From Mother Duck to Mother Lode: Clinical Education for Deep Learning

This lovely mixed metaphor had its origins in a recent presentation by Vicky Niederhauser (2009), who described the need to shift from the longstanding “mother duck” model of clinical education and humorously portrayed the great risks to the “baby-duckling” nursing students as their mother-duck faculty member attempts to lead them through a clinical day. And the “mother lode?” That refers to the gold mine of potential learning that surely exists in clinical settings; however, there are many barriers to striking that mother lode—not least of which is a model of clinical education that is ill-suited to contemporary practice.

The call for reform in clinical education is reaching a fever pitch. Lack of available clinical placements has been repeatedly cited as a factor in limited educational capacity (American Association of Colleges of Nursing, 2007). Reporting on a national study of clinical education, Ironside and McNelis (2009) described the challenges that clinical faculty face in helping students gain the most out of their clinical experience while protecting the safety of an increasingly vulnerable patient population. A report from the National League for Nursing Clinical Education Think Tank (2008) lays out several elements of a reform model.

High-fidelity simulation has been introduced as one possible solution to both the shortage of faculty and the lack of clinical sites. We are beginning to get some evidence about the effectiveness of simulation in clinical learning, as presented by Harder in this issue of the Journal of Nursing Education. The introduction of high-fidelity simulation has raised a new set of questions by regulatory bodies—specifically, can simulation replace some of the time in “real” clinical practice, and if so, how much? This question begs a more fundamental question—if we are to be regulated by the number of clock hours in clinical, how many of those clock hours result in new learning? The study by Ironside and McNelis (2009), as well as students’ anecdotal accounts, suggests there is far too much down time, far too much time focused on doing repetitive tasks that do not result in new learning, and far too little time focused on learning higher-order thinking skills. The sole reliance on a clinical education model that requires students to provide total patient care as their only or primary clinical activity is what stands between us and the mother lode of deep learning.

True transformation of clinical education will require a fundamentally different way of approaching clinical education:
- Considering the kinds of learning that need to occur, and therefore the kinds of learning strategies that may be most effective.
- Considering the creation of new kinds of clinical partnerships to make best use of limited clinical sites.

Kinds of Learning

When the total patient care model was introduced in the early 1930s as a replacement for functional, task-oriented clinical practica, Goodrich (1930/1973) argued that through providing care, students would learn not only how to perform all the procedures of care, but also how to be empathic. Certainly this is an important aspect of clinical learning—having the time to develop a relationship with a patient, developing interpersonal skill, the skill of involve-

ation, and an understanding of oneself as an instrument of care, as well as beginning to understand the illness experience through connection with patients and their families. In their national study of nursing education, Benner, Sutphen, Leonard, and Day (2009) argued that this is a critical and central aspect of clinical education.

But there are other kinds of learning that can and must occur in the clinical context, and that may require some different kinds of learning activities. For example:
- Deepening and extending theoretical knowledge, and learning how key concepts are exemplified in practice. In the early 1980s, Benner’s now-classic studies have called attention to the development of practical knowledge gained only through experience. This kind of knowledge is essential for pattern recognition and skillful clinical judgment (Benner, 1984; Benner, Tanner, & Chesla, 2009). Approaches to concept-based learning have been described in the literature, and early studies provide promising results (Heims & Boyd, 1990; Lasater & Nielsen, 2009; Nielsen, 2009).
- Developing practical skills in essential nursing procedures. For example, to learn a motor task, students need...
repetitive experience, reaching some degree of automaticity so that they can extend their focus beyond the immediate task at hand.

- Developing skill in clinical judgment and other habits of thought such as ethical reasoning, reflection on practice, and system thinking. Clinical judgment rests on development of experiential knowledge (Tanner, 2006) and practice working through situations in context as they unfold (Gillespie & Paterson, 2009).

- Developing an understanding of the culture of health care and nursing, the effect of this culture on patient care, roles of team members, and ways of functioning in interprofessional team work. This requires immersion in a clinical environment, with opportunity to be viewed and treated as a fully functioning member of the team.

A promising clinical education model, built on the notion of purposefully designing clinical education activities to enhance different learning goals, is currently being tested by faculty in the Oregon Consortium of Nursing Education (Gubrud-Howe & Schoessler, 2008, 2009). Other states are actively engaged in developing and evaluating new approaches to clinical education (Niederhauser, 2009).

Clinical Partnerships

Several programs are trying different organizational arrangements to engage our clinical partners in education of prelicensure students. The Dedicated Education Unit (DEU) is receiving increasing attention as a viable alternative for expanding clinical education capacity. As Moscato, Miller, Logsdon, Weinberg, and Chorpenning (2007) described, ‘The DEU model was visualized as a ‘village’ working together and contributing talents to ‘raise’ the student nurses” (p. 36). Staff nurses who want to teach as clinical instructors are prepared for this role, and faculty expertise is used to support the development and comfort of the staff nurse as clinical teacher. The model makes it possible for faculty to devote more time to fostering critical thinking skills of students. Early results suggest the DEU can dramatically increase capacity and have a positive effect on student and nursing staff satisfaction. A variety of clinical partnerships designed to increase capacity in the face of a nursing faculty shortage have been described (Baxter, 2007; DeLunas & Rooda, 2009; Kowalski et al., 2007), and the conversation continues in the article by Kruger included in this issue of the Journal.

It is heartening to see movement toward new models of clinical education and new clinical partnerships, as well as systematic investigation on their effectiveness. These approaches are a clear movement away from the mother duck model, in creating a village to nurture our students and in the purposeful design of strategies to foster clinical learning. The current research will help us learn if these new approaches will, in fact, lead to the mother lode.

References


Christine A. Tanner, PhD, RN, FAAN
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