



Book Reviews

Enhancing Adult Motivation to Learn, Revised Edition

R.J. WLODKOWSKI

Jossey-Bass, San Francisco (1999)

376 pp., ISBN 0-7879-0360-4, US\$32.95

In the preface, Dr. Wlodkowski distinguishes this book from the many others targeting “adult learners” by emphasizing its focus is on motivation. “Motivation,” he states, is the “energy” that fuels adults’ “natural inclination ... to be competent in matters they hold to be important.” He goes on to state that adult learners have never been more diverse and that we as teachers must be attuned to the influence of diversity and culture on motivation and hence on learning. This second edition focuses a great deal of attention on the influences of ethnicity, race and gender within the motivational framework. Rather than developing an “add-on” chapter or two on the influences of diversity on adult learning, the author weaves references to diversity issues throughout each chapter, creating a coordinated, comprehensive and often practical guide.

The book is organized into chapters, not sections. There is a clear delineation, however, between the first three chapters, which address theory from a multidisciplinary perspective, and the last five chapters, which provide practical examples and strategies. In Chapter 1, the author summarizes the adult learning literature from the perspective of motivation and cultural influence. Chapter 2 is devoted to the author’s description of the five characteristics (pillars) of a motivating instructor. These “pillars” include expertise, empathy, enthusiasm, clarity and cultural responsiveness. Wlodkowski makes a case for each of these characteristics by drawing on literature from motivational theory, cultural and ethnic studies, cognitive psychology and constructivist theory. Chapter 3 introduces the author’s “Motivational Framework for Culturally Responsive Teaching.” This framework includes the following conditions: (1) establishing inclusion, (2) developing attitudes, (3) enhancing meaning, and (4) engendering competence. The author posits that motivation is inexorably bound to both social construction and individual determination and that attention to the four conditions mentioned above creates a “common culture” in which the needs of *all adults* are valued and engaged.

Chapters 4–7 address the four conditions of culturally responsive teaching, with a chapter devoted to each. The author does an excellent job of providing background, examples and strategies for incorporating each condition into common teaching settings. For example, in the chapter on “establishing inclusion,” the author begins by providing background information on several “dimensions of cultural variation,” including “low contact versus high contact” cultures, “individual versus collective” cultures, “rigidity in reference to gender roles” and “high versus low content” cultures. This discussion is followed by a number of strategies that take into account cultural differences when attempting to create an inclusive environment. The final chapter serves as a summary with the addition of two examples of instructional planning using the “Motivational Framework for Culturally Responsive Teaching.”

Although I really enjoyed this book and will refer to it many times in the future as a rich resource, it may present a challenge for some in the health professions community,

since none of the book's examples are framed in a clinical context. In addition, some knowledge of basic educational theory is useful, although not necessary due to the author's descriptive abilities. With that said, I have great confidence that my clinical colleagues can overcome these obstacles and benefit from reading and referring to this book. It is, to my knowledge, one of the better examples of thoroughly integrating issues of cultural diversity into instructional planning for the purpose of enhancing motivation to learn. The strategies listed are explicit and in most cases quite easy to generalize across settings. This book will be helpful to those of us who teach health professions students in schools of medicine, nursing and allied health, as well as those of us who teach patients (most of whom really are adult learners).

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The World Health Report 1999—Making a Difference. Report of the Director General, World Health Organization, Geneva

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Orders can be placed online at the WHO publications website: < <http://www.who.org/dsa/> > , or via e-mail to: < bookorders@who.ch > , in addition to conventional WHO publication outlets.

This 121-page report presents the “WHO’s approach, priorities and work in the years to come” as seen by the new Director General (DG) after 10 months of being in charge. The report argues that “with vision, commitment and successful leadership (...) we can make a difference.”

The report points out that action continues to be required against the “remaining inequalities (which) needlessly burden disadvantaged populations; the problems posed by demographic changes, the diseases rising to prominence such as cancers, heart disease, stroke and mental illness, ever resurgent malaria and tuberculosis, the emergence of HIV and the magnitude and consequences of the tobacco epidemic.” It introduces catchy phrases, such as “Roll Back Malaria,” “Tobacco Free Initiative,” and “Stop TB Initiative,” which are given high visibility.

What makes this report *different* from previous ones is that it puts a very strong emphasis on poverty and “the burden of excess mortality and morbidity suffered by the poor.” Obviously written by a team of bright economists, the “difference” announced in the title is that “for the poor it will be not only in improving their quality of life but also, through increasing their productivity, in addressing one of the roots of poverty.”¹ The new DG states: “I have pledged to place health at the core of the global development agenda. That is where it belongs. Wise investment in health can prove to be the most successful strategy to lead people out of poverty ... We need to remind prime ministers and finance ministers that they are health ministers themselves.” Based on her experience as former Prime Minister, she says that “you cannot make real changes in society unless

the economic dimension of the issue is fully understood.” This is a task that might be more formidable than eradicating smallpox and, as it states in the report, the “W.H.O. has been less good at helping senior decision-makers deal with the big picture.”

The new DG takes a strong moral stance. “Our values cannot support market-oriented approaches that ration health services to only those with the ability to pay.” Bravely she states that she “will be meeting the Director General of the World Trade Organization twice a year on a prepared agenda.” She mentions “forging more influential partnerships with the World Bank and the International Monetary Fund.” To accomplish all this in order to “regain our place at the center of the health sector development agenda” requires “repositioning the WHO.” “We need to shift our strategic direction substantially. I wish to see a shift in the way the WHO thinks and acts in its work with countries.” This shift is called a “New Universalism” that “recognizes governments’ limits but retains government responsibility for leadership, regulation and finance of health systems.” It also “requires changes in W.H.O. (in order to) reposition W.H.O. internally.” She goes on to state that “the W.H.O. staff constitute our ultimate resource.” These “hard-working people, often accepting workloads that many national civil servants would turn down,” have been recruited all around the world. Some of them graduated from all the universities training health personnel. We have been reminded, year after year, in all the WHO reports up to 1998 that the “relevance and quality” of such training required “reorientation under changing socio-economic conditions.” Are the new staff to be recruited from universities in need of reorientation? It is therefore surprising that the education and training of health personnel is not mentioned once in this DG’s report.² The whole sector of Human Resources (HR) has totally disappeared from the map. From less than 500 words in the 1998 report we are now at the zero level. During the 10-year interval following the Halfdan Mahler’s time as DG, the gradual disappearance of HR has taken the form of fewer posts, smaller budgets and diminishing visibility.³ Even the name of the division⁴ reflected this slow death. It moved from Health Manpower Development (prior to 1988), considered too sexist, to Human Resources for Health (HRH). Then HR was absorbed under Organization of Health Services (OHS) to reappear, by yo-yo effect, as Human Resources and Capacity Building (HRB), but not for long. It is now hidden behind the label Health Systems (HSS). I’ve been informed that the 2000 DG’s Report should be devoted to “Health Systems.” Rejoice EfH readers: “the return of HR” is at the end of the tunnel.

Notes

1. The mysterious “New Paradigm” presented as panacea by the previous DG in his opening speech for the 45th WHA in May 1992 was never really understood by the many on the WHO staff. But inside information provided at the time proposed that it meant: health should not be considered only as a cause of expenditure but could be a source of economic gain. Is the present message the same, translated into more comprehensible language?
2. Curiously, one can find in the index (p. 120) reference to “SmithKline Biologicals,” with of course the usual proviso on the cover that “the mention of specific companies (...) does not imply that they are recommended by the WHO etc.”
3. The number of Resolutions concerning HR voted by the World Health Assembly

from 1948 to 1998 shows a parallel decline. From more than one each year until 1988, the number dropped to a total of two between 1989 and 1998.

4. Divisions are now called “clusters,” another “difference.”

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Collaborative Clinical Education: The Foundation of Effective Health Care*
JANE WESTBERG & HILLIARD JASON
Springer, New York (1993)
403 pp., ISBN 8030-2, US\$49.95

Collaborative Clinical Education is an exhaustive handbook of clinical teaching with a problematic title. This book contains everything that the clinical teacher needs to know about clinical teaching. In my 25 years as a medical educator, I have poked my nose into virtually every major area relevant to clinical teaching, and they are all covered in this book. Would you like to know how to prepare for clinical teaching? How to assess learner needs, formulate goals, or develop good relationships with your learners? It is all in here. Would you like to know how to ask questions? The book has 20 suggestions. Would you like to know how to demonstrate skills? It has 22 suggestions. Listen effectively? Seventeen suggestions. The book is packed full of useful suggestions drawn from a vast literature, both in higher education and medical education, on every substantive topic of use to the clinical teacher.

It does more than provide suggestions. Each chapter is organized into three sections. The first section contains a detailed justification for the particular teaching practice that is the subject of the chapter. The second section raises “Important Issues and Considerations,” and the last section presents the suggestions. The new teacher who wants to know why teachers should observe learners or encourage self-reflection or give feedback might be drawn to the first section of each chapter, where the rationale for these practices is clearly explained. Experienced faculty members and professional educators will find, in these justification sections, excellent material for introducing their workshops or seminars.

The issues raised in the “Important Issues and Considerations” sections are meaty ones that invite reflection. They could easily become the focus of group discussions. For example, in the chapter on providing constructive feedback, the authors raise the following issues: the difficulty of both receiving and giving feedback by teachers and learners who have had hurtful experiences with feedback and the fear that feedback might damage relationships.

What surprises me is that so few of my clinical colleagues have a copy of this book

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although it has been available for 5 years. The explanation, I am convinced, lies in its odd title. When I hand it to my clinical colleagues, they typically wrinkle their noses at the word “collaborative.” It seems that collaborative education sounds to them like some special type of education, something different from what they do. It is not. This book is about accepted practices for effective clinical teaching. In the context of this book “collaborative” means “effective.” There is nothing spooky about the book except its title. Unfortunately, books will be judged by their covers, and this cover may be responsible for some lost sales to clinical teachers who are unfamiliar with the educational literature and who therefore may be more responsive to the goal of becoming an effective teacher than a collaborative one.

Although confusion regarding the word *collaborative* is but one sour note in a symphony, it has an unfortunate reverberation that reaches into the text. *Collaborative education*, in current usage, means education in which the teacher and learner jointly set the agenda; it means that learners share the responsibility for finding resources, for evaluating the teaching and learning, and for developing methods of teaching and learning. These so-called collaborative characteristics are indistinguishable from the characteristics of effective education that have been with us for a long time, at least since 1938 John Dewey, as the authors themselves point out. Dewey in the 1930s, Bruner and Rogers in the 1960s, and a deluge of authors in the 1980s and 1990s were the harbingers of a paradigmatic shift that has taken place in the meanings of the concepts of “teaching” and “learning.” The old metaphor of teaching as telling or as sending messages is gradually yielding to a new metaphor of teaching and learning as conversation or dialogue. Teaching is seen less as a performance and more as a kind of relationship. Teaching is seen less as an act of molding or of shaping inert material and more as helping learners who are active partners in the teacher–learner relationship.¹⁻³ Of course, the authors are well aware of all this. Indeed, at several places in the book they use *effective* and *collaborative* interchangeably.

Thus, the book is really about effective teaching that also happens to be collaborative. It is not about a special kind of effective teaching. The problem is that the authors get carried away with the importance of the concept of collaboration, and they turn it into a kind of shibboleth for a special type of teacher. Chapter 2 is devoted to explaining how messy, demanding, and difficult it is to be a collaborative (effective) teacher. It ends with suggestions for helping the reader decide whether he or she wants to become a collaborative (effective) teacher. But, if “collaborative” really means “effective,” then Chapter 2 is demeaning, or at least confusing, to the reader. Why would I not want to be effective? What is the alternative? There is an uncomfortable ring to being asked to raise our hands if we are ready to make the commitment to be effective teachers. This reader wants to be treated as an adult learner who has good intentions. I raise this rather subtle point out of concern that this truly great book could be rejected by my clinical colleagues who might be put off by the unwittingly condescending tone of Chapter 2. I would like to see this chapter provide some real alternatives, say different levels of commitment to teaching appropriate to one’s career profile, or a developmental path for gradually becoming more effective (collaborative). At this early point in the book I need encouragement, not a test of my conviction. I thought that it failed to respect my time pressures and my situation, a violation of one of the principles of the book.

Although there may be some confusion regarding the relationship between the concepts of effectiveness and collaboration in this book, the theme of collaboration does afford useful parallels between clinical practice and clinical teaching. Summary tables

draw striking parallels between the collaborative approach to medical practice and to medical education. These tables present compelling evidence that the effective clinician shares many characteristics with the effective teacher. As the authors write: “While the contents of these tasks differ in the two settings, the processes involved in carrying out these tasks have many similarities. Being effective in one setting can be an excellent starting point for becoming effective in the other setting.” Each chapter begins with an analogy between the teaching practice and clinical practice taken up in that chapter. For example, the chapter on asking questions begins with the sentence, “In health care, asking questions of patients in a central task.” The second paragraph begins with, “In education, asking questions should also be a central task.” The good news about the authors’ attempt to justify the book in terms of collaborative clinical practice is that it makes the book more accessible to the clinical teacher by demonstrating the strong parallels between patient care and teaching.

I recommend that you not try to read this book through like a novel. It can overwhelm. Nor do you have to. It is so highly organized that it can be used as a reference. Every idea is printed in large, heavy, boldfaced type followed by a paragraph or two of explanatory text. The boldfaced headings enable you to flip rapidly through its 375 pages to the section relevant to tomorrow’s teaching; I suggest that, as soon as you get the book, you acquaint yourself with its entire contents simply by reading the boldfaced text. Then, whenever you have a question about teaching, take it down and read the relevant pages. I keep my copy pulled slightly forward from the other books for ready access.

This is a major work. It is a virtual library of educational ideas packed into one book and written by two authors who bring enormous experience from both education and the clinical context. Although most of the references in the book date from the 1960s to the 1980s, with much fewer from the 1990s, they are not out of date, not even today. The principles that the authors write about are not recent. I mention this point about the references only because they might seem out of date to medical researchers who are used to throwing out articles that are older than 5 years. Still, in a few places, more recent reference could have been added, more for the direction they might provide the interested reader than for anything they would add to the text. Despite its outrageous price in Canada (\$74 Canadian), I have two copies because one is always being borrowed.

References

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