

Learning about professional learning: a curriculum where ‘self’ takes precedence over ‘action’ and ‘knowledge’ (in medicine)?

Chris Trevitt

*Centre for Educational Development and Academic Methods
Australian National University*

Chandi Perera

*Clinical lecturer, Medical School, Australian National University
Chief Medical Registrar, The Canberra Hospital*

Abstract

Recent work on conceptualising the curriculum in higher education has posited a three-way mix across the domains of knowledge, action and the self. In this paper we use this broad theoretical framework as a viewpoint to retrospectively inquire into the nature and intimate ‘learning about professional learning’ experience of one mid-career medical physician (Chandi) committed to becoming a professional medical educator. The documentation that we draw on was compiled, in turn, as part of Chandi’s experience of engaging with the professional learning (academic development) environment that I (Chris) put into place under the auspices of a graduate program in higher education. Chandi’s account concerns aspects of his own ‘metamorphosis’ (as he calls it) from clinician to medical educator.

Postgraduate medical education, the focus of Chandi’s action research, is fast becoming ‘hot action’. The stakes are high for all concerned. A key driving question for Chris has been (and still is): How best to support practising professionals (eg medical practitioners) who are in turn motivated to find more informed and proven ways to support their colleagues’ professional lifelong learning?

A major purpose in rendering this combined account is to seek to demonstrate by example how both the ‘self’ domain is elevated to prominence in the curriculum, and how changes in each of our own personal professional practises, roles and, ultimately, identities, can contribute to a valued chain reaction. In the final part of the paper, we briefly canvas the implications of our argument and experience for the broader collaborative possibilities and roles that Academic Development Units (eg CEDAM) and professional bodies and organizations (eg medical colleges) might aspire to conduct in the name of enhancing professional lifelong learning.

Introduction

Professional lifelong learning is an increasingly important theme for many professions. Slowly but surely, it is creeping up the priority list of current concerns; both for individual members and for their professional organizations. Where once it was possible to get away with what really amounted to an amateur approach to fostering or enabling professional lifelong learning, now an increasing number of members of an increasing number of professions recognise this as a bygone age. The pressure is on to professionalise: to get slick and savvy about what and how to ‘learn on the job’. At the same time the pressure is on to update what we mean by

‘professionalise’; and to determine what exactly we mean when we say ‘slick and savvy’. What criteria do we or should we adopt when favouring one approach over another? What is the rationale behind our choice?

Of all the professions engaged with this issue, one that now has substantive experience is medicine. Medical education is now a disciplinary focus in its own right. A focus that concerns itself with the full range of learning agendas within the profession: from identifying and proving strategies for selecting candidates to embark on a medical qualification through to those which enhance lifelong bedside learning; from elucidating and enacting principles of curriculum design to those which lead to best practice approaches to assessment in a clinical context. Medical education as a focus within the broader profession has now matured to the point that it offers a substantial suite of journals for scholarly publication, and a growing range of academics and/or practitioners working out of specialist units attached to university medical schools, teaching hospitals and the like.

Against this background, we are the first to admit that we are mere novices. Each in our way, we are new to this particular professional scene, even if we bring a substantive number of years experience in pursuit of other professional and academic interests. That novice status however has sensitised us to the steep ‘on the job’ learning curve that we have not only enjoyed during the experiences recounted in this paper, but also further enjoyed in the very act of ‘retrospective sense-making’ that this paper represents. Certainly, this latter step has proved to be a powerful means of consolidation of the personal learning involved. Our hope is that the result reflects a useful freshness of approach with adequate broader appeal rather than a professional naiveté.

In this paper we draw on our combined professional learning experiences when working together over a period of one academic year (ie, our shared practice in 2005) to examine the notion of ‘curriculum’ in a professional (medical) lifelong learning context. The curriculum goal is ‘becoming a medical educator’, and the approach taken involves the creation, structuring and appropriate exploitation of a personal ‘space for learning’.

Thinking about curriculum: a view from the literature

One point of departure for thinking about curriculum comes from the recent work of Barnett et al (2001) and Parker (2003), though the much earlier work of Carter (1985) is also of relevance. Barnett and colleagues’ offer a schema that posits a three-way mix across the domains of knowledge, action and the self. They suggest that the relative weighting across – and degree of interaction between – these domains varies with broad disciplinary area, as follows:

<i>Broad disciplinary area</i>	<i>Emphasis across the three key domains</i>
Science and technology	Knowledge > action > self
Arts and humanities	Knowledge > self > action
Professions	Action > self = knowledge

In this schema ‘>’ denotes ‘has a greater weighting than’ and ‘=’ denotes ‘has an equal weighting with’.

Within the current broader shift in society toward a commodified approach to education, one which envisages a greater ‘performativity’ for higher education, Barnett and colleagues suggest that the ‘self domain is, as yet, an embryonic component of the curriculum’ (p445). In a passionate critique of this work Parker (2003) makes a plea to move beyond ‘the prevalent commodified discourse in Higher Education’ and, instead, embrace the idea of a ‘transformational curriculum’ – one where potentially the student is actively involved in negotiating their own customised approach across the three domains posited by Barnett et al. She envisages a community-based approach within the disciplines, premised on their operation as a community of practice.

In view of Barnett and colleagues’ self-declared focus on higher education, and picking up on Parker’s plea leads us to consider whether there may be merit in envisaging a fourth strand to the general Barnett et al model, thus:

Professional Lifelong Learning Self > action > knowledge

This offers one way to highlight the desire for a personal ‘space for learning’. We return to this notion in later discussion, but first we recount a brief snapshot of the shared ‘hot action’ of professional lifelong learning that brought us together in the first place.

Learning about professional learning: the action

This section of the paper comprises a joint account of our work together during 2005, under the auspices of a graduate program in higher education. Chandi was enrolled as one of about a dozen mid-career clinician participants in this academic development program, designed and conducted in part by me (Chris), as one of the three main facilitators.

The documentation we draw on here was compiled as part of Chandi’s ‘student’ activities. Chandi’s account revolves around the design, implementation and evaluation of a new mentoring program that he piloted in a postgraduate clinical medical context (ie the *action* domain of the curriculum). However, space limitations preclude our giving details of the specifics of this project work (but see Trevitt, 2005b). Instead, our focus in this section is on his account of his own ‘metamorphosis’ (as he calls it) from clinician to medical educator and, for my part, around the provision of ‘space for learning’ (as I call it), which was intended to assist such a ‘metamorphosis’ (see Clegg et al., 2004). While we have compiled the account jointly, we have retained our individual voices (eg Winter, 1998) for the purpose of making it clear how one account is embedded within the other.

Concerning our shared professional learning environment

The GCHE comprises four courses. Class contact is 3 hours per week over two semesters – for a total of 25 weeks in a calendar year. Only the *Capstone Review* course is compulsory. It is generally completed in conjunction with the *Negotiated action learning* (action research project) course, with the terms of the project outlined in a project plan that is jointly devised and periodically renegotiated (for more details, see Trevitt, 2005b).

The crux of the Capstone course is the *Capstone Review* module. This is a substantive piece of reflective writing. It is a self-assessment that serves as a final, summative, arbiter on ‘quality’, and helps verify that all participants achieve certain minimum expectations. In this module, participants are expected to review and synthesise the outcomes of their learning across all the preceding courses, and offer a diagnosis of issues and priorities in their current practice. It is an opportunity to link personal experience to formal program outcomes, which read as follows:

‘... participants should have the knowledge, skills and commitment to:

- engage in the ongoing diagnosis of their own individual professional learning and development priorities ... informed by literature, practice and their own professional context;
- develop, implement and evaluate outcomes of plans and actions in pursuit of these priorities; and
- feel prepared to undertake a leadership and mentoring role in their professional workplace with regard to teaching, supervision and/or management.’

These expectations are workshopped with the group some 6 to 8 weeks before the *Capstone Review* document is required in final form. Participants are encouraged to anticipate needing to submit at least one draft for feedback in the interim. I make available a number of previous *Capstone Reviews* that previous participants have kindly made available for this purpose, noting that these should not be viewed so much as exemplars, but simply as specific instances of the way others have seen fit to tackle this task. Together we explore the way that common desired features are present. These include:

- an outline of their personal professional context;
- cross-referencing to key ideas from the educational literature;
- an outline of key actions that they have been engaged in during the year;
- a summary of how they have brought ideas from the scholarship to bear in a locally specific way within these actions and, finally,
- identification of one or more specific ways in which the intended outcomes of the GCHE program have been achieved.

The overall length is usually some 5 – 7 pages.

Concerning the clinical medical education context

Box 1 is an extract from Chandi’s *Capstone Review*. It sets the scene, at both the personal and the collective (institutional setting; wider profession, etc) levels. It offers insights into key nuances of the professional learning environment and the educational development context in which Chandi was working, and hence addresses the first of the above listed desired features.

Box 1: Setting the scene

I had the opportunity and privilege of being a medical educator in a less than traditional setting. In this capacity I took on the role of Director of Physician Training which, following the usual hospital pattern, involved myself as Chief Medical registrar and a cohort of interested physicians engaged in preparing the candidate registrars for the national assessment process (An exam conducted by the Fellowship of the Royal Australasian College of Physicians, or FRACP). The FRACP

qualification process is in the main currently based on a traditional or discipline centred approach to post graduate medical curriculum, with a two tiered exam (assessment) process to assess candidate suitability to proceed into specialist medical training in internal medicine. The exam process is viewed with fear and is regarded as being punitive by many registrars; being held only once a year nationally and usually having a national pass rate of about 60%. A candidate registrar is expected to complete three years of basic physician (clinical) training to be eligible to apply for the exam.

Each hospital and area health service is expected to assist with their candidate registrar's exam preparation. There are however no formal regional or national guidelines on developing and delivering a programme. There are broad college guidelines to assist the candidates with their preparation during their work in the different subspecialties. Most metropolitan hospitals have formal teaching programmes for their registrars with some having better result outcomes than others. Which raises an interesting question i.e. why?

In my capacity as the senior medical registrar at The Canberra Hospital I set about the task of restructuring the existing preparation programme for our registrars appearing for the fellowship exam in same year in which I completed the GCHE. This final preparation phase takes place over some 6 months at the end of an intense 4 year period during which candidates have worked as an intern, resident and registrar (true practical experience), engaged in critical reading (journals, databases, books etc) and been exposed to a range of subject experts in various forums.

Concerning action, and shouldering professional educational responsibilities

Box 2 outlines the objective of Chandi's *Negotiated action learning* project. While space precludes us from providing more details, in essence Chandi sought to devise, implement and evaluate what he terms a 'reproducible mentorship program' (see Box 2). While on the one hand a generic program structure was sought, on the other hand, Chandi's experience (and documentation of that experience) exemplified how such a program had to be tailored in its implementation to meet the attributes and needs of the particular individuals involved. He noted that 'available mentors [were] matched to the candidates', and this is further elaborated under the heading *Academic Leadership* in Box 3. He further noted that, following the observation of Pololi and Knight (2005; 866), 'research on mentoring in academic medicine is limited'.

Thus, in the same way that I used a generic framework for the negotiated learning project course, and worked with participants as they customise this to their context and immediate need (Trevitt, 2005b), so too Chandi did likewise with his mentorship partnerships. This accords with the recommendations by Talbot (2001; 674) for devising an approach '... in which the experience, meaning and significance of the trainee are paramount.'

Box 2: Designing and implementing a novel mentorship program

Objective of my action research

Design, construct and try out a reproducible mentorship program for FRACP candidates (2005), at The Canberra Hospital (TCH) and evaluate its success using a (triangulation) combination of (a) mentor evaluation (b) candidate evaluation, and (c) success at the clinical exam.

Concerning reflection, and learning from experience

Box 3 contains a small extract from Chandi's *Capstone Review*. It focuses on his experience of undertaking the *Negotiated action learning* project but, in accord with the intention of the *Capstone Review* course, was written after the action had taken place. It addresses some of the desired features listed above, as required, and is clearly a highly personal account, as required. While this ensures that plagiarism is never an issue, it also demands that the assessment approach needs to be adjusted accordingly (which is also the case with the project course, see Trevitt, 2005b). In such cases, Winter (2002; 145) suggests that we should ask ourselves not:

‘Is this narrative ‘true’?’ but [rather], ‘Is this narrative shaped and moulded in such a way that we feel it is trustworthy, i.e. does it *persuade us* that we might helpfully rely on the insights it presents about that particular situation to guide our thinking about other situations?’

We should not ask for ‘an authoritative summary’ or an ‘accurate’ account, but merely one that is ‘trustworthy’ (Winter, 2002; 148).

Box 3: Reflections on the experience and outcomes

The reflection stage of action research is an important phase that is often glossed over. This phase could also be termed as restorative and regenerative. It was a somewhat confronting experience to review the performance indices for the registrars, the mentor and examiner feedback and the registrar feedback given that it left me vulnerable to my own demons of self doubt and inadequacy as an active clinician cum educator. However I did appreciate this obligation as an integral component of the program.

Academic leadership

With hindsight, I believe I was naïve in assuming that I could provide and sustain the level of academic leadership required to develop and drive the program, although in hindsight this may have served as an advantage. I think academic leadership in program development, delivery and evaluation is an area that is taken for granted and is poorly resourced and studied especially in the context of medical education. For instance, for the third trial exam I invited an external college examiner from interstate to participate as the chief examiner. I had to coordinate her participation without an actual expenses budget. My first task lay in convincing the hospital administration (who held the purse strings for expenses) that this was an integral component of the program and needed funding. I was an advocate for my students and my program; this together with a manifest self-belief was instrumental in my successfully arguing the case for sponsoring an interstate examiner visit, given that I had no substantive ‘data’ to offer as support to the assertion that my registrars would benefit from such a visit other than my own convictions.

A second instance concerned the development of the mentor program. This was done with consideration being given to the complementary pairing of registrars and clinicians having pre-identified individual weaknesses of the candidate. For example a candidate whose communication skills were thought to be weak was paired with a mentor considered to be a superior communicator. This process was fraught with some danger given that my individual bias may have interfered with my judgement in both identifying apparent ‘weaknesses’ and in the pairing off process. To minimise this danger I involved other senior clinicians and the director of physician training in examining my reasoning and suggested allocation of mentors.

Academic responsibility is an important component of leadership and one must be willing to argue for what would be beneficial for ones students. Any gardener worth his or her salt will agree with me when I say that a rose tree will only grow and be as strong as the effort put into providing it with the right conditions to grow.

Personal professional learning

I engaged in an individual journey that resulted in a personal metamorphosis from being only a ‘teacher’ to a ‘student-teacher’ constantly learning from the teaching experience (the interaction at the student-teacher interface) and from the students. Driving the program involved developing the overall structure, coordinating and implementing its delivery, evaluating its impact and sustaining the program in the long term. It is a responsible role that requires a passion for academic leadership and teaching, self-belief, tact, innovation, flexibility, multi tasking skills and humility. The metamorphosis resulted in an increased awareness of myself as a teacher, my direction in this role, my limitations and my strengths and how to overcome my limitations within the role.

From a more practical viewpoint I was cognizant of a potential conflict of interest in my role as administrator (registrar rostering, leave allotment, recruitment and human resource management), and my roles as educator and facilitator of professional development for my group of registrars. This latter role combined academic leadership together with facilitating the professional wellbeing and development of the registrars. It resulted in my involvement at the student-teacher interface as coordinator, facilitator, teacher and student with a vested interest in the professional

and academic progress of my group postgraduate medical registrars. I believe that my close involvement established a trust and rapport that encouraged the perception of institutional support in their wellbeing. Teaching postgraduate students is a difficult brief given the time and resource restraints that clinical staff have at the best of times. Yet I believe with the right approach, marshalling available resources can result in a significant positive impact on the success of a teaching program.

Final reflection

The success of the registrar program was a gratifying experience. However, it wasn't a journey of glory or personal edification but more a quest to develop a program that engaged and enhanced the experience of post graduate medical registrars with the dual objectives of preparing them for the FRACP exam process and becoming a safe, competent physician caring for the whole patient.

Personally for me - as a clinician becoming increasingly involved in teaching and program design - the journey was also an enlightening experience resulting in my metamorphosis from being a teacher to a facilitator of conceptual change. It was a dynamic and vibrant experience that has significantly altered my practice of teaching and my approach to educational program design.

Discussion

Our brief review of one model from the curriculum literature gives rise to a suggestion that one way to think about the *theoretical* 'curriculum' framework within which these experiences can be viewed is a 3-way mix where *self* takes precedence over *action* which takes precedence over *knowledge*. Crucially, we'd suggest that the experiential account summarised above makes clear that the *self* at issue here is not just that of the participants (eg Chandi), but includes that of the program designers/facilitators (ie Chris). In other words, the successes of professional programs of the sort we describe depend in part on recognition of the need for and a willingness to engage in personal professional growth on the part of both facilitators as well as participants. Thus, for example, while Chandi was devising ways to set up and run his mentoring program, Chris was working out how best to scaffold and then assess Chandi's (and his colleagues') learning (see Trevitt, 2005b). In these ways we were each reviewing 'our practice for opportunities ... to create spaces for [our colleagues] to work collaboratively and creatively' (Clegg et al., 2004; 34) and hence create a climate that fostered learning (Boud and Walker, 1998).

Our experience engaging in the 'hot action' of professional co-development further suggests, following Parker (2003), that even as the *self* assumes primacy, it must not be at the expense of the *integrated whole*. How the *self* interacts with *action* and *knowledge* 'should be at a maximum' suggests Parker (2003; 542), at the same time noting that interaction 'is the big and hitherto largely untheorised question in curriculum planning' (p541). In our experience, the emphasis on *self* and an *integrated whole* leads to a number of challenges that we need to work through, if we are to address the issues opened up by Parker.

The first challenge concerns the nature of the learning that is required. The sort of personal professional metamorphosis that Chandi describes involves learning that

differs markedly from that which typifies institutional education systems (eg see Chandi's remarks in Box 3 under the heading *Personal professional learning*). It involves the emotions in a central way (eg Boud and Walker, 1998), and it has led Hager (2004; 29), for example, to contrast what he terms 'the product view of learning' with 'learning as a process'. He suggests that the former has dominated until recently, been 'pervasive in its influence', and amounts to a 'systematic and ubiquitous misunderstanding of learning' (p24-5). He then outlines 5 major problems associated with this view (p27-28). In contrast, he suggests the process view is an 'emerging view of learning', one 'that changes both the learner and the environment (with the learner being part of the environment rather than a detached spectator...)'. In accord with our experiences, this 'view of learning underlines its contextuality, as well as the influence of cultural and social factors.'. He goes on to argue in favour of a '(re)construction' metaphor as one way to give meaning to this view, noting that it includes 'construction of the learning, of the self, and of the environment (world) which includes the self.' Winter (1998; 59) puts it this way: 'the curriculum itself ceases to be a fixed 'body of knowledge' and becomes instead the site for an on-going action research process'.

Secondly, new 'ways of knowing' are demanded by this shift in emphasis across the 3 domains of curriculum. There is much about this shift that is powerfully counter-cultural. Medical practitioners, whose profession is historically and operationally grounded in a 'global' scientific way of knowing, for example, are not, by and large, predisposed to the 'individual' and interpretive way of knowing that characterises the field of education. Our experience even in just compiling this account has highlighted that we have both needed and wanted to depart from the 'broadly "positivistic" framework' that has been typical of most 'mainstream medical education', certainly prior to the last few years (eg Cribb and Bignold, 1999; 204). At the same time, we have been equally aware that we wanted our account to 'speak' to our colleagues who, as is the case for each of us, have almost certainly been educated (schooled?) within this 'positivistic' framework and approach over the course of many years. In accord with the rationale offered by Winter (2002) we sought not so much to offer the definitive authoritative account as one that is merely authentic and trustworthy. An account that even as it is grounded in our respective personal professional experiences, also derives a robustness from the structured action research approach that was pursued (Trevitt, 2005b).

Third, negotiating and agreeing an appropriate approach to assessment is also of central concern, as noted by Trevitt (2005b), even though this issue has not been addressed in detail here. This follows because the veracity of our claims turns on the authenticity and trustworthiness of *individual* accounts. As professionals involved in a myriad of day-to-day judgements within our own professional ambit, we aspire to enjoy a professional autonomy that permits us to exercise certain professional discretion when making these judgements. The on-going issues in need of further work concern how best to: understand and develop the associated personal professional ethics and responsibilities; gauge what levels of discretion are admissible and under what circumstances; and, how all these factors are evolving and changing with time.

Taken together, these three issues are significant for what they imply about a fourth challenge – how best to create an appropriate time (or 'space') for learning (eg

witness Chandi's remarks in Box 3 under the heading *Academic leadership*; and see Clegg et al., 2004). That the foregoing issues and expectations are as counter-cultural as they would seem to be, implies that the provision of an appropriate amount of time (for appropriate reflection, self-coaching, etc) will be a crucial factor to the success of any such professional lifelong learning program. But what is a realistic timescale? How might it vary from situation to situation? Participant feedback in our context suggested our 'drip on a rock' approach was particularly valued, and this only becomes a serious option when timescales of the order of 6-12months are available (as we enjoyed in the case recounted here).

Likewise, the provision of appropriate scaffolding that enables professionals to learn with and from their peers undergoing broadly similar development programs appears to be essential. As is building up a trust-based relationship with those facilitating the program (consider, for example, the nature of Chandi's entire project ambitions, as well as Chris's work supporting the project crafting process itself – see Trevitt, 2005b – both were sensitive to such needs; and see also, Boud and Walker, 1998). Further, these scaffolding factors also seem to need to operate over a certain minimum timescale if they are to be effective. Yet another key scaffolding issue is associated with introducing the idea and expectations of reflection and reflective writing. As Trevitt and Roberts (2004) report, some participants are not naturally reflective or have difficulty adapting to the writing requirements. Such cases appear to encounter one of two main stumbling blocks. First, as noted above, there is the need for an expansion in ways of knowing, or coming to know, and of developing some level of professional comfort with a new or expanded worldview. Second, there is the difficulty in achieving meaningful, practical and valued reflections, and avoiding the 'danger of reflection for its own sake' (Parker, 2002; 384). To be meaningful, practical and valuable, reflection must balance successfully the art of situation analysis, 'context diagnosis', and priority setting for actions; while also ensuring that all these activities are achievable given the resources to hand. Fook, for example, argues that what is needed is a situation where the 'moral and political dimensions' are comparatively clear, and 'some methods suggest themselves as superior to others and for good reason' (Fook, 2002; 80). Such factors can bring emotional issues to the fore, and this leads to demands on teachers 'to create a climate in which the expression of feelings is accepted and legitimate' and where 'learners are able to express themselves in conditions of trust and security' (Boud and Walker, 1998; 194).

Finally, perhaps the greatest challenge of all is finding out how best to pursue such inquiry within the prevailing limits of existing institutional frameworks and epistemologies (see Chandi's remarks in Box 3 under the heading *Academic leadership*; and, for example, Schon, 1995; Trevitt, 2005a). Finding the room to devise and offer an adequately enlightened approach to individual support and development, an approach that acknowledges the demands and stresses of contemporary expectations of professionals in the workplace, seems to be getting more difficult. The paradox, suggest Clegg et al. (2004; 38) is that just as we experience a diminishing of the 'space for learning' as a result of work intensification, so the need to create and harness such space has never been more acute. It is ironic that just as institutions are compelled to develop even stricter performance and accountability requirements, so too the professionals who work in them experience an intensified need for greater autonomy; safe space where they can work together to explore novel ways of working and learning. Responding to and mediating such

challenges falls as much to Academic Development Units (ADUs) within universities as it does to professional bodies and organizations within the professions, such as medicine.

Conclusions

In this paper we have offered a brief account of two individuals' experiences within a cross-institutional context that yields insights into the requirements for the structured provision and successful exploitation of 'space for professional lifelong learning'. In so doing, we have suggested that where the professional lifelong learning curriculum is itself centred on 'learning about professional learning' then precedence needs to be given to the *self* over the *action* and *knowledge* domains, but not at the expense of the *integrated whole*. This amounts to a variant of a model posited by Barnett et al (2001). A variant that aspires to a transformative approach such as that championed by Parker (2003) but which, in turn, is premised on a transformed understanding of learning.

While the experiences we recount are centred on a particular person and initiative within the medical profession, and are embedded within a particular development programme, we suggest the principles we highlight are applicable more broadly. We further suggest that the broader pressures for social change that effect the medical profession in this instance, are also experienced by many other professions. In contrast, the extent to which appropriate representative professional bodies have come to grips with, and developed, structured responses to these professional lifelong-learning pressures varies markedly, from one profession to another. Likewise, the options for and manner in which ADUs (as one development organ within universities) respond to such pressures also varies widely from university to university.

In these times of change and need, there must surely be opportunities to learn from each other, and find more and better ways for ADUs and professional bodies or organisations to work together on such shared development agendas. This might be one way to professionalise, get 'slick and savvy' and strengthen our capacity to identify what should be at the core of the programmes we each develop. In the process, we might increase the likelihood of getting more for less, and thereby keep our paymasters happy into the bargain.

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