Abstract: The world is facing a chronic and persistent shortage of nurses. Critical social theory can help to understand why nurses are leaving the system. It can also point to solutions. Education in Higher Education has an opportunity to lead the way in changing this dire situation by shifting to a transformative approach for teaching students how to nurse, and how to move beyond practices that maintain their marginalised and dissatisfying status within the health system. This paper will describe, illustrate and critique the processes used in the 5 years that the program has been running.

Keywords: Critical social theory, Nursing education, Transformative Learning

Introduction

Across the world, society is faced with a serious problem – a chronic shortage of nurses (International Council of Nurses, 2006). If current trends continue, the United States alone will be short 275,000 nurses by 2010 (Fagin, Maraldo & Mason, 2005). This number is needed just to maintain present services and is setting aside the growing need for nurses in caring for the aging population, in reaching into rural and remote communities and in providing service diversity through roles such as Nurse and Family Practitioners. Without nurses, society is resorting to the employment of unqualified assistants and then decriyng the state of health services when negligent or harmful care arises (AAP, 2006; Fagin, 2001). In Australia, high numbers of students are entering and completing nursing studies at undergraduate level and 95% of these gain employment on graduation, compared to 79% of education graduates (N3ET, 2005). But 20% of nurses in Australia are leaving the profession during their graduate year or shortly thereafter (Craig, 2004; N3ET, 2005). A similar situation is occurring in the United Kingdom, New Zealand, Canada and the United States (Aiken et al., 2001; Baumann et al. 2001; Hinds & Harley, 2001; Kelly, 1996; McKenna et al., 2003). So something is going seriously awry once graduates enter nursing and realise it is different from their expectations.

When one takes a cultural theory lens to the situation (c.f. hooks, 1994; Giroux, 2001; Greene, 1995; McAllister, 2003), problems are clarifed – graduate nurses are now educated sufficiently to voice their dissatisfaction with how management, medicine and the general public dismisses and diminishes them. Graduate nurses also have more options open to them now than to stay within a system that constrains their contribution, fails to adequately support, and disempowers them – they are exercising their power of resistance by leaving to take up management and leadership positions in the public and private sectors, usually well outside our troubled health services. This is a serious situation because these are the very people society needs to transform health care.

Insights from Critical Theory

Drawing from critical theory, nursing practice is understood to require more than mastery of skills or techniques. It is a human service, involving knowledge work (putting theory into practice and changing theory to reflect practice needs), compassionate care for disadvantaged people, effective and enabling leadership and commitment to social justice (McAllister, 2003). Where critical theory sees the world as serving the interests of some, whilst marginalising alternate voices, nursing can be understood as coming from a long history of oppression and marginalisation (Farrell, 2001). Most nurses, as working class females, have found themselves being spoken for and thus sometimes find they are tentative in speaking out for themselves (hooks, 2000). Many have been denied education and some have been convinced that it is not needed. Some were, and remain, convinced that nurses are born, not made, and that one just needs to release one’s inherent caring nature to practise nursing. This is perhaps why some think that nursing is more about doing than it is about thinking and being. Nursing is, in many places, an oral culture. We talk amongst ourselves but we document poorly (Duffield, Roche & Merrick, 2006; Parker & Gardner, 1991), and so we have been slow in recording our history and our achievements (Roberts & Turnbull, 2002). Many of
us are silent and in the background, disorganised, fragmented and hostile to each other if we detect any differences (Farrell, 2001). We have sometimes internalised the norms and values of the dominant bio-medico-technological paradigm and found ourselves eager to be mini-diagnosticians, treatment providers, and substitution workers when doctors weren’t available.

We have also sometimes been guilty of being just as paternalistic and controlling, ignorantly reproducing top-down hierarchies, and other systems of disempowerment (Arras & Dubler, 1995; Laschinger et al., 2004; Pembroke, 1991; Taylor & Borling, 2004). Nurses have experienced pain from being rejected by medical officers and by our own colleagues, and been misunderstood by the community when we react emotionally to longstanding problems like poor conditions (Fagin, 2001; Mitchell, 2004; Thomas & Dropplemann, 1997). Admittedly, nurses do get relatively well paid for shift work and there is a career pathway. But nursing is always hard work. Rarely do nurses have days to reflect on practice or attend in-service seminars. Perhaps that’s one tactic the system has for maintaining itself – keep nurses so busy and reasonably placated so that we are doing the work but have no time to change it. How much more difficult would health care management be, if large numbers of workers began asking challenging questions?

Collectively, nurses have high levels of unhappiness with their reduced role, and have a low sense of self-efficacy and high attrition rate (Clinton & Hazleton, 2000; Leighton, 2005). Psychosocially, nurses are filled with self-doubt and not allowed autonomy, we frequently shame, bully and bitch at each other (Mcintosh, 2006). We have also tended to devalue, as has mainstream society, special characteristics of our identity – being predominantly female, valuing the human connection, using ways of knowing that are personal, subjective and empowering (Lawler, 1991; Crowe, 2000).

I do not intend to try to provide a grand solution to the complex situation outlined, but I do believe that approaching the situation from many sides is sensible. We can look to the health care culture and attempt to inject more humanism and support as retention strategies. We can look to the student and graduate nurses and work on building their resilience and coping strategies. We can look to the media and education systems as powerful sites of reproduction and challenge the stereotypes that they convey. And we can also look to ourselves – as members of the public, to understand where nursing has developed, listen to nurses’ voices in relation to public policy and reform and demonstrate faith in nurses’ autonomous ability. Looking to ourselves – and changing public perceptions and behaviours has dual benefits: First, the public may learn to value and take more care of this scarce social resource and second, if we grow numbers of people from the public who have a realistic view of what nursing involves today then students will enter Nursing with matching expectations. We also need to do more than just identify what the problems are and this is where higher education can play a part.

"Solutions to social problems are often relegated to the brief end of chapters and end of classes where they are given little attention or academic rigor. Without adequate coverage of structural solutions many students are left feeling that the world is a terribly unjust place – full of powerful people who use their advantage to exploit others and retain their power – and that it cannot be realistically changed for the better” (Johnson, 2005, p.48).

Dominant education models so far used in nursing education emphasise humanism, skill development and problem-solving (Diekelmann, 2001). An alternative, one that focuses more on solutions, is critical education, an application of critical social theory, which emphasises a close educative relationship between teacher and student wherein the student comes to recognise and value cultural diversity, learns skills to rethink traditions and routines, and to deconstruct and rebuild old epistemologies (hooks, 1994; Giroux, 2000).

Critical Theory and Critical Education also Points to Solutions

Critical theory sees that while oppression and domination are prolific in modern society, marginalised groups are not automatically rendered powerless (Giroux, 2000). Those who are oppressed need to experience consciousness raising in order to understand their own position, to engage in struggle to change the ways of dominant groups and to secure for themselves a valuable and enduring place in society (hooks, 1994).

Similarly, nurses who better understand their collective and individual histories, learn skills to resist dominant groups, and reclaim their own ways of knowing and being are likely to enrich and revitalise nursing and health care. It is only when things go unnoticed, taken for granted, that they can work quietly away at destabilising and destroying nursing.

The big ideas here are to notice and be sensitive to issues of power, injustice and marginalisation; to reveal myths and practices that are reproduced hegemonically, out of habit; to begin to see differences in points of view, cultural practices and
sites of resistance; and to value intentionalism rather than essentialism (Giroux, 2000, McAllister, 2005). Maxine Greene (1995) argued that the challenge in critical education is how to facilitate the process of awakening that is needed to overcome complacency. Greene believes that for this to happen, there must be “a shock, a crisis made from a combination of negative critique and questioning one’s own existence in relation to others” (Britzman & Dippo, 2003, p. 133).

Illuminated Solutions

Thus, a critical or transformative approach in nursing encourages the sometimes difficult reflection on one’s own cultural past including experiences of marginalisation, as well as achievements. Students may come to reject some of the myths that have become taken for granted: that care for individuals and groups is natural and simply a matter of following rules and regulations; that cure is always the ultimate aim for people with health problems; that being problem-centred is how nursing, like medicine, needs to operate; that control over patients’ behaviours is necessary; and that patients don’t need to be consulted or involved.

Culture is reproduced when practices are taken-for-granted and thus there is benefit in noticing and then Unlearning habits, routines and rituals of working that have become common place. Examples include the ritual of doctor’s rounds where nurses with the 24 hr up-to-date knowledge of a patient’s progress are silenced as one defers to the superior authority of medicine; taking observations regularly but failing to report their significance in documents (Parker & Gardner 1991); using handover as a place for discussion of disorder which further marginalizes a focus on patients’ strengths (Parker, Gardner & Wiltshire, 1992); the routine of allocating experienced nurses the better rosters (Kelly, 2005); the assumption that experienced nurses make the better teachers of students, even though evidence suggests that newer nurses have more empathy and more explanatory skills (Atencio, Cohen & Gorenberg, 2003, Buchel & Edwards, 2005, Kendall, 1999).

It is also beneficial for students of nursing to become aware of, critique and replace the sites where oppression for nurses gets reproduced: in education systems, the media and the workplace. For example, Sellers (2002) found that even academics in universities, who work alongside nurses as colleagues, continue to hold the very same views that the public do about nursing. Indeed, perhaps they were even harsher in their perceptions because no participant in this qualitative study was aware of any contribution to the literature made by a nurse. Participants also expressed patronising solutions to the complex problem of where education should be located... “if you want religion, you go to church. If you want to be a nurse, go to a hospital”.

In relation to the media, students can engage in film and television analysis of representations of nursing to become informed and to see patterns of domination. Assignments which challenge students to use critical literacy and change theory help to give them confidence in arguing an alternative view and overcoming a sense of helplessness about doing anything to change the ‘way of things’ (Johnson, 2005).

It is also useful to appreciate that Nursing has been essentialised, grouped together in an amorphous body, but nurses are not all the same - Midwives, mental health nurses, Alcohol and Drug Nurses, Nurse Practitioners – there are many permutations. Shifting to a focus on intentionalism, it is more useful to see nursing practice as diverse, with many various purposes and functions and that its common goal is to provide health care that is professional, accountable, and ethical.

In inspiring nurses to become transformative and change, rather than simply serve, the present system, nurses can become outspoken and convey with pride and assertion that nursing values offer humanising potential to health. There are many reasons to be proud of nursing’s unique identity. It has the traditions of; using personal knowing; participatory leadership, compassion; respecting the intimacy that we have with patients’ bodies, to their pain, to their distress; and, valuing everyday connections that we have with other professionals, families and carers, who trust us because we are unpretentious and accessible.

Major building blocks assisting in transformative teaching in nursing are summarised in Table 1. Ways of attending to process and the importance of relationship between teacher and student are detailed elsewhere (McAllister, 2005 a & b).

<table>
<thead>
<tr>
<th>Process</th>
<th>Content</th>
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<tr>
<td>Be explicit about pedagogy</td>
<td>Build a critical consciousness</td>
</tr>
<tr>
<td>Form a relationship: roles, silence, power, differences</td>
<td>Learn nursing’s history</td>
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<td>Create space for voices and dialogue</td>
<td>Develop proud identity</td>
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<td></td>
<td>Teach strategic thinking skills</td>
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Table 1: Transformative Teaching in Nursing
Model the benefits and the limits of experience (naivety brings fresh views, experience can obscure vision) Build community and harmony Use many ways of knowing and activating students

Learn to wait Think critically Dialectical thinking Replace binaries Critical Literacy & Discourse analysis Claim Practice Critique every day practices Reflect on change Show ways of being with patients in solution focused ways

A New Identity – Solution Focused Nursing

One important cultural shift for nurses is to reject the idea that nurses ought to be problem oriented. A problem orientation has obvious benefits to scientific thinking required of clinicians, but it also has costs (see Table 2). Nurses who adopt a solution-focused philosophy can then learn and integrate more complex technical and interpersonal skills in ways that move beyond a medical approach (McAllister, 2003).

Table 2: Benefits and Costs of a Problem Orientation

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Costs</th>
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<tr>
<td>Gives nurses a language to speak about practice eg diagnosis of a disease</td>
<td>Narrow one’s view to see only problems</td>
</tr>
<tr>
<td>Enables short-hand communication with colleagues</td>
<td>A focus on strengths as an afterthought</td>
</tr>
<tr>
<td>Much of a nurse’s work involves problem solving because treatment of disorders in hospitals is the main service provision</td>
<td>Emphasis is on the problem solver and problem, rather than the person</td>
</tr>
<tr>
<td>Homes the important skills of being logical, rational, ordered, planned, and dispassionate, which help in being deductive to accurately identify problems</td>
<td>The ‘treatment of disorders’ remains dominant, and other services are marginalised</td>
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<tr>
<td></td>
<td>Proactive, pre-emptive, preventative services and roles come last, even though they should be prioritized</td>
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<tr>
<td></td>
<td>Logic precludes taking a passionate stance can be perceived as an uncaring stance</td>
</tr>
<tr>
<td></td>
<td>Creativity, imagination, risk taking are not valued or developed, even though they are crucial to generating novel, personalized solutions</td>
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Most nursing curricula base themselves on teaching problem solving, question posing and reflection. Solution focused nursing values these concepts too but also shifts the emphasis on to solution searching – a skill that requires creative, non-lateral thinking and partnership with clients to brainstorm ideas and try out novel approaches. It also emphasizes working with and for clients, rather than on them - a tendency which occurs within the dominant illness-care system (McAllister et al., 2006).

This is a simple, subtle, yet powerful shift in a nurse’s philosophical stance with clients. It means that rather than assume the client to be passive and in need of expertise and care, a more effective, motivating and sustainable approach is to think about the client as also having expertise, a person who is after all in charge of their own body, and who will eventually need to take care of it themselves on their own, without a nurse. This aspires to being an empowering approach whilst also practical.

Solution Focused Nursing is based on the assumption that people can reorient a focus from thinking that problems are at the centre of living, towards restoring a healthy balance. Problems are part of life, just as ritual, routine, peace and happiness are. For a full and happy life to be sustained, three elements must exist in balance: health for the body; harmony for the planet; and peace for the spirit. And the focus for nursing is at three levels of transformation: change in clients, change in nursing, and change in society.

Teaching transformatively, in contrast to transmissionally, means supporting students and new nurses with close guidance and support rather than distant direction and hierarchical leadership models. It also means attempting to enact family friendly workplace conditions, providing regular opportunities for reflection and or supervision, expecting clear expression of nursing’s interests, implementing practice development and linking academic and clinical nurses by appreciating difference rather than attempting assimilation. Transformative learning in nursing is about students gaining knowledge and social relations that help to transform, not just serve...
the order. It involves attending just as much to the process or teacher-student relationship as to the content (hooks, 1994).

**Teaching the Skills of Critical Thinking**

In a study by Bowles, Mackintosh and Torn (2001) student nurses prior to training on solution focused education, said that they felt overwhelmed with the patient’s problem, they didn’t feel like they were offering clients any solutions, they felt inadequate, and felt they were directionless in conversations with them. It is clear that students need to learn how to be strategic and to think critically to generate solutions with and for clients.

Some of the particular concepts of thinking developed in students within this solution-focused teaching approach is to counter the tendency for nurses immediately to leap into action. Nurses are doers (McMillan, 1999), but sometimes it is important to hesitate and to think. One strategy designed to be provocative is to use the statement “Don’t just do something stand there!” to trigger discussion. The importance of contemplation, question posing and seeking input from others prior to acting for patients are discussed (Lewis, 1990).

As Lawler (1991) argues, busywork can be a distraction, tying nurses to routine, rather than critical thought. By pausing, there is an opportunity to rethink the situation and to generate new ideas to old problems. If nurses were to wait a while, he/she might have an opportunity to help the client generate their own solutions and nurses can then have an active role in coaching and encouraging them, rather than taking over.

Another tendency that can be countered with critical thinking is the unconscious, yet common use of dehumanising language in health care. Medical labels are a good example. Whilst there are benefits in students of nursing learning the language of medicine, this is the precise situation when nurses need to move beyond it because it fits nursing’s humanistic, empowering aims poorly. Rather than speak of a client as a disorder, such as “the schizophrenic”, one can teach the power of ‘person-first language’ – the person with schizophrenia, for example.

Changing habitual thinking takes work and practice. But using language consciously is crucial to cultural change. Language is one of the most important tools for reproducing, and also for changing, a culture. Using language cautiously, playing with it to subvert taken-for-granted practices, and using words preferred by individuals and groups are all part of the practice of being transformative (Sim & Van Loon, 2000).

Raising students’ critical literacy is a way for them to be more aware of how nursing/health issues are being represented. Apart from a few exceptions, nurses and patients are portrayed similarly – as weak, in need, a problem needing to be fixed (Hills & Lindsay, 2003). Students can be awakened to this and equipped with persuasive argument skills so they can feel able to resist dominant and demeaning messages and suggest alternatives (Johnson, 2005). An example of how discourse analysis is taught and applied in nursing is offered here.

**Discourse Analysis**

After raising students’ consciousness about the nature of discourses, students are then offered opportunity to practice discourse analysis. For example, on a topic concerning youth health, students are asked to document representations of youth in television, magazines and films over a period of days. Later they are asked to identify common themes or patterns from their observations and use the literature to critically reflect on how these images might influence perceptions and ultimately nursing practices. They learn, for example that there is a widespread pessimism conveyed within the media about youth. Giroux (2000) argues that media stories about the assets of youth are rare, but cases of violence committed by youth pervade our newspapers, television and film. In Australia, the tradition of ‘Schoolies’ week’, where school leavers take a collective, celebratory beach holiday is a good example. The media repeatedly report this event is associated with increased incidents of crime – and so it is. But the perpetrators, unlike the offensive implications made by journalists, are usually older people, intruding and exploiting the younger ones (Athom, Nov 20, 2005; Haywood, Nov 28, 2005). This is a classic example of being problem oriented. The implication for nursing is made clear by emphasising that negative discourse about young people can deter clinicians from choosing to work with troubled youth, those who do may tend to set low expectations for them (Giroux, 2000) and young people are hardly likely to use health services that judge or devalue them. So, in class effort is made in encouraging students to counter stereotypes and be aware of practices and structures that work to disempower young people.

There is an opportunity then to move to showing students how to be solution oriented with clients by discussing what happens when a new lens is focused on youth. For example, a recent report by Aronowitz (2005) looked at success stories - young people who had overcome risky situations and showed resilience. Local youth health workers’ wisdom is conveyed to
students to show them practical ways of being solution focused (Table 3).

Table 3: Being Solution Focused with Young People

<table>
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<th>Practice</th>
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<tr>
<td>Respect young people as knowledgeable</td>
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<td>Challenge ourselves to go beyond seeing young people as objects or people at risk. They have strengths and resilience</td>
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<tr>
<td>Facilitate trust and listen with genuineness</td>
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<tr>
<td>Try to see solutions instead of just the problem, so look for the problem and then work on solutions.</td>
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<tr>
<td>Involve young people in as many aspects of the service as possible and share decision making</td>
</tr>
<tr>
<td>Try to see the problem as manageable, by maintaining hope and optimism</td>
</tr>
<tr>
<td>Attempt to find meaning during social interaction. Sometimes interactions can be educative and enlightening, rather than always simply fun or a distraction</td>
</tr>
<tr>
<td>Change the way we look at a problem, because this will produce a change in future action and effects, so help the young person to describe their often-told stories differently</td>
</tr>
<tr>
<td>Keep channels of communication open by maintaining conversation even when there may be silences and obstacles</td>
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Giving more voice to discourses of hope, rather than discourses of risk and danger is useful. Talking more about what youth can and do achieve, their own ways of speaking in the world, and then showing them the possibilities of their agency can be empowering. As authority figures nurses need to be aware that power is worked out in many spaces, and so nurses can benefit from doing more listening, offering young people skills to speak on their own to participate in problem solving on matters that affect them, and provide the nurturing and necessary conditions for young people to challenge dominant social forms.

Not only do students learn from what resources can and should be offered to young people, but they hear stories that show that change is possible and an optimistic stance reaps dividends (Seligman, 1995). These are surely the characteristics we want to build up in nurses of tomorrow — equipped with strategies and hopeful about their role in building a more connected community.

Claim Practice as Crucial to Nursing

Nursing is a practice discipline, but it also needs preparatory knowledge. For the last 20 years or so in Australia, nursing has been taught in universities. This has many benefits — it emphasises the professionalism of nursing, it offers opportunity for us to develop our own disciplinary knowledge and evidence base. However, it also comes at a cost — we are criticised for not producing graduates who are fast enough, tough enough or multi-skilled enough to work as a competent generalist RN (van Loon, Clare & Brown, 2002). Academics would argue that students are more critical thinkers, and they might take time to come up to speed, but once there they will be more valuable to employers (Duffield et al., 2001). All this criticism sometimes means that we complain about there being a theory-practice gap in nursing, and so many times we've been tempted to throw the baby out with the bathwater — get rid of theory, have more practice (Heslop, McIntyre & Ives, 2001). However, practice without theory is inherently conservative and dangerous, and theory without practice is irrelevant.

Instead, nursing should claim practice as its defining characteristic. Nurses are practical people, down to earth, reliable, efficient and trustworthy (Leslie & McAllister, 2002). Nurses and academic teachers could value and emphasise it and build it in to all learning contexts — including those that are theoretical in order to deconstruct it, revise it, and build upon it.

In claiming practice as crucial to nursing, one does not imply a carte-blanche acceptance or idealising of practitioners. Rather, practice can be considered and critiqued in everyday learning experiences. For example, one can invite students to be observers on a clinical practice excursion and to ask questions about it: what is the purpose of this practice; what's the history behind it; what (if anything) does it achieve; whose interest is it serving?; Does it respect the client/culture?; Is there something missing here? Are there any silences/omissions/gaps? For an example of how this critical view can illuminate understanding and point to solutions, see the work of Estefan (Estefan, McAllister & Rowe, 2004).

In this way students are working to surface and reveal the dominant paradigm. Habits of practice are being scrutinized and deconstructed, which can illuminate areas for practice change. The dominant paradigm in health care is that which sets the agenda — and very often nurses find themselves doing things that are about servitude, assistance. Sometimes nurses can feel a discomfort or impatience with their practice, perhaps because there is no time to do other things (like talk to the patient, attend an education session, undertake further studies). Students can learn that some taken-for-granted practices may be useful, such as the calming ritual of nurses taking afternoon
Build a Critical Consciousness

If nursing is to change, collectively nurses need to understand why many of us have come to the place we have today — still feminised (caring and at the same time easy to silence and dismiss). I argue that despite nursing’s diversity, it is possible and valuable to build a shared cultural consciousness because it offers solidarity, empathy and motivating stories. As critical theorists argue, those who are oppressed need to experience consciousness raising in order to understand their own position, to engage in struggle to change the ways of dominant groups and to secure for themselves a valuable and enduring place in society (Freire, 1972; hooks, 1994).

In discussing the idea of consciousness raising in nursing, the video “Critical thinking in nursing: lessons from Tuskegee” (Wade, 1993) is useful. It tells the story of Eunice Rivers, an African-American nurse researcher working on the infamous Tuskegee Syphilis Study in Alabama in 1932. Rivers, once revered by other nurses for being independent and empowered, encouraged black men with untreated syphilis to remain in the study while they falsely believed they were being treated. Students first view the video and are asked to look beneath the surface of the story to reveal dominant beliefs, evidence of injustice and dynamics of disempowerment. Students discuss being caught within the dominant paradigm, acting in misguided ways, developing a false consciousness, forgetting about ethics and care.

In a similar vein I’ve used the parable of the good Samaritan (McAllister & Ryan, 1996) — where a traveller who has been beaten and is in need of care, is initially ignored by two devout holy men who are on their way to temple and not permitted to touch blood without cleansing rituals. Meanwhile, a Samaritan, who is not Jewish, and therefore not bound by this Church law, sees the distressed traveller. He tends to the man by soothing his pain, bandaging his wounds and finding someone to care for him in the longer term.

Both of these stories are, in different ways, historical stories that reveal the problematic nature of caring: the limitations of blindly following orders; the risks involved in caring when others don’t appreciate it; being afraid to care because of past misadventures; and finally in having the courage and compassion to move beyond unjust rules and to think for yourself. The aim is to help students to see that taken-for-granted practices are sometimes deeply rooted in history and culture, but they can be surfaced, challenged and replaced.

Taking Action

The stories are a reminder that critical theory, like nursing, is action oriented, and that theory (or rules) without practice, is empty and irrelevant. So in this transformative, solution oriented model of nursing education, the idea is to understand, critique and then “be the change you want to see” in the clinical world. Here is one final strategy to illustrate this action-oriented practice.

Knowing from experience that students frequently have emotional stories to tell after they’ve been on clinical practice, this activity aimed to give them voice, to prompt reflection on practice, to challenge students to think laterally about solutions and then to encourage empowered action.

Students were shown typical images of what I anticipated their practicum to be like (patients in need, hurried and harried nurses and technical procedures). Then I invited students to set me straight and offer their full and open critique of the nurses and doctors that they worked with. There was more tension, bullying and marginalisation than I expected. Next, the concept of conflict transformation was explained (Chinn, 2004). This is about active peacemaking, that assumes all people have power and therefore can benefit from learning how to be a good leader — one who has clarity and vision, can replenish energy and address conflict constructively; who knows when and how to yield gracefully or use the gentle art of verbal self-defence.

Students were then asked to write a story of validation and constructive criticism about their time in the clinical field. These stories and skills were then put to use in a novel way. One of the rich rituals of clinical practicum for students is the giving of a thank-you card. This is when the students collectively get an opportunity to show the clinical staff how much (or little) their efforts meant. Instead of simply writing “thank-you”, which is thin on detail, students were asked to write out their story as an example of what was meaningful for them, and send a group of stories back to the agency. In this way, students used their voice, practised conflict transformation, and showed clinical staff how to be effective supports for future students. This is critical theory in action — noticing oppression, refusing silence, deconstructing, reconstructing, reconstruction and active change.

Table 4: Active Peace-making through the Thankyou Ritual

<table>
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<tr>
<th>To the Nursing Staff,</th>
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We want you to know that as students on prac it was really helpful when you gave us strategies for communicating with clients, and allowed us to show that we can be helpful (thanks Tony!). Remember, we are your biggest fans, and when you are patient and optimistic towards us it makes all the difference. We are the outsiders and are incredibly grateful when you include us!

Students of 2005

Conclusion

In summary, there are some key points for teachers and advocates of nursing that come from linking critical theory to nursing education. These are:

- Note that Nursing is not just a technique, it is a culture, that gets represented and reproduced and so there is a possibility for change if we attend to sites of resistance.
- Calling attention to discourses that obscure or mislead, means that taken-for-granted, habits and routines, won’t easily be passed on or absorbed. There is a possibility that people might stop, listen and change.
- There is a valid reason to teach (nursing’s) history. It shows progress and change and encourages students to imagine a new future.
- Being nurturing on its own may not build courage, risk and change. So teachers need to gently interrupt practices that can not be justified, or which harm others and show students how to be more solution-focused.

These are just some ways to teach nursing transformatively and to integrate critical social theory into everyday classroom teaching. Sharing them in this way is a way of acting politically. It is done in the hope that it might raise awareness and promote deeper dialogue to extend pedagogy so that many more nursing educators are able to adopt a pedagogy that walks towards freedom in ways that are “humane and decent and just” (Greene, 1995, p. 135).

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