

Health Care Leaders' Perspectives on How Continuous Professional Development Can Be Promoted in a Hospital Organization

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Introduction: Leaders play a central role in continuous learning processes aimed to improve health care. However, knowledge of how leaders with power and influence in hospital organizations promote the means for continuous learning in practice is scarce. This study aims to explore how key stakeholders in a hospital organization think about approaches and roles when promoting the reflective practice in small groups as means for continuous professional development in their organizations.

Methods: Six key stakeholders from a regional hospital (two department directors, two ward managers, and two resident supervisors) were recruited through purposive sampling. Semi-structured interviews were conducted, and an abductive content analysis was performed.

Results: In the current study, leaders stressed that cultural and structural conditions at all levels in the system were important for the practice of small-group learning. Yet, their suggested approaches referred exclusively to a limited part of the system and were directed to staff at lower hierarchical levels within their jurisdictions.

Discussion: The identified gap between the suggested approaches and the claimed conditions for implementing a new strategy for continuous professional development among leaders in a health care organization illuminates difficulties in the implementation process. Providing adequate conditions at all levels of the system demands implementation approaches that include the entire hospital system. This requires that leaders first recognize their need to learn and apply a systemic perspective, and second, that they can create such learning opportunities for themselves.

Keywords: system thinking, leadership, quality improvement, experiential learning

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Expanding scientific knowledge and rapid developments in technology require all health care professionals to learn, collaborate, and apply new insights to deliver safe and informed health care. The growing need for up-to-date knowledge among health care professionals challenges the health care sector on how to organize and stimulate continuing professional development (CPD). Economic and personnel resources in health care limit the number of health care professionals that can be excused from clinical duties to participate in formal courses. Research in the field of CPD stresses the need for strategies to extend learning activities beyond traditional educational approaches.¹ By applying formats of learning that can be integrated into daily clinical practice, access to CPD could increase.

Reflective practice in small groups is a format of learning that could be applied as a part of daily clinical work. This practice can be organized with a facilitator that is engaged to support discussions on clinical issues. Educational research shows that reflecting on experiences has the potential to increase acceptance of feedback, improve self-assessment, and promote the development of professional identity.²⁻⁴ Furthermore, enhanced learning and improved collaborative competence have been linked to reflective practice in a small group setting.⁵ Beneficial effects for clinicians engaging in small group reflective practice in an enhanced sense of well-being, job satisfaction, and professionalism have been reported in several studies.^{6,7} Learning through reflective practice in a small group setting is

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Upon initiation of the study, an application for ethical approval was sought from the regional ethical review board at Göteborg, Sweden. Because the study was judged not to concern the processing of sensitive personal data, the application was deemed exempt from review. The participants were given written and oral information about the aim of the study, the procedure of data collection, confidentiality, and their voluntary participation, in accordance with the provisions of the Ethical Review Act (2003:460) (24).

Ethical approval: When transcribing, data were de-identified, and no data that could be linked to a person were registered. The study population consisted of six individuals within three different professions and three organizational roles. To ensure anonymity, it was decided that quotes would not be linked to profession or role in the presentation of findings.

The datasets used and/or analyzed during the current study are available from the corresponding author upon reasonable request.

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underpinned by socioconstructivist learning theories where learning occurs as a result of the learner's active internal processing and active interaction with other people and the environment.⁶

However, the task of accomplishing organizational uptake and incorporation of new learning formats in different practices in a hospital organization is a challenge. The integration of new practices in a complex system such as a hospital necessitates engagement and learning at and between all levels.⁹ Medical education has traditionally been based on a teacher-oriented perspective, and education in the clinical setting has been organized in apprenticeship models.^{8,9} Introducing reflective practice in small groups denotes a shift from a teacher-oriented learning perspective to a learner-centered perspective that could be difficult to advocate.¹⁰ Supporting active learning rather than teaching others what one knows puts demands on supervisors and teachers that could evoke feelings of uncertainty and resistance.¹⁰ Moreover, in the system, there may be divergent and even conflicting views among individuals at different levels of the organization, not only about what it means to introduce new learning practices but also on how development is best initiated and driven in the system. The notion that development is accomplished through a leader-led rational agency stands in contrast to the notion that agency is distributed and constructed through social interactions that are influenced by context.¹¹

Considering the challenges to accomplish change in a health care organization, ambitions to implement new means for continuous learning may fail if leaders are unaware of their role in the implementation and how to exercise support in a complex system. A hospital organization is a complex system where different interacting and interdependent parts continually adjust to changing circumstances. The system can be illustrated by a micro-meso-macro-level model.^{12,13} Taking a macro perspective means including a whole organization as a system, where a part of a system is considered from a meso perspective and individuals are considered from a micro perspective.¹² We argue that leaders at all levels in an organization play a central role in continuous learning processes aimed to improve the delivery of health care services. Although managerial support has been demonstrated to be essential for a successful change process,^{12,13} the research focus so far has mainly been on how to implement learning opportunities and how to motivate individuals on a micro-level. Insights in how key stakeholders at different levels in a hospital organization perceive approaches and roles when promoting CPD within their establishment could inform future organization of CPD within health care.

In this study, we aim to explore how key stakeholders at the macro- and meso-levels in a hospital organization think about approaches and roles when promoting the reflective practice in small groups as a new strategy for CPD in their organizations. The meso-level in this study refers to the departments and wards at the hospital, whereas the macro-level refers to the entire hospital organization represented by the hospital board.

METHODS

A project to integrate reflective practice in small groups in the clinical work, as a new strategy for CPD and as the development of local clinical practices, was developed at a Swedish regional hospital. Reflective practice was arranged in small groups to

discuss clinical matters brought up by the participating residents. The group sessions were led by a tutor as a facilitator. The tutors were prepared for their tasks within the project. In the process of incorporating reflective practice in small groups in the hospital organization, both educational leaders in the clinic and managers at the meso- and macro-level in the organization were considered key actors. Accordingly, in this study, perceptions among these leaders about approaches and roles when promoting the reflective practice in small groups as a new strategy for CPD in their organization were explored.

The point of departure for this study is an interpretative paradigm, meaning that interpretations of phenomenon or experiences in a specific context are considered useful for understanding actions and thoughts.¹⁴ Thus, a qualitative approach for the collection and analysis of data was chosen. Six health care leaders at the macro- and meso-levels at the hospital were recruited through purposive sampling (Table 1). To gather rich data, we aimed to include participants with diverse experiences and potentially diverse perspectives. Variety in gender, age, supervision experience, profession, and role in the organization contributed to the elucidation of different perspectives on how reflective practice in small groups could be promoted.

Data were collected through semi-structured in-depth interviews.¹⁵ In the study, three domains were explored: perceptions of reflective practice in small groups, potential benefits in clinical practice, and thoughts about the application in clinical practice in the hospital organization.

The interviews rendered a large amount of rich data and were read and considered as a whole. In the interest of keeping the presentation clear, this article reports the results relating to the domain about application in practice. The other domains will be presented in detail in later publications. In summary, the health care leaders perceived reflective practice in small groups as an important opportunity to reason about experiences and learn in collaboration with others both related to individual development and as a support to improve practices in the organization. They also pointed out its potential for discussions about challenging issues such as ethics, behaviors, and emotions.

The domain about the application in practice was initiated with the question: What do you think about your role in promoting the reflective practice in small groups? Initial answers were followed up with probing questions to enhance the collection of rich data, and the participants were encouraged to give examples and to further describe their views. The interviews were tape-recorded and lasted between 30 and 52 minutes. Transcriptions were made verbatim. Content analysis with an abductive approach using a nonlinear relation between data and theories was applied.^{16,17} This means that even though no predefined theories were directly applied, the process of selecting data and identifying patterns was influenced by the character of the data and by the researchers' previous experience and knowledge of the concepts studied.¹⁸

TABLE 1.
Description of the Respondents

Role in the Organization	N	Profession	N	Gender	N	Age
Educational leaders in the clinic	2	Nurses	2	Female	2	34–62 years
Health care unit managers	2	Physicians	3	Male	4	
Department directors	2	Psychologist	1			

N indicates number.

The transcripts were read repeatedly to obtain a general understanding of their content before meaning units were identified. Based on variations and similarities, the units were then grouped into categories before being further condensed into codes. The codes within each category were interpreted considering their underlying meaning, resulting in three main themes and two sub-themes. Table 2 illustrates an example of how an original transcript was condensed and interpreted. Two of the authors (C.S., Å.A.) read all the transcripts, and one of the authors (Å.A.) identified the meaning units and grouped them into categories that were discussed among the authors before they were condensed into codes. The interpretation of the codes and identification of themes was a collaborative process where all authors participated. Two of the researchers (A.P., C.S.) are teachers at a faculty where reflective practice in small groups is a means of teaching and learning. The third researcher (Å.A.) is a clinical teacher at a regional hospital where this practice is uncommon. Although the researchers all have research experience in medical education, we represent three different health professions: nurse, physiotherapist, and physician, and our different experiences have enabled us to contribute with and elucidate different aspects in the process of interpreting data.

RESULTS

Three main themes were identified when interpreting responses from the respondents. Cultural and structural conditions important for practice are illuminated in the first two themes: *Culture shapes conditions for reflective practice in small groups* and *Learning necessitates space and place*. Ideas of how and by whom practice could be stimulated are elaborated on in the third theme: *Approaches to accomplish change*. The quotes are marked by a letter in brackets that represents the different respondents, A–F.

Culture Shapes Conditions for Reflective Practice in Small Groups

The existing culture, in norms and attitudes to learning, was described to set the scene for reflective practice in small groups. Leaders at the macro-level were described to have the responsibility to signal the importance of reflective practice in small groups to lower hierarchical levels in their organizations.

“...An awareness among healthcare leaders of an organization that this [reflective practice in small groups] is important is demanded. It has to be expressed in some way and diffused down in the organization...”(A)

Experiences of a nonhierarchical culture characterized by sharing knowledge in an open atmosphere were exemplified to promote reflective practice in small groups: “...Then...it [the

implementation of reflective practice in small groups] depends a lot on the culture. Is it ok to educate, to accept new knowledge, and share knowledge with each other? That is not always the case...” (C)

Attitudes toward qualitative methods, in general, were described to influence perceptions about reflective practice in small groups. Skeptical attitudes toward qualitative methods, reflective practice in small groups, and discussions about ethical issues were described as constraints for the implementation: “...The challenge will be to find supervisors suited for the task. Sometimes there is a mentality towards those methods” “... Well, there could be resistance towards qualitative methods that hinder learning in small groups...” (E)

Learning Necessitates Space and Place

Sufficient space and an appointed place of learning in the organization appeared as a key for the implementation of reflective practice in small groups. Space and place were not only described as structural resources consisting of human and economic capacity in the health care organization but also as cultural signals of importance. Instructions and responsibilities on how to disseminate knowledge and participate in reflective practice were explained to signal importance and promote implementation. Appointed educators with mandates to create opportunities for reflective practice in small groups were identified as central actors for change in practice.

“...The person who is to implement it [reflective practice in small groups] must have a clear mandate to arrange an adapted schedule...where there is space for education...” (C)

Existing ideas that reflective practice in small groups reduces resources for health care appeared as a hindrance to the implementation.

“...If you take some individuals out of healthcare production to participate [in reflective practice in small groups], others have to compensate for them being away...” (D)

Approaches to Accomplish Change

Ideas of how to promote the use of the reflective practice in small groups came to the fore as different approaches. On the one hand, participants identified how they, as leaders, could drive change. Yet, on the other hand, they placed the responsibility for change in the lap of the hospital organization. The first subtheme (“how leaders can drive change”) illuminates ways the respondents, in their capacities as leaders, could stimulate reflective practice in small groups in their organization. Contrasting perceptions of the system as the agent for change make up the second subtheme, “assigning responsibility for change to the hospital organization.”

TABLE 2.
Steps in the Process of the Content Analysis Illustrated by an Example

Meaning Unit	Category	Code	Sub-theme	Main Theme
“...The organisation has to create possibilities to be absent from the clinic to do other things, such as lunching or participating in education and so on...”	Conditions required to accomplish change	The organization has to create possibilities to be absent to participate in education	Assigning responsibility for change to the hospital organization	Approaches to accomplish change

How Leaders Can Drive Change?

The respondents, as leaders, expressed themselves to be initiators and driving forces for change. The use of reflective practice in small groups could be promoted if the participants as leaders acted as role models and prioritized learning in practice: “. . . It is really important to set a good example. If we, for example, are really busy at the ward, I can, as a manager, bring in extra staff to liberate time. . .” (F)

Talking about reflective practice in small groups and involving co-workers in creating structures that would enhance its use was expressed as means for leaders to be supportive: “. . . We have worked a lot with improvements. Among other things, we have considered how to adapt the work schedule to be able to work with reflective practice in small-groups. . .” (F)

Involving representatives from all health care professions was stressed to stimulate a positive attitude toward changes in general, which was also believed to be important when increasing the use of the reflective practice in small groups in the hospital organization: “But if I, as a leader, can find some small change and involve all professions in working with the change, I believe that it could feed a change culture. . .” (A)

Another proposed method for a leader to drive change was by giving their formal support or approval: “. . . I would not mind working to implement it or support it. . . Well, it could be to suggest. . . or approve of time being used to work in this form. . .” (D)

Assigning Responsibility for Change to the Hospital Organization

The enhanced use of the reflective practice in small groups in the hospital organization was expressed to demand active support from the organization in structure, resources, and leadership. Structural hindrances to participate in small-group learning were to be resolved by the organization. The organization was assigned accountability for learning opportunities: “. . . The organization has to create possibilities to be absent from the clinic . . . to participate in learning . . .” (B)

The allocation of resources was identified as an organizational obligation: “. . . Education must be prioritized and built into the system; enough resources must be reserved so that as many as possible can participate in education. . .” (E)

Leadership in the hospital organization that promotes a team culture was deemed important for the use of small-group learning: “. . . I believe that it [the development of a team culture] is a question of leadership. We have had managers that have worked to make the staff become a part of the organization. I believe that is the key to making people grow potentially beyond yourself. To demonstrate a belief in the staff you have that you want them to engage and participate. . .” (F)

DISCUSSION

The current study provides insights into aspects that leaders on the macro- and meso-levels in a hospital organization find important when promoting the reflective practice in small groups as means for CPD in their organizations. Interestingly, a gap was exposed between the leaders' views of prerequisites for the practice of reflective practice in small groups and their strategies to stimulate practice. On the one hand, they referred to systemic conditions in a hospitable climate, sufficient room, and

also an acknowledged value of reflective practice in small groups at all levels of the organization. On the other hand, their suggested strategies referred to a limited part of the system. Ideas of how to make a difference in their roles as leaders were described exclusively in relation to the staff they were in charge of. Notably, they talked about the macro-level as something outside their reach. Instead of acknowledging themselves as being a part of or having the ability to influence the system as a whole, the macro-level was described as a separate autonomous entity.

Consistent with sociocultural learning theories, both cultural and structural circumstances were found relevant to the reflective practice in small groups.¹⁹ Importantly, the leaders identified engagement at all levels of the hospital system as a prerequisite for creating such circumstances and implementing new practices of education in line with learning organization theories.²⁰ The somewhat contradictory finding that their strategies focused exclusively on staff at the lower hierarchical levels of their jurisdiction mirror previous studies of the difficulty to connect the macro-level with operational approaches at the meso- and micro-levels.²¹

Interestingly, the findings indicate that the leaders had an interest in and knowledge of how to interact and drive development by supporting learning at the micro- and meso-levels of the organization. Their strategies refer to different incentives for participation in reflective practice in small groups in structure and cultural prerequisites, such as allocated time for learning, work structures adjusted for the benefit of learning, and the existence of a nonhierarchical culture. However, although these strategies may be supportive at the meso- and micro-levels, we argue in line with theories of learning organizations that they will not contribute to the incorporation of the practice in the hospital system unless they are disseminated at all levels of the organization.²⁰ Moreover, isolated practices relying on a few stakeholders are not likely to be sustainable over time. If leaders at the meso- and macro-levels do not stimulate engagement and learning in the whole organization, including their colleagues at the same hierarchical level or above, there is, from our perspective, no obvious actor that can take on the role of creating engagement and learning in the entire hospital system.

We claim that a shift in strategy is the result of an active process in which different perspectives and experiences are considered. Following this line of reasoning, a shift in strategy among leaders demands them to engage in a transformative learning process.²² Although, to engage themselves and develop a strategy that stimulates learning and engagement in the entire hospital system, we claim that they not only need to accept their own learning needs but also to create learning opportunities for themselves. Notably, the leaders in this study identified the importance of culture, time, and space for the education of their staff in line with socioconstructivism learning theories.¹⁹ Leader engagement in their learning processes could be counteracted by existing cultures and traditions in their organization. A top-down management culture, as signaled in the findings of the current study, may impede leaders from learning strategies on how to interact between levels and drive change in the system as a whole.²⁰ Moreover, creating learning opportunities that attract leaders with divergent views about the practice of learning is a challenge.²³ Views of learning as an occasion where professionals are taken out of daily practice and where knowledge is primarily delivered stand in contrast to views of learning as a process where learners construct knowledge together in daily practice.

A limitation of this study is that the findings are based on inquiries from a small number of respondents in one setting. Nevertheless, it is beneficial that they represent different health care professions and leadership levels in a hospital, and through the in-depth interviews, they contributed rich data that illuminate the research questions. The research process, from its design through the collection and interpretation of data, is clearly described to enhance the ability of readers to judge its credibility and potential transferability to other settings.

The authors' professional knowledge and preunderstanding may have affected the interactive process of collecting, analyzing, and interpreting the data.¹⁷ All authors were engaged in reflection at different stages of the study to improve rigor. Their different roles and knowledge made it possible to challenge each other's assumptions and continuously return to data for confirmation of interpretations and to reflect on methodological procedures.

Future studies that explore how leaders can be supported to learn and apply systemic strategies are warranted, considering that the future delivery of safe and efficient health care services depends on leaders having the knowledge and motivation to influence conditions at all levels of their organization.

CONCLUSION

A gap was exposed between the views of prerequisites for reflective practice in small groups among leaders in a health care organization and their strategies to stimulate practice within their organization. Although the leaders identified key conditions for learning at all system levels in time, space, and learning culture, their strategies focused exclusively on staff at the lower hierarchical levels of their jurisdiction. The exposed gap illuminates the need for leaders to approach conditions in the entire system when implementing learning practices within their organizations. However, the application of an approach that includes the entire system demands that leaders recognize their own need to learn how to apply a systemic perspective. In addition, they need to be able to create such learning opportunities for themselves and their leader colleagues at the same level or above. External incentives may be needed to initiate this transformative learning process considering the indications of top-down management culture in the findings of the current study.

Lessons for Practice

- Sustainable implementation of new practices of continuous learning in a hospital requires approaches involving the entire hospital system.
- Leaders at all levels of a hospital organization must learn how to create support in the entire hospital system for new learning practices to become sustainable.
- In a top-down management culture, external incentives may be needed to initiate the transformative learning required for leaders to engage in learning and application of an approach involving the entire hospital system.

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REFERENCES

1. Kitto SC, Bell M, Goldman J, et al. (Mis)perceptions of continuing education: insights from knowledge translation, quality improvement, and patient safety leaders. *J Contin Educ Health Prof.* 2013;33:81–88.
2. Mann KV. Reflection's role in learning: increasing engagement and deepening participation. *Perspect Med Educ.* 2016;5:259–261.
3. Barry M. Reflection: turning experience into learning. In: Boud D., Keogh R., Walker D. eds. *(Book Review)*. London, United Kingdom; Methuen, MA: Taylor and Francis Group; 1986:197.
4. Schön DA. *The Reflective Practitioner: How Professionals Think in Action*. Aldershot: Arena Publishing, Canada; 1995.
5. Dennick RSJ. Medical education: theory and practice. In: Dornan T., ed. *Chapter 9 Teaching and Learning in Small Groups*. Edinburgh, Australia: Churchill Livingstone/Elsevier; 2011.
6. Gleeson C. Education beyond competencies: a participative approach to professional development. *Med Educ.* 2010;44:404–411.
7. West CP, Dyrbye LN, Rabatin JT, et al. Intervention to promote physician well-being, job satisfaction, and professionalism: a randomized clinical trial. *JAMA Intern Med.* 2014;174:527–533.
8. Spencer JA, Jordan RK. Learner-centred approaches in medical education. *BMJ;* 199;318:1280–1283.
9. Rassie K. The apprenticeship model of clinical medical education: time for structural change. *N Z Med J.* 2017;130:66–72.
10. Burgess A, van Diggele C, Roberts C, et al. Facilitating small group learning in the health professions. *BMC Med Educ.* 2020;20:457.
11. Caldwell R. Things fall apart? Discourses on agency and change in organizations. *Hum Relat (New York)*. 2005;58:83–114.
12. Hannah ST, Lester PB. A multilevel approach to building and leading learning organizations. *Leadersh Quart.* 2009;20:34–48.
13. McGrath C. *What We Talk About When We Talk About Change: A Study of Change Practice and Change Agency in Higher Education [doctoral dissertation]*. Stockholm, Sweden: Karolinska Institutet; 2017.
14. Crotty M. *The Foundation of Social Research*. London, United Kingdom: SAGE publications Ltd; 2003.
15. Kvale S. *Den kvalitativa forskningsintervjun. 3. [rev.] uppl.* Brinkmann S, ed. Lund, Sweden: Studentlitteratur; 2014.
16. Graneheim UH, Lundman B. Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Educ Today.* 2004;24:105–112.
17. Atkinson P, Delamon S. Analytic perspectives. In: Denzin NK, Lincoln YS, eds. *The Sage Handbook of Qualitative Research*. 3rd ed. Thousand Oaks, CA: Sage; 2005.
18. Thomas G. Doing case study: abduction not induction, phronesis not theory. *Qual Inq.* 2010;16:575–582.
19. Illeris K. Comprehensive understanding of human learning. In: Illeris K, ed. *Contemporary Theories of Learning: Learning Theorists in Their Own Words*. 1st ed. London, United Kingdom: Routledge; 2009:7–20.
20. Senge PM. *The Fifth Discipline: The Art and Practice of the Learning Organization*. London, United Kingdom: Century Business; 1993.
21. Knill C, Lenschow A. "Seek and Ye Shall find!": linking different perspectives on institutional change. *Comp Polit Stud.* 2001;34:187–215.
22. Mezirow J. Transformative learning as discourse. *J Transform Educ.* 2003;1:58–63.
23. McGrath C, Barman L, Stenfors-Hayes T, et al. The ebb and flow of educational change: change agents as negotiators of change. *Teach Learn Inq.* 2016;4:1–14.
24. *The Act Concerning the Ethical Review of Research Involving Humans (2003:460)*. Available at: http://www.epn.se/media/2348/the_ethical_review_act.pdf. Accessed May 30, 2022.