



# Subjectivity and the valid assessment of pre-registration student nurse clinical learning outcomes: Implications for mentors

Simon Cassidy \*

Nurse Education Centre, Princess of Wales Hospital, Coity Road, Bridgend CF31 1RQ, United Kingdom

Accepted 24 June 2008

## KEYWORDS

Reflective practice;  
Student/mentor  
relationship;  
Humanistic learning;  
Holistic assessment

**Summary** This discussion, supported by the author's personal reflections as a mentor and teacher, examines the issue of subjectivity when assessing the competence of pre-registration nursing students during their clinical placements. A difference is highlighted between *valid* and *invalid subjectivity* affecting the quality of mentors' assessments. *Valid subjectivity* refers to situations where students and mentors enter into a contract of trust and commitment from the outset of placement learning, enabling the 'substantiated' opinion of mentors to become a credible part of proficiency assessment. *Invalid subjectivity* presupposes that there has been limited investment in the student/mentor relationship and that assessment is therefore more reliant on the 'unconfirmed' views of mentors. Humanistic approaches to evaluating student learning are explored and a question is posed as to whether the trustworthiness of subjective assessment is improved when there is a sense of mutual reciprocity between students and mentors. Particular reference is made to reflective practice in adding meaning to this connection. Finally, an example of holistic assessment during 'live' clinical supervision involving a student and this author is offered (Table 1), in order to illustrate the implications for mentors attempting to enhance subjective evaluation of student learning.

© 2008 Elsevier Ltd. All rights reserved.

## Introduction

Evaluating the capacity of pre-registration student nurses to integrate knowledge, skills and attitudes within nursing practice is a contemporary issue for nurse education from the United Kingdom (NMC, 2004, 2006) and international perspective

\* Tel.: +44 1656 752557.

E-mail address: Simon.Cassidy@bromor-tr.wales.nhs.uk

(Schwartz and Abbott, 2007; Turner and Beddoes, 2007; Gobet and Cassy, 2008). This discussion aims to

- explore how mentors' subjective assessment of pre-registration nursing students in clinical settings might be enhanced by a shared appreciation of the evolving realities of practice;
- examine how paying particular care and attention to the context of care events by teasing out important learning components can add meaning for all legitimate partners involved.

Providing consistent and honest evaluation of student performance in clinical settings is seen as a critical part of rigorous assessment (NMC, 2005). This is particularly important as in the UK 50% of pre-registration nurse training is assessed in practice. Yet clinical proficiency also hinges on the credibility of assessment strategies, of which mentors' subjectivity plays a vital part. Crucial, not least because of misgivings about mentors failing to address poor student nurse performance (Duffy, 2004). Whether the subjective views of mentors are consistently reliable enough as a measure of student performance therefore, has become a significant issue. This also depends on how mentors' interpret and articulate their own practice.

Undoubtedly, there is an acknowledgement that competence should be concerned with the ability to master specific clinical skills and possess necessary personal characteristics to function effectively as a nurse including the capacity for reflection. In addition however, competence assessment also needs to be balanced with the student's ability to apply technical prowess and personal attributes to the local context of care situations. Being receptive to such open interpretations of experiential learning gives both mentors and students an opportunity to extend competence assessment *beyond* invalid subjectivity by adding meaning and background to the learning opportunities both parties are experiencing. This position may also go some way to addressing concerns about mentors using invalid subjectivity to give students the benefit of the doubt when assessing practice outcomes, without first building empowering student/mentor learning relationships (Duffy, 2004).

### Valid subjectivity and humanistic assessment of practice

Certainly nurses are encouraged to provide evidence-based care and up until recently nursing

has tended to favour research which relies on systematic, objective methodology (Rycroft-Malone et al., 2004). Still, if nursing incorporates aesthetic as well as empirical ways of knowing (Carper, 1978), clearly a wider range of evidence is needed to explain some of the more illusive aspects of nursing practice such as intuitive expertise. Furthermore, there is a strong argument that sources of evidence informing the practice of nursing care need to transcend judgemental divides between quantitative and qualitative research traditions (Rolfe, 2006). Knowledge can also be derived from the *context* of where care takes place, involving an amalgam of the perceptions of all participants involved in care episodes, including patients.

It might be argued that assessment which involves *valid subjectivity*, drawn from a unique attentiveness to what may be happening in the evolving moments of clinical situations, is no less important than propositional evidence. Indeed, responding to care situations in this way provides a further credible means of assessment available to mentors attempting to capture clinical episodes as a shared learning experience with students. Over the last three decades, nursing practice has seen a general move from expert led medical models of care based on efficient task allocation and curative expectations of illness, often with the passive participation of patients, towards more empowering approaches (Priest and Gibbs, 2004). Encouraging patients to make informed decisions, the development of person-centred planning systems and a holistic approach to health promotion, have become central goals within humanistic health care endeavour (Siddell et al., 2003).

These philosophical changes have been mirrored in nurse education, notably influenced by humanistic psychology (Rogers, 1969; Mezirow, 1981; Knowles, 1984) with adult style learning founded in self direction, creativity and personal discovery.

In his pioneering work, Rogers (1969) sees humanistic teacher/learner relationships as facilitative encounters fostering personal enquiry. Students are viewed as autonomous individuals taking responsibility for their own ongoing learning. In this sense, the process of learning becomes worthy of examination as much as curriculum content (Knowles, 1984). It is proposed here, that humanistic approaches provide an opportunity to examine proficiency in terms of the subjective experience of students and mentors involved in learning situations and through reflection, allow some examination of the accuracy of personal thoughts and feelings.

It seems all too tempting though, to see anything other than humanistic approaches to learning

as reducing the possibilities for self inquiry. In reality, a more pragmatic standpoint needs to be taken. Rogers (1996) provides a helpful image of behavioural, cognitive and humanistic learning theories as a continuum. For example, behaviourist teaching might well focus on rote learning, but also encompass a more expansive exploration of how personal responses can shape interpersonal communication with patients. Likewise, cognitive approaches to learning have the potential to prompt an understanding of how simple nursing concepts relate to each other, or excitingly, provoke a sophisticated evaluation of health care using discovery based learning strategies (Ausubel et al., 1978).

It may be more appropriate therefore, to think of learning as requiring an eclectic mix of theoretical perspectives which will need to be employed with some fluidity depending on the environmental setting, particular concepts being examined and the needs of individual students. It was Kolb (1984) who identified that people may have very different educational leanings. Students favouring a 'convergent' learning style for example, may be more interested in solving technical problems rather than analysing interpersonal issues. Equally, 'accommodative' learners may be more interested in active experimentation, wanting to immerse themselves more quickly in new experiences. Being able to identify students' individual learning preferences therefore, becomes especially significant for mentors using valid subjectivity as part of their assessment criteria.

Yet, if valid subjectivity relies on mentors using multiple sources of evidence to assess student competence, it needs to be clear that there is a legitimate audit trail to accompany their accountability for decision-making. Mentors who have negative expectations of students may not be open to the potential for learning to include the whole contextual environment of clinical settings. Some mentors may see learning as happening incidentally (Kneafsey, 2007), or feel that decisions about the suitability of learning opportunities are best left for individual students to explore unaided (Hutchings et al., 2005). Alternatively, mentors welcoming students as potential co-researchers may recognise that whilst there is a need for formal instruction and guidance within this relationship, the terms of the bond are nevertheless founded on humanistic collaboration and mutual growth (Spouse, 2001; Papp et al., 2003; Pearcey and Elliott, 2004).

Certainly, those who advocate the usefulness of analysing clinical experience as a vehicle for new learning, contend that nursing is an intricate hu-

man activity requiring emotional as well as practical intelligence (Freshwater and Stickley, 2003). It might be argued therefore, that an evaluation of students' learning depends on how far their thoughts and feelings are perceptibly linked with the realities of nursing practice. Subsequently, mentors' subjective assessment of competence, founded on a sound dialogue with students, might then support the idea of 'substantiated' rather than 'unconfirmed' opinion.

### Subjective assessment, reflective practice and clinical supervision

Proactive mentorship can thus be seen as a balance between exposing students to challenging experiences based on their individual learning styles, whilst also providing purposeful support. Cutcliffe et al. (2001) see this dialogue as embedded in effective clinical supervision, especially in being able to deal with possible conflicts between purposeful challenging of students' thoughts and feelings related to practice, whilst also promoting students' sense of personal worth. It is proposed here, that engaging in reflective practice through 'live' clinical supervision can expand the quality of student/mentor relationships which also makes valid subjectivity more likely.

Integrating theory and practice in nursing situations can be seen as requiring a therapeutic blend of technical skills and intuitive responses to solve particular problems, a concept Titchen and Ersser (2001) describe as 'craft knowledge.' It is anticipated that where nurses are able to apply such therapeutic blends in clinical practice, a more reciprocal connection with patients becomes possible (Benner and Wrubel, 1989). Examining the informal theories nurses may hold about their practice becomes significant therefore, especially as nursing actions are inevitably influenced by private, cultural or educational experience (Cowan et al., 2005).

Despite concerns that some pre-registration students find reflective practice problematic (Smythe, 2004), there is evidence to suggest that students have been actively seeking enabling styles of mentor supervision for some time (Perry, 2000; Field, 2004; Lindgren et al., 2005; Clibbens et al., 2007). Nonetheless, if competency assessment is to include reflection about the artistry as well as the science of nursing, questions remain about how intuitive understanding of patient care is made visible as a learning experience. Stockhausen (2006) identified that although students may be

involved in high quality clinical practice with their mentor, they may not automatically internalise the significance of their experiences. As a result, there is a danger that the authentication of knowledge derived from reflective practice does not expand beyond 'single loop' learning (Greenwood, 1998). In other words, there is a discrepancy between what nurses claim they are doing and how they are actually behaving.

In contrast, valuing what comes out of the uncertainty of care episodes can become a valid source of evidence in relation to what it means to offer holistic care (Malinowski and Stamler, 2002). The facilitation of reflective learning in these situations can be seen as rooted in phenomenology, where participants attempt to immerse themselves in the midst of practice. Rather than simply asking 'what skills apply here in order to help this person,' students and mentors might also apply virtue ethics in asking 'what kind of person am I being in this moment' (Seedhouse, 2004). At the same time, students new to practice may not have the emotional capacity to bridge previously acquired knowledge with their current practice, a situation described by Spouse (2001) as 'knowledge in waiting.' Ronsten et al. (2005), attempt to map this transition suggesting essential groundwork between students and mentors. This involves acknowledging students' uncertainties whilst offering a 'shared world view' of practice (expressing sympathy); promoting an egalitarian atmosphere which encourages comfortable self expression (establishing acceptance); validating students' work in practice (acquiring understanding) and confirming students' personal and professional capabilities including the affirmed authority to act (manifesting competence). Such investment in student/mentor relationships can be seen as enhancing assessment strategies which include valid subjectivity.

An analogy can be made with the development of novice to intuitive nurse (Benner, 1984). Benner suggested that in moving from formal knowledge, relied on by novice nurses, to more experiential integration of that knowledge within practice, 'expert' nurses are able to gain an intuitive grasp of situations at hand. Using an example of helping a person who may have a physical impairment with their personal care, Benner's journey would promote a shift from 'knowing that' high standards of cleanliness are important, to 'knowing how' to provide intimate support to a vulnerable person whilst also making a subtle assessment of their emotional state of mind. It is this artistic sensitivity therefore, that contributes to an intuitive understanding of nursing situations. Yet as Clarke

et al. (2003) highlight, there is a further stage neglected by Benner that involves the ability to articulate what is happening whilst in the midst of action. Critically for the student/mentor relationship, through articulation there is also the possibility that intuitive knowledge can be shared. Furthermore, Rolfe et al. (2001) offer a way to incorporate both articulated practice and valid assessment within 'live' clinical supervision.

## Implications for mentors

Having made a plea for the role of reflective practice within the student/mentor relationship, some implications for mentors as assessors of competence are now examined. A commentary of how intuitive learning can be articulated through 'live' clinical supervision as a credible way to enhance valid subjectivity during the assessment process is described in Table 1.

In this sense, reflection as action stimulates a continual reframing and re-evaluation of the event, prompting further action and new reflection. For each of us involved in delivering the bad news to Jack, whether as the main participant or legitimate partner, there was a need to act (sensitive discussion with Jack), reflect on what was happening (respond to Jack's need for attentiveness and to be left alone) and to reflect on how the unfolding episode was being dealt with (continually noticing the impact of our presence on Jack's assimilation of bad news).

As a legitimate partner, Lisa was able to experience some of the contextual realities involved in the episode such as enabling patients' autonomous decision-making. The situation may also have helped Lisa identify the process of being the 'internal supervisor' of her own practice (Casement, 1985), by tracking the evolution of the episode from initial strategy decisions to ending the contact with Jack. These insights are nevertheless dependent on students and mentors having an understanding of their clinical identity which affords a sense of moral authority to act, something O'Connor (2007) refers to as 'professional habitus.'

Cutcliffe et al. (2001), stress the importance of developing qualities which are influenced by this total learning experience. For Lisa, the application of theoretical knowledge (patients have a right to information that allows them to make informed decisions) to practice situations (there are implications for supporting patients comprehending information about their care) becomes much more visible as live clinical supervision. Trust, confidentiality and imagining novel solutions, characterise a

**Table 1** Case study

This event involves a client (Jack), a second year student (Lisa), a Ward manager and the author, as a community learning disability nurse. Personal details have been disguised.

#### *The event*

Jack has a mild learning disability. He had been admitted to a medical ward because of respiratory problems. There was going to be a delay in Jack's discharge back to the community group home where he lived. The problem had arisen because of funding issues relating to Jack's challenging needs. Delivering this bad news to Jack needed to be sensitively managed as he was expecting to be discharged shortly. I invited Lisa to be a part of this process. The Ward manager, Lisa and I discussed when and where to talk to Jack about the delay. It was decided that I would lead this process. Although by telling Jack the truth, the therapeutic value of hope might be compromised, withholding news about the funding would only delay his inevitable increased anxiety when his anticipated discharge date came and went.

I suggested we went into the visitor room as a venue for the conversation. I was aware that responding to Jack in a supportive and attentive way was made more difficult being the bearer of bad news. At the same time, I felt that I was considered in my approach to Jack with my non-verbal behaviour and the phraseology that I used. Lisa also made some important contributions. At first, Jack appeared receptive to our communication. He seemed to take the news surprisingly well and thanked us for being frank with him. I repeated the information again, but Jack seemed comfortable with the idea of a delay and asked to go for a cup of tea.

#### *Reflection*

Initially, Lisa and I felt some relief that Jack had apparently accepted his position following our conversation. At the same time, both the Ward manager and I felt uncomfortable about Jack's reaction, as his passive response seemed incongruent with the personal consequences of the information. We both sensed that Jack's reaction did not fit with previous conversations where he had been consumed with an eagerness to be discharged. Despite a temptation to leave the ward as it was now approaching the end of our shift, I felt that we needed to give Jack more time to digest the information we had discussed with him.

The three of us discussed some of the reasons for these intuitive feelings. There are indications, for example, that nurses overestimate the comprehensive skills of people with learning disabilities in deciphering more complex issues (Banat et al., 2002) and that people with learning disabilities may not be able to recognise the full impact of emotionally charged messages (Richardson, 2000).

I felt that some of these issues may have influenced my delivery of the bad news. The Ward manager, Lisa and I had a pertinent discussion about the difficulties of power distinctions between patients and nurses and how this may have been particularly relevant to Jack's interactions with us, given historical patterns of institutionalised relationships between people with learning disabilities and professionals. Lisa drew on the point that her wearing a uniform might have subtly reinforced this power discrepancy, contributing to Jack's seemingly passive acceptance of significant information.

#### *Valid subjectivity*

Of particular concern was the tension between our 'relief' that Jack had apparently accepted the bad news, yet our intuitive feelings that he had not fully comprehended his position. This conflict approaches what Gilbert (2001) describes as the difference between 'self-interest' and 'selfless obligation' in nursing. We talked about how our feelings of anxiety might be alleviated if we left the ward, which we were entitled to do as it was the end of our shift (self-interest). Yet, this was balanced with a sense of moral duty to see the situation through (selfless obligation). We made some analogies about how virtue ethics were influencing the situation with Jack ('what kind of people were we being at this moment'), whilst also acknowledging that these principles were fundamental in most nursing situations. Through her participation in these discussions and in the episode as it was happening, Lisa (and all other professionals involved) were attempting to advance their 'knowledge in waiting' (Spouse, 2001) through the integration of theory and nursing craft.

'Live' supervision episode of care.

student/mentor relationship that permits reflection in the messiness of practice, prompting students to become more than the passive recipients of knowledge.

Accordingly, the degree of mutual reciprocity between mentors and students has the potential

to open up the learning experience as 'a place of possibility' (Gillespie, 2005). This depends on mentors being able to acknowledge and feel comfortable about their own imperfections (Todd, 2005), involving a philosophical shift in becoming facilitators of learning as opposed to simply handing over

expertise to students. It is here that valid subjectivity takes on a greater significance, as mentors are enmeshed in clinical situations, attempting to evaluate student performance and articulate practice as it is happening.

## Conclusion

This discussion has focused on ways to enhance mentors' subjective assessment of pre-registration nursing students in clinical settings. Valid subjectivity is seen as more likely when there is an investment in student/mentor relationships based on humanistic learning. Such associations involve proactive groundwork in establishing, sustaining and progressing learning opportunities. This includes mentors being willing to confirm students' authority as legitimate partners in practice.

Being able to reflect during 'live' episodes of care, is proposed as a way for students and mentors to share a connection between theoretical knowledge, the use of interpersonal skills and the evolving realities of practice. It is suggested that by continually evaluating day to day decisions in practice and importantly, reflecting on how clinical episodes are being dealt with as they unfold, adds meaning and context to students' learning experiences. Being legitimate partners in clinical events is promoted as a mutually beneficial activity, allowing the possibility that intuitive practice can be articulated for better or worse as it is happening. This reciprocity between students and mentors in knowing the extent of each other's responsive capacity towards patients is seen as having critical repercussions for valid subjectivity and thus a more comprehensive assessment of practice outcomes.

## References

- Ausubel, D., Novak, J., Hanesian, H., 1978. *Educational Psychology: A Cognitive View*. Holt, Rinehart and Winston, New York.
- Banat, D., Summers, S., Pring, T., 2002. An investigation into carers perceptions of the verbal ability of adults with severe learning disabilities. *British Journal of Learning Disabilities* 30, 78–81.
- Benner, P., 1984. *From Novice to Expert Excellence and Power in Clinical Nursing Practice*. Addison-Wesley, Menlo Park, CA.
- Benner, P., Wrubel, J., 1989. *The Primacy of Caring. Stress and Coping in Health and Illness*. Addison-Wesley, Menlo Park CA.
- Carper, B., 1978. Fundamental patterns of knowing in nursing. *Advances in Nursing Science* 1 (1), 13–23.
- Casement, P., 1985. *On Learning from the Patient*. Routledge, London.
- Clarke, C., Gibb, C., Ramprogus, V., 2003. Clinical learning environments: an evaluation of an innovative role to support pre-registration nursing placements. *Learning in Health and Social Care* 2 (2), 105–115.
- Clibbens, N., Ashmore, R., Carver, N., 2007. Group clinical supervision for mental health nursing students. *British Journal of Nursing* 16 (10), 594–598.
- Cowan, D., Norman, I., Coopamah, V.P., 2005. Competence in nursing practice: a controversial concept – a focused review of literature. *Nurse Education Today* 25, 355–362.
- Cutcliffe, J.R., Butterworth, T., Proctor, B., 2001. *Fundamental Themes in Clinical Supervision*. Routledge, London.
- Duffy, K., 2004. *Failing Students*. NMC, London. Available from: <<http://www.nmc-uk.org>>.
- Field, D., 2004. Moving from novice to expert – the value of learning in clinical practice. A literature review. *Nurse Education Today* 24, 250–265.
- Freshwater, D., Stickley, T., 2004. The heart of the art: emotional intelligence in nurse education. *Nurse Inquiry* 11 (2), 91–98.
- Gilbert, J.T., 2001. Reflective practice and clinical supervision: meticulous rituals of the confessional. *Journal of Advanced Nursing* 36 (2), 199–205.
- Gillespie, T.M., 2005. Student–teacher connection: a place of possibility. *Journal of Advanced Nursing* 52 (2), 211–219.
- Gobet, M.F., P.Cassy, 2008. Towards an alternative to Benner's theory of expert intuition in nursing: a discussion paper. *International Journal of Nursing Studies* 45, 129–139.
- Greenwood, F.J., 1998. The role of reflection in single and double loop learning. *Journal of Advanced Nursing* 27, 1048–1053.
- Hutchings, A., Williamson, G.R., Humphries, A., 2005. Supporting learners in practice: capacity issues. *Journal of Clinical Nursing* 14, 945–955.
- Kneafsey, R., 2007. Developing skills in safe patient handling: mentors' views about their role in supporting student nurses. *Nurse Education in Practice* 7, 365–372.
- Knowles, M., 1984. *The Adult Learner. A Neglected Species*, third ed. Gulf, Houston.
- Kolb, D.A., 1984. *Experiential Learning: Experience as the Source of Learning and Development*. Prentice-Hall, New Jersey.
- Lindgren, B., Brulin, C., Holmlund, K., Athlin, E., 2005. Nursing students' perception of group supervision during clinical training. *Journal of Clinical Nursing* 14, 822–829.
- Malinowski, A., Stamler, L.L., 2002. Comfort: exploration of the concept in nursing. *Journal of Advanced Nursing* 39 (6), 599–606.
- Mezirow, J., 1981. A critical theory of adult learning and education. *Adult Education* 32, 3–24.
- Nursing and Midwifery Council, 2004. *Standards of Proficiency for Pre-registration Nursing Education*. NMC, London.
- Nursing and Midwifery Council, 2005. *Guidance for Mentors of Student Nurses and Midwives*. NMC, London.
- Nursing and Midwifery Council, 2006. *Standards to support learning and assessment in practice. NMC Standards for Mentors, Practice Teachers and Teachers*. NMC, London.
- O'Connor, S.J., 2007. Developing professional habitus: a Bernsteinian analysis of the modern nurse apprenticeship. *Nurse Education Today* 27, 748–754.
- Papp, I., Markkanen, M., Bonsdorff, M., 2003. Clinical environment as a learning environment: student nurse's perceptions concerning clinical learning experiences. *Nurse Education Today* 23, 262–268.
- Pearcey, P.A., Elliott, B.E., 2004. Student impressions of clinical nursing. *Nurse Education Today* 24, 382–387.
- Perry, M.A., 2000. Reflections on intuition and expertise. *Journal of Clinical Nursing* 9, 137–145.

- Priest, H., Gibbs, M., 2004. *Mental Health Care for People with Learning Disabilities*. Churchill Livingstone, London.
- Richardson, M., 2000. How we live: participatory research with six people with learning difficulties. *Journal of Advanced Nursing* 32 (6), 1383–1395.
- Rogers, A.C.R., 1969. *Freedom to Learn*. Merrill, Ohio.
- Rogers, C.R.A., 1996. *Teaching Adults*. Open University Press, Buckingham and Philadelphia.
- Rolfe, G., 2006. Validity, trustworthiness and rigour: quality and the idea of qualitative research. *Journal of Advanced Nursing* 53 (3), 304–310.
- Rolfe, G., Freshwater, D., Jasper, M., 2001. *Critical reflection for nursing and the helping professions*. Palgrave Macmillan, Bristol.
- Ronsten, B., Anderson, E., Gustafsson, B., 2005. Confirming mentorship. *Journal of Nursing Management* 13, 312–321.
- Rycroft-Malone, J., Seers, K., Titchen, A., Harvey, G., Kitson, A., McCormack, B., 2004. What counts as evidence in evidence-based practice? *Journal of Advanced Nursing* 47 (1), 81–90.
- Schwartz, M., Abbott, A., 2007. Storytelling: a clinical application for undergraduate nursing students. *Nurse Education in Practice* 7, 181–186.
- Seedhouse, D., 2004. *Health Promotion: Philosophy, Prejudice and Practice*. John Wiley, Chichester.
- Siddell, M., Jones, L., Katz, J., Peberdy, A., Douglas, J., 2003. *Debates and Dilemmas in Health Promotion – A Reader*. Palgrave, Basingstoke.
- Smythe, E.A., 2004. Thin king. *Nurse Education Today* 24, 326–332.
- Spouse, J., 2001. Bridging theory and practice in the supervisory relationship: a sociocultural perspective. *Journal of Advanced Nursing* 33 (4), 512–522.
- Stockhausen, L., 2006. Métier artistry: revealing reflection-in-action in everyday practice. *Nurse Education Today* 26, 54–62.
- Titchen, A., Ersser, S., 2001. Explicating, creating and validating professional craft knowledge. In: Higgs, J., Titchen, A. (Eds.), *Practice Knowledge and Expertise in the Health Professions*. Butterworth Heinemann, Oxford.
- Todd, G., 2005. Reflective practice and socratic dialogue. In: Johns, C., Freshwater, D. (Eds.), *Transforming Nursing Through Reflective Practice*. Blackwell Publishing, Oxford.
- Turner, S., Beddoes, L., 2007. Using reflective models to enhance learning: experiences of staff and students. *Nurse Education in Practice* 7, 135–140.

Available online at [www.sciencedirect.com](http://www.sciencedirect.com)

