Committed Learning - a Core Issue of Curriculum in Health Education

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Abstract: - Training staff for health area seems to be, more than ever, an important issue of the new millennium society. This assumption is generated by the new dynamic of the illnesses connected to the complexity of a new global world. This paper aims to propose a reflective approach of the results of a multiple years’ of activity as scholar and researcher in the field of higher education, from Cognitive and Constructivist perspective. There are suggested and argued some key aspects of designing and implementing curriculum (with application in health education). The entire approach is focused on the necessity of ensuring a proper developing of what is called as a competent personality. The ongoing process of the birth and the life of a competent personality is explained. The role of the scholars in developing the components of such a personality in early ontogenesis and further is another argued aspect. Committed learning as a desirable learning style to be achieved by the students is explained

Key-Words: - curriculum design, health education, studying-learning situation, committed learning, learning experience, learning environment

1. The Postmodern Philosophy in Education, with Application within the Health Education Field

It is not only the field of health education which needs a new approach in teaching and assessing focused on learning process. Even this way to express the emphasis represents a new point of view. I could noticed, working several years with students in health field, as a scholar involved within their training for a possible didactic career, an interesting philosophy of scholars and students. In my opinion an important issue is not correctly understood: the necessity to train future nurses or physicians as effective professionals not as minds full of information. The entire curriculum of the medical field should be focused on developing and, finally obtaining, a high level of quality of each component of a specific competence profile for the medical area. Several aspects are to be discussed from this perspective, and they represent the key issues of the following presentation: what does it mean a competence profile, generally speaking, and for a specialist in health area; what kind of curricular approach is it necessary in order to reach such a competence profile; which should be the core value of the curricular approach.

2. Competence Profile for a Specialist within Health Area as the Outcome of an Effective Curriculum

2.1. Competence as an Outcome of the Educational Process

The term competence is highly discussed in different specialty materials. There are discussions about the spelling itself of this term. Two words are used – competence, with the plural competences, and competency with the plural competencies [6]. I do not intend to focus the presentation on the entire debate about the meanings of these terms. But I would like to express my opinion that the two terms could be used together competency/ competencies expressing the components of what we should use only as a singular term: competence.

The structure of competence is complex and includes different components (competencies):
Knowledge which is functionally structured, step by step, during the entire educational process;
 Capacities/ abilities such as cognitive, specific professional and social abilities;
 Attitudes, values and capacities to cope with the present learning experiences which represent ‘knowing to be’ as circumstances demand and attitudes, values and capacities to cope with dynamic challenges and changes. They represent ‘knowing to become’ in response to demands
It is clear that knowledge is the necessary foundation of the competence. By experience, everyone gets the means to deal with acquired and continuously changing knowledge. These acquisitions are expressed in skills, cognitive capacities, and motivational abilities. The human being also acquires the power of judgment, as a criterion for using knowledge, making it independent of its point of origin. Attitudes, which may regulate the competence, involve cognition as well as motivation and volition.

Competence then could be understood as an effective expression of specific experiences and of assimilated and practiced knowledge, within the context of specific (studying)-learning experiences. Competence, in other terms, could be considered to be a synergetic outcome of several verbs: to know, to know how, to be able to action effectively, to know to be as requested, and to know to become as circumstances demand.

2.2. Developing the Competence as a Potential of the Personality

Developing competence should be considered as a core issue in educational process. In this respect competence should be analyzed from, at least, three perspectives in order to be correctly understood as an outcome of a training process:

1. Competence as defining a general potential of a personality is presented as the first hypostasis. This may refer to a potential capability to function in different given situations and this is very much the line set out by McConnell, E. A. [4]. This potential is expressed, from the health area point of view, in the capability of a person to fulfill the specific professional or social responsibility in the field, and to solve precise or general professional problems and handle current situations.

2. The mature hypostasis of competence already built, manifested in the professional and social life is presented as the second one. I suggest for this hypostasis the term competencies in practice. The reason of this term is that practice represents the obvious place of proving a competence as the potential of the personality (expressed by all its structural components). In the case of the activity in health field, a mature hypostasis of competence already built during so many years of training, is expressed by its components as obvious elements manifested in the concrete medical professional and social life. This emphasis on professional and social dimensions means that, during developing the bases of a mature competence, the educational process should take into account not only the mind of the students but their souls, their personality as an assembly too.

3. The developmental hypostasis of competence (situated in ontogenesis before the previous presented) is the third hypostasis and it is the most important issue from the educational point of view. I suggest for this hypostasis the term competencies in action.

The figure nr. 1 intends to explain the way of developing a competent personality through developing competencies in action during the training process in order to ensure a high quality and effectiveness of the competencies in practice during the entire professional life.

<table>
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<th>Personality considered as development process.</th>
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Education during school life time (formal, non-formal and informal education) is the most important factor of developing the competent personality, managing the action of the two other important factors: heredity and physical and social medium. The early and primary education creates the bases for so called instrumental culture. The secondary education develops the general culture and, step by step, professional aspects are introduced within the educational context. This ontogenetic period develops the components of the future
competence meaning: a. developing functionally structured knowledge; b. developing abilities and capacities/ skills; c. developing attitudes based on values. These components are considered as evolving/ increasing competencies or competencies in action. The students start their professional training based, of course, on the level and the quality of the previous stages of education, when they are in the first school with a specific curriculum focused on professionalizing for the medical field the. After finalizing their professional training (as nurse or physician) the graduate is not any more an adolescent but a young adult with a defined personality. The quality of the previous educational process is responsible for the quality of the graduate’s competence, as a potential of his or her personality. This potential contains knowledge (general and professional), capacities/ skills/ abilities (general and with professional specificity), attitudes which define the graduate as a human being and as a professional.

We are talking now about crystallized competencies expressed by: functional structures of knowledge, functional sets of capacities/ skills/ abilities, functional sets of attitudes. All these are a synergic result of competencies in action, and they represent the portrait/ the profile of a competent personality.

From now on the professional, already initially trained, enters into the social and professional life, where the competence, as a potential of the personality, is proved in specific professional and /or social situations. The educational process is not finished because the adult’s life offers enough challenges, being, as a whole, a complex of life long learning situations, generating individual and specific learning experiences.

2.3. Curriculum and competence profile

The curriculum of the initial educational period should be determined by what it is called as professional competence profile (nurse’s competence profile, physician competence profile, with specific nuances according to the particular medical fields the student is to be trained for). I consider that it is necessary to define the concept curriculum in this context. I chose for defining it, a very simple but meaningful way. Curriculum should be considered as the entire complex of learning situations which determine specific and personal learning experiences for each student (in this case each student in health field). These learning situations are primarily designed in the formal context, in the educational process managed by the scholars. Non-formally, they appear and are particularly designed and implemented by the practitioners of the health field (in hospitals, laboratories or other specific places where the practical training of the students is realized). But they exists as hidden curriculum in the context of all the formal or non-formal learning situations, as a result of the entire relational, emotional, material context, and they are reflected in a large variety of very individual learning experiences. On another side, the life itself offers, for the students in the health field, learning situations lived and experienced in a specific way, according to their status, their statement of training and, of course, their personality.

The “competence profile” for an effective graduate in health field, in this case, (no matter what level of graduating is considered), is considered, in my view, as a matrix containing in its structure [5]:

- **Knowledge** which are structured on domains and specified in terms of must, should would, as degree of necessity to be learnt (with specified standards of functionality for each category); for instance: a graduate nurse/ or a graduate physician before specialization must know x,y,z,…… as a basic standard of 50% of them, a higher standard of 75% and the highest standard 100%; he /she should know a,b,c,……, also detailed on levels of standards and would know: i, ii, iii,… detailed on standards too.

- **Capacities/ abilities/ skills** which are connected to knowledge on domains, but with possibilities of transfer. They have the same specification in terms of must, should and would.

- **Attitudes and values** with the same structure, considered as general human attitudes and values, and specific ones according to the deontology of this profession.

Designing curriculum should start from an in depth understanding of such a competence profile. This is followed by choosing appropriate contents, adequate teaching- assessing methodology, scheduling a proper time for training. These steps should determine the synergy of all the mentioned elements, following the ways of the educational aims, goals and objectives, towards the outcomes represented by the components of the defined competence profile. It is a way to rationalize the educational process focusing it on outcomes with a clear understanding of them in terms of the following questions: what/ why/ what for/ how and what kind of connection between?

It was a great debate focused on the appropriateness of outcome-based education. This philosophy comes from William Spady, and has its roots in Mastery Learning [7]. It had a wide acceptance, even if a lot
of critics too. In Australia, for instance, a lot of authors as Griffin, 1988, Willis & Kissane, 1997 considered Spady’s philosophy as the basis for an outcome approach of education. Spady [1] describes three main types of outcomes: traditional, transitional and transformational, with an obvious accent on the last category. I do not intend to develop this idea, because in my opinion, it is not necessary to focus the curriculum on outcomes but on an effective design and management of the learning situations, which involves not only the outcomes but all the other four components: contents, teaching methodology, assessing methodology and time; all five of them should be considered in their synergy managed by the educational objectives.

3. Developing an effective learning style as a key issue of a successful professional and social life

Attitudes, values and capacities, as engines of knowing to be and of knowing to become, are important components of competence. They are, finally responsive for the effective use of knowledge and of the capacities. Are they enough emphasized during the training process of a specialist in health field? This is a major question for the curriculum in the area. The scholars should be attentive not only to what kind of contents offer inside of the learning situations, but they should influence in a positive way the students’ learning style through the used teaching and assessing methodology. This learning style is an important acquisition by itself, because it represents the future student’s (and further graduate’s) way of approaching the new learning situations within professional and social context.

A learning situation within the formal education (as a course, a seminar or a laboratory) should be designed in such a manner to determine an active student’s studying- learning activity, not a passive one. A classical course designed as a traditional exposure of a specific content, determines at the students, in the best case, a listening behavior, if not even a “hearing ‘one. A traditional request for students’ presentation of read materials, for the seminars, could determine the same kind of behaviors for their colleagues. A traditional demonstration could determine a seeing / hearing students’ behavior, or, in the best case, they could rich a looking and listening one, even if it is accompanied by very clear explanations.

The active attitude of the students for learning is hard to be developing in these situations. Nowadays students are not better not worse but different, because the life itself, with its requests is different today. A postmodern scholar should adapt the teaching and –assessing methodology to the specificity of the new millennium, when the dynamic of the science, of the technology and of the life is more intense than never before. That is why the scholar’s approach should be a teaching- assessing focused on learning, a new type of learning expressed in a more appropriate way by the concept of study. This concept becomes a key issue for a more effective design of the learning situations. Even the phrase learning situations could be turned into “studying-learning situation”. I agree with John B. Black and Robert O. Mc Clintock [2] that students should be determined to study, in terms of determining them to construct knowledge, not only to receive information. A simple reception of information could be accompanied by the student’s effort to decode it, to understand it, and to internalize it, in connection with previous knowledge. In this case it is possible to turn the information into new achieved knowledge. But a hearing or seeing student’s behavior has a negative effect on learning. They substantially contribute to turning the genuine learning into a memorizing activity, without any kind of effectiveness in terms of developing competencies. Studying means much more. It starts with a listening and watching students’ behavior, followed by their own effort to understand the information, to integrate it into their system of knowledge, and to practice the new knowledge in different other contexts, discovering new knowledge. It is here what Furey, D. has called as a generative leaning [3].

I do agree that the term study “captures better what should be going on during knowledge construction then does the term learn” [2]. Learning, understood as an achievement of new answering behaviors for new situation, could be considered as an effect, in terms of new constructed knowledge, new capacities or abilities, new shaped treasure of personality. This should be the effect of a long and voluntary process of studying as an aware, reflective, inquiry, intrinsic motivated action of the studying-learners. The manner we, as scholars, could determine our students to become studying learners is a key question for an effective educational reform. An effective study process needs a “study support environment instead of < instructional systems>” [2]. In health education field, this study support environment has a specific meaning. The school/ university and the hospital/ polyclinic should represent such a kind of study support environment by their material, social, relational contexts.
Taking into account all these aspects it becomes possible to develop, in time, a new learning style for our students. The proposed concept for this new learning style is “committed learning. The term “committed learning” is understood as a synergic result of the active, reflective, socio-cognitive and self-motivated involvement of a studying-learner within the studying-learning process. This studying-learning process is considered as a complex set of studying-learning situations, involving student into an individual or a team effort. Defined in these terms committed learning is more than an attitude towards the learning process, it is action, cognition, reflection, motivation and attitude, all together.

Figure nr. 2 express the context of the ongoing process during the life time with its complex of studying-learning situations as generators of a committed learning style. This could be responsible for the quality of competencies in action, competence as a potential of the personality and, further, for the effectiveness of the competencies in practice.

Entire this ongoing educational process fundamentally depends on the philosophy of the initial training. The design of the learning situations during this period should ensure the selection and the structuring of appropriate contents, the appropriateness of teaching and assessing methodology, and their focus on students’ effective studying-learning activity. These are the major conditions of students’ effective learning experiences expressed in effective evolving competencies in action, and leading to a high level of a competent personality. The life itself, will prove professionally and socially this quality of the competent personality by effective competencies in practice and by the openness for their constant improvement.

All the professions need such an evolution. But more than all the range of professions, educational field with its teachers/professors and the medical one with its physicians request this kind of philosophy.

It is not true that education and health fields are not productive for society as politicians say. The education produces the most important product of the world: the human being as a personality, starting from the point of a simple candidature for humanity; and the medical field repair the same important product when it is necessary.

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