The chapter describes how hierarchies may appear in a teaching context of interprofessionality involving all kinds of health professions and how these hierarchies represent challenges for learning. The student group embodies different experiences of the health care system that are brought into the teaching context and played out in ways that may hinder teaching processes that are open enough to promote learning.

Profession based hierarchies as barriers for genuine learning processes

Inger Lise Teig

Introduction

Knowledge of student learning processes is important in order to help ensure good teaching. There are many aspects of the learning process that affect how and what students learn. Education cannot be reduced to mere processing of information or sorting knowledge into categories. Neither can it be reduced to an individual interpretation of the meaning of the utterence of the teacher. "Each word tastes of the context in which it has lived its socially charged life […]", according to Bakhtin 1984, 293), and in light of this sociocultural perspective on language and communication this chapter will discuss how we can help students construct meaning with a "cultural sensitive approach" (cf. Bruner 1997).

In health care settings, a pressing problem is that health professionals cannot or will not cooperate (Axelsson & Axelsson 2009) and professional cultures contribute to challenge effective interprofessional teamwork (Hall 2009; Hindhede and Andersen 2019). Interprofessional

teamworking in practice is thus diffiult to realise but is essential in order to improving services and to maintaining the health of the population (Xyrichis and Lowton (2008). Interprofessional teamwork may thus be a challenge in health care *practice*, but will teaching in an interprofessional health care *educational setting* transcend this challenge?

In order to understand the dynamics of teaching health care professionals in a interprofessional contesxt, this chapter focuses on how hierarchies (e.g. stratified social orders between professions) can appear between different categories of health professionals enrolled as students in continued health management education, and how these hierarchies may represent challenges for learning. A student group composed of different health professionals embodies different experiences of the healthcare system as such. These backgrounds are brought into the teaching context and played out in ways that may hinder sufficiently open teaching processes that promote learning. To overcome these challenges, a teacher should arrange teaching methods and techniques with an eye to creating genuine dialogical meetings between the students in this kind of teaching context.

Teaching is a complex process, almost an art (Kubli 2005). To understand the teaching process better, several theories of teaching as well as theories of students' learning and understanding have been developed. Theories can influence teachers' behaviour, and the more closely they match the complex reality of the classroom, the more real help they can provide (Kubli 2005). Much educational research has studied structures of classroom discourses, less has focused on teacher-student dialogue (Skidmore and Murakami 2016). However, Alexander (2001, 2017) has developed a model of 'dialogic teaching, inspired by Bakthin which is a teaching principle that centers on the power of talk to stimulate and extend students' thinking in order to advance their learning and understanding. Dialogic teaching depends upon the participants' willingness to "relinquish the floor to the other or to make room for the other's active responsive understanding" (Bakhtin 1986, 71). A dialogical approach to teaching opens

the tone in the classroom (or other group learning settings) in a mutual shaping way when the utterance is not dominated by a single, authoritative voice. From a dialogic pedagogy perspective, a key premise of learning is that the student participates in a genuine multi-vocal and dialogical teaching context (Dysthe 1996, 2002, Alexander 2001, 2017; Skidmore and Murakami 2016).

Dialogism

Bakhtin emphasizes that all sociocultural phenomena are "constituted through the ongoing, dialogical relationship between individuals and groups, involving a multiplicity of different languages, discourses, and symbolizing practices" (Bell and Gardiner 1998, 4). In order to understand the teaching context of continued education in health management at a Norwegian University, I turned to Bakhtin and his dialogical approach--the "dialogism". According to this approach, language is of fundamental importance to our identity, and the language has an *ontological nature*, as the language is about who one is (Bakhtin 1981); "we *are* our conversations" (Sandywell 1998, 199). Our voice thus "also includes a person's worldview and fate. A person enters into dialogue as an integral voice. He participates in it not only with his thoughts, but with his fate and with his entire individuality" (Bakhtin 1984, 293).

As language is part of a person's worldview, the goal in teaching implies that it is important to develop the linguistic identity and voice of the students (Dysthe 1996). According to a dialogical perspective, reality occurs not only *through* multiple voices, but *in confrontation* between different voices. Bakhtin distinguishes between different voices - one's own voice (*svoj golos*) and a foreign voice (*čužoj golos)* - and "we communicate by crossing barriers: leaving our *svoj* or making another's *čužoj* our own" (Emerson and Holquist 1981, 424). Consequently, in order to ensure good learning processes we have to cross barriers: We have to leave our own voice in order to open up and to listen to the voices of others,

then to experience that the voice of the others modifies one's own voice. Bakhtin's dialogism focuses on the fact that one's voice is always oriented towards the voice of the other. By incorporating the other's perspective into one's own, increased insight and nuance is enhanced. Learning occurs when this new (the other) voice is incorporated into one's own voice, as this voice is carried out on alien territory (Robinson 2010) and fuses into one perspective. Additionally, within this dialogic approach the teacher's power is deconstructed when multiparty participation is cultivated. Creating opportunities for multiple perspectives to transact with one another is thus at the heart of dialogic teaching (Steward 2010).

However, it is not always easy to make room for multiple voices in a concrete teaching context. According to Delpit (2006), we, teachers included, must "be vulnerable enough to allow our world to be turned upside down in order to allow the realities of others to edge themselves into our consciousness" (Delfit 2006, 47). Classrooms must therefore become places where dialogue takes place through the confrontation of different voices. For enabling the confrontation of different voices in my teaching context, I had to reorient my pedagogic approaches and introduce the sociology of the health professions into the classroom from the very first lecture. The aim of this chapter is to explore how teaching can be organized to promote different professional voices to give way to each other, to facilitate a better learning process; i.e. how to get into a dialogue in a Bakhtinian sense.

Professions and hierarchies

The term '*profession*' is a debated term, but it usually describes an occupation with socially recognized knowledge and skills that distinguish it from other professions. The occupational group has control and monopoly of the tasks and a high degree of autonomy in the execution of them. Professions are knowledge-based groups that have developed through an institutionalization of education, establishment of professional

organizations, and development of ethical standards; they claim jurisdictional control based on specific knowledge(Freidson 1970; Light and Levin 1988; Evetts 2013, 2003). The knowledge boundaries between the various professions are not finitely determined but rather are to some degree fluid, which means that professional conflicts are being played out at the borders between professional groups. Such professional conflicts have significantly affected and still affect the healthcare sector. Although professions depend on each other to perform their tasks, this dependency is characterized by different levels of control and a hierarchical order, for instance, formal guidelines require that a physician (or staff the doctor has delegated authority to) is the only one who can hand out medicines. However, if a nurse has delegated responsibility for the distribution of medicine, the nurse may not delegate the task to auxiliaries. For health care professions knowledge claims play an important role in achieving jurisdictional control and is a power struggle (Hindhende and Anderson 2019).

Continuing education students are coming to the classroom socialized and educated with this kind of professional hierarchy as a form of tacit knowledge achieved through their professional training. I gradually realized that the hierarchy of the health professions was unfolding in its magnitude in the classroom. The student's social status in the classroom as "student" was not neural, it was rather "health care professional" with all its sociology embedded.

The teaching context

The university course 'Health Management' is a continuing education experience for healthcare personnel at a Norwegian university and requires at least two years of work experience in the healthcare sector. It provides 20 credits and is included as one of three subjects (the others are health economics and quality improvement) in an experience-based master's degree offered at the university. The course is set up as four one week gatherings

during the autumn semester. Students participate in five full days of teaching activities at each of the week sessions. The students are required to present a group project with a given theme in the plenary during the third session, as well as write an individual essay with a self-chosen theme before the fourth session. The student must pass both requirements before the exam.

The student group is normally heterogeneous and consists of all types of health professionals (nurses, doctors, health technologists, auxiliary nurse, etc.). Students come from both primary and specialist health care services, some are relatively new graduates, others have decades of experience. Some are leaders, others aspire to become leaders, some have PhDs, and others do not have further education or courses beyond their professional education. Overall, the student group is composed of a good representation of the health service as a whole. This diversity, however, also represents a significant challenge for teaching, especially in order to make teaching equally meaningful to the whole group, and to create meaningful discussions and conversations across all of these experiences.

The teaching challenge

The main challenge in this interprofessional group context was to integrate students' different experiences and professional training backgrounds in order to achieve active participation and conversations to provide all students with an open learning context. In several occasions, as a teacher, I noted that many students did not attend plenary discussions despite a small group of participants (25-30 students). Regardless of the fact that I actively and systematically tried several ways to make silent students participant, this pattern did not change. I gradually learned from student evaluations that some professions were perceived to be more dominant than others, and thus some students “feared” or avoided disputing or openly disagreeing with the perceived dominant students. When this same pattern was repeated the two following semesters, I actively tried to encourage

full student participation and attendance due to my belief that active participation leads to better learning.

An additional, but highly important premise for the study is that it is experience-based and that student reflections, analyzes, examples discussed from practice discussed in class are or may be based on the experiences students have experienced or observed through their professional work life. If only certain students from certain professions attend class and express their experiences, insights and knowledge gained are limited or biased. Important aspects of healthcare practices were therefore at risk of being silenced and thus not paid the necessary attention if voices from all healthcare profession were not heard.

The implementation

I assumed that the challenges I met in the classroom required a change of pedagogy. I had to implement a different approach to teaching. The aim of the implementation was 1) to increase the interprofessional interaction and dialog, 2) to increase all students' participation in the classroom, and 3) to improve interprofessional cooperation after the course with the intent of having an impact on daily healthcare practices. The overall aim was to increase their sociological awareness and improve the dialogical professional competence, both practically and theoretically.

Method

In order to get better interaction and engagement between the students by overcoming professional hierarchies, I had to think both practically and theoretically. The idea was that these two perspectives could enhance each other positively. I sought to change the pedagogical approach through an implementation of two measures: 1) splitting up the whole student group in more interprofessional groupings (not allowing doctors cooperating with, or sitting next to, other doctors, etc.), and 2) giving students lessons in

theories of professions, of social hierarchies, power and organizational practices.

The first intervention I implemented was to make students work in cross-professional groups over several weeks to collaborate on a joint task they had to present at a plenary talk of the third session. I divided students into groups based on their different professional background, from different parts of the health service, variation in age and gender, and I mixed somatic services with psychiatry. In previous classes, I allowed students to self-select the other students they wanted to work with. However, as often happens in self-selected groups (Baer 2003), these students chose to connect with people they already knew or who had the same professional background (doctors with doctors, hospital staff with students from hospitals, nurses with nurses, etc.). When I started the implementation, I had seen that these homogeneous groups became less challenging and I noticed that this structure preserved familiar interaction patterns from their daily practices, in which amplified hierarchial barriers between the professions.

The second intervention implemented was to start the very first gathering by lecturing on the theory of professions and emphasizing reflections on the importance of professions, organization of healthcare services, and power. The intention was to stimulate thinking about the context in which they are located, their practices and the meaning of professions in the healthcare context. My presumption was that they have previously completed a mono-professional education that structures how they perceive, cooperative with and experience other professions in their daily work. This again affected how they relate to other professions in other contexts, such as within the university teaching context.

Result

Based on the observations and evaluations of the student groups of 2017 and 2016 compared to the groups of 2015 and 2014, I noticed a remarkable

increase in student interaction. Plenary talk became more inclusive and less dominated by doctors, and more students engaged in these discussions. Responses from students emphasized that they felt that the class situation for engaging in discussions was open and generous. Evaluations of the group work underlined that the task was interesting and useful and that the groups cooperated very good. They became acquainted with many of the students in short time, and no one had experienced problems of cooperation even though they did not know any of the participants in their group in advance. On the contrary, they reported that they had learned more of the entire healthcare service by hearing the experiences of others. They also emphazised that they had had time to discuss with students they did not know and who had experiences and knowledge unknown to them.

Discussion

Several studies show that the bridge between teaching and learning is strengthened when the teaching context promotes dialogical meetings (Dysthe 1996, Kubli 2005, Skidmore 2016). The learning environment can be improved by focusing on elements that contribute to dialogue such as the role of the teacher and the degree of participatory symmetry (Dysthe 2002). In my case, there was a noticeable improvement when I as a teacher more actively composed working groups by thinking more systematically (and sociologically). The classroom is not a neutral meeting place that eradicates social factors (here: hierarchy of the professions), but rather a context that often *enhances* social distinctions leading to communication and understanding difficulties. The awareness that I had to facilitate dialogical meetings more actively than I previously did, led to a twist from homogeneous student participation (choice of group partners) to heterogenous participant symmetry. In this context participant symmetry led to the development of student ability to challenge the hierarchy of profession. This implied integrating the voice (and thus the experience) of others to a greater extent than they had previously been the case. This

insight underscores Bakhtin's (1981) belief that an understanding of the ways in which culture and language transact in the classroom can help teachers create classroom environments based on genuinely dialogical interaction between teachers and students, and among students, instead of an authoritative discourse. Effective teaching rests on the teacher's ability to create spaces for dialogues, and classrooms must become places where *heteroglot* voices (Bakhtin, 1981) are openly represented. When heteroglot voices and viewpoints – in this context; when interprofessional voices and viewpoints are welcomed into the classroom, dialogical learning is promoted. Dialogue enriches learning, and an open learning environment stimulates the development of critical skills. Steward (2010) argues that learning to examine differences is one of the keys to what he calls *authentic learning*, and that authentic learning has the power to engender social and political change instead of simply leading students to shallow, simple answers to questions that they have little interest in answering. If we interpret authentic learning as dialogical learning, we can use Steward's argument in the case described in this article. As students open up their own voice and incorporate other voices into their worldviews, their social, professional, and potentially political perspectives on the healthcare sector can be more fully explored and may lead to a changing and more complex view on the education process in which they are engaged. This expanded dialogic communication during the continuing education course may also lead to an increased awareness of the entire field of healthcare practice impacting future daily healthcare practices.

My altered pedagogic approach was motivated by the insight that the students had to become comfortable and capable to cross disciplarary and professional boundries in order to break down barriers that they were not conscious of in the immediate learning context. These communication structures had led them into conversational patterns that reproduced professional hierarchies and facilitated the continued dominance of power of one profession over others.

Heirarchial inbalance privileged one group over another and the authoritative word thus created prevents true dialogues. According to Bakhtin's (1981), "the authoritative word demands that we acknowledge it, that we make it our own; it binds us, quite independent of any power it might have to persuade us internally; we encounter it with its authority already fused in it" (Bakhtin 1981, 342). The problem with the authoritative word is that it does not create room for dialogue or promote doubt and resistance. The authoritative word embeds a social authority, as we can see in the case described in this chapter, where the words of the doctor who presumably knows everything best, dominated. The authoritative word is not related to outspoken students as such, but in the way the language binds us through authorized truths or persons recognized as authorities in the hierarchy of healthcare professions.

Summary

In summary, we may transfer this case of overriding of professional barriers into a learning situation as a Bakhtinian dialogism that exceeds the pure categories and looks at multilingualism (interprofessionalism) as an opportunity for growth (knowledge based on experience and professional history) - a form of confrontation between different realities that create new realities through the actual teaching context. This opens health profession students up for learning, for when freely listening to the voice of other professions, after having minimized the authoritative voice, students are able to become more aware of the other's experiences and, by implication, made more aware of their own perspectives *as* perspectives. This in turn provides a deeper insight into the experiences of the field students are part of and opens them up to the opportunity to learn something new from the exerience of those from other fields. When students integrate new knowledge with existing knowledge it is both learned and remembered better (Brandsford, Brown and Cocking 2000, 14-18). It is when they share their own voice as healthcare professional that the students can

more fully experience open learning activities and discussions. It is the teacher's responsibility to contribute to reducing barriers through a dialogical approach in the actual teaching context. A dialogical approach thus helps one to "become sensitive to everyday discursive phenomena" (Shotter and Billig 1998, 14) that often remain unquestioned or unspoken. "All words have the "taste" of a profession, a genre, an age group, the day of the hour. Each word tastes of the context in which it has lived its socially charged life…" (Bakhtin 1981, 293). One's profession and the hierarchy embedded in the system of different health care profession may work as a significant barrier for genuine learning. By creating teaching approaches that mix professionals in strategic ways facilitate crossing this barrier, allowing an open and dialogical learning process to emerge. it is not enough to simply understand the other's perspective. Only when one is made other than oneself by being seen from outside, can something new or enriching emerge, as in this context; genuine learning through acknowledging the other professions' worlds (Bakhtin, 1981).

We thus reach "active responsive understanding" (Bakhtin 1986, 71) through "authentic dialogue" (Steward 2010, 6) when students are able to construct knowledge together as they are becoming aware of other students' worlds of understanding, when "someone else's words [are] introduced into our own speech," Bakhtin (1984, 195). By allowing multiple voices to exist and to be contfronted through in the classroom dialogue, social barriers such as professional hierarchies are transcended and genuine learing are made possible.

Lessons learned

Dialogic teaching enhances learning in an interprofessional context and is a fruitful model for education in interprofessional settings. Dialogic teaching may decrease implicit social barriers and lead to a more genuine

learning process with implications for health care practices beyond the very teaching context.

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Biography

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