

Adult learning

Learning outcomes

By the end of this chapter you should be able to demonstrate an understanding of:

- How adults learn
- · An experiential learning cycle
- How best to improve motivation

Introduction

While adult learners differ from children and adolescents in a wide variety of ways (largely as a consequence of the voluntary character of adult learning), they retain some characteristics, particularly a perceived need to see the teacher as a repository of knowledge and insight. In general, however, adult learners (and health professionals in particular) can be thought of as having the capacity to demonstrate different attributes (Knowles, 1973).

Autonomy and self-determination

These are not always possible in formal learning but in general, health professionals have at least the capacity to take decisions about the direction and timing of their learning. Where decisions are taken out of their hands – for example by being sent on a course – there may be some initial resistance unless learning can be experienced as stimulating and valuable.

Pocket Guide to Teaching for Medical Instructors, Second Edition. Edited by Ian Bullock, Mike Davis, Andrew Lockey and Kevin Mackway-Jones. © 2008 Blackwell Publishing, ISBN: 978-1-4051-7569-2.







Life experience and knowledge

Most health professionals have had many years of formal full-time education (13 years in school, 3–6 years in university) and many years more in postgraduate training. No matter how receptive they may be to new ideas, there is a great deal of conservatism which needs to be overcome before learning can occur. This has been represented by Lewin (1951) in the following way:

Unfreezing
$$\rightarrow$$
 change \rightarrow refreezing

Unfreezing is the point at which the learner becomes open to the idea of change (in understanding, affect, skill level); change is then incorporated and reinforced through feedback (see Chapter 8).

Goal orientated

Many adults like to have an outcome or a clear product from their efforts. Learning for its own sake may have some attractions at certain times, but it is not a luxury that busy professionals can include in their working lives.

Relevance orientated

Similarly, learning has to be relevant to work-based practices if it is to be valued by learners. As well as subject matter, this also relates to level: material can fail to be relevant if it is too easy or too complex. Content needs to be constructed around the experiences of the learner.

Practical

Learners get a great deal from integrating skills, knowledge and affect in complex, practical learning events, preferably related to previous experience and/or expectation of future practice. As a recent candidate on a European Provider Course wrote:

... we are not machines and this course gives room for us to think and makes the whole teaching session and the teamwork alive and interesting. It opens up for discussions and that is where you really learn something – not only from the instructors but also from the other candidates.

(Nana Gitz Holler, Denmark)

Esteem

Ask health professionals about negative experiences of learning and they are likely to mention humiliation. Good education acknowledges the contribution that learners can make to the







learning of others including the teachers (and respects their achievements thus far).

The experiential learning cycle

There are a number of theories of adult learning that are relevant to those involved in continuing medical education, but it is beyond the scope of this book to explore them all. Relevant titles are included in Chapter 11 for those who are interested in exploring some of these. However, there is one theory that is useful to explore briefly here, that of experiential learning.

This theory was based on ideas about reflection developed in the 1930s by John Dewey (1938). One of the components is the experiential learning cycle, illustrated in Figure 1.1.

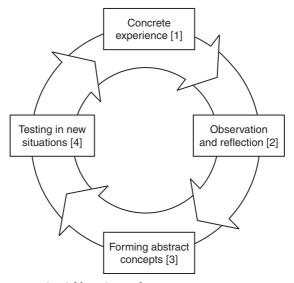


Figure 1.1 Experiential learning cycle.

This model, attributed to Kolb and Fry (1975), is a helpful source of explanation for what we do all the time. We have hundreds of experiences every day but most of them pass us by. If, however, we are to learn from them, we have to be willing and able to go round the cycle.

Experience, any event, however small. Enabling learners to utilise experience provides the foundation for them to maximise learning.





Observation and reflection is the process of describing the event and trying to understand its significance. This stage can sometimes be captured by asking the following questions:

- What happened?
- What did it feel like?

These questions are intended to enable the learner to look in some detail at events and identify some of their emotional components.

Forming abstract concepts is an attempt to generalise from the specific, by asking:

- What does it mean?
- Do I need to change?

Take as an example, being late for a workshop. The focus of your observation and reflection will (inevitably) be related to that specific event, that is being late on that occasion and your thinking might be: 'The next time I am due to lead a workshop, I will set off a little earlier'. The conceptualisation phase, however, will explore being late in other contexts and the generalisation would be framed in more general terms, thus: 'When I am due to go somewhere to do something, I will set off earlier than I think I need to, just in case something holds me up on the way'. This kind of thinking, therefore leads into:

Testing in new situations, considering the question:

• How might I be different in the future?

Note that it is 'I' being different. It is easier to change your own behaviour than it is to change that of others.

By going round the experiential learning cycle, a learner can capitalise on personal insight into events that are often taken for granted, but which can benefit from closer examination. Most experiences probably do not justify this exploration, but if behaviour seems to be working against us (e.g. as in the case of being habitually late), there is some real merit in exploring experience in a more systematic way.

In the context of continuing medical education, the experiential learning cycle has the merit of the systematic, shared exploration of repeat practice in a controlled environment, with feedback and discussion seeking to achieve improvement and develop competence which can be employed back in the workplace (see Chapter 8).

Maximising motivation

Adult learners have to be motivated if they are going to learn and the principle of voluntarism is a key feature of successful adult







learning experiences. Almost by definition, learners in continual medical education contexts will be voluntary – in that nobody is forcing them to attend a programme. Nevertheless, they may be extrinsically motivated, that is the factors that are influencing their attendance may be driven by outside forces. In the context of continuing medical education these include gaining recognition, having something to put on a CV, or filling a need for career progression.

Malone and Lepper (1987) has detailed how intrinsic motivation has different, and predominantly internal, drivers and these can be summarised as in Table 1.1.

Table 1.1 Intrinsic motivation

Factors	Elements
Challenge	Meaningful goals that challenge learners just beyond their comfort zones
Curiosity	An expectation that there may be better ways of doing things; that there are things that you do not know
Independence	Learners demonstrating the need to move towards autonomy
Imagination	The capacity to work in 'let's pretend' environments (see particularly Chapter 5) where risks can be taken in safety
Social comparison	The desire to judge personal performance against that of others
Interdependence	The willingness to contribute towards others' learning
Esteem	Knowing that success will contribute towards feeling good about oneself

Extrinsic motivation is often regarded as 'bad' in comparison to 'good' intrinsic motivation, and it is generally true that people are more likely to own up to intrinsic drivers when asked, for example, why they are attending a course. It is likely that most individuals are motivated both extrinsically and intrinsically. Those motivated solely by external factors can, however, still be effective learners if certain needs are met.





Chapter 1

Most reports of Maslow's hierarchy of needs (1971) have five layers in the pyramid but the model shown in Figure 1.2 acknowledges his later thinking.

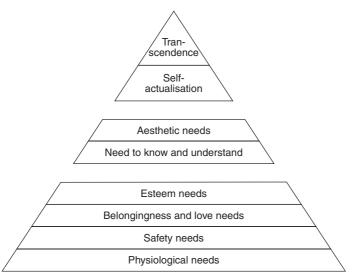


Figure 1.2 Maslow's hierarchy of needs (http://chiron.valdosta.edu/whuitt/ COL/motivation/motivate.html).

This classical theory of motivation demands that much of the lower-level needs have to be met before the learner can move up to the next level. In practical terms, this means that an educational experience has to guarantee a number of conditions. These are explored in Table 1.2.

Table 1.2 Maslow's hierarchy of needs

Need	Implications for programme design and presentation
Physiological need	s (to maintain homeostasis)
Warmth, food, drink, shelter, sex	Attention to the environment: adequate accommodation, regular refreshment breaks, a reasonable working day
Safety needs (to be free fro	m the threat of aggression, hostility)
Physical and psychological security	Guaranteeing freedom from external threats (fire, etc.); secure boundaries; no obvious ego threat

Continued

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Need Implications for programme design and presentation

Social needs (to develop a sense of belonging)

Legitimate membership; community
The opportunity to interact through social

exchange (e.g. during registration, but also in opening activities through introductions and an opportunity to share experiences, thinking)

Esteem needs (to develop a sense of self-worth and the capacity to engender that in others)

Respect, confidence, competence

The opportunity to acquire knowledge and skills and the ability to manifest appropriate attitudes through structured learning interventions with supportive and authentic feedback

Through demonstration, modelling,

Cognition: types of questions

Skills: four-stage approach

(e.g. team membership)

specific instruction and feedback, learners can move through the levels via:

Attitudes: encourage appropriate affect

Cognitive needs (to know and understand)

Different levels of cognition

Knowledge

Comprehension

Application

Analysis

• Synthesis

Evaluation

Different levels of skill acquisition

- Perception
- · Guided response
- Mastery
- Autonomy

Different levels of attitudes

- Perceiving
- Complying
- Accepting
- Internalising

Aesthetic needs (to value symmetry, order)

A programme that works, for example runs to time, experienced and competent instructors who care about learning – for themselves and others –

and fun

Continued







Table 1.2 Continued.

Need	Implications for programme design and presentation
Self-actualisation (to be an autonomous individual)
In touch with reality	An experienced faculty capable of
Acceptance of self and others	manifesting these behaviours as a matter
Spontaneous	of routine gives learners confidence and
Problem solving	also models appropriate behaviour
Tolerance of ambiguity	
Gemeinschaftsgefühl (empathy	
and compassion)	
Creativity	
Self-transcendence (to	develop actualisation among others)
Concern for others' development	As above
Ego security – not threatened by	
others' achievements	

Maslow's theory has been criticised for its lack of scientific rigour but it does have some useful things to say about how events can be organised and presented. It is certainly true that unless the basic needs at the bottom of the hierarchy are met, at least to some extent, then learning will be hampered. Accordingly, attention to the conditions within which learning is to take place is essential. More important, however, is the psychological domain within which people will interact with others in a complex, dynamic environment. It is the responsibility of the trainer to ensure that this is a challenging but safe area within which people will learn.

Summary and learning

Adults are usually voluntary learners and need to be actively engaged in their own learning. They need goal-orientated, relevant, practical experiences in order to get the most from teaching. While many admit only to intrinsic motivation the reality is that many external factors affect this as well.

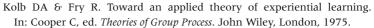
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