Chapter 6

Pedagogising of my claims to know in the development of an *inclusional* pedagogy of the unique

6. 0 The previous chapters presented my insights into my belief system and how I think, in terms of my enquiry into what structures and influences my thinking and knowing. The purpose of this chapter is to look at what it means to me to become a critical educator and to revisit the development of my educational pedagogy. I engage with my curriculum issues, in terms of their history, theory, design, assessment and evaluation. This chapter evidences my original contribution to education by showing how the development and format of the values that I have made explicit emerged into living standards for a healing curriculum. These standards, with their embedded inclusional thinking and values, combined with the authority and power of the state, were moved from ideas on paper to the reality of praxis. Standards in nursing are important to me as I care deeply about my profession. As a profession I feel that we need to ask and find answers to the questions of what direction our profession is going to take and, as educators look to our inner teachers, namely our hearts, to see if we are truly educating our future nurses in care and critical thinking. This is necessary alongside inculcating ideas of the autonomy of thinking, including acceptance of the responsibility of such thinking when transformed to praxis. This chapter shows the human side of moving an idea forward, as it weaves its path to acceptance as a valid knowledge base. The ideas have been shaped and moulded by many different sources which are discussed in this chapter, yet throughout the process the original idea of compassionate critical caring has never wavered or been changed. What

has been modified is the cultural sensitivity of the learning outcomes in their cultural context.

This chapter pays close attention to the process of my pedagogising my claims to know and my knowledge, examining the development, implementation, assessment, and evaluation of my curriculum for healing reflecting nurses in a Japanese university. I will explain my self-critique process as an educator. This includes how I integrated my declared values into my curriculum. I am not using 'critical' in the sense of a *bad* thing or to *criticise,* rather I am using Wink's (2005, p. 31) sense of critical, to mean *seeing beyond.* Becoming critical is for me a process of prodding and probing, of not actually being sure what I am going to stir up or reveal in myself, my values and my practice as I seek to realise my insightfulness.

6. 1 The process of enquiry: Becoming critical

During my last visit to my supervisor in England, in September 2006, as I was preparing to present two papers at the British Educational Research Association annual conference, I came to realise that I had been studying for ten years. During those ten years, I had done all I could to master the student role of a knowledge gatherer and researcher as I passed through the higher education system of the United Kingdom. Here I was, just months away from finishing my PhD thesis, when the realisation hit me that I had the authority of my own scholarship and could ground what I wanted to say in the depth and breadth of my reading. I needed to let go of being the universal student and move into a maturity of engagement with creating my own knowing. I came to realise that I could tell my stories in narrative form and still be scholarly and critical. This process had been so long in the

realisation that I felt both relief and a grieving, for I could no longer lay claim to being the student - instead, I now had to accept the authority of my learning and seek to use it wisely.

[Each of us has our own worlds that are part of the reality of who we think we are. I can choose to enrich myself and others by the living and sharing of these worlds. My own unique world is the culture I know best; it is where I feel the most at home. I speak the language and understand the codes, both explicit and implicit, yet no-one's world or culture is 'best' or most correct. Becoming critical has enabled me to free myself from inappropriate forms of thinking in myself, and to see with a joy of celebration the other's forms of knowing which can so enrich my own existence. Becoming critical has given me courage to enquire and such enquiry has become my treasure-box as I reveal the differing and complex layers of my own humanness, and that of others, in and around my world.]

I recognise that I am a product of my own educative journey, one where reflective practice and researching my own understanding of my Western "I" are fundamental aspects of my own being. Yet, in the same context, I see my Eastern Buddhist understanding as the dissolving of the concept of my "I", and as being equally important and fundamental. Being and becoming critical are now key aspects of my ontology, yet I struggle with trying to see the separate areas of me, namely those of the nurse, the teacher, the reflective practitioner and researcher, as separate items or areas. For me they are all parts of my whole understanding and existence; in fact they form my inclusional/holonic concept of myself (Wilber 2000; Rayner 2003), which is constantly evolving as I seek understanding of my "I" in my living educational theory. I find myself, a Western white man, in an Eastern society fighting for Eastern values against an Eastern system of education that has become so colonised by the West that they are at times more Western than the West. Evidence-based nursing has an important role to play in nursing, but it has to be balanced

with the not so easy to prove needs of spirituality, cultural awareness and compassion. As previously discussed, after the Second World War the United States rewrote the Japanese constitution and introduced an American model of healthcare and nurse education. Some Japanese scholars are voicing similar opinions, for example Hisama (2000) is also critical of modern Japanese nursing following blindly a Western model of nursing while at the same time acknowledging that Japanese nursing makes rapid progress when it works in association with other countries and cultures (p.454). Sato (1986, p.216) suggests that: "*…an examination of the methodology of nursing in Japan and the recovery of the identity of nurses is important."* What I am suggesting is that Japanese nursing has a strong history of spiritual caring (Hisama, p.451) and a middle way needs to be sought by Japanese nurse scholars, one that is inclusional and embraces both medical and spiritual concepts of care.

In my MA dissertation (Adler-Collins 2000) I delineated my epistemology and explored my ontology concerning the issues of *space creating* and how such a space was opened, held and protected by my values of love, compassion and critical reflection. Over a period of ten years, I created healing spaces that were protected through my enactment of those values that provided the necessary conditions for the healing of others. My praxis was to create, maintain and understand a safe healing space and to construct a valid account of my professional practice. There seems to be a process at work in becoming critical. It is not something that happens suddenly; however, insights happen in a *flash of inspiration*, although I would argue that even such flashes are grounded in a database of knowing. Such a database is acquired over time and accessed by critical keys of consciousness. Wink (2005, p. 5) refers to becoming critical as *critical pedagogy*, which she says includes the process: *to name, to reflect, critically act.* However, I sense that Wink's process needs further engagement and exploration. Wink stressed the need *to name the problem*. In

order to name the problem, a complex order of thinking must take place in terms of consciousness and values. Analysis can only occur when and after a known knowledge base is used as the benchmark against which I can assess any new data, situation or knowledge. This knowledge base is highly complex and evolves as new actions and the ideas of others are processed by our sensory input and weighed against what we know, experience and remember. In order to give a name to the problem we have to see it, but seeing is problematic, subjective and not always reliable. I ask myself the question: *How then do I see?,* closely followed by: *How does my seeing affect or enhance my becoming critical?*

[There is no easy or short answer to the complexity of the above questions. To become critical I need to make discernments. I need to understand that these discernments may be flawed at best or even outrightly mistaken. In a lively debate with my supervisor, the different understandings of 'mistaken' and 'making mistakes' came to light between us. My supervisor believes that we can make mistakes which are judgement calls grounded in the assessment of a situational outcome. I, with my Buddhist understanding, do not believe in making mistakes. Rather I believe that all I do is for my learning, the consequences of all my actions are for my understanding and enlightenment. There are situations which I do not wish to repeat; if I do repeat them then the teachings of that situation re-present themselves. This links into the Buddhist understanding that every one, thing, form, object is your teacher. I need to understand that the 'seeing' I do is subjective to my learning and my capacity to step outside what is the given norm. By this I mean that even to see that something is wrong, one first has to think that something is not right. Where, or how, this trigger for the formation of a question to interrogate comes to consciousness intrigues me. Maybe it is the influence of or exposure to the ideas of others, the violation of a held morality or ethic, or value. I do

not know. Yet it seems to me that without inclusional thinking in terms of the questioning of the thought, there is no place to go in order to see.]

To reflect critically: Here again I have what appears to be a simple statement, but when looked at in greater depth it poses some interesting questions. In my understanding, if I reflect then I am looking backwards at events in general terms. My consciousness is placed in the past and I become the observer of events and my actions and feelings. *Yet of what value is reflection if the values base of emotions and knowledge is not consciously known and understood*? *Of what value is reflection when the bias we hold colours all that we see?* The very construction of the word 'reflection' speaks to me of images that have been distorted, as all reflections are by the source of the reflection. In the case of mirrors it is light; in the case of consciousness it is the filters of my senses, memories, experiences and actions that reflect back to my consciousness. Embodied within each of us is the bias of the cause and, for me, the implications of that bias are extended into and beyond my praxis. Therefore, to give reflection too much value is problematic and I believe flawed. However, in what seems a living contradiction, reflections demand much attention, conscious thought, and practice. Such practice is brought about by working with the art of enquiring of oneself in a Socratic manner and, more importantly, opening up one's internal thinking and enquiry to examination, testing and/or validation with the ideas and thoughts of others.

[Perhaps I am dealing with my own Buddhist filters as I seek to move my reflection of the moment to be in the moment. Reflective practice is often used in nursing to include the concept of learned

knowledge gleaned from experience of the actual results of theory in practice. I can assess how to clean a wound because of the actions I have performed in the past. As I apply the results of those actions to the conditions I am seeing now I can critically assess, with a degree of certainty, that such and such is a good course of action. My knowing is also reinforced by the knowledge base of learning that belongs to my profession. I strongly believe that there are different forms of reflection that are linked to space and time. I examine in Chapter 7 a critical incident where this point is explored at more length and in greater depth.]

The last element of Wink's statement above is: *To critically act.* Such an action assumes that your reflections have informed your praxis and such praxis is under the conscious scrutiny of the self or ego which is evaluating each and every aspect of the process. I believe that critical praxis is something I strive for; a state of mind that is in tune with the moment, informing my teaching as I respond to the needs of my students. The opposite of critical praxis is mindless action, performed under the premise: *doing something is better than doing nothing.* It has been my experience that to act in haste means to repent at leisure. I would extend Wink's ideas with the addition of having to hand some process for evaluation and modification of thought, word or deed that comes from my praxis and informs new cycles of thought, leading to new praxis. Nieto (1996) suggested that becoming critical is an exploder of myths, and I can certainly confirm that many of my own myths have been exploded as I sought a state of critical awareness.

6. 2 The process of engagement: Turning theory into practice

6. 2. 1 Early days: Reflections

I clearly remember when the idea of developing a curriculum for healing first presented itself to me. In 1995 I was between positions (the polite way of saying unemployed!), working as a volunteer manager at an addiction drop-in centre in Glastonbury (UK). Glastonbury is famous for its hosting of an annual music festival, and in its chequered past it lays claim to being the home of the hero of English folk history, King Arthur of the Knights of the Round Table. It is a vortex for people on their spiritual quests, with an exotic mix of covens, earth mothers, sun children, the black arts and no doubt a few Harry Potter fans. Workshops for enlightenment, spiritual gurus and soul partners abound. It is a place where being *weird* is actually quite normal. I used to frequent a local watering hole called the Blue Note Café which served delicious vegetarian food to a background of rhythmic blues and didgeridoos, and at very reasonable prices for a between-positions spiritual traveller like myself who was looking to realise his inner child, address his femininity issues, learn to tie his ponytail and, of course, realise his universal potential of being an ascended master and saving the universe. The matter of cash was important as the work at the centre was for food and board. I have written at length about this period in (Adler-Collins 1996). I had experience in my work of people who had tried strange alternative medicines, healings and therapies along with cocktails of organic herbs and plants and strange tobacco. I experienced a deep sense of dis-ease as I attended more workshops and became critical of the content of these workshops. I was critical in the sense that many participants could neither substantiate their therapeutic claims nor say where their body of knowledge came from. When asked, the most common reply was that it was channelled from a spiritual teacher, a guide, or was inspirational. Of more concern to me was meeting an ever-increasing number of nurses who came to these courses as they

sought ways of improving their patients' therapeutic care. In England, nurse licensing is very clear in that the nurse is legally responsible for his/her actions. Including aromatherapy, reflexology and other forms of alternative healing in nursing care was and is highly problematic. What was also very clear was that there was no regulatory process within the teaching of complementary medicine and healing. Anyone could set up a centre or a school and become a teacher. At this time I was reading the work of Skolimowski (1993, 1994) and thinking deeply about his words :. . *We are still novices in the art of thinking. Great discoveries in ourselves and in the cosmos at large will depend on the invention of new forms of thinking, you are what you think (p. 169).* If new ways of thinking are the way forward, then it becomes a matter of importance to learn what the present thinking of the government and the health care sector is.

Historically, the field of training in complementary medicine has been surrounded by controversy, and there has been a lack of clear understanding of the nature of professional standards or practice in complementary medicine and the complex process of validating the standards. I used my work as a complementary therapist (Adler-Collins 1999) as a starting point for extrapolating my meanings and values from within my practice.

After 1995 I moved to my own centre with the intention of opening a school and clinic and, through studying my own practice as a Director of a School of Complementary Medicine, a Registered Nurse, practising therapist and researcher, to offer some insights on the way my curriculum evolved over time (Adler-Collins 1999). I hoped to overcome the problem highlighted by Johannessen (1994):

Another problem in research on unconventional Medicine seems to be that many unconventional practitioners have no training in research and therefore have difficulties performing research of [an] adequate standard (p. 57).

Johannessen (1994). COST European Commission

The above report by the European Commission acted as a challenge to me to become involved in the design and implementation of standards in complementary medicine. At that time I had no idea what it would entail or where it would lead, nor had I any conception of what it would cost.

6. 2. 2 Early beginnings and context

My curriculum development was grounded in its national and European context. The following gives a clear insight into the issues I was facing which shaped my thinking and my praxis. *Government policy permits a doctor registered with the General Medical Council (GMC) to use or prescribe therapies (BHSS letter UNP/13 of 2.9.1985)*. The United Kingdom Government's statement of 3rd December 1991 confirmed a Registered Medical Practitioner's right to delegate treatment of patients to specialists, including complementary therapists. Such treatment can be paid for either by the Health Authorities

or fund-holding GPs. What the statement conspicuously did not say was that it gave any form of approval to any particular therapy. The responsibility clearly remained that of the prescribing doctor, hence the term complementary medicine was born as it was complementary to the care of a doctor and not a replacement for it. Complementary medical treatments such as aromatherapy and healing touch became an attractive option for nurses seeking to find ways of helping the recovery process of their patients. This is a very important distinction from alternative medicine, which is outside the authority and responsibility of doctors because alternative therapists claim autonomy in diagnosis and treatment.

The GMC's rules for doctors, published in *Professional Conduct and Discipline: Fitness to Practice* dated February 1991 (paragraphs 42 and 43), allow a doctor to delegate to persons trained to perform specialist functions, treatments or procedures provided that he (the doctor) retains ultimate responsibility for the management of the patient.

In 1994 the Government, through the Department of Employment, commissioned a project in which National Occupational Standards for health and social care would be developed. West Yorkshire Health Authority has published Guidelines (1995) for the employment of complementary therapists in the NHS. There are as yet, however, no national standards for training, curriculum, assessment or validation of therapists, and the British Complementary Medicine Association (BCMA) Executive Committee is still seeking trust status.

6. 2. 3 The European context

The European Union has undertaken developments on several fronts relating to complementary medicine, its direction and training standards. The European Parliament document, reference A3029194 part B, 1994, was issued by the Committee of Environment, Public Health and Consumer Protection. This shows that complementary health practitioners (Heilpraktiker in Germany) are treated differently in different countries. Six member countries of the European Union either tolerate the profession or recognise it officially. The approach in the United Kingdom and Ireland is based on Common Law dating back nearly four hundred years. Since 1970 Denmark has permitted people who are not doctors to practice non-conventional medicine subject to certain conditions. Germany recognised the profession of Heilpraktiker in 1939. Since 1981 the Netherlands has not prosecuted complementary health practitioners and a bill to recognise them as an independent profession is currently being drafted. In Spain, finally, the Supreme Court has ceased to convict practitioners who are not doctors.

Each country wishes to protect its citizens, and the European Union is faced with a paradoxical situation in which a health practitioner who is recognised as competent and practices in one country may be prosecuted in another member country for practicing illegal medicine. This situation conflicts with the principles of the Treaty of Rome, in particular those concerning the free movement of persons and the freedom of establishment (Title 111, Articles 52, 56 of the Treaty of Rome).

... The Commission states that proof of therapeutic efficacy cannot be obtained by generally accepted scientific methods. The Commission requires a guarantee relating to training and suggests that legislation must be enacted on teaching by specifying the content and establishing who is competent to teach, and goes further to suggest that the teaching structure should be to university standard qualifications or a high level diploma. Such study should take place in university facilities or private institutions licensed and subsidised by national authorities. These should lead towards a state recognised diploma.

(European Parliament document A3029194 Part B.)

In 1990 the Committee of Environment, Public Health and Consumer Protection presented a proposal for a European Directive aimed at widening the scopes of European Directives 65/65/EEC and 75/319/EEC by including homeopathic medical products. This proposal was included in Directive 92/73/EEC. The European Parliament was consulted and was called upon by the Commission, by a large majority, to implement all the appropriate measures to ensure the harmonisation and status of complementary medicine.

[An Explanatory Statement (1995) on the status of complementary medicine in Europe hinted at things to come and there was an attempt by the EEC (now the EU) to regulate training in complementary medicine. This was known as the Lannoye report. Lannoye's comprehensive report on the status of complementary medicine in Europe brought together a series of European papers and made recommendations for the harmonisation of training standards in complementary medicine within member states. It championed a higher education platform for the education of therapists across borders. The report called for the licensing of centres of excellence and their working

towards state approved qualifications. It was critical of the several member states who actually contravened the Treaty of Rome, which calls for cross-transference of skills across the borders of member countries. An important point made in this report was that being a qualified doctor does not mean that you automatically have the right to be a complementary therapist. It implied that further training is required. A point to note is that they were looking for a training period of 4-5 years at higher education or university level (Paper A3-0291-94 part B. EEC Commission Brussels). I wanted to be part of this process and so I joined the British Complementary Medicine Association. In 1996 I was voted on to the executive council where I helped to respond to the Lannoye report. My interest in standards for nurses was well and truly burning bright at this time. It needed to be, for I was in no way ready for the politics of money and power in relation to the complementary medical sector. As this sector is part of the private sector, and is driven by business needs and drives, getting the different groups to work together was almost impossible. Claims made by therapies such as aromatherapy and reflexology, to name but two, just could not stand up to critical examination. Often the therapists were commercially motivated and linked to private schools that licensed practitioners at will, with vastly different inputs of knowledge that were never challenged. Such dishonesty in terms of products and the claims of what the oils could do as cures were, and still are, major stumbling blocks to the acceptance by the establishment of aromatherapy as a viable tool.

As a member of the BCMA executive I was concerned about many items in the Lannoye report, but at the same time could completely understand the vision of the objectives, both short- and long-term, alluded to within the report. We produced an internal paper that called into question the use of the words 'alternative' and 'complementary', as there is much play with the semantics of words which do however bear great relevance. Alternative medicine is practiced without the use or input of a qualified doctor. Complementary medicine is exactly that; it complements the care already being

given by a qualified doctor. The document in itself was self-serving; this is hardly surprising because the BCMA represents 25,000 practitioners.

The document outlined our concerns about Lannoye, and in certain areas tells Lannoye what the UK position is. The disturbing thing about this document is that it takes the viewpoint that the BCMA has the right to view this platform as its own. One of the interesting factors of the report, however, is that it does appear to accept most of the Lannoye report including element 1, which refers to the training of complementary therapists at a higher educational level leading to a state award. This is quite surprising really, as most of the therapists within the BCMA have very poor qualifications. The implementation of the Lannoye report is going to cause the sector as a whole tremendous difficulty if it goes its own way. The BCMA makes no reference to how the Lannoye report will impact upon their training schools. At this time I had finished my PGCE at Bath University College and presented the BCMA executive with a framework curriculum for the different therapy groups to modify to their specific needs. I then took my curriculum with me as I started my Masters degree in Education at Bath University.]

6. 3 The issues of training and standards

Complementary medicine as a generic includes healing, and as a sector has to address the issues of training and standards and all the sub-issues of accreditation, validation and research protocols. There is ample evidence that the classical medical model of research, with its use of control groups for testing the efficacy of different medicines, appears inappropriate when the intentions of therapists and the feelings of patients are to be taken

into account. (C. O. S. T. Action B, Unconventional Medicine, First Annual Report, European Commission 1995).

Because of the value-laden nature of education, the issue of defining the standards of professional practice in any form of education depends on defining, communicating and legitimating the values-based criteria of assessment. In 2000, nursing in the United Kingdom was undergoing its own process of complex change as it moved towards the placing of nurse education in the universities and extending training to four years under the Project 2000 scheme. Day *et al*. (1995) have made the following suggestion for the nursing curriculum: . . . *the work of the Care sector Consortium could complement the work of the UKCC (United Kingdom Central Council) & ENB (English National Board) to inform the setting of standards and educational training in Nursing, Midwifery and Health Visiting.* They continued: … *perhaps it is not surprising then that curriculum developers are now examining NVQ approaches to identify the best principles of practice and how these might be applied to the Nursing Curriculum.* The National Vocational Qualification offered a way forward in looking at the development of a set of criteria for healing and complementary therapies within nursing.

Late in 1995 I was immersed in the training of nurses and the question of standards. I took those issues that concerned me to the three steering groups of which I was a member, and then used that information as part of my enquiry in my Masters course. At this time I was asking myself questions of the nature: *What standards of practice do I use in accounting for my work as a nurse practitioner, priest, and teacher director of the Laurel Farm Clinic*

of Complementary Medicine? *How do these questions inspire, contribute or construct my curriculum design?* My choice of a heuristic action research approach to my educational enquiry arose partly out of asking the above questions. Cohen (1995) said of action research:

> *...Action Research . . . Essentially an on the spot procedure designed to deal with a concrete problem located in the immediate situation. This means that the step by step process is constantly monitored (ideally that is over varying periods of time and by a variety of mechanisms; questionnaires, diaries, interviews and case studies, for example). So that the ensuing feedback may be translated into modifications, adjustments and directional changes, redefinitions are necessary so as to bring about lasting benefit of the ongoing process itself. (p. 223)*

The choice of heuristic living action research was largely determined by the nature of my question. Because the question involved a self-study of my own practice which includes the designing of a curriculum, I needed an approach which might enable me to answer such a question. The only research approach which appears to embrace the 'I' of the researcher as part of both the object and subject of an enquiry is that of heuristic living action research.

[There are several different schools of action research. Noffke (1997) and Hughes, et al, (1988) have argued that it is important to understand the theoretical antecedents of the approach used. I

looked at Whitehead's (1993) living theory approach and felt some affinity for it because it focused on the individual creating his/her own explanations for his/her own practice in enquiries of the kind: 'How do I live my values more fully in my practice?'. A deeper question was simmering in the back of my mind; I wondered at this point whether a living-action-research curriculum could allow the students the space to engage with critical thinking skills as well as developing the practical skills of a therapy?]

I wanted to go further in my curriculum design than interpretation of methodological issues and to put myself and my practice at the heart of my enquiry. In 1997-8 I was asking myself questions of the kind: *"Could I bring my living values as forms of judgement into a curriculum that would hold transferable values in terms of standards of actions and competency for healing nurses?"* In seeking an answer to this I explored the collaborative action research approach and, for a module of my Masters in Education at Bath University, worked with Professor André Dolbec of the University of Quebec in his work on collaborative inquiry. Our work produced a benchmark paper (Adler-Collins 1999) indicating a clear link and remarkable similarities between the expectations of the client and the therapist in a safe space. This paper laid the groundwork for my understanding that the values we give things, when made clear as repeatable standards of judgement, provide a safe framework for therapy. I was also at this time elected to a Government steering group for the development of standards in health care and to the Royal College of Nursing steering group for standards in complementary medicine pertaining to nursing practice.

At this time I became greatly focused on space and the boundaries of what made up or defined space. I saw space as being in and part of everything. I took Lewin's theory of tension (1939) and modified it to create a neutral safe zone where both the student in my curriculum and I would be safe to explore the concepts of the curriculum without violating the other in our quest for knowledge. I suggest that Lewin's theory of tension, of A dominating B or B dominating A, can be modified by creating a neutral zone of 'safe communication' where both A and B can examine the issues or facts and take on board what they are able to integrate into their own truth and understanding. An inclusional curriculum needs to be one that creates a safe space for such a process to occur. The seeds of my understanding, that my curriculum was to have more than one layer of meaning and/or outcomes that were not just educationally driven but could contain a values agenda, had been sown at this time. I did not, however, have a conscious understanding of all that I was trying to do.

6. 4 Clarifying my living values

I wish next to provide a clarification of my embodied living values and the knowledge from which I designed and pedagogised a curriculum for the reflective healing nurse.

I have identified these fundamental Buddhist values in myself as respect, sensitivity, openness, flexibility, love, non-judgementalism, non-violence, the capacity to forgive, and compassion. These values are, I believe, fundamental to nursing and have been at the core of my thinking as I have sought to design an appropriate and viable form of curriculum. This conceptualisation of my curriculum needed to fulfil a set of self-imposed criteria, an example being: *That I provided a clear academic audit trail of good practice and*

scholarship. This is important for me so that I can provide an audit trail for external validation or verification of my educational process, thinking and rationale, thus facilitating easier assimilation by the academy. Providing an audit trail would lead to good quality control processes. Showing educational rigour and scholarship would make it harder for the dominant medical paradigm to reject the content, as it would then be rejecting the very foundation on which its own power base is built. I believe firmly that what are seen as *outrageous claims* become *meaningful insights* once you have passed through the necessary academic hoops. Secondly, rigour and scholarship would provide the *means of skills transference;* and I am including here the normative values of orthodox nursing curriculum content. The concept of *life skills* is to be seen in terms of the competency of the art and practice of my students' nursing as they engage in healing practice in the workplace, supported by the knowledge they acquire from the healing nurse curriculum and especially that of its values base. I recognise that such an outcome is desirable, and I believe critical, to compassionate criticality exercised in nursing judgements, but it is very hard to prove that it has been achieved.

I view my everyday living through the aspects of my active value filters. I am using them consciously in the moment of knowing through doing. Yet as I change outward roles my inner ontology remains firmly grounded in my values and my faith. Through the praxis of *where we are* my conscious understanding deepens these values and solidifies them into *certainty* (Heidegger 1962). From this positional understanding of *certainty* I set about building my framework within which I see and make sense of the world. Such a framework is my *living truth*. I use 'living truth' in the sense that Burke (1992a) described it, as differentiated from spectator truth. The *living authentic* truth of a situation can be fully understood only from within the situation. The picture that emerges will never be as

clear-cut as that provided by *spectator* truth with its imposed rationalised framework. I also believe something that in one way is problematic in its description, namely that I move from the consciousness of the immediate, in the moment and the living truth, to the reflective, past, spectator truth.

I claim that it is this framework that is my emerging epistemology, for as my ontology is deepened and modified as a continual process of my conscious existence, so then, in the Rayner (2003) sense, my epistemology evolves and metamorphoses into new forms of knowing in, on and around the moment of conscious understanding.

I claim originality for my concept through my own authority of being. It is this concept on which I build my pedagogy of the unique, for it is my spirituality, truth and the very cosmology that I live by which directly influence my being and are direct results of my own experience. Through this process, by critical reflection, I identify key aspects and areas of learning that have occurred. My living truth, I believe, is grounded in the practice of my nursing, my teaching and the daily living of my humanity, where theory has to be borne out in practice on a daily basis by the very nature of my work.

I bring to my teaching the instruction and ideas of experience grounded in my practice as a nurse, and offer these for open debate and analysis with the idea that the students will engage with these values. In this case I can provide evidence of process but not evidence that the learning has been for Good. (By 'good' I am acknowledging my tension around the desirability of the need for critical thinking attested to by nursing scholars, for the future of nursing as a profession and the industry that is dominated, as explained above, by

medical Doctors and owners of individual private hospitals, as is the norm here in Japan. There is no evidence yet that producing critically thinking nurses is a good thing for the student nurses we are training for the industry in Japan.) I can even provide analysis of the power structures and relationships to knowing and knowledge, but I cannot prove understanding. The universal nature of the values I hold, as core human values of mindful living, are embedded in my curriculum. I hope that the students, by their selecting the seed values and making them their own or not as the case may be, will over time allow them to take root in their cosmology as they evolve into caring healthcare professionals. As I set these values, I designed and piloted a curriculum as a goal, and what I eventually did and where my new goal ended up is an example of the transformation of embodied values. My analysis of that transformation shows originality and critical judgement. I show how living action research extends to the borders of expression and pushes those borders to embrace new epistemologies. In keeping with the cycle model of heuristic living action research, I constantly revisit my experiences to seek their teaching and learning.

6. 5 Setting the scene

I developed and refined my educational content and the structures of my curriculum by using them as the basis of my research as I passed through the higher education system of the UK: *Further Adult Education Teaching Certificates 1&2* (FAETC), *Postgraduate Certificate of Education, Further Adult Education* (PGCE FE), *Master of Arts in Education* (MA) and now my PhD. I grounded my theory and ideas in the practice of my own schools of healing studies in Bath (UK) in 2000, and Kumamoto (Japan) in 2002, finding out what worked and what did not, then modifying the learning outcomes accordingly. This curriculum was based on my previous experience of the Governmental Steering

Group on Standards in Complementary Alternative Medicine, of which I was a member in 1996. What were being anticipated as levels of competence and subjects of study were concerns of the Royal College of Nursing Complementary Alternative Medicine (CAM) steering group. I was elected to this group in 1999. Levels of competence were a main concern of the group, as was what a CAM competence would look like. I was elected to the Executive Committee of the British Complementary Medicine Association (BCMA) and was well versed in the European movement and political agendas relating to healing and complementary alternative medicine. I moved to Japan in 2000 to study Shingon Buddhism and undertake another 100-day fast. In 2002 I was notified that my curriculum for the healing nurse, which I had submitted to the Japanese Ministry of Education and Health in 2000, had been selected for inclusion in the curriculum of a new university being built in Tagawa City in Fukuoka Prefecture. The university start date was April 2003 and I was duly appointed as a Lecturer in Mental Health, teaching theory and practice of healing and complementary medicine.

6. 6 Re-defining my practice, making explicit my position: understanding my learning (2005)

My living educational theory is being practiced within the context of another set of contradictions (Whitehead 1989). Within educational circles this is known as the paradigm wars, mentioned briefly in Chapter 3 in relationship to ethics, described by Gage (1989, p. 43) as: … *a minefield of conflicting polarities,* and by Schön (1995, p. 32) as: … *an epistemological battle*. The paradigm wars are very real. Donmoyer (1996, p. 19) wrote of them: … *the fact [is] that ours is a field characterised by paradigm proliferation and, consequently, the sort of field in which there is little consensus about what research and*

scholarship are and what research reporting and scholarly discourse should look like. The paradigm war within the Western academy is at least explicit. Here in Japan another kind of conflict is also occurring that is not so explicit and is much harder to detect. As well as the issues raised in the paradigm clashes and conflicts I have witnessed, there is paradigm colonization under way. This, I believe, is a far more serious issue. For example, the importation into Japan of Western concepts of nursing, ethics and research, and the subsequent use of these concepts, shows that there has been a change in the way that the ideas are understood by the Eastern academy, as compared with the Western academy, although the ideas originated in the West. Japan is often cited as importing models and paradigms en bloc; a trend that started with Japan's drive to westernise during the Meiji period of the 19th Century (Takemura and Kanda, 2003; Hisama, 2000; Wolferen 1990). As a result, at the end of the 1930s, according to Wolferen, Japan was: … *left heirs to a farrago of disjointed, ill-digested bits and pieces of knowledge* (p. 239). The problem then, and I would say now, is that the very contextual roots from which the knowledge was grown were not transferable or even fully understood. Hence the situation for Japanese academics was problematic - on the one hand they sought external forms of knowing in their drive to be Western, but on the other hand did not have the resources to reproduce those same paradigms in Japan because they were considered to be culturally inappropriate. I refer to this situation as *flower-arranging education*. By this I am using the metaphor of the flowering of different types of knowledge. When Japanese scholars see the flower they cut it and bring it back to Japan. It is not difficult to see that the flower is appreciated for being a flower, careers are even based on this, but, however, the flower is but the blooming of a process. Without the roots and stem (cultural context) the flower will die. Even if attempts are made to preserve it, soon the inevitable changes in what was originally attractive will occur.

Japanese nursing scholars have entered many foreign universities to take higher research degrees in ever-increasing numbers. On graduation they bring back, quite naturally, the teachings and knowledge they have gained. In the process many become converts to new ways of thinking and many have claimed to have been changed by their experience of studying abroad (Doutrich 1993, p. 141). These new ways of thinking are presented to the nursing academy as new directions, and careers are built by academics following one particular paradigm or another. However, it is often the case that serious consideration is lacking as to the suitability of the imported knowledge for the cultural needs of Japan. I was surprised to find that my own thoughts were expressed by Dr Raphael Kroeber as long ago as 1914 (cited by Wolferen 1990, p. 239) when he said: … *these scholars import only the flowers which amaze people without trying to transplant the roots. As a result we have people who are greatly admired for bringing the flowers but cannot find the plants that produced them*. I believe that there is a real danger that the *West is Best* thinking is taking root in many areas that are seeking to upgrade nationally so as to be on a par with the West, such as defence, medicine, dentistry, nursing and other healthcare and para-healthcare disciplines. This danger is even more significant and pressing as I seek clarification of my own embodied values and knowledge in order to design and pedagogise a curriculum for the healing and enquiring nurse. I need to understand what my own values were right from the beginning of when I started to live the paradigm fusion. This, as my thesis has shown, is a process I have often been through, becoming more discerning with my reflections as my insights have deepened and I have sought to make sense of what was often incomprehensible. My analysis of my teaching and methodology progressed over time and I had a sense that the nature of the questions was changing, reflecting, I would claim, a more inclusional understanding of the context in which I/we taught and

learned. Examples of these questions are: *What is our practice and what do our patients require from us? How can we improve this course for future students?"*

I have grave concerns as I not only watch the paradigm wars unfold here in Japan but live embedded in them as a foreigner in a culture that has a feudal system of education. By 'feudal' I mean that the professors have total control over what low-ranking teachers can and cannot do. Because of cultural expectations, seniority in Japanese institutions is about time served and not about academic ability, qualifications and achievements. It is not uncommon these days to have senior faculty in Japanese nursing with no masters or doctoral degrees but who are associate or professorial heads of department or line managers. It is also not unusual for such faculty not to be qualified teachers. A partial explanation of this is the sudden change in the education of nurses in Japan and the explosion of universities as previously discussed. A direct result of this action, which seems to have been missed by the planners, is the critical shortage of suitably qualified nursing faculty. It is not hard to see how individuals in senior posts feel threatened by more qualified staff in junior grades. Such junior staff members are expected to remain silent in meetings and follow the leadership, however outdated or inappropriate that leadership may be. Nurse educators who have studied abroad feel this disparity most keenly on their return, often opting to remain silent in the hope that they will be reinstated in the communal circle (Doutrich 1993, p. 155). Once again we are reflected back to the living reality of *thinkable and unthinkable* forms of knowing and control of the primordial gap through the use of academic pedagogy and personal power (Bernstein 2000).

[Such thinking is not well received in Japan, especially when it comes from a foreigner who is searching for Japanese meaning within a Japanese contextual framework and cultural practices. It is my contention that Japanese scholars need to be more critical of the imported knowledge and its impact in terms of its ability to fit into Japanese culture. A Japanese person who has returned to Japan after studying abroad, usually in America, would sometimes be called 'Americagaeri', a derogatory term that has embodied within it negative judgements of that individual as being assertive, outspoken, displaying direct and frank behaviour, and speaking without knowledge of the context. I found it fascinating to read Doutrich's thesis, as much of what she researched and discovered about the experiences of Japanese nurses returning from abroad has also been my experience as a foreign nurse educator. Instead of being called Americagaeri I am called a 'Henna Gaigin', this being a foreigner who has immersed him/herself in Japanese traditions, language and culture and is equally mistrusted. There is no equivalent term in English; perhaps the nearest we have is saying that someone has 'gone native' - tolerated by a few but usually despised for what is seen as abandoning their own culture, nationalism, context and roots. I remember with such cutting clarity the occasion when, after my house had burnt down and I had lost all my Japanese priest clothes and kimonos (a form of traditional Japanese dress), a faculty member came up to me and said: . . . "It is nice to see that you have found yourself; your dressing in our clothes was such a joke." I was deeply upset by this, for when I became ordained I wore only traditional clothes. I spoke to a close friend about this incident and, after a moment's silence, she explained that Japanese people are confused to find a foreigner in traditional clothes acting in a traditional manner, especially that of a Japanese priest. Moreover, the cost of the kimonos I wore was more than most Japanese could afford. Few Japanese men owned traditional dress, and to see a foreigner wearing many different kimonos caused anger. Now, because of my contextual awareness, I never wear traditional dress outside of my temple duties.]

Being so deeply involved in this living process it is sometimes problematic to be detached, as I am in the middle of the experience and trying to understand and make sense of it. I reflect on my experiences and I am struck by the need for praxis. For me, my praxis focuses on the development, delivery and assessment of my living-theory curriculum.

In the above sections I have explicated, in a narrative format, my process of curriculum development - from its conception, which I wrote out on a beer-mat in a pub in Glastonbury, England, in 1995 (Adler-Collins 1996), to the day in 2005 when the first student nurse completed an official healing session in a Japanese hospital, a day on which history was made and the first stage of the journey of the healing curriculum, ten years in the making, was concluded. In the remaining narrative I shift my focus on to the educational structure, delivery and assessment of the curriculum as I research my classroom practice and my own ontology and epistemological values. I will use evidence gathered from students to support or negate my knowledge claims and inform my learning process.

6. 7 The curriculum of the healing nurse.

The following framework has evolved out of my steering group work in the United Kingdom where I worked on the design and structure of a possible National Vocational Qualification (NVQ) in health care for complementary medicine. I strengthened this framework for my Masters degree at Bath University in 2000 and introduced a colour code. The structural language of the curriculum is based on that of NVQ which I found to be very clear and logical for my present aims, objectives and outcomes.

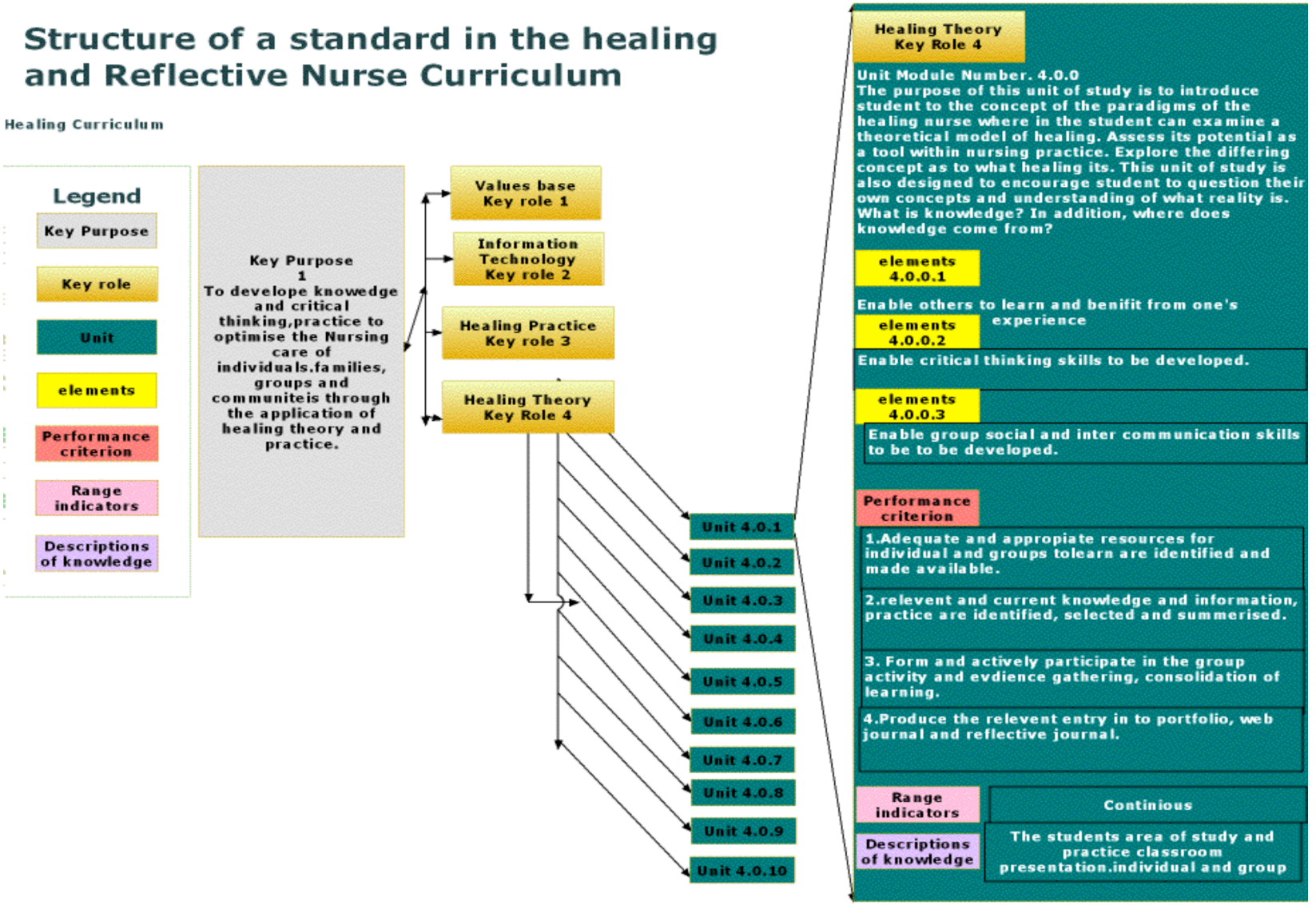
The framework design for my curriculum was as follows:

Key Purpose	The key purpose describes the unique nature and characteristics of the sector that differentiate it from others.
Key role	A key role is a statement describing a major outcome that contributes to achieving the key purpose.
Unit	Each unit is made up of units of competence. Just as key roles are outcomes needed to achieve the key purpose, so unit titles are statements of outcomes that contribute to achieving a key role. A unit is a significant outcome that an individual would be responsible for achieving, working alone or as part of a team. Each unit is introduced by a commentary giving an overview of its structure.
elements	Each unit was made up of sub-elements. Elements are actually detailed outcome statements and define what is to be done to achieve the unit. Each element of competency contains a number of performance criteria and range indicators. Together, these components form the standard. Such a standard can, at a later date, be incorporated as a "national standard".
	Performance criteria detail in depth the quality of the

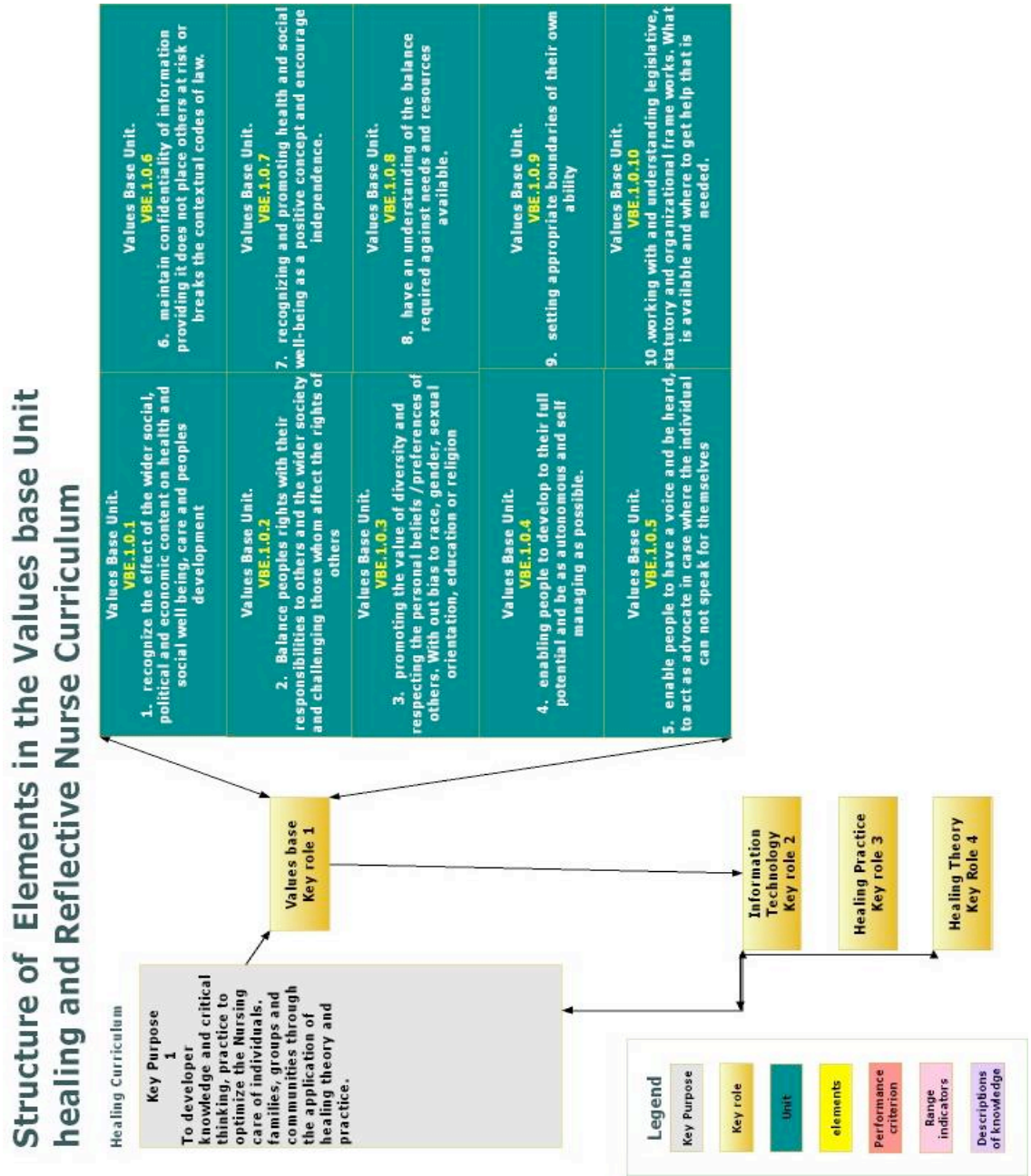
Performance criterion	achievement expected and may relate both to the "critical outcomes" that should be achieved and the "critical process" that needs to be followed. Performance criteria are the benchmarks against which judgements can be made about competent performance.
Range indicators	Range indicators set out the important variables that make significant differences to the performance required, or the knowledge base, understanding and skills that need to be applied. As such, they detail the breadth and scope of an element. Range indicators are grouped under headings such as: *Opportunities, individual and groups.* *a) colleagues; b)trainees entering profession; c) other practitioners; d) students under training.*
Descriptions of knowledge	These refer to the knowledge, understanding and skills necessary for achieving the outcomes described in the element title.

The following graphic shows the structure of a standard in healing therapy that I developed for my curriculum. To view it as a web page follow this link: http://living-action-research.org/PhD_media/Healing%20Standard%20HT%20Curriculum.png

Structure of a standard in the healing and Reflective Nurse Curriculum

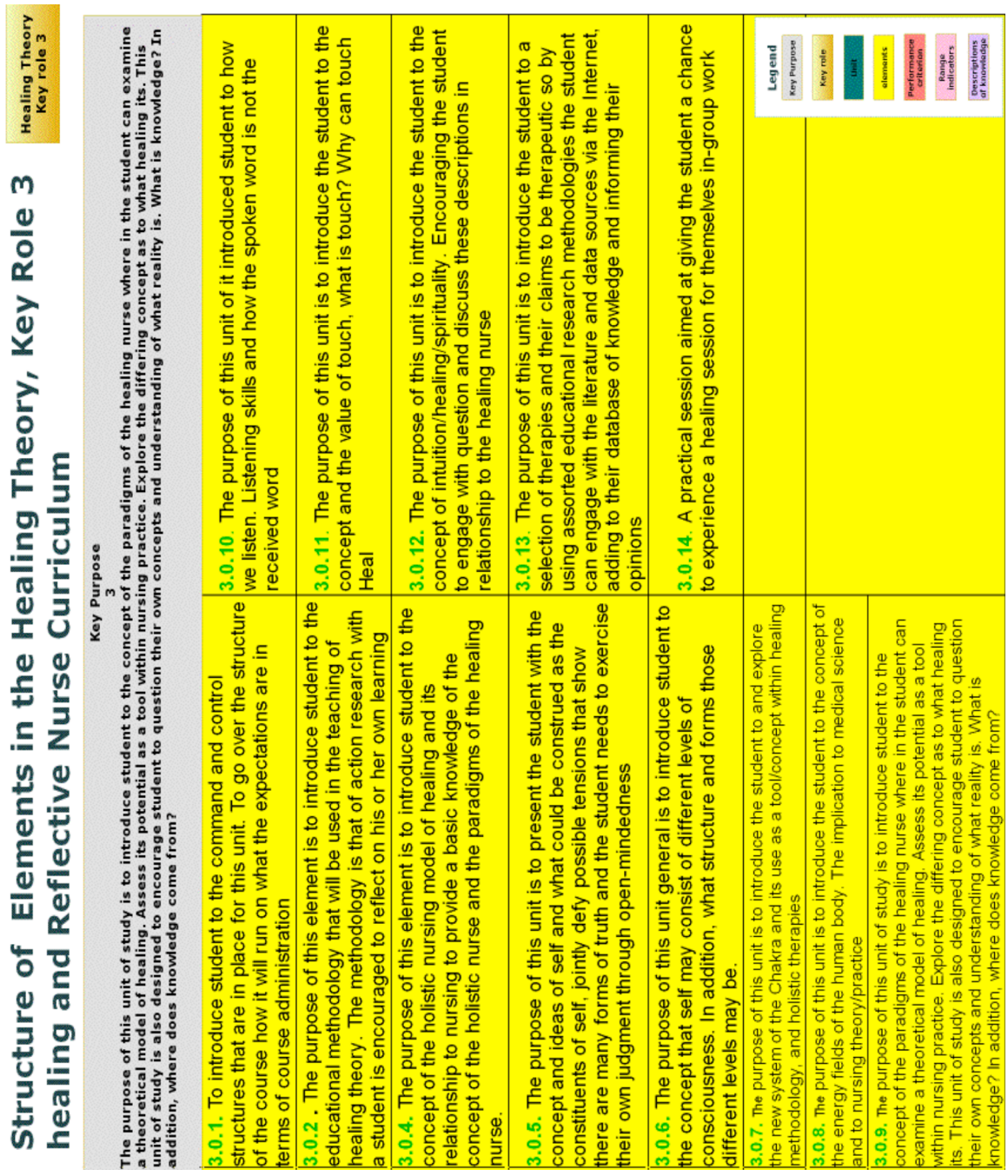


The following graphic shows a key role, unit and elements of my values base, and charts their relationships.



To view it as a web page, follow this link: http://living-action-research.org/PhD_media/values%20base%20unit.jpg

The following graphic shows the structure and relationships to the curriculum of Healing Theory Key Role 3 elements:



To view it as a web page, follow this link: http://living-action-research.org/PhD_media/healing%20elements.png

The next graphic shows the structure and relationships of performance criteria to an element (3. 1. 0) of unit 3. 0. 0 of Key Role 3, Healing Theory:

To view it as a web page, follow this link: http://living-action-research.org/PhD_media/performance%20elements.png

6. 8 My educative values base of the curriculum design for the healing and reflective nurse

I believe that the principles and values of practice need to be clearly defined in such a manner that they are quite rigid in their meanings and interpretation yet at the same time offer flexibility as long as the values and the quality and delivery of care are not compromised. Uppermost in my mind is the truth that real life has no rehearsals and the reality of a mistake can result in a loss of a life. Respect for life and the desire to protect and preserve the life of others during periods of sickness and/or infirmity are, I believe, core requirements for compassionate nursing. This one major belief underpins all my praxis as a nurse and educator, and as such sustains the bedrock of my belief in healing touch as a nursing art grounded in the conscious craft of thinking, reflecting and praxis.

When a profession, or any sector that wishes to be seen as professional or seeks to be accredited as a specialist occupation or skills base, agrees its principles and values, the implications of that values base will impact upon and underpin that profession or sector. I was keenly aware that Nursing had a body of professional knowledge that covered nursing skills, communication, anatomy and physiology, hygiene, nutrition and counselling. I felt it to be a strength of my curriculum that I could write my modules to dovetail into existing nurse teaching and training, so that my curriculum would deepen understanding in such a way that the knowledge presented was removed from the medical model and offered another aspect, that of inclusional thinking, to the knowledge base. Such thinking proved to be problematic, and once again the reality of Bernstein's (2000) rendering of thinkable and unthinkable forms of knowing became a living reality.

Before I take you into the curriculum issues and education debate as to what is or should be a curriculum, I would like first to discuss the educational values base from which I worked, and offer a positional stance against which others can present their critiques. Any standard or social value is only achieved if agreement is reached through a process of discussion and consultation with interested parties and stakeholders. In the ideal case scenario, they are based on best practice with achievable outcomes and embedded values that are important to the context in which the body of knowledge is being taught. For a moment, let us consider this ideal world of best practices in which I hoped I could achieve with the healing nurse curriculum.

Health and social care is delivered through direct interaction between individuals. Those who come into contact with nurse practitioners or healthcare professionals in health and social care expect that these professionals will undertake to discharge their duty of care. What is this duty? What values or expectations could shape its form?

Here is a list of duties that I feel are important for healthcare workers, drawn from my experience in my nursing and teaching in the United Kingdom:

1. Duty of care
2. Duty to be fair and not show discrimination in any form
3. Duty to show honesty and personal integrity
4. Duty to avoid harming the patient in any manner
5. Duty not to exploit their position of power with patients

Duties have values embedded within them. I have made my personal values clear. I must also be aware of the values embedded within my profession. These values are based around respect for:

1. The human condition in all its complexity
2. The essence and spirituality of our humanness
3. Seeing the individual in a holistic sense of being grounded in culture, context and diverse experiences

Values are in turn related to beliefs, especially the belief that all who come into contact with health and social care workers and the delivery of their care can expect as their rights to:

1. Know and be kept informed about their conditions and options, to have access to their records and be informed of decisions that affect them and why those decisions were taken.
2. Be heard. Patients have a right to be heard and listened to. Patients have a voice that is either used directly or through advocacy. In the case where the patient's voice cannot be exercised, then the duty of the nurse is to act as advocate for the patient in their declared interests (if known).
3. Choose to decide what they want to happen as long as the duty of informing the patient has been discharged correctly and the decision is made by informed choice.
4. Be given opportunities and support to develop independent pathways to realising their own potential.

5. Self-manage as much as possible, even if that choice is against medical advice
6. Have care environments that meet statutory levels of safety and environmental conditions and that are conducive to good health and social wellbeing.

From the above it is logical to deduce that there are certain key principles and values that the individual nurse, healer, therapist or practitioner can engage with so as to achieve the key purpose. Such key principles can form a 'values unit' of a curriculum, one where the individual has to show engagement with and understanding of the course material at a level required by her/his position in the workplace. This values unit is a foundational unit that I feel should be required of all professionals in health care before they branch out into their subsequent specialist training areas as nurses, medical doctors, social workers or occupational therapists.

[*In reflecting on this section I left all the above as it stood, for it shows how I was thinking at the start of my Japanese experience. I believe the above shows a logical, well thought out process and clearly evidences the grounding of my thinking in my western educative experiences. My understandings have been modified from that position and fully realise that my values unit is subject to context and culture; however, I believed that the core values of nursing would be the same in any culture. I know now with a degree of certainty that nursing is* ***not*** *the same in all cultures. How do I know this? I recently presented two papers at two international conferences. The first was at the International Council of Nurses Conference at Yokohama, Japan. This conference was looking at nurses dealing with the unexpected, including terrorist attacks, the World Trade Centre, tsunamis, earthquakes and disaster management. My paper was on cultural values and sensitivity in*

the colonisation of nursing. The different accounts of what nurses in different countries thought was another wake-up call for me. I did not know, for example, that male nurses only nursed male patients in the Islamic world. The only consistent theme was the domination of nursing knowledge and research by medicine. Nurses from Indonesia and Malaysia, for example, had no concept of patient advocacy and saw their role as following the doctor's orders. Some nurses I spoke to were concerned about the individual approach that western nurses use as opposed to the family support role in patient care. There were obvious differences that reflected the cultural positioning of women in nursing. However, everyone talked about care. It would be an interesting research project to find out what was meant by the use of the word 'care' in different countries. The second paper I presented was in Korea at the 13th Annual Qualitative Health Research Conference 2007. The keynote (Western) speakers used terms such as 'story narratives' and 'holistic', and all the Asian presenters used Western references and presented their papers using statistical models, from the perspective of an outsider or reporter of the research findings. The keynote address by a Korean scholar was outstanding in its analysis of qualitative research. I could have been sitting in my own university at Bath and listening to a lecture on statistical reporting. What was missing was the voice of Asian nurses, their stories. At the questioning time I stood up and asked the question: Where in the qualitative research presented in this conference is the voice of the researcher and the researched expressed as living theory in Asia? What is Asian qualitative research? Silence greeted my question as the translating took a few moments followed by a sudden collective intake of breath and then the clapping started. The chair acknowledged the importance of the question even more so as it was asked by a Westerner. The chair then used this question to talk about the need for women in Asia to find their voice as researchers. I hesitate to draw any lasting conclusions from what I heard and witnessed at these conferences, but I suggest that what

I experienced in my university is not an isolated case and my research suggests that further investigation is needed into these areas of gender and power issues in nursing, and if nursing is using the same meanings for similar words.]

In the next section I outline the values base of my healing therapy curriculum as it stands for the first four years. In italic text I discuss the modifications that need to be made to turn my curriculum from a colonising one into a culturally sensitive one.

6. 9 The values unit for healing therapy

The values base unit I designed for the healing therapy course was as follows.

The student/nurse would:

1. Recognise the effects of the wider social, political and economic context on health and social wellbeing, care and people's development.

   [*This is OK for the Japanese nursing context*]

2. Balance people's rights with their responsibilities to others and wider society, and challenge those who affect the rights of others.

   [While this is OK as a concept, the balance of power as described by Hisama (2000) and Takemura and Kandy (2003), shows that it would be highly problematic in its application due to the difficulty of communicating with doctors and others in the healthcare profession, including other nurses. I would keep this in the curriculum but balance it with philosophical discussions around power, ethics and values.]

3. Promote the value of diversity and respect the personal beliefs/preferences of others without bias as regards race, gender, sexual orientation, education or religion.

[The same comments as above apply to this statement; while desirable, it is problematic for Japanese society to respond quickly to external world influences including the influx of foreigners to Japan. From my personal experience of being a patient in a Japanese hospital, I feel that this item needs to remain in the curriculum.]

4. Enable people to develop to their full potential and be as autonomous and self-managing as possible.

[*This is OK for the Japanese nursing context*.]

5. Enable people to have a voice and be heard, and to act as advocate in cases where the individual cannot speak for him/herself.

[*Advocacy is not something Japanese nurses understand, as it is not part of the cultural heritage of nursing (Takemura and Kanda, 2003). I feel that this should be discussed in relationship to the nursing of Westerners with an aim of bringing about increased awareness of advocacy as Japanese nursing grows as an independent profession over time.]*

6. Maintain confidentiality of information providing it does not place others at risk or break contextual legal codes.

[*This is OK for the Japanese nursing context*.]

7. Recognise and promote health and social wellbeing as a positive concept, and encourage independence.

[*This is OK for the Japanese nursing context*.]

8. Have an understanding of the balance required as regards needs and available resources.

[*This is OK for the Japanese nursing context*.]

9. Set appropriate boundaries regarding their own abilities.

[*This is OK for the Japanese nursing context*.]

10. Work with and understand legislative, statutory and organisational frameworks, what is available and where to get the help that is needed.

[*This is OK for the Japanese nursing context*.]

These ten points lend themselves to becoming the elements to which learning objectives, with appropriate learning outcomes, performance criteria, and range statements, can be attributed. Some of these points are already included in the Japanese curriculum. I believe that my curriculum adds to what already exists by enabling the *students to display greater evidence of these values.* The preceding graphics show clearly the educative structure used in my course for the healing nurse. What was unique about my curriculum was its integrated use of technology, the Internet, reflective journals and portfolios. These were all new to the Japanese university classroom, as discussed in Chapter 2. I believe that I have given my reader clear insights into the cognitive formal curriculum that I have developed. I wish now to address the issues that cannot be so easily laid out in formal textual terms. The difficulty, I suggest, is that they comprise an abstract idea or value. This abstraction is not a hidden curriculum in the sense that it is an undeclared agenda of mine, or my shadow issues (Uhrmacher 1997). My tension lies around the notion and value of space, and its importance to my understanding and that of the students. The values of space are abstract in meaning yet critical in function. It is hard to define its presence but easy to sense its absence. In the next section I look at space creation and examine the evidence for the process.

6. 10 Space and non-space: The art and craft of space creation

When using the term 'space' I am conscious of the danger of turning what I want to try to explain away from its ontological grounding and into the realms of science fiction. My conceptual framework is one that I have built around my knowledge base, incorporating its values and beliefs. This conceptual framework defines its form in space and time and becomes the body of knowledge of the curriculum. As it stands, it is a framework that is without life but filled with endless potential possibilities. The key to bringing the spirit of learning to bear on my potential curriculum is the engagement of the enquiring mind of the learner. This is achieved by creating dynamic learning spaces.

In a sense I am the conductor of the orchestra of movements that take place in the space. Yet at the same time space embraces the fluid dynamics of both the students and me as we uniquely occupy a joint space that we perceive individually and collectively as a whole or group. We dance, as it were, to our own interpretation of the fluid dynamics of movement, which occurs in the limits of the dynamics of the space. The exciting aspect of space is what Rayner (2003) refers to as the excluded middle, the space between space and non-space. I hold an understanding that agrees with Talbot's (1992) thinking of the holographic universe, one where all thoughts are holographic images in space that are engaged as the consciousness hits the correct frequency of refraction. The amazing quality of a true holograph is that even the smallest element contains the complete picture of the whole. This thinking changed the way I see knowledge generation. It suggested to me that databanks of human knowing existed in or on planes or frequencies that we do not fully understand. Yet when our minds are open to the frequency of a thought it appears in its wholeness.

[I had such an experience on day 75 of my fast when I experienced my mind moving away from my body and sensed row upon row of what could only be described as video screens in coils like huge tubes. Each one was a gateway to a different dimension and they spiralled out into infinity. I know that science will say that my mind was in a altered state through starvation, yet I am most surprised to find that writers such as Talbot (1992) and Bohm (1987, p. 36) share my views. While this is not the time to discuss quantum physics, I do think that it has relevance to exploring knowledge. At this point, however, I alert my reader to my understanding that space is a quantum issue in which I see knowledge as a central topic.]

6. 11 Creating the framework for a space

The topic or the knowledge base is the framework of a script, and each student brings to the framework their life skills and their own harmonics of learning, wet with the meanings and values of experience, and creates their own inter-connected space of learning. Each of us is distinct but not discrete, and I include here the emotional, social and spiritual learning that has the opportunity to be advanced in what, for me, seems like the magic of the moment of teaching. This moment is best described as that instant of learning or comprehension that occurs in the student and me, when we take the framework of the original script and, through our individual and collective synthesis, evolve it into something new. It is that moment when students' eyes light up with comprehension and shine with the passion of new insights.

I believe that teaching and learning require a higher degree of awareness than we ordinarily possess in the everyday. Such awareness is stimulated to a higher degree of sensitivity when engaged with or caught up in creative tensions. Such creative tensions have the potential to act as solvents of the rigid or solidified boundaries of what we think we know,

thus freeing our minds to explore new ideas and engagements. In the next section I articulate my concepts of space and solidify them into a textual framework.

6. 11. 1 Creating my safe teaching/healing space

My healing/teaching space for this thesis is my classroom. University classrooms in my university are utilitarian spaces painted in a uniform battleship grey. I find the space completely and utterly sterile. I am not allowed to personalise the space to increase its beauty. However, I can do something about the feel of the space. I ensure that the room is warm, well ventilated and welcoming with soft lights, pleasant smells of healing oils, incense and candles, this last as a symbol of the light that we work with in the process of healing and learning. For healing theory, the classroom layout is informal and tables and chairs are laid out to facilitate small groups. Each group is provided with a portfolio, pens and crayons, scissors, glue, rulers and drawing equipment. Each student is provided with the scope of work which lays out the boundaries of what is expected in the lesson. A personal DVD has been made of all the PowerPoint presentations (bilingual), the course curriculum and informed consent. Space creation seems to be about making sense of paradoxes, in the sense that I need to have two mutually exclusive ideas presented and acted out in the same space. Here then is my first paradox:

My teaching space, as a space, needs to be both bounded and open, bounded in the sense that it can take on the charge/energy/association of being associated with study as opposed to being unbounded as in social activities, and open in the sense that students can develop a feeling of ownership and of belonging to the space.

Secondly, the text or body of knowledge is bounded by the requirements of the social formation and the stakeholders of power, in terms of the content of the knowledge, the learning outcomes required, and the curriculum items that are testable for providing evidence of learning or assimilation of the course data. The introduction of my new curriculum needed to negotiate its own place in terms of being accepted by certain members of faculty. There is another bounding that affects my openness, namely that of the boundary of my knowing, this boundary being the limit of my knowing and the beginnings of my ignorance. This bounding of the knowledge base keeps things focused on the subject at hand. Engaging with the knowledge content within the boundaries can be achieved by a co-exploration of the theory by both students and teacher, thus creating creative teaching methodologies. To this end I used group portfolios, reflective journals, and dynamic web testing and student participation with role playing. All of these were designed to test and explore the limits of knowing and then to extend those limits.

Space without boundaries is not space in this sense. It is a non-space, a void, full of chaos as students can be fearful of losing their points of reference in having to let go of the known to embrace the unknown. Giving clear boundaries to the students helps them claim the space of their own knowing. Boundaries remind me of the limits of my knowing in terms of structure, and of the new frontiers in terms of discovery and learning. In my Buddhist understandings it is the form that creates the space in time and space. So, for example, it is the form of the cup that defines the space in space. It is the form of the cup with its dynamic physical properties that allows it to be used to hold liquids, for example.

Openness in the form of space gives a different perspective, one that I believe relates to the dynamics of the boundaries. For example, if my boundaries are rigid and closed they

become constricting and, no matter how large the space is, it becomes a closed space. If, however, the boundaries are semi-permeable, as I believe they are, as we reach the level or frequency of mental, emotional and spiritual learning we can pass through the boundaries of ignorance and/or dogma to new spaces and new horizons of knowledge.

This view from the edge presents another paradox for Buddhist thinking, which is always calling for the individual to be centered. My answer to that quandary is that the edge can be the centre of the next thought, which links nicely with Wilber's (2000) ideas of the holonic nature of knowledge in that each thought has with it the (causal) arising of the next. What Eisner, Logue and Wilber offer are expressions of the movement in perception and the elements of risk-taking or praxis that are required as we move from our comfort zones of old knowing to those of new thinking. Boundaries can have another positive meaning in terms of negotiated learning with the co-creation of discovery alongside the students. Such thinking and such a process remind me of the planning at the start of the journey which, in true Buddhist tradition, says that: *arriving at where you thought you were going is not always where you actually land up*. Therefore the process of the journey becomes important rather than just focusing on reaching the goal.

[When I first arrived at the university I was told that it was not my job to teach but to lecture. This caused me considerable problems as the power relationships and fixed ideas of senior faculty dictated what I was to do and how I was to do it in my classroom. This resulted in a protracted and fundamental disagreement about what teaching is and what the classroom space is. I found myself as a trained teacher being dictated to by certain faculty who were not teachers nor trained in teaching methodology but who had the power of status and position. I was charged with introducing a new curriculum for the healing and reflective nurse to a new faculty of nursing. The facts turned

out to be that certain members of faculty felt that healing was akin to witchcraft, not science, and nurse education was taking a step backwards by even entertaining the ideas and giving up hard won ground gained by the sciences. What ensued was a bitterly fought battle that spilled over into the classroom when a senior member of faculty (not a teacher) entered my class without asking and proceeded to tell me, in front of my students, what they thought teaching was and what I should be doing. I pondered long and hard about including these accounts in my thesis. I am not comfortable with using names of members of faculty and reciting some of the events that happened to me. I do believe that it is important to analyse the resistance and the strategies used against the introduction of my curriculum, as it can be shown how the process of power can be engaged with in such a manner that no participants in the conflict are destroyed by the confrontation. Research is not all roses and a sanitised version of events does not honour the process of learning, especially one which pushed me to the very edge of my ability to sustain my own mental and emotional wellbeing. I have taken the decision that, while what was done to me may well be important to my learning, such actions by others add nothing to my research thesis about the pedagogising of the curriculum other than that certain degrees of resistance were exhibited by faculty who disapproved of the introduction of the curriculum. I choose to focus not on the bloodletting and suffering but on the inclusive healing praxis I created in response, and the learning that was then forged from the depths of the confrontation. This I believe is what is important and adds to my thesis.]

6. 11. 2 Maintaining and holding my safe healing/teaching space

Open space or new spaces can present daunting experiences for the traveller. The very same emotions are experienced by learners who have their comfort zones of familiarity challenged or even removed. In my case I was presenting my students with a completely new concept of learning, one which was new for Japan in terms of a university teaching strategy. Living Action Research, portfolio building and reflective journaling, combined

with Internet-based testing and evaluations, were breaking new ground. The stresses of this were further compounded by the curriculum being taught for the first time in Japan, as many of the conceptual ideas, such as a values base unit that underpinned the curriculum, and physical touch as healing, were contextually not relevant. This meant that in the first instance the students had no reference points from which to explore the meanings of my teaching and the required learning outcomes. They needed time to make sense of it, and this usually took the shape of a period of confusion as old values had to be let go of and new ones looked at. I took responsibility for my students whilst they were in my care or teaching space. I worked at maintaining the safe space and this required that my own mental and spiritual disciplines were in place. I worked at ensuring that I was focused in the moment. This, for me, was achieved by the discipline of meditation and prayer before each lesson when I offered up a mantra that all which is learned is for the good and benefit of the learner, and here I include myself. I need to be on top of my game, focused and engaged ready to explore the dynamics of the classroom, and open to the fluidity of the situation. Yet no matter how many times I have stood before a class I always feel a tension in my stomach, as each teaching experience is a journey into new territories. Murphy's law is never far away!

If students are to process learning at the deepest levels, they must not feel so safe that they fall asleep, as the idea of the classroom is not that it constitutes therapy or a therapeutic environment, and students need to understand that feelings of discomfort and pain are there as learning experiences, are part of our life world, and need to be faced with compassion. The students visited issues of pain and antagonistic issues in their lives, and it was these issues that caused the dis-ease. Each student arrived on the course with his/her own life history and accompanying coping methods. Healing and counselling were made available

outside the lesson time when any issues that were raised by the students could be made safe.

[My healing theory class had 100 students, seven of whom needed help with the issues raised, one student needed professional psychiatric intervention for suicidal feelings relating to a domestic situation, and eight needed advice concerning sexual abuse/harassment. 32 needed counselling relating to life pressures, part-time jobs and study pressures. I believe that no student was left unsupported. The total number of formal interventions by counselling and healing was 48 students, a number that surprised me and brought insights to other issues of the curriculum that concerned previous life learning as touched upon by the course. I feel that this is an issue that needs further investigation, because nurses are expected to deal with any condition a patient has. It matters not what our personal issues are. We have to, in effect, bracket our private issues from those of professional practice. Little time is spent on this in the nursing curriculum. I know how I felt when I had to nurse a convicted paedophile. I was torn between my professional nursing duty and feelings of wanting to end that individual's life. Of course my professional duty won out, however the fact that I was capable of such feelings showed me that I had unresolved issues to sort out.]

I valued my insights as they permitted me to see these issues in myself and others without being invasive or abusive, but at the same time strong enough to allow the process to take place. This often meant that I was exposed to antagonistic energies, which were released from the student in the form of emotional releases or even antagonistic thoughts/actions. Sometimes the student's frustration and anger was difficult to deal with, as my own issues from my autobiography (Adler-Collins 1996) were often reflected back to me during a course of teaching a healing curriculum, and I worked at responding to these in a way that was helpful to the learning of the student.

Maintaining the space also includes giving space for the individual voice and expression of the student and the group; both are important routes to learning although sometimes the individual voice may be in conflict with that of the group. Deeper learning occurs when the students are given permission to explore by themselves the finding of their voice. I present samples of videos of classroom activity, portfolio entries and students' evaluations of my teaching and their experience of that teaching in the next chapter: "The Students' Voices."

In my maintenance of the space, I am required to listen to the harmonics of the words, the vibration of the class and the students' body language. I reflect back to them from time to time for clarification or challenge, in order to show the group what is being heard and to check if I am hearing correctly. Since working in Japan, I have included the use of silence as an actual form of communication, be it positive companionable silence or confused, fearful, hostile silence. Even though the space may be empty of words, it is far from empty of meaning, as the messages from body language, eye expression and energy of intent sometimes scream out louder than any words. The Art of Silence is part of my maintaining my space. I use silence as respect for their words; I use silence to create the space for listening.

6. 11. 3 Understanding my healing/teaching space

I now want to take a 'risk' in Winter's (1989) sense that the action researcher reveals himself o herself in a vulnerable way. In what follows I simply want to communicate that I understand my healing/teaching space in terms of positive and negative energies, prayer, love and compassion. There is a process that I have evolved; I work at transcending the antagonistic

energy and making it 'safe'. I do this through the process of prayer, expressing love, compassion and understanding, and listening without judgement. My practice is based on a combination of my training and my intuitive recognition of these energies.

6. 12 Inclusional pedagogy and the primordial gap

The concept of Pedagogy was germane to the development of my thesis. I am using my understanding of my pedagogy as a natural extension of my ontology and epistemology. It too is inspired by Rayner's (2003) concept of inclusionality which resonates with the teachings of Shingon-Shu Buddhism. For that reason I refer to my pedagogical approach as Inclusional Pedagogy. I build on Bernstein's (2000) ideas about pedagogy where he stated:

> *... pedagogy is a sustained process whereby somebody(s) acquires new forms or develops existing forms of conduct, knowledge, practice, and criteria from somebody(s) or something deemed to be an appropriate provider and evaluator - appropriate either from the point of view of the acquirer or by some other body(s) or both. (p. 78)*

In relation to the pedagogising of my healing nurse texts, the distributive rules suggested by Bernstein (2000) are significant because they distinguish between two different classes of knowledge. Bernstein believes that it is the very nature of language that makes these two classes of knowledge possible. He terms them the *thinkable class* and the *unthinkable class* (p. 30). He believes that there is a potential discourse gap between these two classes and stresses that it is not a dislocation of meaning, but it is a gap.

I would like to focus on this gap, which I will refer to as the *primordial gap.* I am using this term in the context that the gap that exists between the two classes has the potential for originality of mind.

For example, according to science (thinkable class), healing is firmly in the unthinkable class, consequently all the forces and power available to the thinkable class in terms of voice, validity and distribution are brought to bear in order to negate, silence or control it. The answer lies in what Rayner alludes to as the *excluded middle space of non-space.* As I understand it, this excluded space, far from being an emptiness between the opposing Bernstein poles of *thinkable and unthinkable,* is the *primordial gap.*

Understanding this *primordial gap* is particularly important for attempts to pedagogise knowledge. This is because any distribution of power will attempt to regulate the realisation of this potential discourse gap between thinkable and unthinkable knowledge. Bernstein believes that part of the reason why the rules of the pedagogic device are stable is that this gap will always be regulated. He points out that any distribution of power will regulate the potential of this gap in its own interest, because the gap itself has the possibility of an alternative order, an alternative society, and an alternative power relation (p. 30).

In developing my own ideas about the primordial gap I am mindful of the issue of stability in relation to colonial forms of knowing. In the move to reduce the damaging aspects of colonial thinking, and seeing with a colourless gaze as in my Buddhist teaching, it is important to examine Bernstein's work for what is, in effect, an excellent critique and analysis of colonial working. This limits the use of his work in terms of his

understandings, but offers a sound analytical framework for analysing the colonial system of knowing and its power relationships.

The advent of self-study theses emerging around the world shows that, when ready, Living Educational Theories do influence social formations. The hold that any distribution of power has on controlling the primordial gap is influenced by context; but for those of us on the edge, in the Christopher Logue sense, we keenly feel the negations of our values. It is, however, as we emerge from the primordial gap with new forms of knowing and understanding that we can offer hope for the future. Living Educational Theories are spawned, born and nurtured in this primordial gap, a sort of black hole outside the control of the educative space. However, the fact remains that different power agencies, including myself, support different and perhaps conflicting pedagogies. I do not see these conflicts as negative, even if the situational context is a negative one. My reasoning for this is that confrontation and agitation bring about new focus. Such agitation stops knowledge from becoming certainty and stagnating. The dynamic of learning may be contextually painful, but such feelings are a small price to pay for an evolution of the mind. In the next chapter I will be looking to see if such an evolution has started in my students.

6. 13 To summarise this chapter, I have shown the conception, history and development of my curriculum and given my reader insights into the educational structure of what I am doing. The standards developed have been made clear through their emergence into practice. The passion, trials and tribulations of researching and developing standards in a culture not of your birth is a daunting task, one which never ends as each cycle of learning brings modifications to the learning outcomes and a deeper insight to the embedded meanings and values of the healing nurse curriculum. In the next chapter I will examine

what my students' experience was in their passing through my curriculum, by using extracts and analysis from samplers of students' data sets. Such data acts as a mirror to my values as they are seen through the eyes of others and help me modify them in their emergence. This process showed how the expectations I had been given concerning the students' ability to be critical was proved to be unfounded. The students' voice rings loudly and clearly with insights that show a remarkable honesty.