

Experiential learning: Transforming theory into practice¹

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Abstract

Whilst much is debated about the importance of experiential learning in curriculum development, the concept only becomes effective if it is applied in an appropriate way. We believe that this effectiveness is directly related to a sound understanding of the theory, supporting the learning. The purpose of this article is to introduce readers to the theories underpinning experiential learning, which are then expanded further in an AMEE Guide, which considers the theoretical basis of experiential learning from a social learning, constructionist perspective and applies it to three stages of medical education: early workplace experience, clerkships and residency.

This article argues for the importance and relevance of experiential learning and addresses questions that are commonly asked about it. First, we answer the questions ‘what is experiential learning?’ and ‘how does it relate to social learning theory?’ to orientate readers to the principles on which our arguments are based. Then, we consider why those ideas (theories) are relevant to educators – ranging from those with responsibilities for curriculum design to ‘hands-on’ teachers and workplace supervisors. The remainder of this article discusses how experiential learning theories and a socio-cultural perspective can be applied in practice. We hope that this will give readers a taste for our more detailed AMEE Guide and the further reading recommended at the end of it.

Introduction

This article aims to introduce readers to a new AMEE Guide in the ‘Theories in Medical Education’ series, which considers experiential learning (Yardley et al. 2012). It has three key objectives. First, to present the origins and historical development of experiential learning. This gives readers an overview of key names in the field and can be used to understand the historical context and evolution of experiential learning. It also provides a ‘starter’ source for new researchers in medical education who are interested in socio-cultural theories and developing research skills incorporating application of these theories to our field. The second objective is to explain how social learning theories can be applied to experiential learning. The third objective is to explain how experiential learning can be structured and delivered at three points in the medical education continuum, from early undergraduate studies, through clerkship experience, and into ongoing postgraduate education, which has important similarities with experiential learning in continuing professional development.

To whet readers’ appetites for our Guide, this article makes an argument for the importance and relevance of experiential learning theory, emphasising how medical educators can bring a socio-cultural perspective to bear on their educational practice. This article is structured to answer questions commonly asked in relation to these issues.

What is experiential learning?

In its most simple form, experiential learning is constructing knowledge and meaning from real-life experience. In the context of medical education, the term is most commonly applied to experiences which have been included in a curriculum design to bring the learner into contact with others in a particular role and context. This article and the Guide focus specifically on learning that is triggered by authentic practice-based experience. We chose this focus because experience gained in authentic workplaces that are concurrently involved in education and delivering real-life services is the most important medium through which people learn to practice as healthcare professionals. Experiential learning is, therefore, ‘situated’ in a context relevant to learners’ own future careers.

There are competing traditions of learning theory – associated with familiar names like Dewey, Kolb and Knowles – which originate from different philosophical views of the nature of knowledge. The experiential learning theories, developed by these and other authors, provide explanations for how individual people learn individual things in individual ways as they react to their individual perceptions of experiences. This individualistic concept is underpinned by the philosophical principle of constructionism, from which perspective social interactions are fundamental to

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experiential learning. The fundamental role of interpersonal interaction, combined with the importance of the contexts in which learning episodes are situated, locates experiential learning theories within the broader theoretical family of social learning theory.

How is experiential learning related to social learning theory?

Social learning theory is a theoretical perspective on how experience and its learning consequences are essentially located in social milieus. Conceptualising learning as a social and cultural concept rather than a purely individual process can be traced back to the Russian scholar Vygotsky (1986), who is generally regarded as the 'father' of socio-cultural learning theory. Two main perspectives are prominent in contemporary socio-cultural learning theory: one is activity theory; the other is communities of practice theory. The key tenets of these, in common with other social learning theories, are discussed in detail within our Guide. Of particular note is the idea that learners actively influence learning environments, just as learning environments actively influence learners. Experiential learning, then, is located within bi-directional (or multi-dimensional) interactions. Learning results from collaborative engagement within 'communities of practice', which learners enter as 'legitimate peripheral participants' (Lave & Wenger 1991). Vygotsky's work is most widely known for his metaphor of the 'zone of proximal development' – the learning space that is opened up to a person by receiving support from someone more knowledgeable or experienced. Locating learning within whole communities rather than just inter-individual interactions opens up Vygotsky's metaphor to the space created within the social arena of workplace interactions. This shift from individual to community in contemporary conceptualisations of experiential learning extends the work of Kurt Lewin on group dynamics, which focused on tensions between the direct concrete experiences of trainees and the conceptual models of their teachers (Argyris & Schon 1978; Kolb 1984).

Why are these ideas (theories) important in medical education?

Medical education has a centuries-old tradition of 'learning on the job', which experiential learning theory describes remarkably accurately. Indeed, the currency of experiential learning theory supports the continuation of medicine's time-honoured experiential learning tradition, but contemporary learning theory calls also for some changes to traditional assumptions. Taken together, the philosophical stances of experiential learning and socio-cultural theory call for learning to be thought of as a lifelong continuum. Learning not only changes with increasing experience, but previous experience affects how learners approach new experiences, ultimately affecting their ability to learn (quantitatively and qualitatively) different things. This is particularly important as for any learning experience, there are several elements which need to be identified to maximise the potential for constructive learning.

First, it is necessary for people to recognise what is common between the new and their previous experiences. Second, they have to be able to identify not just what is different but why. It is only if they can achieve these first two elements of experiential learning that they can begin to learn how to recognise circumstances which call for them to judge how to translate, or refine, learning to meet a new or unusual challenge and so enable extension of their existing learning whether this is in the development of new understanding or of additional nuances. Dewey (1938) addressed this aspect of experiential learning when he conceptualised experience as an organising focus for lifelong learning and development. His work, along with the insights of others regarding necessary cognitive, affective and environmental conditions needed in order for adults to constructively and effectively learn, such as those later identified by Knowles (1980) supports Kolb's assertion that learning should be defined as 'a process whereby knowledge is created through the transformation of experience' (Kolb 1984, p. 41). Similarly, Piaget argued strongly for the development of understanding about how knowledge develops in order to develop appropriate educational interventions (Smith 2001). Put simply, if someone 'fails' to perform a task, we need to know what their reasoning and explanation for their actions/inaction that led to 'failure' was, rather than simply assuming a particular cause. If, for example, lack of confidence to challenge perceived workplace norms of a particular environment is the underlying issue, then imparting more abstract knowledge to them will not form a suitable intervention.

Why are these ideas (theories) relevant?

Regardless of whether you are an educator, researcher or learner (or perhaps a combination of them), experiential learning is likely to be important to you. Medical students now usually engage in workplace learning – a form of experiential learning – from the start of their studies, and their ability to learn from experience in authentic workplaces becomes more important, the further they progress through clerkships and residency. In just the same way, experienced doctors have to be able to consolidate learning outside the workplace and translate it into their daily activities to keep their practice up to date throughout their careers.

A body of research in medical education has begun to study 'experiences in action' (Dornan et al. 2009; Teunissen et al. 2009; Yardley 2011). Common themes in these studies include the importance of learners, believing that they are accepted as a legitimate part of the workplace (by everyone, not just their immediate supervisors), supported to make sense of their experiences and integrate themselves into the workplace, and wherever possible given meaningful forms of participation in the primary functions of the workplace (*albeit* with a focus on what they can also learn). When interacting with students, it is necessary to ensure that workplace learning is not reduced to meeting-intended learning outcomes superficially while ignoring the richness of the workplace context as a source of applied knowledge (Morcke et al. 2006). This will then allow

consequential learning to be maximised even when unstructured, unintended and opportunistic.

How can experiential learning theories and a socio-cultural perspective be applied to daily activities?

Experiential learning theorists from Dewey onwards have recognised that learners have to be active engaged within their surroundings if they are to gain applied knowledge. By linking new experiences to prior ones – assimilating or accommodating new knowledge – educators can guide students to understanding their current and future workplace activities in personally meaningful ways. Specific considerations include, for example, how different levels of experience might affect the perceptions and, therefore, the knowledge and meaning which learners construct from experiences in workplaces. You might ask of the professionals present ‘Are you working in a way that encourages new learners to become part of a team or group, and with systems of working which are explained?’ or ‘Are you talking to learners about their positive and negative experiences when in authentic workplaces – and can you identify common themes in their answers which might be addressed or shared as good practice?’

The theoretical principles of social learning theory and experiential learning detailed in our Guide may help educators provide appropriate experiential learning opportunities, although some gap between these ideals and what happens in practice is almost inevitable. In your own specific context, you can consider how to narrow the gap or at least explain it to learners. For example, are there features of your workplace which demand flexible approaches to the application of guidelines? Do you tell learners why you have deviated from them? Do you discuss with learners what they might transfer from your workplace context to other contexts, and what changes or refinements they might need to make? By explicitly linking the experiences your learners are engaged into the future demands of practice, you can help them develop transferable knowledge (Dornan et al. 2011). Learners in workplaces are seeking to construct a sense of identity as well as gain knowledge and skills, and will therefore appreciate any help you can give them to relate experiences to their personal career goals. Offering participatory roles appropriate to learners’ stage of training with graded increases in responsibility is one way to ensure that they gain a sense of purpose and legitimacy through making contributions to the functions of workplaces.

Conclusions

The progression from new medical student to clerk, then the transition to qualified doctor, resident and beyond relies progressively more on experiential learning. The core condition of learning is participation. There is no ‘neutral’ position: learners who do not feel legitimate (a mandate to be present) in workplaces will experience a sense of exclusion that hinders their learning. To ensure that it does not occur,

workplace supervisors and other people learners encounter in workplaces need to provide active support and include learners in workplace activities. A sense of exclusion risks not simply a lack of knowledge but also counter-productive ‘learning’. Different learners must be expected to need qualitatively and quantitatively different support to maximise the potential for ‘positive’ learning from experience at different career stages. The various experiential learning theories discussed in our Guide provide a conceptual grounding for promoting favourable learning conditions throughout the spectrum of medical education. Comparing the ideals we have described to learners’ experiences of practice can point the way towards curriculum improvements.

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Note

1. This short article refers to Experiential Learning: AMEE Guide No. 63. The full version of this guide is published as a web paper in this issue and is available at: <http://informahealthcare.com/journal/mte>

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