Den gode uddannelseskultur - hvad skal der til?

Tutorcentret, AHH

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Kultur: Definition

”En ikke-genetiske videreførelse af adfærd til en ny generation”

Semiotisk (læren om tegn) definition iflg. Wikipedia 28.11.2016

Dagens emne: **Videreførelse af god uddannelsesadfærd til en ny generation**

Kulturen har indflydelse på alt hvad der foregår på en læreanstalt: Hvad man taler om, viljen til forandring, måden at instruere på, og opmærksomheden der gives til studenterne og den læring, der foregår på fakultet.

Deal & Peterson, 1994; Firestone & Wilson, 1985; Newmann & Associates, 1996

Det er op til afdelingslederen, vejledere og lærere—at identificere og eliminere giftige kulturer samt at forme og fastholde en stærk positiv uddannelsesfokuseret kultur.

Kulturen formes af deres ord, deres nonverbale budskaber, deres handlinger og deres resultater.

De er rollemodeller, byggere, digtere, skuespillere, og healere. De er historikere og antropologer. De er visionære og de er drømmere.

Ved at vise indgående opmærksom på den symbolske side af skolen, er ledere med til at udvikle grundlaget for forandring og succes.

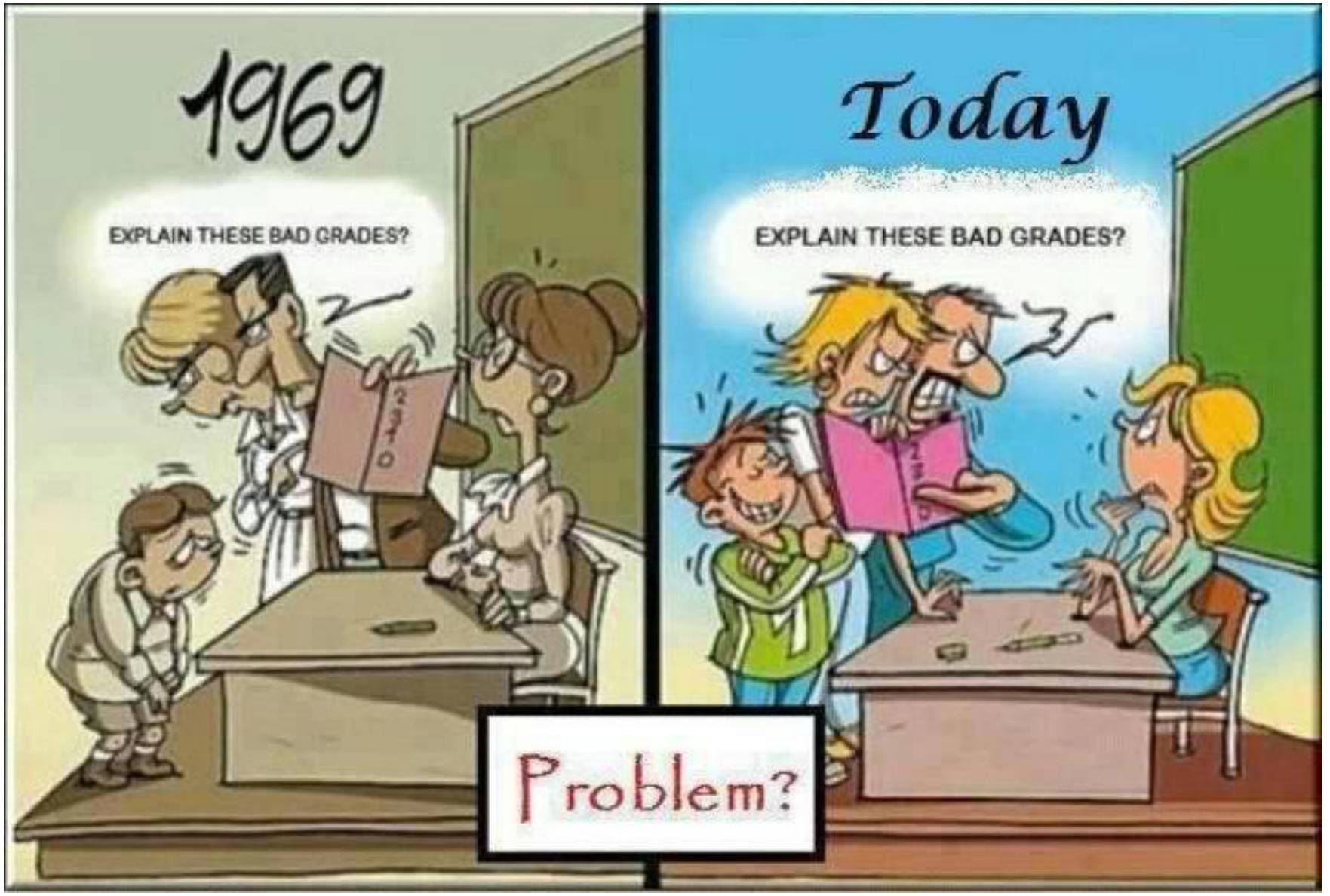
Kent D. Peterson and Terrence E. Deal . Realizing a Positive School Climate. Sep.1998; 56: 1. 28-30

Før jeg kan lære ny adfærd…

- Ikke bange
  - Mulighed for feedback
  - Jeg ved hvad der forventes af mig
- Passende udfordringer
  - Ordentlig feedback
    1. Det gør du godt
    2. Det skal du gøre mere af
    3. Det bliver jeg nysgerrig på
  - Gode rollemodeller

Væsentligt i min optik

- Jeg føler mig velkommen
- Respekt for ”det lidt jeg kan”
- Jeg bliver spurgt om, ”hvad jeg vil gøre”
- Respekterer at vi lærer på forskellig måder
- Ingen gør fejl med vilje


1969
EXPLAIN THESE BAD GRADES?
Today
EXPLAIN THESE BAD GRADES?
Problem?

The chains of education, experience, and culture

David Metcalfe

This is the last in a series of articles dealing with aspects of managing change in general practice.

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BMJ 1992;305:33-4

The striking thing about the series of articles on managing change in primary care is that while it will be seen as worthy but not saying anything new by many general practitioners, there will be an equal number to whom it will be revelatory, and possibly another group who will either reject the ideas or avoid reading the articles altogether. The "limiting condition" of general practice is its heterogeneity, and that heterogeneity is its Achilles' heel as far as managers and politicians are concerned.

In fact there are two components to this heterogeneity, one more defensible than the other. As general practitioners are, or try to be, responsive to their patients' needs practice activity and style will be different in different places—for example, in the BMW lined "villages" of the home counties compared with the shattered manufacturing centres of the north east. That sort of heterogeneity is right and proper. That which comes from self indulgence and intellectual sloth is not. Why is there such variation?

- Medical education fails to teach the use of clinical logic to manage uncertainty
- Experience as a predictor of response to change is to do with feelings and not strictly objective
- As well as social class and ethnicity doctors' beliefs are shaped by their role models throughout their training, and these will influence their response to change

A triangle of forces

The variations in values and attitudes, and therefore behaviour, among general practitioners represent the interaction of three influences on them as people (the fact that they are people seems often to be overlooked by those within and outside the profession). These are education, experience, and culture, which should be seen as a triangle of forces. Thus the same experience of change will provoke different reactions depending on the individual's educational or cultural background. Similarly, the same education given to people of differing culture will result in differing attitudes to change. Why, for instance, does the experience of working under an autocratic and exploitative senior partner lead some general practitioners rigorously to avoid following suit, while others can't wait to assume the senior partner's mantle?

The shortcomings of medical education and training are all too well known. It singularly fails to teach the use of clinical logic to manage uncertainty and that general practice, dealing with initially small variations from normal health without instant recourse to technological investigation, centres on the management of uncertainty, and therefore leaves the alumni with a load of anxiety.

Experience isn't history, it's biography. Of the myriad things that happen to us or which we see happen to others only those which are "internalised"—that is, connected up with our other observations and values—constitute experience. Essentially, therefore, experience as a predictor of response to change or suggested change is to do with feelings, and may not be strictly "rational" or "objective."

The culture of power

But education and experience are not superimposed on a blank sheet. They happen to people who belong to, or come from, a given background, characterised by its values and beliefs: a culture. These values and beliefs are absorbed from our earliest years and are strongly influenced by the community in which we grow up, and therefore by factors such as ethnicity, social class, and local ways of looking at things (for instance, the difference in views between north and south, whether Scandinavian compared with Italian, or Cumbrian compared with Kentish).

Such absorption isn't limited to childhood, and values and beliefs continue to be inculcated as we clamber up the educational ladder. As we do so, the power of precept is displaced by that of example, and role models, negative as well as positive, become strong influences on attitudes and values. The power exercised by senior clinicians and the way they exercise power is perhaps central to their influence as models. The most important aspect of culture with regard to change in general practice is power.

The traditional British system of teaching values, inculcated by the public schools and the forces for which they were preparing people, was that power and privilege had to be earned by taking responsibility (hence the prefect, the junior officer). This method may always have been for a minority of people, and certainly is now, when it seems that power is seen as a desirable end in itself, and responsibility an unfortunate and hopefully avoidable encumbrance. But the practice of medicine starts with responsibility, and to discharge that responsibility you often have to exert power. (In the Larrinaga operating theatre of the old Liverpool Royal Infirmary was a quote from Hippocrates along the lines of "It is the duty of the surgeon to make his assistants and the patient cooperate with him"). Unfortunately in the traditional British culture power, like enthusiasm and cleverness, is deeply suspect, and therefore disguised, so that the exercising of it is often covert, idiosyncratic, and arbitrary.

The value of respect

Over and over again in this series of articles the question of relationships within hierarchies, whether between partners or between principals and other members of staff has come up but seldom been addressed in cultural terms, and, in particular in terms of the culture of power. In any organisation who has power over whom, and what sort of power, and how it is exerted, are crucial factors in the way the organisation works. Does seniority confer power; if it does, why, and what sort of power; and is this generally accepted within the practice? These things are unlikely to have been dealt with explicitly. Are staff colleagues, subordinates, or servants (in reality if not in name)? Useful evidence is the use of first names, nicknames, or titles.

The abuse of power can and does obstruct growth