Freidholm, A., Savin-Baden, M., Henningsohn, L and M Silén. (2014) Autonomy as both Challenge and Development in *Clinical Education Learning, Culture and Social Interaction*

**Introduction**

This study examines autonomy in learning, related to medical and health care students´ perception of learning and development in clinical education. An understanding of the ways in which students´ learning and professional development is facilitated by autonomy, and a qualitative different understanding of the concept is vital for future development of learning and teaching strategies in medical and health care education.

Self-directed learning and autonomy in learning are connected to factors such as motivation, locus of control, ability to seek and apply knowledge, choice, ability to identify learning needs and to evaluate learning outcomes (Regan, 2003; Lee et al, 2009; White & Fantone, 2009; Levett-Jones, 2005; Williams, 2004; White, 2006; Zimmermann, 1990; Miflin, 2004).There is a gap in the body of knowledge regarding the concept of autonomy in learning when it comes to how autonomy influences individuals thinking, actions and awareness of learning. Many studies merely depict autonomy as a strategy, a way of managing your education in an autonomous way (Savin-Baden, 2000; 2003) (Barnett, 1990; 2000).

The notion of self and management of the learning situation have been stressed, and is still stressed within health care and medical education, thus not much attention is paid to the internal processes of learning involving responsibility and independence (Silén & Uhlin, 2008). This is in contrast to the need within these professions for individuals who are responsible and make independent decisions. A limited view of the meaning of self-directed learning can be hindering for stimulation of student development of independence. Therefore there is a need for a deeper understanding of other dimensions of what autonomy might mean for student learning and for health care professions. Eneau & Develotte (2012) shows how autonomy in learning can be seen as a process reaching the goal that is autonomy of the learner and how this autonomy has a social, meta- cognitive and emotional dimension.

**Theoretical framework**

Self-directed learning and self-regulated learning are both fundamental components of autonomy in learning with different emphasis depending on concept definition, the former with roots in adult education and the latter in cognitive psychology. Self-directed learning has often uncritically been interpreted as independence of classes, courses and faculty (Miflin, 2004). Furthermore authors such as Savin-Baden (2000; 2003) and Barnett (1990: 2000) suggest the current literature still focuses mainly on a more instrumental aspect of self-directed learning, often measured by the ability to seek and apply propositional knowledge. To develop self-directedness, students need feelings of being in charge and of having a genuine impact on the learning situation. Feelings of being in charge are connected to understanding the demands of the learning context, experiences of managing and getting feedback. Thus students need challenges, support and feedback in their struggle to become self-directed learners (Silén & Uhlin, 2008). To be able to develop capacities leading to self-direction, motivation, both extrinsic and intrinsic, plays a key part (Williams, 2004). The term self-regulated learning is often used interchangeable with self-directed learning. However, the definitions of self-regulated learning emphasize issues more regarding control, ability to make choices and moral, emotional and intellectual independence (Regan, 2003; Lee et al, 2009; White & Fantone, 2009; Levett-Jones, 2005; Williams, 2004; White, 2006; Zimmermann, 1990; Miflin, 2004).

The concepts of self-directed learning and autonomy in learning are often used interchangeably. In psychological terms through the self-determination theory, autonomy relates to motivation and can be understood as the inherited fundamental propensity of any living organism to be self-organized and psychologically self-ruled. This is shown as a basic need to experience self-governance and ownership of one´s actions. Self-determination theory distinguishes between two forms of motivating conditions: controlled and autonomous (Chirkov, 2009). Controlled motivating conditions include external factors such as explicit or implicit rewards or punishments. Autonomous motivating conditions are driven by personal interest and perceived importance and meaning and include a sense of agency and choice (Albanese, 2010). Eneau (2008) suggested there is a need to broaden the view of autonomy from simple questions of control, to questions about constructing personal identity, not only through the learning process, but also through the learner´s interpersonal relationships. Eneau (2008) views autonomy as the prerequisite for development of individual identity, and identity as “the subject’s inclusion in a structured relationship of interactions” (Eneau, 2012 p. 16).

Following these ideas, autonomy must be viewed as something that takes place “through a reciprocity based on exchange and otherness” and “supposes that autonomy is born out of a realization of the interdependence of people who are summoned and bound to construct a social contract” (p.246). This view raises new research questions in the field between autonomous learning and the autonomous learner. In a more practical sense, a different view on learner autonomy, could shed light on how autonomy could be constructed through concrete learning situations (Eneau, 2008).

However, it would seem that what is essential for autonomy in learning, are perceptions of being competent, having intrinsic motivation as a driving force and a personal locus of control (Fazey and Fazey 2001). Thus autonomous learners must be in control of their decision making, take responsibility for their own actions and have confidence in themselves. Littlewood (1996) stresses that at the core of autonomy in learning, is the learner´s ability and willingness to make independent choices. Whereas, White (2006) is concerned with the importance of motivation and states that motivation, autonomy and control in learning all have powerful external influences in the form of educational setting, pedagogical structure and approaches, and means that these can create intrinsic motivation per se. Within these ways of viewing autonomy it seems autonomy may be seen as both ends and means. Heron (2010) defines four levels of autonomy which can be used for understanding student development in clinical education. The first level is the learner being self-directed within teacher-prescribed learning activities, the second being students being invited with teachers to take part in program planning and assessment and the third level offers students to be self-directed in their own program planning and assessment. The fourth and last level of autonomy Heron defines as students´ participation in decision making regarding who should make this or that decision within program planning and assessment.

According to Marton & Trigwell (2000), learning is about experiencing but a prerequisite of learning/experience is discernment. A necessary starting point for learning is discernment of an object. The learner has to discern the object in its environment to be able to “see” it and “experience” it in terms of a learning object. What we discern depends on our pre-understanding (Marton & Booth 1997). Studies in a problem-based nursing context (Silén, 2000; 2004) have shown that a high degree of self-directed learning constantly creates situations where students have to discern meaning and relevance of different phenomena and learning objects. This discernment might produce a meta-cognitive awareness that could create qualitative different understanding of a field or profession. When students are forced to take responsibility learning is perceived as meaningful and developing, but can also without the proper support create feelings of uncertainty and abandonment.

Williams (2004) investigated self-directed learning in a problem-based education program and came to the conclusion that it enhances meta-cognitive skills. Marton (1979) defines meta-cognitive understanding or awareness as an aspect of understanding that reinforces the sense of meaning and coherence and allows students to think and reason about their own understanding. Therefore in this study autonomy is seen as an outcome of self-directed learning which contains abilities and traits such as motivation, control, ability to reflect and make independent choices, responsibility, learning strategies and feeling of being in control. Conditions for self-directed learning and self-regulated learning are provided by the educational system in form of pedagogical structure, epistemology, curriculum construct, support and feed-back.

To develop and plan learning and teaching strategies for professional development in medical and health care education we need to know more about how the educational system in clinical education affect student experience of autonomy in relation to self-directed learning and self-regulated learning.

***Aim***

The aim of the study was to investigate the relationship between autonomy in learning and narratives of personal challenge and development in the context of student experiences in clinical education.

**Methodology**

The study was conducted within a hermeneutic ontological framework interpreting participants experience in a life- world perspective. The study was undertaken using narrative inquiry since stories are collected as a means of understanding experience as lived and told, through both research and literature (Clandinin and Connelly, 1994). The term narrative is used to explain human experiences and human meaning making of materials and circumstances (Josephsson et al, 2006). This was important in this study as stories invariably reveal actual practices more than responses derived from interview accounts.

It is argued here that the life world is mediated through narratives where individuals´ subjective understanding and sense-making of their life world becomes visible. Ricoeur (1985) suggest that narrative emplotment is a central function in the creation of meaning and thus “meaning is seen as relational rather than as a stable entity for the individual” (Josephsson et al, 2006 p. 88). Due to this relational aspect of meaning, findings in this study must be viewed as co-constructions between the participants and the researcher (Nyman et al (2012). A narrative told by someone, is invariably a retrospective reconstruction, recreated in the setting of the research situation, and so the situation and the researcher must be considered. Thus narratives are always situated, and meaning derived from these is relational (Josephson et al, 2006).

***Participants***

Twelve interviews were conducted with students from different educational programs, age, gender and background. Four students were medical students, four nursing students, two occupational therapy students and two studied to become a biomedical analyst. All students had started the clinical phase of their education, varying from semester 3-8. Of the twelve participants two were men. Participants were between ages 20-50 with the majority between 20-30 years. Eight participants came from homes were one or two parents had an academic education. Three of the participants had parents with other nationality.

***Data collection***

Sampling was undertaken with a combination of snowball sampling and purposive sampling in order to find students with different experience of and views on clinical education. Students were asked to tell narratives about situations from their clinical practice which had entailed some sort of personal development and some sort of difficulty or set back. No direct questions about autonomy or self-directedness were asked. The tape-recorded interviews were between 45 and 75 minutes long. Each interview began with a conversation about demographic data. Narratives were captured by asking two very open questions; *”tell me about a clinical situation you felt was important to you, a situation that has stayed with you, where you felt that you developed, went forward, learned something” and “tell me about an opposite situation.”* These open-ended questions were chosen to enable rich narratives and not limit our scope of inquiry or to risk any circular reasoning. To be able to achieve as rich narratives as possible, a large amount of follow-up questions were asked, such as *“Tell me more about”* or “*could you elaborate?“, why?” and “how did you feel*?” The taped interviews were transcribed verbatim.

***Ethical considerations***

The ethical principles adopted in this study adhered to the principles of anonymity were possible secure data processing, transparency and minimality and lawful data collection. All participants received an information letter where the aim and context of the study was described. The letter stressed voluntarism and pointed out the right to confidentiality and to stop taking part in the study at any given time and without having to declare any reason. Contact information to the authors was given and questions were encouraged. Each interview opened with a presentation of the study and with participants again reading the information letter and signing the informed consent paper. Once again confidentiality and the right to abort were highlighted. The interviewer had no previous knowledge about or connections to the participants previous to or after the study to minimize the risk of any dependency issues.

***Data analysis***

It is important to ensure as a researcher that there is clarity about whether an analysis of stories is being undertaken or the process of narrative analysis is being used. Within the narrative tradition Polkinghorne (1995) built on Bruner´s classification in order to draw a clear distinction between (a) analysis of narratives and (b) narrative analysis. Analysis of narratives refers to studies in which the data consists of narratives that are then analyzed to produce categories. In this study analysis of narratives has been undertaken, partly by using event narratives such as those described by Labov and Waletsky (1967) with a general structure that includes abstract, orientation, complicating action, evaluation, resolution and coda, and partly by creating categories. In the analysis we draw on Ricouers (1973) identification of distanciation as the element that creates space and freedom in the interpretation of the material. Geanellos (2000) describes this distanciation as a removal of authorial intent, an objectification of the text allowing the researcher to move away from the idea that only one understanding, or meaning, is possible or correct. In this study distance is created by the structure of the analysis of data. Data analysis started with a naïve reading of the interviews, thereby creating a naïve understanding of the text and the narratives, and moved forward to more interpreting steps as described below.

All twelve interviews provided very rich in-depth data and provided a large textual material. Thus, narratives were refined examining issues of challenge and development in the clinical setting by extracting irrelevant and redundant information from the data. This analysis was made through using event narratives to examine the actual narrative from the whole interview account and was repeated four times to ensure that all significant data were extracted. After each time the story was read together with the original interview to ensure that no narrative elements concerning challenge and development were lost. These steps constituted the movement between what the text “says” to what it “talks about” (Ricoeur, 1976, p 88). Through this constant movement between the whole and the parts in the narratives an interpreted meaning emerged. The movement in this hermeneutic spiralhad its base in Ricoeur´s (1976) thoughts on textual analysis with the help of closeness and distance, explanation and understanding thus moving from a naïve understanding to interpretation.

The final part of the analysis was performed through the creation of core narratives speaking in shorter, but cohesive and coherent, terms about the students´ experience of challenge and development (Mishler, 1986). These core narratives can be seen as condensed narratives representing students´ experiences. This process resulted in 25 core narratives, two narratives per student in all but two cases. Finally, these 25 core narratives were analysed with regard to similarities and differences in interpreted meaning, resulting in four themes expressing the experiences of the participants.

**Findings**

The main finding of this study is that students´ narratives about clinical situations where they experienced challenge or development all focused on experiences of more or less perceived autonomy - or indeed the lack of autonomy. The themes are representations of this perceived autonomy and what it means to the student in different clinical contexts. Focus of the narratives varies from focus on the student, on the clinical supervisor, to the patient and the clinical organization.

Findings consist of four themes; *Dependence of the clinical supervisor, Feelings of ambivalence, Professional becoming and Need for authenticity.* All themes are exclusive with the exception of *Need for authenticity* which should be read as a cross-sectional thread through the other themes and as a prerequisite for autonomy to be experienced.

***Feelings of Ambivalence***

The feelings of ambivalence vary over time and depend of the context. Students experience feelings of ambivalence in regard to themselves which manifests as perceived competence in one situation and uncertainty in the next. As a consequence the need for independence and support varies, which became visible in the relationship to the clinical supervisor where the support that is needed in one situation might be too much in another. A familiar context might strengthen the student to dare to be more independent and lessen the need for supervision.

Feelings of ambivalence were constantly present in the clinical experience. Students had a need to perform and try for themselves, but they also needed to be checked and given feed-back to be sure they are performing tasks correctly. There was a variation over time in perception of oneself as independent, competent and able, wanting to be in control, to feelings of dependence with need for help and support. These ambivalent descriptions were also characterized by expressions of “can`t be with and can`t be without” the clinical supervisor, something that varies with the belief in participants own ability. One day you might feel secure and want to try more on your own and the next day you would like to stand back and watch. As one student explained; “*She thought from the start that it was important I took responsibility and that I should do much on my own, and that was mostly good. But sometimes I felt that it would have been great to have someone with me in the room. Sure, you don´t want like a tail after you, but sometimes I could have used more help”* (stud. Nr.1).

***Dependence on the clinical supervisor***

The relationship to and the dependence on the clinical supervisor is described as dominating the clinical experience. This relationship can be both developing, but also something that slows the students down in their learning. Development is perceived both in situations where the student is being challenged by the clinical supervisor and in situations where the student feels safe and comfortable. As the students are so dependent on the clinical supervisor they stress the importance of the supervisor´s personality and whether this personality is compatible with that of the student.

The clinical supervisor is the source of inspiration and the need to impress or be liked by him, or her, can be a motivating factor for the student to perform well. Sometimes you also have the feeling that you want to pay the supervisor back by being a good student. One student describe how a good relationship makes him want to perform well, almost as a gift to the supervisor; “*Well, you might want to give them like a receipt that they are good supervisors, like, check it out, you are a good supervisor, I am learning”* (stud. Nr. 11). The supervisor can force you to action, to take responsibility and to think for yourself which sometimes is positive and serves as a driving force; “*It´s like when you are riding with someone in a car and you are supposed to learn the way, you will not remember it anyway, or I won´t. If you just are riding along, it is easy to believe that you know the way, and then when you shall drive on your own, you can´t find it”* (stud. Nr. 2).

On the other hand, this experienced force could create feelings of being unsafe and unequal in the environment and having no control over your situation. To achieve control the students described adaptation to the clinical supervisor. A constant adaptation to different supervisors however could be challenging, whilst also perceived as necessary to function in the clinical setting. The clinical supervisor is seen as an authority which was both a security and a source of comfort, and it is easy to take a step back and only observe when the clinical supervisor is present. To have a good and developing relationship with the clinical supervisor was wanted, appreciated and described as vital for learning by all participants. As one of the students put it; *“…I think it´s hard to achieve an equal relationship in the teaching situation. It is always so that the teacher stands a little bit above you, because it is him or her that does the assessment, who knows stuff…and so. So it´s not quite equal…but on the other hand …the important thing is that it feels safe and that you can both succeed and fail without feeling bad…”* (stud Nr 3).

***Professional becoming***

Professional becoming is defined as feelings that emerged from the sense of being a” real professional.” The students felt like real professionals when they were given the opportunity to play a role in the patients care and, ultimately, in the patients´ life. Participants particularly felt that the trust given to the students by the patient was important. The relationship with the patient was facilitated by being able to meet the patient alone and from the beginning taking the role of the professional.

For example, with a nuance of delighted surprise, feelings connected to discoveries of being a real professional appear. To be given the trust by patients and personnel to take care of patients, and to “be enough”, especially in the eyes of the patient is a very important experience. One student explained the importance of connecting with the parents to a severely ill son; “ *I am proud that I succeeded, although they were in their, big, big crisis with a son* *who just had a traumatic injury…that I managed to reach them. I learned a lot, I think”* (stud. Nr 8).

Professional becoming was evident in narratives about taking a moral responsibility for the patient, to watch out for your own patient and taking responsibility for ones actions, even if it sometimes becomes uncomfortable and scary*“ I think they respected that it was my patient….and they let me do it… and I threw myself into the situation”* (stud.Nr. 4) . The discovery that participants had something to give to the patient, instead of taking from them or stealing their time, was a novel experience and provided a great sense of accomplishment.Professional becoming also created a feeling of wanting to take part, to be a legitimate part of the workplace more than there was given opportunity to.

However professional becoming was also thwarted by the sense, in some cases, that the students felt they knew better than the clinical supervisor and this was painful and disappointing as well as creating uncertainty in the student role. When the clinical supervisor failed to live up to expectations and lacked in moral responsibility, students sometimes felt a need to take action and this created feelings of uncertainty and sometimes anger and guilt; “*I felt like I wanted to talk to her, I should have taken that battle, but I never did and I can feel a little sorrow over that, but I still feel good that I tried to do it right (…) Normally you look up to registered nurses and take after them (…) but I can´t feel that I look up to her”* (stud. Nr 4).

***Need for Authenticity***

The need for authenticity is here seen as the prerequisite for feelings of development in the clinical education. Situations needed to be real to have importance and to make a strong impact on students´ learning by creating feelings of relevance and meaning i.e. really matter in the clinical situation and not be created as education. A real situation was characterized by part taking and the students´ decisions and actions having an impact on the patient´s situation.

Relevance and meaning became apparent when actions and decisions had consequential impact on patients´ wellbeing and life situation. When students were allowed to take responsibility, when they were the ones to know and act, then an understanding of the whole clinical situation emerged. To be able to be the professional in the eyes of the patient enhanced participants sense of belonging as well as their perception that they could dare to be more professional when alone with the patient; *“There is something there. The difference is that for the patient I am the doctor. If I come there as some kind of unspecified tail, then I am some obscure student. If I come in and, at least preliminary, make the decisions myself, I will have another role for the patient, and we therefore create another connection”* (stud. Nr 12).

Visible in the stories were the accounts indicating that the reality itself was not enough, actual real-life situations in actual settings are not enough – instead participants argue that meaning occurred when students´ actions and decisions had actual impact on the patient, when they actually mattered to the patient, had formed a relationship and had moral responsibility for the patient.

Whilst this theme has described a core issue, it is also a theme that transcended other themes running like a red cross-sectional thread through the other themes. In the theme of *Dependence on the clinical supervisor,* there was a need for authenticity, but too much authenticity was perceived as frightening, thus increasing the dependence on the clinical supervisor. In the theme of *Feelings of ambivalence* there are similar needs of authenticity, but also feelings of not being quite capable.

In the theme of *Professional becoming* positivedevelopment is described by the students after experiences of being viewed by patient or staff as “real” professionals with the ability to really help and contribute to meet patient needs. Negative experiences of authenticity, when the situation was perceived as “too real”, were narrated when students sometimes came to the painful realization that they in some situation knew better than their clinical supervisor

D**iscussion**

In this study we sought to capture the ways in which autonomy in learning was expressed in students´ narratives of challenge and development in clinical education. We will analyze the findings from a social perspective (Wenger, 1991; 2010) (Eneau, 2008) and from perspectives on autonomy encompassing choice and decision making.

The basic presumption for the social theory of learning (Wenger, 1991; 2010) is that we are social beings and that learning takes place in this social world through participation. The goal of learning is to experience the world around us and to perceive our relationship with this world as meaningful. When really participating, we are active in the practices of social communities and construct our identity in relation to these communities. Such participation shapes both practice and importantly, how practice is interpreted. The social theory of learning defines learning through practice with learning as doing, community with learning as belonging, identity with learning as becoming and meaning with learning as experience. As the concepts of the theory are interconnected and define each other, we put forward that the emphasis of the theory can be changed for the purpose of examining each concept more closely in relation to our findings. We suggest that by focusing on *Identity*, it will be defined through *Learning, Practice, Community* and *Meaning.* Emphasizing *meaning*, meaning will be defined through *Learning, Practice, Identity* and *Communit*y and so on. Using this as a theoretical framework in conjunction with the findings, it confirms that learning must take place within a community that is relevant and students must be able to act and practice within this community. Learning shapes our identity through becoming as a process and through meaningful experience.

The dependence on the supervisor and the ambivalent feelings towards him or her together with feelings of professional belonging, were all connected to autonomy. Autonomy issues had to do with the relationship with the supervisor and the varying need for security and support or for more independence within practice. Authentic situations mostly enhanced feelings of professional belonging.

Authenticity seemed to encompass all the above described components of the theory and bind them all together. If, according to Eneau (2008; 2012) individual identity is shaped from autonomy, authenticity plays a key role in identity shaping. When experiencing an authentic situation, students felt that they belonged and were allowed by the community to take responsibility. Students were the actors, the doers in these situations, and what they did had a real impact on the situation and on the patient. These feelings of “being” the nurse or the doctor, at least for a moment in time, resulted in students experiencing and understanding the situation in a deeper, more meaningful way, for example resulting in them taking greater responsibility or expressing a larger understanding of the whole situation, not only part of it. Authenticity was also what created meaning and made the situations specifically important for learning.

Viewing the findings of this study in relation to the social theory of learning, autonomy can be seen as a dimension in all the concepts. Autonomy was seen in the ambivalent relationship with the supervisor and the dependence of the supervisor, in the theme professional becoming autonomy played a significant role where students try to position themselves in relation to the patient and the organization, and in the need for authenticity students expressed the need for situations that enabled them to be autonomous.

So, when analyzing the findings of autonomy and authenticity described through the looking glass of the social theory for learning, autonomy becomes connected with practice, community, identity and meaning, thus moving away from autonomy as an personal trait alone and towards autonomy as a social phenomenon. As Eneau (2008) indicates, autonomy only can be constructed in reciprocity, by creating relationships that allow personal development, thus making autonomy something that only can be created by giving and receiving. This way of reasoning is strongly connected with the students´ narratives about professional becoming. To be seen in the patients´ eyes as the authentic professional helper that has a value for the patient, seemed to have been vital for the view of oneself as a professional, giving the situation meaning and relevance. So; if identity, is a creation of autonomy as suggested by Eneau (2008; 2010) and authenticity, as our findings indicate, is a prerequisite for autonomy, then authenticity plays a key role in the development of a professional identity.

Littlewood (1996) has suggested that autonomy is largely connected to choice described in different hierarchies regarding the choices that constitute a persons´ behavior and ranges from low-level choices that control events within an activity to high-level choices that govern the action itself. High-level choices control the overall activity, the overall aim and direction of the activity and also to choose if whether to act at all (Littlewood, 1996). Related to the social theory of learning this could be seen as connected to the dimensions of practice, meaning and community. To actually be responsible for a patient and allowed to assess needs and to plan a real course of action, may offer students the opportunity to act out this autonomy by making high-level choices or decisions. Findings in this study show that such high-level choices only can be made in the authentic clinical situation. In a less authentic situation, choices become unreal and not the actual source of clinical action, therefore perceived as not so important. Findings show that each clinical situation was different and the ability to choose and decide was closely linked to the specific situation. This, in turn, created variations in what constituted autonomy and how autonomy was operationalized in different settings with different people.

Our findings suggest that autonomy with an emphasis on decision making and choice should compel academics and practitioners to rethink clinical studies in practice, involving students in early stages in planning and organization of care. Following the work of Marton and Trigwell (2000) and Silén (2000; 2004; 2008) this decision making and subsequent discernment, might lead to a meta-cognitive awareness and a qualitative different understanding.

The theme relating to authenticity is the one theme that most of all raise novel questions about clinical learning in practice. Authenticity was regarded as the most important factor for creating a feeling of development in the student narratives. Interestingly, it was often the frightening and at first described negative experience of being uncertain that created the rewarding authentic situation in hindsight.

These findings therefore seem to illustrate a different perspective from much of literature on autonomy where autonomy mainly is perceived as a personal trait or quality, focusing self-determination, choice, decision making, locus of control, motivation and agency (Chirkov, 2009; Albanese, 2010; Heron, 2010; Fazey and Fazey, 2001). Instead, using the theory of social learning and using autonomy as a concept through which students are supported or disabled in making identity choices, a less instrumental view of autonomy, and indeed self-directed learning, can be seen as trajectory. Such as trajectory shifts from autonomy being seen as the students as being independent and capable of managing the learning process, to a more complex view where autonomy might be the ultimate goal of education, a journey of personal development in relationship with others. New research questions regarding the role of authenticity and the connection to autonomy and identity are raised and need close attention.

***Strengths and limitations***

The largest strength of this study is the richness of data in the twelve in-depth interviews with very thick descriptions. In the interpretative process of data there have been several researchers to check interpretations of findings through a constant discussion. Voices of the participants remained highly present in the account of the findings through the core narratives and appropriate quotations and therefore the account of data is very representative.

A limitation is found in the sampling process where the sought after variation might not have been totally achieved with an imbalance of male and female records and the limitations to age group, but it is our believe that data can be transferred through the applied theoretical analysis. Also due to the thick descriptions in the interviews, there is a potential risk that data have been lost in the necessary condensation process. It is recognized that the interview situation provides a specific social context that is a part data and that meaning from data therefore is relational. This can be seen as both strength and a limitation, the strength being the ability of the researcher to convey an understanding of the narrated “world” of the participant that might lead to more in depth accounts in the interviews. Using narrative theory and narrative method, data is invariably a relational product, but we believe there are stable enough traits that through analysis can be seen as more transferrable or indeed general.

***Conclusions and implications for practice***

By seeing autonomy as also a social phenomenon, there are implications for clinical education practice in the way clinical studies are organized, for example the level of student engagement in the clinical workplace, the length of the clinical placements and how to make use of the students´ knowledge and how students are supported in taking responsibility for patients and forming relationships with them.

The findings suggest that in order to create autonomy in learning in medical education, it is important to move away from the image of an independent learner who is learning from the patient, to a learner who learns together with the patient in a reciprocal relationship. Furthermore, is vital to make the student a part of the ongoing clinical work, not as an outsider, but as one of the team. Tasks given to students must be significant for the clinical work, and play a real role in the caring process. If this is achieved, the result might lead to learning perceived by students as more meaningful than any other.

Finally it is hoped that this study will contribute to the design of clinical education especially taking into account the issues regarding authenticity, a new vision of autonomy and a more in-depth recognition of the role of these concepts for the construction of professional identity in clinical education.

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