Theory before practice: Implicit assumptions about clinical nursing education in Australia as revealed through a shared critical reflection

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Abstract
The transfer of nursing education into the higher education sector occurred over a 10-year period in Australia (1985–1994). Australian nurse leaders settled on a single outcome measure to be applied for all nursing graduates in the form of national competency standards. While this move enabled diversity, the lack of consistency in curriculum design has subsequently led to increasing confusion for clinicians who support students' learning in clinical placements. Using a shared critical reflection method, the authors reviewed (1) the evaluation comments from nurses in one nursing unit of a hospital in one Australian jurisdiction and (2) an historical review of nursing literature at the time of the transfer of nursing education into the higher education sector. The reflection suggests that the aim of the transfer, to create critical thinking graduates, has been undermined by the implicit clinical education practices that have since emerged. In order to address the contemporary challenges for clinical staff working with students from multiple universities, as well as increased student numbers to address the nursing shortage, we recommend a new approach to curriculum design: a national clinical curriculum drawn from social, as well as cognitive, learning theory that at once informs clinicians of students' potential abilities and provides the scope to accommodate the increasingly difficult and critical learning requirements of tertiary-based nursing students.

Keywords: clinical curriculum; pedagogies; social learning; nursing; culture

Introduction
In Australia the transfer of nursing education into the higher education sector in the period 1985–1994 was assisted by the decision of nurse leaders to adopt a single outcome measure for all nursing graduates, a national competency standard for the registered nurse (Percival, 1995). This decision provided curriculum designers in higher education institutions around Australia with the scope to develop programs of study that met local needs, while ensuring that the graduates met a minimal national standard.

While higher education institutions and hospitals partnered locally, the diversity of curricula was not an issue. However, with partial deregulation of the higher education sector and increasing shortages of skilled nurses, many health agencies began to partner with multiple higher education institutions to provide work experiences for nursing students. Clinicians today are confronted by
students from different tertiary providers, with different curricula, and different levels of preparation. Clinicians’ taken-for-granted assumptions about how students learn, which inform ‘operational’ models for workplace learning are being challenged by the diversity of students, as well as diverse curriculum expectations, in their workplace. This often leads to tensions in the work unit that can reduce opportunities for learning.

As with other jurisdictions, one university in one jurisdiction of Australia had enjoyed an exclusive relationship with its partner health service. The introduction of nursing students from other higher education institutions resulted in increased tensions that were difficult for staff to explain. In discussing this situation with a senior colleague, and considering feedback on their experience from staff, one author (LS) questioned the cultural expectations within the work unit. This paper reports on a shared critical reflection of both authors on clinical education practices.

BACKGROUND
Clinical education for pre-registration nursing students has provided significant challenges for nursing educators interested in preparing a competent, critically thinking, graduate nurse. Despite the plethora of studies done to date, clinical education has not progressed (Levett-Jones & Lathlean, 2008). The value of pre-registration clinical education to nursing is not contested in the nursing literature. What is contested is how much emphasis in curriculum should be on practice and how to best facilitate student learning in the workplace.

One key element is consistently reinforced in the plethora of nursing research studies of clinical education done to date. Students’ access to appropriate clinical experiences, and therefore learning, are dependent upon clinicians’ openness to student presence and inclusion of students in their everyday practice. In the last 30 years, a range of clinical education models has been developed and trialed to determine the ‘best’ way to enhance student access, without returning to the apprenticeship model of training found in hospital-based programs. More recently, the term ‘belonging’ has been coined as a way to acknowledge students’ requirement for access to worthwhile practice experiences (Levett-Jones & Lathlean, 2008).

Theoretical development in the discipline of work-based learning suggests that learning is dependent upon ‘engaging in work activities that are novel and thereby extend the individuals’ capacities, securing appropriate guidance from experienced coworkers, and being able to access practice in prized tasks’ (Billett, 2002, p. 29). Billett (2002) suggests that opportunities for students to engage in clinical practices are shaped by workplace practices grounded in unique histories and traditions. Following Billet, it is then logical to assume that some of the history and traditions of pre-registration nursing education, grounded in the apprenticeship model of hospital-based programs, continue to exist in contemporary health services.

In a literature review on the topic of supernumerary status of pre-registration nursing students, Elcock, Curtis, and Sharples (2007) found that access to clinical experiences is dependent upon being ‘let in’ – this can be through a mentor, a clinical teacher, or not. In this study, students who do not get ‘let into’ staff conversations and culture have limited learning experiences – often completing repetitive low-level tasks to try and get in. Further, Elcock et al. (2007) found that the definition and operationalisation of supernumerary status is not clear and the lack of clarity raises issues around access to clinical experiences and the gatekeeping role of clinical staff, particularly the clinical manager or leader. These findings are consistent with other studies of clinical learning environments (Dunn & Hansford, 1997; Hart & Rotem, 1994; Saarikoski, Isoaho, Leino-Kilpi, & Warne, 2005).

One recent Australian study found that three barriers to knowledge translation were lack of engagement of students, lack of affordances for student learning, and teacher dispositions (Newton, Billett, Jolly, & Ockerby, 2009). Again, these findings emphasise the difficulty with negotiating student access to workplace experiences. In
Another Australian study was how to prepare students for the social, political and cultural arena of clinical practice (Newton, Billett, & Ockerby, 2009). These research studies reinforce the value of the social in knowledge translation and learning.

Curriculum, including clinical education, is an ‘amalgam of heterogeneous and conflicting practices’ (Darbyshire & Fleming, 2008, p. 267). In the early twentieth century, curricula were designed locally, with a series of practice-based experiences supplemented by theoretical lectures, and validated by the government regulatory authority. As found in an historical analysis of curriculum in South Australia, there are now multiple stakeholders in curriculum, more than simply regulatory bodies and medical fraternity (Kako & Rudge, 2008). While universities may continue to offer diverse theoretical curricula, the need for consistency in the clinical curriculum is increasing due to the number of stakeholders with an interest in graduate nurse capability (Darbyshire & Fleming, 2008). With the shift from state-based to nationally-based registration, Kako and Rudge (2008) suggest that it is timely to consider a national curriculum, particularly in the area of clinical or practice-based knowledge.

It is acknowledged that clinical education has limitations that include, but are not limited to, exposure to learning practices that are dangerous, shoddy or inflexible, the difficulties of learning knowledge not readily available in the workplace such as conceptual or symbolic knowledge, and difficulties with accessing appropriate expertise and experiences (Billett, 2002; Hughes, 1998).

Walker and Holmes (2008) argue that the conceptualization of nurses as ‘doers’ rather than ‘thinkers’ makes educating nurses in higher education most vexed. Using research into nurse sensitive indicators on patient outcomes, Walker and Holmes (2008) argue that theoretical, rather than practical, knowledge makes a difference to patient outcomes in the acute setting and call on the profession to reconsider the emphasis in nursing education on the practical. This is supported by those who suggest that nurse should make scientifically sound contributions to the health outcomes of individual patients (Daly, Macleod Clark, Lancaster, Bednash, & Orchard, 2008).

Another consideration in contemporary clinical education is the increasing diversity of students in higher education (Commonwealth of Australia, 2008). Diversity, combined with the emergence of student autonomy, requires educational approaches that are student, rather than teacher, centred. Darbyshire and Fleming (2008) suggest that the notion of students as autonomous and self-governing is a relatively recent historical arrival, introduced with the humanistic models of nursing in the late twentieth century. The unique and personal nature of clinical learning is revealed in a recent study of 67 nursing students’ perceptions about clinical placement. Using a Clinical Learning Environment survey tool, Midgley (2006) found that students were anxious about their clinical placement and there was strong evidence that students found it to be a personal experience. Midgley (2006) recommends that clinical teachers are aware of students’ individual learning styles, which are drawn from their unique histories.

The need for partnerships between higher education facilities and health service agencies is assumed. Partnership models published in the nursing literature initially emphasized two partner models (Mann et al., 1999) and more recently describe one higher education facility partnering with multiple health service agencies (Featherstonhaugh, Nay, & Heather, 2008; Owen & Grealish, 2006). The model of collaboration between one health service and one university continues to succeed in regional USA (Horns et al., 2007), although it is increasingly rare in Australia. With the deregulated health environment, multiple partnering between health services and higher education facilities is becoming a dominant practice but the implications for curriculum design and delivery have not been fully explored.

In order to understand the constructs of nursing education, some have used historical literature...
reviews. In an historical review of the Harmer, later Henderson, textbook, *The Principles and Practice of Nursing*, the increasing value of liberal education over time is revealed, with a significant shift from an emphasis on learning ‘how to do’ nursing to learning about nursing by ‘doing’ (Boschma, Davidson, & Bonafacio, 2009). In a Foucauldian genealogy of nursing education through textual analysis of nursing textbooks published between 1907 and 1969, Walker and Holmes (2008) demonstrate that clinical experience during this period was focused on servitude and discipline. An historical analysis of clinical education, at the time of the transfer of nursing education may reveal implicit assumptions about contemporary practices in clinical nursing education.

**THEORETICAL FRAMEWORK**

Clinical education in the twenty-first century continues to be contested. While some authors advocate for privileging clinical education through strategies such as faculty practice (e.g., Barrett, 2007), others suggest theory and research should be privileged (e.g., Walker & Holmes, 2008). The practice-based nature of the discipline of nursing, which is now grounded in the research-based academy, is challenged by the long-standing theory-practice gap. In the absence of high-level evidence on teaching nursing, novice nurse academics require opportunities to reflect on their teaching experiences in critical ways, drawing on theory from the discipline of education and the experiences of more senior colleagues.

Critical companionship has been used by nurse academics as a framework to analyse and develop teaching practice (Gribben & Cochrane, 2006) and is advocated as a process for developing practices that are person-centered and evidence-based (Vanlaere & Gastmas, 2007). In the spirit of mentorship and practice development, two nursing academics, one new to the academy and the other with over 20 years of experience, reflected critically on one author’s (LS) recent experience of clinical education. Data used for reflection included:

- Feedback from staff in one health service unit, in one jurisdiction following one semester, that was collected through a routine open-ended survey; and
- An historical analysis of the nursing literature during the period of the transfer of nursing education from hospitals to higher education in Australia.

In undertaking this reflection, the authors worked to identify the hegemonic assumptions about clinical education that informed their experience of teaching practice. This approach is consistent with critical reflection as defined by Brookfield (2009), where ‘critical reflection calls into question the power relationships that allow, or promote, one set of practices considered to be technically effective’ (p. 293).

**THE TRIGGER EVENT**

Until the time of this incident, the university had enjoyed an exclusive relationship with the local hospital. In 2008, the academic facilitator experienced a feeling of emerging unease from the clinical staff in relation to the students. This unease appeared to be related to the new arrival of students from two other university nursing programs. In the presence of groups of students from other university programs, individual RNs began to express their concerns regarding how to support the students to one of the authors (LS).

During the semester, both authors would meet and discuss the situation, developing strategies to support student learning and develop clinician understanding of clinical education for pre-service nursing students. In the experience of the senior academic (LG), the concerns expressed by the staff were similar to those in other partner health agencies that held multiple higher education relationships, raising questions about broader socio-political dynamics. On completion of the semester, a standard clinical evaluation was undertaken, which included open-ended feedback from the nursing staff.
Open-ended survey comments were in response to questions:
• What worked well?
• What did not work well?
• What would you like to see improved?

While the number of survey responses was small (N = 14), the findings were consistent with reports from other units and can be found in Table 1.

While recognizing the limited value of the findings in terms of research, the findings provided a reasonable data set for critical reflection on clinical nursing education.

The transfer of nursing education from the hospital to the higher education sector took place over a 10-year period. There was widespread support for the transfer from nursing regulators, professional and industrial bodies, and nurse teachers. Key reasons advanced for the transfer were to broaden the focus of nursing from hospital work to include public health (Patten, 1979) and to develop nursing as a research-based discipline from its history of tradition and servitude (Bolton, 1981; Watson, 1982). At the time of the transfer, nursing leaders agreed that highly valued professional standards should be produced through processes of critical thinking and values analysis rather than reproduced by a ‘captive workforce’ (Bottorff & D’Cruz, 1985; Hart, 1985; Pratt, 1980).

In order for tertiary-based students to have access to practice, new relationships between higher education institutions and health services were required. Establishing these relationships was initially difficult (Bell, 1983) and maintaining the relationships continues to be recognized as essential (Levett-Jones, Parsons, Fahy, & Mitchell, 2006; Parkes, 1995).

TABLE 1: THEMATIC ANALYSIS OF STAFF FEEDBACK

<table>
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<tr>
<th>Staff feedback</th>
<th>Theme</th>
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<tbody>
<tr>
<td>Possibility of students returning [to the hospital] when they graduate. Good to create a bond between students, university and institution.</td>
<td>A collaborative bond between students, agency and university is valued.</td>
</tr>
<tr>
<td>Challenge to find time to teach/explain aspects of nursing when they are busy. A DLN [clinical support person] is needed on all wards.</td>
<td>Teacher must give information before student does procedure/activity.</td>
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<tr>
<td>Clear guidelines and/or a quick reference regarding what students can and cannot do for their year level’ Unclear what level the students should be working at. Too many students [between 6 and 8] on any given shift.</td>
<td>There is an expectation of a pre-determined ‘order’ to skill acquisition, with concomitant expectations about levels of ability.</td>
</tr>
<tr>
<td>Education for staff to gain information about the students. Occasional combined debriefing of students and staff. Students are a great support to staff. Enjoy having students. Extra pair of hands. Most students want to work and learn. Frustration expressed when students who were not interested kept disappearing, taking long breaks, and leaving early.</td>
<td>More comfortable with patient allocation than team nursing delivery model. Staff want to understand the ‘right’ way of engaging with students. Nurses can engage with students who show interest, watch, ask questions and help out.</td>
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As planning for the transfer progressed, models of learning in the clinical environment were advanced. These early models emphasized the need for nursing students to observe ‘good’ nursing practice (role models; Howie, 1988; Kanitsaki & Sellick, 1989; Pelletier, 1985; Sweeney, 1986) and reflect on their experiences (Bottorff & D’Cruz, 1985; Mander, 1992). These new models of clinical education required that the students were supernumerary, rather than counted as a member of staff, so that they could be dedicated to full-time learning (Patten, 1979; Watson, 1982). Through these changes, the hegemonic assumption that learning is a separate activity from work was enacted.

There was agreement from many leaders at the time of the transfer that:

- The nursing student in the higher education sector would be a self-directed learner (Gibbons, 1982; Harte, 1976; Pelletier, 1985);
- The nursing student would be active in his or her own learning (Kermode, 1984; Milligan, 1995);
- Nursing was a life long journey of learning (Darbyshire, 1993; Jarvis, 1987; Roberts, 1981);
- Clinical experiences were required for learning (Bell, 1983; Bolton, 1981; Orr, 1981);
- The focus for clinical learning shifted from learning by doing tasks, procedures and skills to learning by providing individualized patient care (Gray, 1981; Hart, 1985; Roberts, 1981); and
- Student learning was dependent upon the characteristics of the placement environment (Dunn & Hansford, 1997; Hart & Rotem, 1994; Kermode, 1984).

From these agreements about clinical education, one can see that skill acquisition, something highly valued in the hospital-based programs was rendered invisible through the language adopted during the transition. The focus of clinical education shifted from nursing practice and tasks to individual learning about holistic nursing care and the application of knowledge in patient-care contexts.

Preceding the transition of nursing education into the higher education sector, there were many authors arguing for a change in nursing delivery as well as nursing education. The transition of nursing education was accompanied by widespread changes to nursing delivery in hospitals, from team nursing and task allocation to primary nursing or patient allocation. Patient allocation was argued to be more consistent with emerging nursing theories where the registered nurse could provide total and holistic patient care (Hart, 1985; Patten, 1979; Roberts, 1981). This shift required registered nurses, or sisters, who once were in charge of an area or a team of nurses, to change their practice to include the delivery of personal care (Orr, 1981). This undoubtedly created additional role confusion during the transfer of nursing education, which led to unexpected negative outcomes for already qualified registered nurses during the period of the transfer (Herdman, 1998), with many resenting the new tertiary education system. Yet, the value of holistic nursing care dominates as a key assumption of clinical nursing education.

The focus of nursing education in the higher education sector was upon concepts, relationships and principles, preferably derived from nursing research (Bell, 1983; Watson, 1982). Nurse leaders called for content from the physical, biological and behavioral science areas (Martins, 1980) and the development of a nursing science (Gray, 1981; Roberts, 1980). Curriculum design aimed to produce a nursing graduate who was able to use research-based theory to think beyond the immediate situation (Gray, 1981; Martins, 1980; Roberts, 1981), something that continues to be well recognized as an important graduate attribute for most professions today (Guile & Young, 1998).

There was strong agreement that the curriculum should be designed so that content was sequentially ordered and cumulative to ensure effective learning (Gibbons, 1982; Harte, 1976; Kermode, 1984), with the risk of a ‘crowded’ syllabus acknowledged (Pelletier, 1985). Early nursing curricula were designed so that clinical
experiences and theory were as closely integrated (time ordered) as possible, consistent with recommendations from nurse leaders (Parkes, 1995). From this discourse of curriculum design emerged the assumption that students learn theory in order to apply it directly to practice.

In summary, we conclude that there are three key assumptions, contributing to an ideology about clinical nursing education that emerged around the time that nursing education was transferred from the hospital to the higher education sector. Firstly, at the time of the transfer of nursing education, nurse leaders claimed that the enforced work associated with hospital-based nurse training should be replaced with supernumerary learning experiences in the workplace – *working and learning were separate activities*.

Secondly, the focus on holistic nursing care that arose during the time of the transfer effectively worked to render skill acquisition invisible. While supernumerary clinical experience was acknowledged as necessary for nursing education, the focus of learning was the provision of holistic patient care rather than specific skill acquisition. The second key assumption underpinning clinical nursing education is that *holistic nursing care provides the framework for nursing practice*.

This has led to the third assumption about clinical nursing education: *theory must come before practice*. This third assumption is enacted in clinical teaching practices where students learn by observation and reflection on those observations, by asking questions, and demonstrate understanding by explaining rationale for their actions. It is also enacted by curriculum designs that match theoretical learning with clinical experiences, usually in specialties such as pediatrics, mental health, medical-surgical nursing, intensive care and aged care.

**Discussion**

In reflecting critically on the findings of the staff evaluations and on the review of the key Australian literature published during the transition of nursing education to the higher education sector, and considering our personal experiences, we sought to understand the challenges confronted in the delivery of clinical education today. From the literature published during the time of the transfer of Australian nursing education into the higher education sector, we identified three key hegemonic assumptions about clinical education for nursing students. In this discussion, the ideology of clinical education, espoused at the time of the transfer of nursing education to higher education, is manifest in the language, habits, and culture of the unit that triggered this reflection, and possibly in others. In this section, we argue that these three hegemonic assumptions, so closely embraced by the profession, are working against our development as a profession and limiting how we can prepare critically thinking graduate nurses.

**Learning and working should be separate activities**

The separation of learning and working was made when nursing education was intentionally moved away from the hospital workplace. At one level, this move required new relationships between health service and educational institutions to be established and nurtured. The value of the collaborative bond is evident in the feedback from the clinical staff in the evaluation feedback, indicating recognition of the separateness through the value of the relationship. When there is a collaborative bond between all of the stakeholders, the likelihood that there will be a culture in the clinical environment that elicits a positive learning experience for the student is increased (Hart & Rotem, 1994).

Separating learning from working has limited the development of critical thinking skills. Student behaviours such as observing, asking questions, and doing activities perceived by the nurses as helpful were remarked upon by the nurses in this study, with frustration expressed by student behaviours that did not conform to these expectations. These expectations are consistent with those clinical education practices advanced during the transition of nursing education.
The value of observation, particularly observation of ‘good’ nursing practice, was espoused as a key pedagogy – as a more effective way of learning than doing – by nurse leaders (Kermode, 1984). As cognitive activity, watching and thinking about practice (reflection) was thought to provide more time for learning (Patten, 1979; Watson, 1982).

The supernumerary status of students, which was prized during the transfer of nursing education, has further increased the reliance of students on clinicians who control their access to practice. Students who are trying to ‘get in’ will undertake repetitive low-level tasks (Elcock et al., 2007); they adopt behaviours that demonstrate servitude and compliance with cultural norms.

The delivery of content, usually in lectures and seminars, positions the student as a passive recipient of knowledge (Orr, 1981) creating the relationship where the teacher is the ‘teller’ of the knowledge. When students are continually exposed to content-driven curriculum, they develop patterns or habits of learning. When these students then move from the classroom to the field, they continue to draw on these habits, with clinical staff responding by continuing to provide information to the student. While these models appear supportive and assist the student in developing a theoretical body of knowledge, the learner becomes more and more dependent upon being told what is ‘right’ and less likely to initiate private study (independent learning). Clinicians, who are also trying to determine the ‘right’ experiences to offer students, reinforce this type of thinking. Rather than promote critical thinking, such practices lead to a passive graduate, constantly seeking guidance from others, with a ‘professional’ graduate considered to be one who works effectively within the constraints of the work place (Howie, 1988).

Established pedagogies from the classroom are sound for academic study but do not translate well into the workplace setting. Setting students up in tertiary education, separate to the service sector, required new ways to access the practice experiences required for learning. Nurses in this particular unit valued students who showed interest by watching, asking questions, and helping out; students who adopted these practices had access to learning experiences. But, as suggested by Walker and Holmes (2008), students and clinical nurses who adopt these practices are reproducing practice that is based upon servitude and discipline.

**Holistic nursing care should frame clinical nursing education**

The nursing staff members working in this hospital were like others working around Australia – they work in the delivery model known as patient allocation. This work model is dominant in Australia and lends itself well to particular pedagogical practices such as preceptorship (one-to-one) and information giving/‘telling’. While nursing students may value the one-to-one model of clinical support (Hart & Rotem, 1994), it is unsustainable in light of increasing numbers of students required to meet the growing international demand for qualified nurses.

Despite the focus in curriculum design on holistic nursing care, there is an expectation for an implicit order to skill acquisition from supervising nurses. Requests for guidelines and references suggest that the clinical nurses perceive nursing students as being at particular points on an educational journey and seek direction on how to engage with students at each point. Knowing the ‘level’ of student, where the student is positioned in the journey of the course, could provide the clinical staff with valuable information that can be used to include students in their working world. However, due to the diversity in curriculum design, it is risky to assume that students in different tertiary programs have the same clinical abilities based on their progress in a program of study.

There is also evidence to suggest that specific skill lists based on course progression have the potential to reduce rather than support student learning (Grealish & Trevitt, 2005). When students are not encouraged to draw on their learning histories, their progression and development on the path of lifelong learning is limited (Jarvis, 1987). One way of supporting student-centred
learning, without reducing the practice experience to a list of skills to acquire, has been the use of learning objectives to guide clinical learning has not been widely investigated to date and is an area for future research.

**Theory should be applied to practice**

Clinical staff members in this unit appear to assume that they are responsible to provide information to students before doing a procedure (refer to Table 1). The staff also reported that they found it challenging to find time to explain aspects of practice to students, and this may be related to their report of too many students on the shift (refer to Table 1). The emphasis on knowledge application to practice is evident in these staff responses. When supervisor nurses get busy with service, they are not able to share theory and may assume that the student is not learning. This assumption may contribute to the recommendation by some nurses in this study that a clinical support person is needed on all wards. The value of theory before practice is implicit in these findings.

The provision of information by the clinical teacher appears to be grounded in early assumptions about learning for ‘tertiary’ students. At the time of the transfer of nursing education, nurse leaders were arguing that theory learned in university could then be applied to practice whereby the student would learn about nursing in a supportive environment (Kermode, 1984) rather than doing procedures on-the-job without necessarily understanding the rationale for them (ritualised procedures), as was common in hospital-based education (Bottorff & D’Cruz, 1985; Watson, 1982). Logically, the perceived need for so much content before the student ‘meets the client’ led to pedagogical practices where the teacher becomes the ‘teller’ of the information, with significant proportion of lectures or assigned readings. As foretold by Pellettier (1985), the nursing syllabus became ‘crowded’ with theory.

There is emerging evidence to suggest that ‘front loading’ curriculum with theory before practice experiences is inefficient (Eraut, 1999). Process knowledge, that required to ‘do’, is not dependent upon content knowledge (Edmond, 2001). Further, experiences where students engage in tasks can motivate and enhance further learning (Eraut, 1999; Grealish & Ranse, 2009). The breadth of clinical learning is beyond what can be predicted in the classroom, and therefore clinical learning remains largely unguided (Polifroni, Packard, Shah, & MacAvoy, 1995) and characterised by implicit, reactive and deliberate learning (Eraut, 2004). Further, there is increasing evidence that student learning is critically dependent upon ‘feeling’ welcomed as a valued member of the work team (Hart & Rotem, 1994; Kanitsaki & Sellick, 1989; Levett-Jones et al., 2006) which suggests that having adequate theoretical knowledge to ‘do’ practice is less important to students’ clinical learning than first assumed during the time of the transfer.

**A way forward**

The recent introduction of social theories of learning into clinical nursing education discourse (Andrew & Tolson, 2008) holds promise for the development of new models of clinical education. Social theories suggest that participation in a practice community and learning are mutual processes (Billett, Barker, & Hernon-Tinning, 2004; Wenger, 1998), incorporating the sense of belonging identified as important for nursing students (Levett-Jones & Lathlean 2008). In the example presented here, the social community is a hospital ward where nurses, doctors, families, patients, physiotherapists, social workers, cleaners, receptionists and many others form a practice community. The student enters this community with an identity shaped from experience in previous communities of practice. In joining a new practice community, the student undertakes a unique learning curriculum. Lave and Wenger (1991, p. 97) define a learning curriculum as ‘a field of learning resources in everyday practice viewed from the perspective of learners’. The student, as a newcomer, is exposed to the curriculum,
shaped by workplace norms, intended to provide instruction for practice (Lave & Wenger, 1991).

Learning in communities of practice occurs through three modes of belonging: engagement, imagination and alignment (Wenger, 1998). Engagement, active involvement in the process of negotiating meaning within the community, requires the workplace to afford opportunities to participate, observe and listen and students to undertake everyday work activities. Imagination, where the student extrapolates from the here and now experience to see connections with other places and times, requires teachers who will guide the student through modeling, coaching and scaffolding practice. Students need to be trained in the skills of reflection, peer learning, and case comparisons. Finally, the energy of the clinical staff members and students requires coordination so that their interests are aligned within the broader structures and expectations of the health service agency, the higher education provider, and the broader social agendas of government and a range of interest groups. This can be facilitated by external teachers who use Socratic questioning, problem-solving, comparison, and scenario building. It is through these methods that ‘invisible’ personal, professional, organizational, and societal values can be made evident to the student.

As described earlier, the student comes to the workplace experience with his or her expectations for the learning experience. Student agency, expressed as a willingness to engage in the community of practice, is necessary for learning (Billett, 2002). But also, the workplace must afford opportunities to participate in the practice in order for the student to learn (Billett et al., 2004). The reciprocal processes of learning and participation are therefore premised on access to tasks of increasing criticality and accountability over time (Billett, 2002). Activities can be sequenced in ways that move from those where ‘imperfect performance has negligible consequences through to activities that have high levels of criticality and where mistakes carry significant consequences’ (Billett, 2002, p. 32). This is an important element and is consistent with the clinical staff members’ requests for guidelines and Kako and Rudge’s (2008) recommendation for a national curriculum in pre-registration nursing.

Most experienced clinicians can provide guidance by managing the pace and sequencing of accessible activities. These activities would need to have increasing criticality and accountability to enhance student learning. Billett (2002) suggests a pedagogy with three elements:
1. Intentionally structure participation in activities;
2. Acknowledge the consequences of different kinds of workplace affordances; and
3. Encourage engagement to develop the robust practice and concepts rather than limited situation specific knowledge.

Social theories of learning provide the scope to shift the emphasis on the care from the individual patient, advanced at the time of the transfer of nursing education into the higher education sector, to an emphasis on health service delivery in the specific, situated context. Social theories of learning provide a framework to develop students’ ability to extrapolate this experience to broader social and political frameworks through critical analysis beyond the provision of holistic nursing care. With a clinical guide, or a national clinical education curriculum, students can embark on a learning curriculum that is afforded along a continuum of criticality and accountability.

**Recommendations**

The decision by nurse leaders at the time of the transfer was to recommend that graduates from all university courses met professional entry-level requirements. As nursing student numbers rise, and increasingly hospitals and other health services will be partnering with a range of universities, and thereby university curricula, there is an urgent need to reconsider how clinical placements are conceptualized within university curricula. We recommend a refocusing of curriculum
design on clinical education with clinical experiences emphasising:
• Student engagement in nursing work;
• Students actively welcomed into the team and provided with feedback on behaviours that reduce opportunities to learn; and
• Students prepared for clinical experience with a core, national framework for pre-service clinical education addressing expectations about professional behaviours, undertaking tasks of increasing criticality and analysis, as well as developing proficiency in reading literature and reflective practice.

An example of how a generic national guideline for the nursing process could be derived from social theory of learning is provided in Table 2.

In this guideline, the first year student undertakes tasks of low criticality and carries limited accountability whereas the third year student will increasingly undertake tasks of higher and more variable criticality, requiring higher levels of judgement, as the final year progresses. The focus on evaluation in the third year emphasizes accountability and requires full participation.

CONCLUSION
The international shortage of qualified nurses continues to challenge taken-for-granted assumptions about learning to be a nurse that were dominant at the time of the transfer of nursing education from hospitals to the tertiary sector in Australia. Continuing clinical education approaches, where students arrive in the field armed with ‘learning objectives’ only to have these dismissed by busy nurses who do not have time to ‘teach’, continues the historical nursing qualities of servitude and discipline.

Contemporary clinical education models, derived from those models advanced during the transfer of nursing education into the higher education sector, are founded on three implicit assumptions that may not be in the best interests of student learning:
1. Learning is a separate activity to working;
2. Holistic nursing care is the framework for clinical education; and
3. Theory should be applied to practice.

It is time to develop and evaluate new models of clinical education, where students are engaged in the work of the unit as members of the team, and supported with pedagogical approaches that relate situation specific learning with broader clinical, social and political theories. A structured approach to the clinical placement, in the form of national guidelines, with clear practical outcomes that reflect criticality and accountability but are not limited to regulatory required competence can re-position clinical experience in professional nursing education.

The collaborative relationship between health service agencies and higher education providers are highly valued in Australia, creating an

<table>
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<tr>
<th>Year level (progress)</th>
<th>Activity</th>
<th>Participation</th>
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<tbody>
<tr>
<td>First year</td>
<td>Assessment leading to generation of care plan Tasks assigned by clinical staff</td>
<td>Peripheral participation Low criticality</td>
</tr>
<tr>
<td>Second year</td>
<td>Assessment &amp; planning leading to generation of evaluation criteria Identify and undertake interventions as negotiated with clinical staff</td>
<td>Peripheral participation Low criticality Participation is variable Criticality is variable</td>
</tr>
<tr>
<td>Third year</td>
<td>Assessment, planning and evaluation of personally generated interventions</td>
<td>Full participation Criticality is variable High accountability</td>
</tr>
</tbody>
</table>
opportunity for national change. New clinical education models are required to engage students in practice in ways that manage the risk of injury to health service clients, to value the learning histories of individual students while providing opportunities to participate in practice communities, and to hold students accountable for their learning within an environment that provides adequate guidance for them as newcomers.

References


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