practitioners may feel that holding a vision is unnecessary because it has no function. Practitioners may scoff at the need to have a vision or take offence that someone might suggest what their vision should state or that somehow they are deficient or incompetent in some way. Egos are quickly insulted. As Henry Miller writes (1964, p. 33):

> We have first to acquire a vision, then discipline and forbearance. Until we have the humility to acknowledge the existence of a vision beyond our own, until we have faith and trust in superior powers, the blind must lead the blind.

Miller suggests that a vision needs to be salient, not just say anything. Practitioners must accept that they may not know best and have the humility to be guided. Contemporary healthcare is grounded in the ideology of person-centred practice. Clearly, anybody contemplating a vision must be strongly influenced by this idea.

The idea of person-centred practice is loaded with cultural significance for both the person and the healthcare practitioner. It demands a *working with* approach that is culturally aware, sensitive, and safe. It is not so much a question of understanding the person's culture were different from the practitioner's own but examining the practitioner's own attitude and response to ensure cultural safety.

Hence any practitioner's reflective quest is to find meaning in their vision and work towards realising it *as a lived reality* rather than just rhetoric. It is easy for any practitioner to believe they are person-centred. Indeed, it would be difficult to admit that they were not. Yet if practitioners were to be observed, the contradictions would be stark simply because organisations are not person-centred. They are deeply impersonal.

Visions are a moveable feast as practitioners begin to appreciate and live the vision's words through reflection. They are always something aimed for,[1] raising such questions as – What

does person-centred practice mean as something lived? How do my attitudes need to shift to practice it? How might the organisation of healthcare need to shift to accommodate it? In other words, holding a vision is one thing. Realising it is quite another considering the prevailing social norms that mitigate against realising it.

Mandy Reflects on Having a Vision for Practice

In one reflective practice workshop Chris shared his experience of constructing the Burford model vision. This was a sharp wake up call. I recalled that the department had its own philosophy but if I was challenged as to its contents I would have failed miserably. Once back in the department, I eventually found the operational policy buried away in a filing cabinet. Included in its contents is the department's philosophy of care however it did not state who had devised it and when. I asked one of my colleagues who had worked in the department for many years as to the origin and author of the philosophy; she looked at me blankly and said 'I am sorry, I did not know we had one duck'.

*In my next management supervision I raised this issue with my manager who also was ignorant of these facts but thought it might have been based upon the acute services philosophy. I compared the department's philosophy with one of the acute inpatient wards, only to discover that it was exactly the same. Johns (*2013*) draws attention to the difficulties caused by having an imported philosophy imposed on a practice: it denies articulation of the practitioner's own beliefs and values and is easily forgotten. What then is the point in having a generic philosophy devised by someone else, locked away in a filing cabinet? None-whatsoever. Reflecting upon this, I established that the team believes that we provide a high standard of individualised care for patients within the department. However, we lack evidence to validate this. By not having a philosophy of care constructed on our collective beliefs and objectives of our practice, how do we know where we are going and the rational for the journey?*

Barriers

The practitioner strives to understand the nature of creative tension and what must be done to resolve it. Pinar (1981, p. 177) notes that 'it is only when practitioners truly understand themselves and the conditions of their practice, can they begin to realistically change and respond differently. To understand, the reflective practitioner creeps underneath habitual explanations of his actions, outside his regularised statements of his objectives'. The practitioner must question 'what constrains me from responding in more desirable ways?' These constraints or barriers may not be easy to recognise and shift because they form the fabric of everyday practice and are largely taken for granted. Some guidance may be helpful (see Chapter 7). If practitioners were rational, they could change their practice on the basis of evidence that supports the best way of doing something. However, we do not live in a rational world.

Fay (1987) identifies three barriers as tradition, authority, and embodiment (Table 1.1) that govern the fabric of our social world. Fay (1987, p. 75) writes from a critical social science perspective that gives reflection its critical nomenclature:

> The goal of a critical social science is not only to facilitate methodical self-reflection necessary to produce rational clarity, but to dissolve those *barriers* which prevent people from living in accordance with their genuine will. Put in another way, its aim is to help people not only to be transparent to themselves but also to cease being mere objects in the world, passive victims dominated by forces external to them.

TABLE 1.1

Barriers to Rational Change (Fay 1987)

Tradition	– a pre-reflective state reflected in the assumptions and habitual practices that people hold about the way things should be.
Authority and power	– the way normal relationships are constructed and maintained through authority's use of power.
Embodiment	– the way people have been socialised to think, feel, and respond to the world in a normative and pre-reflective way.

The influence of these barriers lies thick within any experience. They are evident in patterns of talk that are deeply embodied to serve the status quo (Kopp 2000). It is obvious that to bring about desirable change, these barriers need to be understood, and practitioners are skilful and empowered to overcome them. Thus reflection is concerned with un-concealing these barriers. Greene (1988, p. 58) writes:

> Concealment does not simply mean hiding; it means dissembling, presenting something as other than it is. To 'unconceal' is to create clearings, spaces in the midst of things where decisions can be made. It is to break through the masked and the falsified, to reach toward what is also half-hidden or concealed. When a woman, when any human being, tries to tell the truth and act on it, there is no predicting what will happen. The 'not yet' is always to a degree concealed. When one chooses to act on one's freedom, there are no guarantees.

Tradition

Tradition is reflected in the way practice gets done. It is handed down, perhaps shifting slightly to prevailing ideas and directives. It constitutes 'normal practice' and, as such, is largely taken for granted. When tradition is dissected, it can be viewed as the assumptions and attitudes that govern everyday practice. Bohm (1996, p. 69) writes:

> Normally, we don't see that our assumptions are affecting the nature of our observations. But the assumptions affect the way we see things, the way we experience them, and consequently the things we want to do. In a way we are looking through our assumptions; the assumptions could be said to be an observer in a sense.

Practice is contextual set within particular organisational settings. Dawson (2015, p. 25) notes that 'context refers to the grand societal narratives, those clusters of beliefs and cultural norms that give shape and meaning to the human cultures within which we live'.

Responding in more desirable ways to a situation is likely to disrupt normal practice and require a shift in cultural norms and assumptions and, as such, may be resisted by those who have an investment in maintaining normal practice and its status quo. You might say, 'I believe in treating patients with dignity and compassion' and believe your practice reflects that. However, on reflection you may acknowledge that your responses lack these qualities leading to uncaring behaviours what Jameton (1992) and Corey and Goren (1998) have labelled the 'dark side of nursing'. So next morning you may set out to remedy this in your own practice and get criticised by other staff for getting too involved with your patients. The pressure is immediately put on you to conform to normal practice. You feel the creative tension and the difficulty in resolving it.

Authority and Power

One aspect of tradition is the way authority works through power. Power is embodied through socialisation processes and reinforced through everyday patterns of relating. Hence it is normal and largely unchallenged. Subordinates get told what to do. Play the game, do as you are told, keep your head down to avoid sanction, and then one day you too will gain authority with power over others.

Force is the negative aspect of power used to ensure people conform to certain ways of behaviour endemic within transactional organisations such as the NHS whereby people are subordinate to authority transmitted down through its hierarchy where power is invested in positional roles. Positional power is laced with a coercive threat of sanction if resisted (French and Raven 1968) that can constrain the practitioner from taking desirable action. This works at every level of the organisation. Hence those who exert power at one level have power exerted on them from a higher level.

Power is also invested in professional roles – so for example, doctors often perceive themselves as superior to nurses, coining the expression nurses are the 'doctor's handmaiden'.

It can be argued that nursing, as a largely female workforce, has been oppressed by patriarchal attitudes that have rendered it docile and politically passive and thus limits its ability to fulfil its therapeutic potential. If so, then realising desirable practice would require an overthrow of oppressive political and cultural systems. The link between oppression and patriarchy is obvious, considering the way nursing has been viewed as women's work, and the suppression of women's voices in 'knowing their place' within the patriarchal order of things. Images of 'behind the screens' where women conceal their work, themselves, and their significance (Lawler 1991) and images of emotional labour being no more than women's natural work, therefore unskilled and unvalued within the heroic stance of medicine (James 1989), are powerful signs of this oppression.

No easy task. Those in authority have vested interests to maintain the status quo, to keep people in their place rather than in the place they need to be in tune with realising their vision. Hence being in place becomes a contested arena. As Mayeroff (1971, p. 68) notes:

> I am in-place because of the way I relate to others. And place must be continually renewed and reaffirmed; it is not assured once and for all, for it is our response to the need of others to grow which gives us place.

Fear is a powerful deterrent for being different. It suppresses practitioners from voicing their opinions and asserting autonomy. Yet how comfortable are people in their illusions of truth? Is it better to conform than rock the boat? Is it better to sacrifice the ideal for a quiet life and patronage of more powerful others? Better to keep your head down than have it shot off above the parapet for daring to speak up?

Nurses are taught to 'know their place' within the order of things. It is natural for dominant professions such as medicine to reinforce subordinate behaviour in other healthcare professions, such as nursing (Oakley 1984). In other words, doctors are always motivated to maintain the status quo and resist rivalry for power. Nurses rationalise their compliance with medical domination because of the need to be valued. Chapman (1983) suggested that doctors reinforce nurses' subordination through humiliation techniques that become a normative pattern of relating. Hence it becomes difficult for nurses to claim autonomy to move into the right place to practice desirably, kept in place by both managers and doctors. It is also the same with students and teachers. Even in Universities, teachers traditionally set the agenda and control the classroom. Students learn to be 'good' otherwise sanctions will ensue. Of course, some students like practitioners rebel against stifling authority. They are labelled 'trouble makers'. They often quit rather than lead unsatisfactory lives.

Embodiment

Practitioners are socialised into a culture determined by tradition and authority. This becomes their normal framework for viewing practice. It is what it is whether you like it or not. For an easy life the practitioner conforms to 'fit-in' to be recognised as a 'good team player'. Because normal ways are embodied they are not normally scrutinised for their appropriateness. Hence we tend to go about practice in the same old way with minor tweaks here and there as authority demands. Reflection confronts this. It demands the practitioner to 'wake up' to their embodied practice. Some practitioners will simply reflect along the surface of their practice, and nothing significant will change. Practitioners can passively accept the 'normal' as their truth. Yet to passively accept suggests they have become aware of the contextual nature of their practice.

Empowerment

Understanding inevitably changes practitioners. However, acting on understanding may be difficult as noted above or because of a lack of commitment. It may be better to swim in the shallow waves than drown in the rip currents of critical reflection? Yet, once practitioners become aware of realising desirable practice, they are likely to become restless knowing that there are more effective and satisfactory ways to practice.

Shifting barriers that seemingly constrain realising desirable practice can feel like hitting your head against a brick wall – what I term 'the hard wall of reality'. It can be painful and frustrating and consequently feel it's not worth tackling. As Smyth (1987, p. 40) notes 'most of us, unless we feel uncomfortable, shaken, or forced to look at ourselves, are unlikely to change. It is far easier to accept our current conditions and adopt the least line of resistance'. Lieberman (1989, p. 88 – cited by Day 1993) notes that 'working in bureaucratic settings has taught everyone to be compliant, to be rule-governed, not to ask questions, seek alternatives or deal with competing values'.

Practitioners need to feel empowered to act. Empowerment is enhanced when practitioners are committed to and take responsibility for their practice, have strong values, and understand why things are as they are. Practitioners may sense they lack agency to formulate and attain their goals. They depict their lives as out of their control, shaped by events beyond their control. Others' actions determine life outcomes, and the accomplishment or failure to achieve life goals depends on factors they are unable to change. They may view themselves as victims of circumstance. To view self as a victim is to experience a loss of personhood and to project the blame for this loss onto others rather than take responsibility for self. Victims are oriented towards avoiding negative possibilities than to actualising positive possibilities. Bruner (1994, p. 41) notes that persons construct a victimic self by:

> Reference to memories of how they responded to the agency of somebody else who had the power to impose his or her will upon them, directly or indirectly by controlling the circumstances in which they are compelled to live.

In theory, reflection would enhance the core ingredients of personal agency, self--determination, self-legislation, meaningfulness, purposefulness, confidence, active-striving, playfulness, and responsibility (Cochran and Laub 1994 cited in Polkingthorne 1996). These qualities are essential to a sense of empowerment. 'I am not a victim! I have agency! I can assert myself!' Not easy for the individual working within organisations. Collective action may be necessary to bring about deeper shifts in tradition and authority. And yet it does happen and quite dramatically.

Finding Voice

The idea of asserting self and empowerment can be viewed as 'finding voice' based on 'Women's ways of knowing' (Belenky et al. 1986). This is particularly apposite for professions that are predominantly women, such as nursing, although equally valid for men. Their typology of voice moves through a number of levels from silence, the most impoverished level of voice, through the received voice, the subjective voice, the procedural voices, to the constructed and assertive voice.

The Silent Voice

So many practitioners' voices are silent or suppressed. Perhaps you can remember being silenced, not so much by others but by yourself. Imagine the practitioner's reflection – 'I wish I had said something but. . .'.

Is it a fear of repercussion, humiliation, or a sense of subordination? Either way it is a reflection of knowing your place is to be silent. Cumberlege (DHSS 1986) observed at meetings concerned with the discussion of her report on community nursing that doctors sat in the front rows and asked all the questions, whilst nurses sat in the back rows and kept silent. She commented how nurses needed to find a voice so they could be heard, otherwise, they would have no future in planning healthcare services. Her comment reflects how nurses have been socialised into a subordinate and powerless workforce through educational processes and dominant patterns of relationships with more powerful groups (Buckenham and McGrath 1983).

Writing 'I wish I has said something but. . .' opens the voice if just on paper. It begs the questions 'what did I want to say?' and why didn't I say it?'

The Received Voice

As a student nurse, I remember sitting passively in the classroom being filled with facts. Often the teacher would write them on the board for the students to copy. Such facts were authoritative to be reproduced as rationale for action. I have no sense of being enabled to develop critical thinking skills, and even if I had, the all-knowing authorities within clinical practice would have soon put me in my place. The received voice reflects how practitioners learn to speak with the authoritative voices of others. They conceive themselves as capable of receiving, even reproducing knowledge from the all-knowing external authorities but not capable of creating knowledge of their own. So if I ask a practitioner, 'why do you practice like that? They are likely to reproduce knowledge from an external authority that has been unquestioned. If I ask, 'how else could you respond in tune with your vision of practice?' You might struggle to think laterally because you have never been enabled to think for yourself. Reflection opens up received knowing for its validity to inform.

The Subjective Voice

The subjective voice breaks through the received voice. It gives vent to self-expression. Its learning mode is one of inward listening and watching, valuing, and accepting one's own voice as a source of knowing. As Belenky et al. (1986, p. 85) note:

> subjective knowing is the precursor to reflective and critical thought. During the period of subjective knowing, women lay down procedures for systematically learning and analysing experience. But what seems distinctive in these women is that their strategies for knowing grow out of their very embeddedness in human relationships and the alertness of everyday life.

The subjective voice is the gateway to self-inquiry. The practitioner has an opinion. They begin to question received knowledge, no longer accepting on face value what they have been told as to their thoughts, beliefs, and actions. As one of Belenky et al.'s respondents noted (p. 85) 'I keep discovering things inside myself. I am seeing myself all the time in a different light'. Such words reflect an awakening of self. Life suddenly becomes interesting with the focus on the self. Such practitioners are curious and open to new experiences. They are ripe for reflection.

Subjectivist women value what they see and hear around them and begin to feel a need to understand the people with whom they live and who impinge on their lives. Though they may be emotionally isolated from others at this point in their histories, they begin to actively analyse their past and current interactions with others. The idea that practitioners might be isolated is intriguing. Does the received voice mode of being deny expression of opinion and feelings, and hence isolate the practitioner from others? It seems likely. However, the subjective voice is tentative, vulnerable in its uncertainty and hence may need to be guided in a community of like-minded people. It may be confusing because it is competing with received voices. As such, it is easy to discount one's own subjective voice as being unsubstantiated, even ridiculed by more 'knowing' others. Listening to yourself, it may seem to be an uncanny stranger on display (Cixous 1996). Reflection opens a space for expression and development of the subjective voice and the means to confront the authoritative voice that has dominated the way they had previously viewed themselves and their practice.

The Procedural Voice

The procedural voice has two divergent ways of knowing: connected and separate knowing. Connected knowing is gained by listening and understanding to the experiences of others known through empathy and reflection. Separate knowing is gained through critiquing extant sources of knowledge for its validity to inform. It is an abstract knowing that seeks to understand things in terms of logic and analysis. Both sources of knowing are significant for the reflective practitioner. The left side of the brain fosters rational logical thinking, whereas the connected voice is related to the right brain that fosters creativity, imagination, perception, curiosity, intuition, spirit and wholeness. Pink (2005, p. 22) considers the left hemisphere analyses the details; the right hemisphere synthesises the big picture. Within a technical rational dominated culture that characterises healthcare education and organisation, there is emphasis on developing the left brain. As such, people go around lopsided. The right brain becomes the dark side of the hill neglected with its attributes atrophied. Yet these right brain qualities are essential for professional artistry. The lopsided mind leans heavily towards the masculine, favouring reason over intuition, justice over care, outcomes over process, science over art. Perhaps the feminine must be privileged to find balance? I wonder – do patriarchal patterns of practice privilege masculine values and demean feminine values?

Schön posited two types of knowledge – technical rationality (research-based theory) and professional artistry (knowing in action). He equates technical rationality as the hard high ground and professional artistry as the swampy lowlands. He argues that professional artistry is the more significant form of knowing because it is the knowing used by practitioners to navigate the largely indeterminate and complex swampy lowlands of everyday practice. The fact is that the practitioner lives in the swampy lowlands and yet can draw on the high hard ground knowledge as appropriate to inform practice. In doing so, they develop their constructed voice.

The Constructed Voice

The constructed voice is the synthesis of connected and separate ways of knowing. It is a fusion between the left and right sides of the brain so that the mind is fully fertilised and uses all its faculties (Woolf 1945). Practitioners with constructed voice speak with an informed and