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We live in a world where there are many alternative accounts of what represents 'best practice'. We deliver nursing care at a time when the consumer may be tempted to take legal proceedings because health care has not been as they imagined it should be. Nursing today is a public performance profession. You almost certainly deliver care within the public eye. It is important to make the best decisions and to work sensitively with the patient and lay carers. The successful nurse is the sensitive nurse. He or she understands not only the theory behind different techniques, but also when it is wise to employ such techniques (Penny and Warelow, 1999). Nurses today not only need to be knowledgeable and skilful, they need to be wise (Bradshaw, 2001).

Twenty or so years ago the nature of nursing was rather more straightforward (Kershaw, 1998). If you went into the nursing care library and took out a book, it was likely to be arranged under medical headings. There would be sections on medical and surgical nursing. Significantly, nursing action would be described in terms of a response to a disease or treatment. There was a formula for asthma care, for post-operative nursing and for managing the care of a head-injured patient. Look back through textbooks of the time and it is easy to become nostalgic. Nursing was less complicated. Nurses followed the directions of medical colleagues and it was possible to list what you did in any given situation. Those who marked assignment questions then knew full well that they could rely upon a limited list of ‘things to be demonstrated’ before the answer was judged passworthy.

Practice is not like that today though. If you have just begun studying nursing, or are perhaps completing a post-registration course, it is quickly apparent that finding the right answers,
saying the right thing, offering the right care are no longer quite so easy (Price, 1998a). Going on a clinical placement can prove daunting precisely because whatever you have read does not quite seem to fit with the reality of care-giving. When you walk onto a ward it’s not simply that you must learn a wealth of information, it is that you must understand how others, the patients and your colleagues think (Morales-Mann and Kaitell, 2001). Practice involves understanding people, as well as processes and procedures (Wheeler, 2001; Wong et al., 2001). We have to learn how to ‘read’ situations and even how to decide whether what we have seen or heard is significant (Price, B., 2001a; Rundio, 2001). When you come to think about it, one of the greatest skills you will learn as a nurse is how to decide whether something is problematic in the first place! This is no idle muse. Health care resources are limited so we must prioritize care and tackle what are sometimes called the priority problems. Identifying what needs our further attention is therefore key to strategic practice.

Within problem- and enquiry-based learning, the nature of the situation, that which might be problematic, is assumed to be unclear. Problems are not always apparent or readily labelled. It is unrealistic therefore to start this book with an instant explanation of every problem that might occur in practice. What is important, however, is to begin with a discussion of what might represent some of the characteristics of problems. This not only informs how or why nurses and others have to investigate practice, but it also explains why nurses need to be consummate inquirers and problem-solvers. It is this which has changed so fundamentally within nursing. Today we need to interpret practice for ourselves. The instant formulas or theories have gone and many in any case were poor guides to practice. It is apparent that the traditional way of learning (hear a theory – apply a theory – check whether it worked) is no longer enough. At best, practitioners are left wondering why theory did not seem to fit practice. At worst, they try to make practice fit the theory.

**WHAT IS A PROBLEM?**

Nurses often describe themselves as helpers and problem-solvers (Erdmann, 1998). This begs the fundamental question, just what
is a problem? In Figure 1.1 I itemize some of the reasons why something (perhaps a health care situation or a future course of action) might be construed as a problem. When you look at this diagram it is worth asking yourself an additional question. Who defines the problem?

There are many situations where the nurse identifies behaviour or environmental factors that represent a threat to the health or well-being of clients. Penicillin-resistant strains of bacteria, asbestos fibres within a working environment or smoking cigarettes are but a few examples. In these circumstances it is often quite difficult to agree who defines the problem, naming the situation or threat as ‘problematic’. For example, even today some employers refuse to acknowledge legal liability for asbestosis, mesothelioma and other illnesses associated with the exposure of workers to asbestos dust. In these contexts there may be relatively few debates about the causation of illness or damage, but there may arise complex arguments about who was responsible for the threat, and at what level something (asbestos dust, cigarettes) become harmful.

Most people would consider something that caused discomfort or pain to be problematic. Surgery, chemotherapy treatment for cancer or group therapy used to tackle unsociable behaviour are all potentially problematic for the patient. They may, however, also be therapeutic. That is, they may offer benefits to the

**Figure 1.1** The nature of problems
patient. Nurses often recommend the worth of dealing with short-term treatment discomfort to achieve longer-term ends. The nurse provides anti-emetics to help the patient cope with nausea after administration of cytotoxic drugs. She helps to counter the problem that she has herself contributed to. In such situations nurses and patients try to redefine the threat as acceptable, tolerable or worthwhile. It may, for example, be worth putting up with some hair loss to protect health in the longer term.

Many ethical problems associated with practice concern the rights of individuals and the rights of groups (Inglis, 2000; Burckhardt, 2002). Consider the situation of a nurse who is HIV positive (Human Immunodeficiency Virus) and who understandably wishes to lead a lifestyle that he considers valuable and professional. Against this, however, there are others within the local community who have misgivings about being treated by such a practitioner and moreover who suggest that ‘HIV Positive people’ should have their names recorded upon a register and then have their professional freedom restricted in some way. Problems are not always open to simple definition. One person’s normality is another person’s problem. Within health care you will meet situations where people cannot agree whether something is problematic. In practice, some problems are personally defined in terms of values, attitudes and experiences. It can be very difficult for us to understand the problems of others, or perhaps to empathize with their position.

The organization of health care itself can be problematic where it limits the ability of the patient to make decisions about and participate in his or her own care. Historically health care professions have defined their contribution on the basis of expertize and the holding of a unique body of knowledge. Sometimes this knowledge is complex. Sometimes it is portrayed as complex because the health care professional wishes to retain control over decision-making. Tilley and colleagues, however, emphasize that nurses should help empower patients (Tilley et al., 1999). However, tensions can and do arise in chronic illnesses where patients research their own conditions and then challenge health care professionals on the best way forward. It can be challenging to help patients and lay carers feel part of a rehabilitation or care plan (Yates, 1997). Problems therefore are frequently associated with power. That includes the power to
define what is problematic in the first place and, thereafter, the power to define what should be done about it.

Problems exist for nurses as much as they do for patients. Consider the scenario where you have completed a literature review on wound care and where you have amassed a substantial body of research evidence that suggests a particular wound care technique delays rather than hastens healing. When you deliver your findings to medical and senior nurse colleagues, they acknowledge that the results are intriguing, but elect to continue with their chosen practice because they feel that further evidence is required before a new protocol can be established. Problems exist therefore where there are differences of vision or goal and where there may also be disagreement regarding the best means to achieve a goal. Health care often involves debates about what should be done, or supported. This is not necessarily a scientific debate. Health care professionals have their own and collective ideologies (Traynor, 1999; Browne, 2001). That is, they try to define what is normal, preferable, appropriate, expert or aesthetic (Woodall, 2000). Where individuals challenge such ideologies, a problem may arise for all parties concerned – the change agent and those supporting the status quo. In these situations the nurse’s challenge itself becomes defined as problematic, because it questions what is understood to be the common good of the team.

So what can we now say about the nature of health care problems? Box 1.1 sums up what may be the characteristics of a problem.

**Box 1.1 The characteristics of problems**

- The origin, parameters or components of the problem may be hotly contested (what caused what?, why did this happen?, what do we need to consider here?).
- Problems may be contextual. What is problematic in one environment may not be so in another.
- Problems have a scale (this may refer to the level of risk, the volume of work or skill needed to rectify the problem).
- Problems may sometimes be necessary. It may, relatively speaking, be necessary to create one problem in order to solve a larger one.
You may agree with many other nurses that nursing practice is more stressful today and that this is associated with the volume and complexity of problems that you tackle at work. While it would be difficult to quantify the volume of problems faced by nurses at different times, anecdotally it does seem likely that practice is experienced as more problematic today. A wide variety of situations and expectations can be conceived as problematic and prompt you to try and change matters (see Figure 1.2). The more the public and health care professionals consider health or illness in problem terms (as something worthy of investigation and resolution) the more important problem solving skills become.

While problems can simply occur (for instance, associated with physical deterioration in old age), they can also be made. Look at the following short studies, which demonstrate this point:

Mrs Joyce is admitted to hospital for hip replacement surgery. She is 78 years old and obese. Surgical techniques, improvements in
anaesthetics and nursing support measures such as the use of anti-embolism stockings mean that treatment is likely to be effective. Having read about the risks of hospital-acquired infections, however, her daughter is eager that Mrs Joyce is discharged as quickly as possible. This will require careful liaison and regular visits by community staff to ensure that her progress remains satisfactory.

Louise is a recently qualified midwife who is committed to the philosophy of woman-centred care and the promotion of natural childbirth as far as this is professionally possible. She suffers a number of uncomfortable encounters with other midwives and obstetricians whom she sees as ‘interventionist’. These colleagues assess the risk to the woman and the importance of her birth aspirations differently. They recommend intervening sooner and often more radically. As a result, there are sometimes arguments in the labour suite.

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**Figure 1.2 Problems and responses**
In the first of these examples part of the problem relates to public expectations. Patients expect more services than in the past and that these are conducted to the highest standards. In previous decades, Mrs Joyce may have been excluded from surgery simply because we could not contain the risks effectively. As health care has improved, so more elderly patients are undergoing bigger operations and achieving greater levels of mobility and comfort. Surgery solves a problem (hip pain and immobility) but expectations associated with it cause other problems. How will Mrs Joyce be supported within the community? How in the interim will we minimize the risk that this vulnerable patient does not contract a hospital-based infection? As Mrs Joyce and other patients live longer, thanks in part to health care treatment, how can we ensure that they receive adequate care in their homes where they would prefer to remain?

The second problem is also manufactured. In this instance, competing ideologies of midwifery care clash in the context of the delivery suite. There are debates about cases that were ‘problematic’. Did these illustrate Louise’s reluctance to read the warning signs and to agree timely intervention? Alternatively, was Louise’s stance correct, holding out and working with the mother to achieve a natural birth, until such time that it became clear that a Caesarean section was unavoidable? If professional colleagues cannot agree a protocol for practice, can they agree means of mutually assessing risk to a client? Is it possible to negotiate parameters beyond which everyone agrees that additional intervention is necessary?

What appears to make health care practice seem more problematic therefore is not only the volume and range of needs and expectations presented by the public, but that the solutions to these problems must be robust. Women having babies desire a natural childbirth but also a process that is ideally also fail-safe. It is then difficult to achieve a balance between these two expectations when there are different recommendations regarding what represents good practice. Nurses and midwives have to make the best possible decisions under time constraints and with finite amounts of knowledge. Standards of practice are widely publicized and equally the scare stories are highlighted within the media. There is greater accountability for practice at a time when, increasingly, society as well as the professions debate what equals best practice.
Not only is health care practice more problematic, but it is also more problem-orientated. We are much more likely to define situations as problematic. This is partly because we are cautious about how others, especially consumers, will interpret practice, but also because there is a wider diversity of opinion on how to proceed. Science has made us more aware of what could happen and society has reminded us of the penalties that health care organizations might now have to pay if the best decisions were not made.

**The Need for the Inquisitive Practitioner**

Circumstances such as those described above make it clear that the practitioner has to be inquisitive and clearly aware of what is to be achieved. That is, we need to be reflexive practitioners (White, 1999). We cannot assume the definition of what is happening nor that other interested parties will see health care as we do. Theorists explain that this is because we live within what has been described as a postmodernist society (Theodore, 1998). We are part of a society where there are many norms for behaviour, many different ideas about what would seem best to do and at a time when people are increasingly encouraged to challenge the view of experts in whatever field they operate. Everyone has an opinion, so it becomes important to understand the different viewpoints when dealing with something as important and intimate as health care.

Studying nursing at university you are very likely to be taught skills of reflection, critical thinking and problem analysis for precisely these reasons (Brookfield, 1987; Milligan, 1999). These are transferable skills that not only help you to address practice needs now, but to go on doing so in the years after you have left the lecture theatre (Gopee, 2000). Arguably, nurses need transferable skills, those associated with inquiry and communication now more than ever before (Bjornsdottir, 2000). The ability to find out and to contribute to accounts of problems and their possible resolution is key to helping you manage the stress of professional life (Dobson *et al.*, 2000). A successful problem investigator is likely to be a practitioner who also gains satisfaction from practice and who feels that he or she is making a worthwhile contribution.

Imagine for a moment what this means in practice. Let’s assume that you are interviewing an elderly man who is being admitted to
hospital with chest problems. It is clear that his breathing is laboured and that he finds it difficult to give a health history. He looks exhausted and you notice a bluish tinge to his face, which suggests that he is cyanosed, struggling to get oxygen around his body. This patient is accompanied by his wife who is clearly anxious about the situation and who does her best to answer most of your questions on behalf of her husband. As she intervenes with answers you realize that she is partially deaf. She has misunderstood what you were asking. Flicking through the case notes that have arrived with the patient you see that a provisional medical diagnosis of emphysema related to smoking has been made. You look up and smile at the couple resting before you. The problem before you is not simply the medical diagnosis of emphysema. It is how to assist this couple most sensitively and effectively. What will you do first? How will you make the patient comfortable? When is it better to reserve history taking until later? Has the gentlemen’s wife really got a hearing problem or might you have posed your questions in too complex a way?

This scenario is relatively common. It is not an emergency nor is it exceptional. When you cast your mind back to the textbooks and lectures you recall that there was information on chest illnesses, on health assessment, on communication skills and upon anxiety and its impact upon health and comprehension of situations. Your greatest wish might be to have a definitive answer to this conundrum – what shall I do first and why? In practice, however, what makes this situation quite unlike the textbooks is that you must decide how to mix the different information you have. How do you combine the knowledge available so that it serves this patient and his wife best?

It can be extremely tempting to resolve the situation by prematurely defining it in one or more ways. It is certainly more comfortable to think of the patient as emphsemic and his wife as simply anxious. But these are labels that might not tell the whole story when we pause to consider what represents good nursing care. They may be sufficient to tackle some of the greatest threats (for instance, associated with oxygen depletion), but they hardly address the patient’s experience of illness. We need to place this episode within the context of the patient’s world. What does dyspnoea represent to him? Yes, it is frightening, but does it also become associated with guilt? Perhaps later the patient confides that he feels foolish having smoked cigarettes all his
life. He feels a burden on his wife and now on the hard-pressed health care services.

To deliver sensitive care it will be necessary to inquire further into the experience of illness and hospital admission. It may be necessary to investigate the care implications when it is discovered that the patient suffers not only from emphysema but also diabetes mellitus. That may mean that you need to reread textbooks, to look at recent research papers, to discuss the health care assessment with the consultant and to debate with the dietician and physiotherapist what represents the best package of rehabilitation in the next weeks. It will be important to know how to find out information and to use this in a particular context. At first, it will be necessary to know where to look for information and what questions should be asked. All of this stems from the nature of the problem that has emerged.

When we pause to consider what is different within this practice it is that we must learn to work in two ways (see Figure 1.3). We need to become expert gatherers of information from the situation before us. We need to make what Eraut (1990) has called ‘tacit knowledge’ apparent to all of our colleagues by talking about what we see or hear. This helps us shape the questions that we ask and the sort of additional information or guidance that might help us respond most effectively. Equally, we need to become good at analysing accounts of problems, the explanations that others offer regarding what is happening or why it is happening. We need therefore to unpick what the explanations mean. What does it mean, for instance, to be cyanosed? What does it mean to be anxious? When we combine work with information from both sources, the situation and the theories or accounts, we are likely to produce better answers.

Problem- and enquiry-based learning approaches are techniques designed to help you develop the sort of inquisitive skills that work well in situations such as those described above. They not only help you to manage a patient’s admission to hospital in a sensitive way, but also help you to understand why other practitioners hold strong views upon health care issues such as childbirth. They help to explain why working in health care can seem stressful and can prompt new ways to feel professional in the face of considerable demands and pressures.

Learning how to make inquiries or to solve problems involves learning how to think and work inductively and deductively.
NURSING WITH PROBLEM-BASED AND ENQUIRY-BASED LEARNING

It teaches you how to combine the two processes. Reflection is not always enough (Taylor, 2001). Simply applying theory from a textbook rarely works. It is the combination of theory and reflection, within the context of a group effort, that makes the fundamental difference to how you operate. I hope that this chapter has set the scene for such learning and convinced you that there is personal benefit in learning using PBL and EBL techniques. They are not simply an educational quirk or a new way of teaching. At their very best they can help transform the way in which you think and work at the bedside! Completed successfully with the help of a facilitator, they can represent the very best means of becoming a confident and then later an expert practitioner of nursing.

**Inductive work**

The nurse ‘reads’ the patient’s face and concludes that the blue appearance means that he is cyanosed. Poor supply of oxygen makes mobility difficulty and may impair thinking. This patient may not be well placed to give a health history right now.

- **Reading the situation**, using our eyes and ears, the questions and tests that we run.
- **Deciding what this means.** What do we need to do? What else do we need to learn?
- **Forming a working theory or account of what is going on** (tentative at first).

**Deductive work**

The nurse has a theory which, whilst not necessarily a perfect fit for the situation, could illuminate why the patient’s wife behaves as she does. It is used to understand why she is tense and asks questions so sharply. As a result, the nurse reacts thoughtfully, helping the wife to cope with her sudden feelings.

- **Anxiety interferes with our ability to interpret situations** – we may react abruptly or defensively.
- **The hospital is a stressful place. It is a new environment.**
- **I need to proceed sympathetically and to expect that he or she might ‘snap’.**

**Figure 1.3** Ways of working with information

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