

Title: Gentle Interruptions: Transformative Approaches To Clinical Teaching

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Introduction

This paper provides critical reflection on recent clinical teaching experiences in the context of Australian nursing and offers teaching strategies for clinical educators. The authors show how transformative clinical education can contribute to more focused, effective educational experiences for students of nursing. It is polemical in nature rather than research-based and draws upon and applies principles of transformative learning. It aims to be solution-oriented rather than problem focused, though examining common problems will be crucial in setting up our argument for changed educational responses. In Australia, clinical instructors are referred to as clinical facilitators, clinical teachers or clinical educators. For the purpose of consistency, the paper refers to them as clinical educators.

In the Australian university classroom, students of nursing regularly discuss the importance of the being and doing of nursing, reflecting on practice, and using an evidence-base. Effort is made to surface values and beliefs, convey knowledge, discuss ethical reasoning and compassionate care, so that when students engage in clinical practice, they are prepared to be thoughtful, supportive and skilled with clients. Despite these pedagogical principles, sometimes the human (rather than technical) attributes are dismissed or met with open resistance from students.

On a recent evaluation of a nursing practice course, this student's demand resonated an all too common position held by, in our experience, many newcomers to nursing. She said:

[give me] longer practical experiences on wards, less nursing theory!

In another evaluation, this time in a psychosocial nursing course, a student stated:

It was interesting and all that, but I still don't see why we need to learn it.

The view that practice is more important than theory is pervasive, even amongst nurses who work in educational, leadership and management roles. For employers, it seems that the main concern is not theoretical rigour in graduates, but work-readiness (Astin et al., 2005; Begley, 2002; Corlett et al., 2003). Subtly, in some domains, university learning for nursing is devalued and this may send a confusing message for students. For example, at a recent

function welcoming students to a busy general hospital a nursing leader proudly announced:

Welcome to the real world, where you will actually get to see real patients
and see for the first time how it's really done.

Similarly, for clinical teachers coaching and supporting students on clinical practice, there may be a tendency to emphasize development of a suite of technical skills and overlook the learning of humanities and an ethic of care (Ironsides, 2004). Technical skill acquisition serves the interest of health service efficiency and management, but it may not always serve the interests of a caring community.

This theory practice binary is also evident in, and supported by, the contemporary Australian university system. The efficiency movement in Australia, wherein universities are being compelled to operate as businesses and provide work-ready graduates for industry, reveals a tendency to favor vocationalism over liberal education (Coady, 2000). In this ideology practice is once again preferred to theory. Furthermore, the government research funding model tends to emphasize industry relevance above knowledge development (Gibson & Hatherell, 1997). This valuing of practice over theory is so common place that there are no shortages of role models presenting themselves to students and subtly encouraging the adoption of atheoretical practices. Even the high achieving student is under pressure to fit in, to belong and therefore to conform to what amounts to a knowledge cringe.

Recently a student observed removal of a surgical drain. When relating the incident the student described how the nurse educator admitted to him that the method she was using was 'bad practice' but that was the way it was done on this ward as it minimized patient discomfort. It was 'bad practice' because the product literature, hospital policy and published research provided different recommendations. Furthermore, when questioned, the student agreed that he was aware of this literature and that he considered that what he witnessed was indeed ill informed. Yet he went on to admit that if he were working in this ward, it would be likely that his practice would be influenced more by how that ward wanted it done, rather than the known risk that he would predispose the patient to surgical infection. Even though this student knew the evidence base behind the practice, and even had reservations about the routine practice he observed, his need to belong culturally was overriding.

The implication here is serious. Despite a university's best efforts, some students continue to believe that nursing is and should be much more about technique than communication, much more science than art. These examples reveal an ideology that is reproduced not just in the clinical setting, but wider society – that practice and theory are dichotomously divided, that this is natural and indeed that, for nursing, practice is favorable to theory. Rather than being

angry with these students for what we perceive as diminishing for the nursing profession, we reflected on transformative learning (Chinn, 1999; Giroux, 2000; hooks, 1994) and were reminded that they are a product of their own schooling.

It is likely that students have passively absorbed enduring and prevailing public stereotypes about nursing. This is an important point in transformative learning - many educational practices and habits that have become accepted as routine deserve contemplation and articulation so that they can be revised or discarded.

Transformative Education

For practice disciplines an inherent tension exists between theory and practice. Theory is needed to advance the discipline and create an evidence-base, yet the practice is a defining aspect of the discipline's identity. Sometimes theory and practice compete for primacy and for students eager to join the practice discipline, theoretical understanding seems remote or irrelevant. The cost for them though is that they may not aspire to excellence and knowledge advancement, achieving only competence in performance.

The challenge is how educators might raise the profile of nursing knowledge and expectations of students of nursing not only for students, but also for clinicians, educators and managers.

To paraphrase the passionate activist and transformative educator, hooks (1994),

When those who know oppress and dominate others and continue to discriminate and attempt to disempower, then education becomes part of the problem.

Education for nursing should not be part of the problem but if students continue to hold accepted truths unquestioningly, and desire to conform to the group before they desire to serve clients, without challenge, then the overwhelming message educators send and receive is that nursing is a practice for which limited education is required. An alternative is to take a transformative approach which values practice linked to theory, and theory linked to practice.

O'Sullivan and Morell (2002, p.18) provide this illuminating explanation about transformative learning:

Transformative learning involves experiencing a deep, structural shift in the basic premises of thought, feelings, and actions. It is a shift of consciousness that dramatically and irreversibly alters our way of being in the world. Such a shift involves our understanding of ourselves and our self-locations; our relationships with other humans and with the natural world; our understanding of relations of power in interlocking structures of class, race and gender; our body

awarenesses, our visions of alternative approaches to living; and our sense of possibilities for social justice and peace and personal joy.

A transformative education aims to activate students so that they critique the social construction of ideas. The theory of transformative learning, originally developed by Mezirow (1978), is informed and extended by many critical social theorists (Freire, 1995; Giroux, 2000; Grabov, 1997; Greene, 1995). Transformative learning occurs when individuals realise how and why assumptions have constrained the way they understand the world, and so begin to consciously use other strategies to rethink issues and define their worlds differently. Thus students need to learn and practice critical reflection, dialogue, being sensitive to difference, be compassionate in caring and utilize creative thinking. The next section provides some strategies that can build skills in transformative education, helping teachers to gently interrupt habits and routines that are reproduced without conscious intent.

Teaching Critical Thinking

Because of the emphasis on efficiency, many Australian Universities are reverting to the use of large lectures, despite the evidence that tutorials are more likely to promote active learning (Bellack, 2005). Whilst it is true that health care is increasingly complex and more content needs to be learned, educational research has consistently shown that transmission of content and lecture based instruction is often unsuccessful in helping students learn (Biggs, 2001; Keyser, 2000). Furthermore, the clinical setting is by its nature going to present problems that are novel, complex, time constrained, specialized and unpredictable. It is not possible to anticipate and discuss every clinical problem students may encounter. Thus, students need to learn critical thinking skills that provide them with a tool-kit they can apply in any challenging incident (Simpson & Courtney, 2002).

Facione (2005) provides some cogent directions for how the transformative teacher might help to make that possible. He cautions that if teachers fail to inspire critical thinking we produce habits without skill. In teaching critical thinking, Facione has some practical advice. He says that teachers need to ask and then be quiet. As he said (Facione, 2005, July 19),

if you talk all the time, there is no time for students to think.

Facione suggested teachers find visual and verbal devices to engage students and then invite their active participation. Vital here is constant encouragement for students to keep questioning, so that they develop interpretive, analytic, evaluative, inference and explanatory skills. Teachers can model creative and critical thinking skills, encouraging students to build excitement for the new habit of scrutinizing issues in this way. It is also useful to patiently and respectfully persist in asking questions of students, so that they can slowly develop the confidence to articulate thoughts. If teachers work to strengthen this habit it encourages

students to develop the cognitive skills and with this, habits may change. Consider the following example, which can illustrate to students the importance of slowing down and articulating thoughts, before moving to action.

Chang, an RN preceptor, and Suzie, a student, were working together in a respiratory ward. Chang invited Suzie to observe and participate in caring for Joe, a 55 year old client with COPD. Suzie performed 'routine observations'. She measured Joe's blood oxygen saturation, found that it was low and began reaching for the nasal cannula. Chang saw this situation as an opportunity to invite Suzie to express her problem solving process verbally. Chang began by saying "before you apply the oxygen, let's think this through. Tell me about your client. What is his history? What's normal for him? What do you think Joe's present needs are and what are the options for his care? What effects might your nursing care have? What are your thoughts?" Chang waited quietly. With these prompts, Suzie recalled that Joe had COPD, his chart showed a pattern in his oxygen saturations that indicated a stable low level, she recalled that oxygen can have positive and negative effects depending on dose and mode of delivery.

This process of thinking out-loud was responded to positively by Chang and together, they decided against administering supplemental oxygen and instead recorded and reported Joe's O₂ levels.

In a class situation, students can be asked to comment on the behaviors of both people and discuss the lessons they learned for future practice after listening to this story. To reinforce the message further, an image of a stop sign can be shown with a caption that reads "Don't just do something, stand there!" Pausing to think critically moves practice beyond ritual and towards rational action.

Noticing Practices That Are Hurtful Or Unjust

Transformative education aims to sensitize students to injustice, oppression, inequality and domination and seeks to build care and connection in society, a critical consciousness about practices that need to change and skills to increase students' input into being active participants in health service (Singer & Pezone, 2003). Giroux (2000) asserts that teachers need to reveal that the knowledge and ideas that are passed off as commonsense are really social constructs that serve to mystify rather than illuminate reality.

Many practices, ideas, routines and rituals that students experience on clinical practice might tend to be accepted as natural when they are in fact cultural - they have been developed, supported and seeped into a culture so that they are no longer questioned, but simply

accepted as normal (Koegel, 2002). A common example is the notion that mental health skills are not important in medical contexts. This ideology is enacted when mental health is not assessed during an examination, when nurses avoid dealing with a client's mental health issues directly, or when clients are stigmatized when he/she displays mental health problems in the general health setting. This reveals a binary or false dichotomy between physical and mental health. Transformative learning argues that binary thinking involves either/or thinking, forcing choice between two seemingly opposite ideals and is a key language tool used to support the status quo (hooks, 1994).

One way to avoid or challenge binary thinking is to teach students dialectical critique. This involves a concerted attempt to examine multiple and competing perspectives on an issue. It may be helpful to teach dialectical critique by applying it first to a common issue. For example, people all have feminine as well as masculine traits, but to recognize this, one needs to engage in some conscious analysis: In what way am I feminine? In what way am I not feminine? In what way am I masculine? In what way am I not masculine? This set of questions offers a way to see both sides of an issue, to examine the thesis and anti-thesis. Then the thinking process can be applied to the clinical setting. Students could select an observed practice such as health assessment and subject it to critique using a process relevant to helpfulness and justice such as: In what way does this practice assist clients, fail

to assist clients, respect clients or exclude clients? Looking at an issue from many sides is what is meant by dialectical thinking. Moving back and forth between observations and ideas helps to deepen inquiry and appreciate complexity in issues.

Assessing Clinical Performance

Another common practice in university education for Australian nurses is for academics to set, mark and grade varied assessment tasks during on-campus learning, whilst clinical learning is usually assessed only once using a summative observation made by the clinical facilitator. This is sometimes problematic when clinical educators voice concern about a student's performance in the clinical setting but pass the student to give them 'another chance' or pass the student because their doubt and suspiciousness for university processes over rides their doubts about the competency of the student. Here is a common scenario.

Unbeknown to the academic coordinator, Ann was a student who was struggling in her clinical practice enormously, to the extent that Jane, the RN preceptor noted that Ann was almost unable to communicate with patients or staff. According to Jane, Ann did not seem to learn new skills; she also demonstrated inadequate knowledge and a weak ability to explain

concepts. However, it was not until the day before she was due to complete this clinical experience, that Jane voiced her assessment and concerns to the clinical educator. Even with this clear assessment of failed competence, Jane asked that Ann not be failed, because this was to be Ann's final placement and Jane did not want to be hurtful to her.

Again what this suggests are hidden binaries, and the danger is that it sets up an either/or stance. There is a binary here between nurture and critique. The clinicians, in their desire to nurture the student, believed that they could not also offer criticism. There is a system/individual binary also operating, whereby if you are pro-individual it means you cannot also be pro-system. There is also a binary between clinical setting and university setting. In this dualism, you are 'for' one and 'against' the other. Hidden even deeper is an allegiance to the technique above cognition, so that even though students may reveal a lack of knowledge or communication skills, if they can demonstrate ability to practice, then that will win out before proficiency (where competence is defined as knowledge combined with attitude and skill).

Continually locking into binary relationships helps to ensure that the status quo in relationships gets maintained. Doctors and nurses for example are still competitive rather than collaborative (Radcliffe, 2000). Clinical nurses frequently dominate and exclude students (Duffy, 1995; Latimer, 2005). Nurse clinicians and nurse academics are not much closer to mutual respect and understanding. Students are still criticised for being too theoretical and not work-ready (Astin et al., 2005; Begley, 2002; Corlett et al., 2003). However, ongoing problems such as recruitment and retention difficulties are unlikely to be resolved by thinking in the same way. It's time to think differently.

Whilst binary thinking is taken for granted, being more conscious and thoughtful can offer another way – to consciously use both/and thinking. A simple strategy that clinical educators can use is to self-correct whenever a binary seems to present itself. For example, "How can I be both nurturing and critical?"

Meeting With Students

Greene (1995) is an educational philosopher who advocates "a curriculum for human beings". She believes that to create democratic classrooms, teachers must learn to listen to student voices. Listening allows teachers to discover what students are thinking, what concerns them, what has meaning to them. Listening actively counters the tendency for students themselves to feel marginalized and unimportant. It encourages differences of opinion to be revealed and paves the way for genuine dialogue amongst people. As Freire (1995) advises, genuine

dialogue between people is what builds connection and community, builds democracy, and produces empowerment.

Even when students may be hesitant to speak, it is important to patiently yet persistently expect them to speak. As Freire also says, one of the keys to marginalised groups maintaining their position is their silence. So, setting out ways to actively voice the students and to create dialogue between each other is transformative. According to Freire, dialogue enables the building of connection between people. Dialogue makes public, private thoughts and reflections, opening ideas up to scrutiny, challenge and revision. Dialogue disseminates insights, helping others to gain from the intellectual leaps that others may have made. It shares insights and can build solidarity, unites previously separated individuals, motivates collective action and reinforces a commitment to change. It also offers potential to unite previously separated individuals and is therefore a motivator for solidarity and collective action.

In this vein it is useful to adopt a listening stance – one that models patience and respect at the same time as the expectation that all students will participate and speak. It is useful to gain students' consent to form a partnership with each other, a collective based on cooperation rather than competition. It is important to spend time engaging them, getting to know each person, getting them to feel like they belong in the group. For clinical educators, it may be helpful to explain the aims for the clinical experience. The educator could ask students, "What sorts of feelings do people have towards the forthcoming clinical? What would you like to see happen? What do you think is going to be expected of you? What challenges do you think may arise?"

In this way, the clinical educator is preparing students to develop expectations as well as strategies to prevent or minimize problems. In the interests of generating two-way conversation, real dialogue, it would be useful for the clinical educator to also offer to share his/her own experiences and the wisdom that may have come from practice. By asking, "Do you want to hear what I think about ways you could prepare?", the clinical educator is being explicit about his/her philosophy of critical education. Being covert about knowledge and practice can be misleading.

Anticipation And Preparation

In Australia there are various models for clinical education – regular days of clinical experience per week; blocks or terms of practice at the end of, or between, semesters; secondments for clinicians from an agency to preceptor students; or short term contracts employing clinical lecturers (Grealish & Kaye, 2004; Mallette et al., 2005). Each may have

advantages and disadvantages, but student preparation benefits both. Recent feedback from a clinical colleague, who was preceptoring students from a number of different universities that each had different clinical models, reflects our sentiment. She believed that

It doesn't matter what model you use, it's up to the individual student to seek out their learning and make the most of their clinical time. I think forming partnerships is a good idea -- have the student set out before hand exactly what they think they would like to achieve whilst on that placement.

Preparation is the key. Before clinical experience, it is helpful to enter some kind of mutual relationship with students. Sometimes this might be called a learning contract (McAllister, 1996). It involves shared responsibilities. Teachers can agree to organize and provide a suitable learning environment, regular encouragement and critical support. Students can agree to mindfully observe practices, share their critical reflections, and remain open to selfcorrection, practice and improvement. Additionally, there are some important cultural issues that students may prepare for by developing specific communication skills, such as diplomacy and conflict transformation.

Nursing, like other struggling and perhaps 'duty-driven' professions such as teachers and police, has a history of workplace tension, power inequality and horizontal violence (Bickmore, 2002; Duffy, 1995). These are cultural artifacts, rather than natural and a transformative approach offers some solutions. It is possible, indeed desirable, to act in powerful ways without being damaging or violent. Chinn (1999) suggests some important proactive strategies that prevents tension and transforms conflict. Important notions about conflict transformation are that conflict is no one person's responsibility. No one person is to blame. Rather it is everyone's responsibility. Understanding when conflict is likely to occur and remaining focused on the issues rather than the personal problem is a shared task. Also, leadership roles need to be shared so that everyone develops the skills needed to mediate tension, keep the group focused on issues and implement problem solving. Providing

constructive criticism is a way to move away from a blaming style of communication. Regularly practicing criticism when there is no conflict allows everyone to build up the necessary skills in a safe context. In the class situation, students can be encouraged to offer critique of each other's problem solving or practices. They can also be encouraged to acknowledge positive behaviors. This builds a sense of safety and commitment to the process, rather than a sense of fear and dread.

A second insight Chin (1999) offers is that habits that set up divisiveness can be interrupted. Such habits might include the tendency to: give the answers because it gets the task done

faster; or become impatient when disagreement occurs. Habits can be interrupted by nurturing diversity instead of divisiveness – taking the time to find out what others think and encouraging discussion. Clinical educators can offer students opportunity to value diversity and practice this new habit in every day encounters. Then, when individuals do experience tension, they will have a stronger basis from which to transform the conflict as this story told recently by a clinical educator shows.

At shift handover and in the presence of students and clinical educator, an exasperated, tired, but evidently intimidating clinical nurse shouted: “I hate bloody students!” The clinical educator was concerned about the effect that such an outburst would have on the student who was allocated this nurse as preceptor, but she was to be pleasantly surprised. Calmly, the student informed the clinical educator that she considered such comments a personal challenge. She intended to work hard and perform so well that the nurse would be forced to change her opinion of students. The feedback provided by the team at the end of the placement indicated that this did indeed occur.

In coping with workplace tensions, students can also be encouraged to practice the gentle art of verbal self-defence (Chinn, 1999) by searching for, then heeding any truth in what the critic might be suggesting; by not allowing hostility to grow, but rather nurturing things one *wants* to grow like peace and love; by staying and talking through the interaction, rather than ignoring, walking away or responding with hostility. These practices send a powerful message that interrupts the cycle of conflict – it says, “I will not act in a way that hurts”.

Another way to actively build peace and power is to apply concepts usually learned in macropolitics to the clinical context – modern diplomacy. Using a novel approach to examine what is a common cultural experience in nursing, students may be inspired to think creatively and feel empowered to enact change. Modern cultural diplomacy is basically about active peacemaking. Where traditional diplomacy tended to be about foisting peace and coexistence onto populations (for example after World War I when nations in Europe such as Yugoslavia were artificially created without consultation), many now realize that top down approaches to change do not lead to willingness for peace in the hearts and minds of the people (Gopin, 2002). Modern diplomacy tends to take a ‘people to people’ approach of working. It is a grassroots method rather than the traditional way of getting only *leaders* of nations to meet. It assumes that for enduring peace to prevail, all of the people need to be engaged and develop cultural ways for each side to understand what they share, and respect their differences (Gopin, 2002). Such insights resonate easily to the clinical environment and thus there is much that the concept of diplomacy can offer students of nursing.

A clinical teaching strategy is to show students common strategies and gestures advocated in modern diplomacy as ways to build peace and a sense of community amongst people who otherwise exist in tension (see Table 1 and 2) and ask them to suggest ways these could be modified to apply to clinical settings. In planning for the end of the clinical placement period, students can be invited to enact one of the identified gestures and to observe the effect that this peace making strategy has amongst their clinical colleagues.

{insert tables 1 and 2 about here}

Finally, it is helpful to be explicit with students about what they can expect of the clinical educator throughout the experience. It may be helpful to say something like, “I am here to share my expertise, to listen to you, to guide you, to correct you, to judge you...” It is also useful to be explicit about the need to build community amongst the group and to discuss with students how that can be done. By, for example, listening to each other, being united and forming cooperatives to share the workload.

Following this active preparation, students may be primed and ready for a challenging clinical experience – where they can learn and develop technical and communication skills, learning ways to be helpful with clients and peacemaking with colleagues.

‘Being With’ Students

Being with students in a supportive yet instructive way, is all about getting a balance between proximity and distance. Students may feel the need to be close to the clinical educator because he/she has legitimate expertise and is also familiar, thus engendering a feeling of safety. Proximity also access to the learning that can occur through observing a good role model. But students also need to have space so that they can practice new knowledge and skills and gain personal confidence.

Students also need to be challenged to ‘interrogate’ their habits (Foucault, 1980) by getting underneath the surface or conscious layers, deconstructing events and practices to challenge, revise or replace the taken-for-granted and the status quo. In Australia, this kind of deconstruction, or reflection on practice tends to happen at the end of the clinical day, during a period known as a ‘debriefing session’. Frequently, students recall the day’s experiences, by telling stories about what happened to a client. In order to move this beyond story-telling and into learning, it is helpful to provide a challenge the students can prepare to answer.

Chinn (1999) suggests three transformative alternatives that move beyond description,

towards active peacemaking and positive change. Students could retell a story of acknowledgment, by providing a brief description of the appreciated event, what this meant for the student, and what this might mean for future practice. Students could retell a story of critical reflection, by using careful, precise language that aims at producing insight. Here Chinn likens the critical reflection to good art criticism – wherein critics do not force opinions, but show that they are well informed, have an opinion and use examples to strengthen their claim. Finally, students could make an affirmation, which is a positive statement stated in the present tense and reveals a desire or a way in which one intends to grow. An example is, “I believe in my role in transforming conflict”.

Being conscious of various ways a clinical educator can ‘be with’ and ‘show how’ a student can be helpful in being both supportive and challenging at the same time. It demonstrates a willingness to care for the student as person but also as learner. Another way to be with students in a supportive and critical way is to interrupt speech and patterns that support or allow injustices.

Using A Process Of Interruption

The notion of interruption is not new in education (Vygotsky, 1962), but transformative education emphasizes the particular need for it in confronting and overcoming social divisions and inequity. Cochran-Smith (1995), for example, recommends it as useful when students use language or practices that unwittingly harm others, such as in making sexist or racist remarks. Interruption can be used gently and effectively to show students alternatives and stimulate new ways of thinking. Thus, critical theorists aiming for transformation in students argue that it is crucial to interrupt students if they are perpetuating injustice or being complicit in supporting practices that, according to the transformative agenda, need to be revised (Apple, 2002; Freire, 1995; Greene, 1995). As Ayers (1998, p. xvii-xviii) states,

Teaching must be toward something: it must take a stand; it is either for or against; it must account for the specific within the universal

In doing this, clinical educators can take a dialectical stance with students – on the one hand they must understand who this unique individual is, what their passions and commitments are, as well as understand fully the reality of the dominant forces in health care that need to change for the promotion of justice and empowerment.

As Tupper (2005) suggested, interrupting someone’s conversation is generally considered impolite, but worse is to allow someone to persevere with a practice that is harmful or self-defeating. Excluding or patronising patients, failing to gain consent or explain procedures, being unsafe or failing to offer appropriate support are harmful clinical practices. Being silent

and inactive on clinical practicum will ultimately be self-defeating for students. The student may not learn effectively, they may not be accepted or feel like they belong, and ultimately they may not reach their full potential. So interruption is an important device that activists and clinical educators can use. It must, however, be undertaken judiciously, because it should not create or support divisiveness or stifle diversity and it needs to happen in the context of consent, with a spirit of good will.

Clinical educators can begin by gaining students' consent for him/her to provide these gentle interruptions by asking, "So, do you want me to give you my honest feedback and interrupt you sometimes where I think it is appropriate?", and "In what circumstances would you like me not to interrupt you?"

Then, the educator can interrupt students simply by asking them to consider what they know and do not know, what is missing from a practice/interaction and why. For example, recently a clinical teacher asked students to reflect on the day's experiences by considering 5 questions:

1. What techniques or skills were most often seen in the ward?
2. Who practiced these skills?
3. What were the positive and negative dimensions to the skill?
4. What messages did it convey to clients about health-care?
5. Which of these skills do you intend to take up in your future practice and why?

These questions help to interrupt a student's inclination to automatically replicate routines and instead encourage a more mindful deliberation so that if/when practices are adopted there are good reasons for doing so. Clinical educators can also gently interrupt students when they express beliefs and values that perpetuate stereotypes, dichotomize theory and practice, diminish nursing or contribute to, rather than transform, tensions and problems. A useful way to proceed is by reminding the student of the commitment the clinical educator had previously made in promising to gently interrupt practices that may not promote positive change, pointing out the practice and together critiquing it for its strengths, limits and alternatives.

Using The Wisdom Of The Group

Recently Lindgren et al (2005) explained how group supervision worked to transform and guide students. Students were engaged in a contract offering confidentiality and voluntariness alongside responsibility and willingness for self-development. They were asked to bring to the group sessions situations from their daily work with clients. One student was to be in focus to tell the group about his/her situation. The rest were encouraged to ask questions aimed at helping the focus student to reflect on the situation. The following questions can be used to assist students to enact transformative learning principles:

1. How did you feel upon entering this situation? On reflection what were your intrinsically held values about the client/treatment/clinician?
2. What languages or practices were operating in this encounter that could have lead to power and influence for some and subjugation for others?
3. Was there any evidence that this attempt to dominate was being resisted? Describe that situation.
4. How could those in authority have used their voice differently so as to invite dialogue?
5. What lessons did you learn that you would take up in your future practice?

In this way, the group, rather than the teacher, becomes generative in providing acknowledgement for the student in focus, offering critique and inviting affirmations to motivate commitment to change. This is likely to build student self-efficacy, autonomy and ultimately empowerment and the teacher can safely and gradually reduce the active input allowing the energy for change to come from within the students themselves.

Using A Process Of Remembrance

Chinn (1999) explained that closure for groups about to end (such as the group completing a clinical experience) is important for many reasons. It assists members to reflect on achievements and to commit to continuing the good work in other groups. It assists members to acknowledge the loss involved in leaving, and to move into the future by appreciating the possibilities in forming effective new groups and crossing new horizons. By using a process of remembrance, one can bring into view that which may have been lost, neglected or abandoned so that one might reclaim and remember rich traditions. This process is not limited to the closing phase of a clinical group, but it does offer a ritual that can add meaning to the last day.

For example, a ritual that developed amongst students completing clinical practice was to give a signed thank you card to the whole clinical unit. Whilst the generosity is always appreciated, the potential for the practice to become a meaningful ritual of active peacemaking and remembrance can be extended. Throughout the clinical experience, students could keep a note of the names of particularly helpful people, the events that were instructive, the gains that students made, and for these to later be written on the card so that it becomes a meaning-rich account that members of the clinical unit can keep on display. It emphasizes connection between clinicians and students and shows the effects that supportive learning can have.

The process of remembrance is also important in the transformative educational view

because students need to be actively and critically re-reading what is offered to them as natural or preferred, so that they can mindfully take up their own position and worldview. So reflecting on the past and reclaiming lost history is crucial for future empowerment. As the ancient Roman orator Cicero once said, 'Those who do not know the past will forever remain children'. In everyday clinical experiences, students can be encouraged to find out about how caring practices have changed, and to continue to question the relevance today.

Further, nursing has an identity that is deeply rooted in history and relatively well known by most. This identity simply needs to be more honoured and proclaimed so that the profession continues to grow and change. Writing a card in which acknowledgement is made specific and elaborated upon is one practical way for that collective pride to grow. Nurses wherever they work, may begin to believe again in a distinct purpose, separate but complementary to medicine and so begin to change their practice. The collective consciousness raising will help to build community, rather than separation and a proud, rather than cringe, culture.

Conclusion

Clinical education informed by a transformative learning approach helps students to gain knowledge that remembers the history, language and cultural traditions of health/nursing and teach students to critique dominant and ritualised practices, and so choose which practice to take up or replace. In this way, students of nursing will be working where necessary to transform, rather than simply serve (or preserve), the status quo. Perhaps by using some of the strategies outlined in this paper, clinical educators will be inspired to integrate these notions of transformative learning into practice.

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Table 1: Modern Diplomacy Strategies (Adapted from Gopin, 2002)

- Work to make individuals feel safe, give them dignity and honor.

- Build an atmosphere of hope

- Encourage both sides (and everyone in them, not just the leaders) to honest selfexamination of their role in preventing peace

- Rehumanize opponents

- Think about, process and recover from loss

- Develop friendships between diverse groups

- Engage in quiet relationship building between significant actors from both sides wherein both sides work on a shared program affecting large populations. Subtle policy shifts are an example.

- Promote new ideas and strategies in the public media and so add public pressure on key leaders

- Make a peaceful gesture or deed. Actions matter, action that harm as well as actions that heal. Do this on a large scale. Piecemeal gestures are tokenistic. Do this in a way that's tailor-made for the situation at hand.

- Encourage leaders, even the belligerent ones, to make these gestures by telling them that they will be the righteous party. This will set in train a different way of relating, a step towards peace and hope.

Table 2: Modern Diplomacy Gestures (adapted from Gopin, 2002)

- Joint ceremonies and practices of apologies agreed upon through negotiation, publicly aired through the mass media, and conducted by leading representatives
- Shared mourning practices by general populations and by leaders in acknowledgement of lost lives, lost children, lost land and lost homes
- Practices of joint aid to the poor, carefully devised for acceptance by the general populations
- Joint research programs with a focus on day to day activities in which and through which general populations can meet and participate on a massive scale, such as house construction, community renovation
- Training in the art of values-based civil interaction for all civil servants at all levels in the bureaucracy, and especially for those who bear arms.