Biogeography as critical nursing pedagogy: Breathing life into nurse education by inspiring spirited students

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This Working Paper is designed to stimulate discussion among nurse educators and social scientists, and spark conversations between social sciences and nurse education. As a work in progress it is not for quotation or citation, but please do distribute widely. We encourage comments on this work through the Social Science and Nursing seminar series website and twitter feed or via email at: contact@socialscienceandnursing.com
Ambition

“I don’t understand why anyone in their right mind would want to do nursing nowadays”, said a staff nurse to one of our students at the start of a recent placement, “all the paperwork, chronic understaffing, and poor pay” (Shewan, 2014: 5). To this litany of negativity we could add a near constant media onslaught and associated low staff morale (RCN 2013). Yet, despite this negativity, later this year over 20,000 people will start pre-registration nursing programmes across the UK (Scottish Government 2014; Health Education England 2014). It turns out plenty of people want to do nursing nowadays.

But, we contend that nurse education can do more – and better – to prepare those signing up to study the profession they clearly care so passionately about. At its heart, then, this paper is about revitalizing nurse education, reinvigorating our students, realising nursing’s academic potential, and recapturing nursing’s professional identity. It is about finding ways to imaginatively overcome the challenges nursing currently faces as a profession; because nursing is vital. It is about ensuring that nurse education emerges fully-fledged from its vocational past to become a truly academic discipline and find a home in the university; because it should be one and it should be there. It is about encouraging educational innovation to equip students to be positive beacons of change; because they will shape the future of the profession and the education of its members. It is about enabling student nurses to be confident in their unique knowledge and skills; because without nurses our National Health Service (NHS) just would not work. It is about raising our game and realizing our potential; and inspiring our students to do exactly the same. It is about putting people and their lives – and the places where those lives and lived – at the heart of our nursing and the way we think and act – as educators, as students, and as nurses.

Our central idea is that placing the concept of biogeography centre-stage within nurse education can revitalize nurse education, reinvigorate our students, realise nursing’s academic potential, and recapture nursing’s professional identity. It is designed to stimulate conversations. As such, in places, we are purposefully provocative. Our paper begins by setting some background, and specifically outlining two dimensions of the contemporary angst that we think currently impede nursing triggered, respectively, by the scandal of Mid-Staffordshire and (associated) tensions over nursing’s transition into the academy: the crises of professional and academic identity. Both issues evidently pre-date Mid-Staffordshire but are writ large in the post-Francis debate and must, we contend, be thoughtfully and carefully considered. We then move to outline our own thinking, and specifically the concept of biogeography, which has been borne of more coffee-fuelled conversations between us than either of us could count (or even quite possibly remember) over the course of the past two years; conversations that also gave birth to this seminar series. Following this formulation of the theoretical rationale for the use of the concept of biogeography in nurse education we move swiftly to its practical application by setting out three ‘spirits of nursing’ to which it can contribute: spirits of enquiry, empathy, and engagement. We conclude by briefly summarising a number of challenges to our approach. Then it will be over to you. But, first, let us begin with a deceptively simple question: what is nursing?

Angst

This is nursing

Although a predictable starting point, understanding what nursing is (and is not) is fundamental to our argument. So, let us begin with Virginia Henderson’s well-rehearsed definition:

“The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he [or she] would perform
unaided if he [or she] had the necessary strength, will or knowledge. And to do this in such a way as to help him [or her] gain independence as rapidly as possible.” (Henderson, 1955: 5)

The Royal College of Nursing (RCN) similarly acknowledges that nursing is concerned with health in its widest possible sense – the wholeness of life itself: physically, psychologically, emotionally, spiritually, relationally. Nurses through their actions facilitate this fullness by providing care or enabling self-care (RCN, 2003), often in small, some might say, ordinary ways, which are nonetheless hugely significant. Remove any other member of the multidisciplinary team and care could continue, albeit with poorer outcomes. Take nurses out of the team and the care experienced diminishes markedly: the casual conversation at the beside; a meal left untouched; the glass of water that is moved within reach. It is for this reason that when nursing fails the NHS fails in the eyes of patients, politicians and the public. Witness the tragic events at Mid-Staffordshire NHS Foundation Trust and through other scandals that periodically and painfully hit the headlines.

Observation of high patient mortality rates at Stafford Hospital in 2007 precipitated an investigation by the then Healthcare Commission and two full public inquiries initiated by the UK Government and chaired by Robert Francis QC (Healthcare Commission, 2009; Francis, 2010, 2013). Each report was critical of standards of care across the Trust. In his first inquiry report Francis stated:

“It was striking how many accounts related to basic nursing care as opposed to clinical errors leading to injury or death”. (Francis, 2010: 9; emphasis added)

In other words care failings were, in the main, not related to complex interventions going wrong. Rather, it was so-called “basic nursing care” that was found wanting. Of course, there is nothing ‘basic’ about nursing care, hence from hereon we simply refer to nursing as nursing: that is, a highly skilled activity in its own right.

In his controversial paper on caring John Paley contended that there are areas of knowledge and practice to which the profession should lay claim (Paley, 2002). Specifically, he argued that nursing should not be ‘enslaved’ to the bio-medical but rather is the core of fields such as palliative care, rehabilitation and the management of chronic disease, three of the most important areas of contemporary health care given demographic trends. These are domains of practice where evidence-based nursing knowledge and skills are considerable. Take, for example, the recognition that encouragement of early mobilization is an important determinant of survival and quality of life following a stroke (SIGN, 2008). Nursing is at its most effective and distinctive when focused on people’s daily lives, when nurses facilitate those activities of daily living (Roper, Logan and Tierney, 2000; Henderson 1955; RCN 2003).

Another important component of care failings at Mid-Staffordshire was a lack of compassion. Recently, Paley (2013) has courted similar controversy in his analysis of these events drawing on social psychology (a debate to which we return later). No-one would disagree that it is a desire to care that attracts the over 20,000 people into nurse education in the UK each year. Nor would they challenge that caring is a central component of nursing (as with all healthcare professions), or that critical reflection on what it is to care should be part of pre-registration nursing programmes. But, nursing need not be defined by care. Returning to Paley's earlier paper, and in considering nursing’s core, it does not have an exclusive claim to care: “...there is no harm”, he writes, “in nurses being caring [...] provided no attempt is made to identify nursing with caring” (Paley, 2002: 32; original emphasis). However, we should not lose sight of the fact that – if we are to learn anything from Mid-Staffordshire – to care is to perform and embody the essential skills and knowledge to contribute to some of the most challenging areas of contemporary healthcare. Specifically, it is to meet the day-to-day – sometimes mundane, always essential, very often dirty work – that supports people experiencing illness or injury to live (or die) well. This is nursing. It needs no qualification.
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Too posh to wash

Except it does. A degree. In the UK this has not always been the case, and nursing's transition into the university has been controversial to say the least, especially as attaining its status as an all-graduate entry profession coincided with publication of the all-encompassing second report into the scandal of Mid-Staffordshire that exposed a litany of care failures by nurses in testimony after testimony. Concern largely revolves around the perception that in its (apparent) move from vocational apprenticeship into the academy nursing has somehow lost part of its identify, or worse, nurse education is simply unable to instill in its future registrants the core skills and values, such as care and compassion, that were previously developed – and could only be developed – 'on the ward'. Put simply, time in the ivory towers does not a nurse make.

This is not a new debate. Nor are its frequently rehearsed terms of reference particularly accurate. Nurses have obtained degrees for decades; at the time of the change over a quarter of nurses already held degrees, and among them individuals who hold prominent positions in the profession. Moreover, in accordance with European Union (EU) agreements, the UK's Nursing and Midwifery Council (NMC) – the profession's regulatory body – stipulate in its Standards of proficiency for pre-registration education that programmes must be no less than 4,600 hours in duration and constitute 50% theory and 50% practice (NMC, 2010). Student nurses must therefore spend at least 2,300 hours in practice working alongside a clinical mentor before qualifying – equivalent to 192 12-hour shifts, or 64 36-hour weeks.

Further, a recent study published in the Lancet reporting the association between mortality and nurse education across nine European countries found that an increased number of graduates decreased patient mortality (Aiken et al, 2014). The Willis Commission on Nurse Education dismissed the notion that a more academic nursing profession was associated with a decline in caring (Willis, 2012). Nursing's place in the academy appears secure, but it is, in our view, far from established.

And we are not alone. Thompson and Darbyshire (2012) chide the profession's killer elite for sabotaging its development as an academic discipline. In their opening salvo, they write:

“The growth and development of academic nursing is being hampered, if not sabotaged, by our very own mandarins of mediocrity. These are the academic ‘leaders’ whose own slender scholarship and contribution to nursing is out of all proportion to the stifling and inhibiting influence that they wield.”
(Thompson and Darbyshire, 2012: 1)

Responses to their paper suggested that many others within the profession agree with their cutting analysis (Thompson and Darbyshire, 2013).

Nursing as an academic discipline faces a challenging future. The move into the university has arguably forced us to raise our game. And rightly so. We are committed to establishing nursing's place as an academic discipline. But to do so requires scholarship to become more prominent. Here we suggest that nursing can do so by learning from disciplines that have occupied (and frequently wrestled with) their place in the academy for decades: the social sciences. Far from diminishing nursing's core – enhances the nursing skills and knowledge we described earlier.

Social Science and Nursing

Here we are also in good company. We are certainly not the first to suggest the need to encourage scholarship or to elevate the role of the social sciences in nurse education. Gary Rolfe (2011) argued the ‘Sociological Imagination’ provides a platform for a more critically engaged discipline and hinted at the potential contribution that it might make to teaching care and compassion. Benny Goodman (2011) further developed
the idea as a tool to enable engagement in critical thinking for nursing students to encourage them to reflect on the socially embedded lives of their patients. And both would likely agree with Neil MacPherson’s assertion that: “sociology should form a central pillar of pre-registration nurse education” (2008: 655). Neither is the idea of integrating geography in nursing education new. Gavin Andrews (2006) has made a compelling case for using geographical insights to encourage students to engage with the spatial aspects of health and health care delivery. Teaching informed by the social sciences, such as sociology, geography, and anthropology, has been a feature of undergraduate nursing programmes, although it has been noted that their inclusion has been far from consistent (MacPherson, 2008) and lacks a clear theoretical rationale (Aranda and Law, 2007; Edgley et al., 2009).

Here we present this clear theoretical rationale by proposing a concept of biogeography as a pedagogical approach and, moreover, provide routes to its practical application in our pre-registration nursing programmes. In doing so, we seize the opportunity to make a much more confident claim that the social sciences – and specifically human geography – should be central to nurse education. Although treading new ground, our aim is to draw together fragmented scholarship which has hitherto hovered expectant and filled with latent potential on the edges of nurse education, and realise its potential to address the angst that hinders nursing’s emergence as a truly academic discipline.

Biogeography

Beginnings

For those of us who studied geography at school the word ‘biogeography’ probably stirs up distant memories of standing in a field in some less than exotic location (almost certainly shivering) repeatedly tossing a quadrat to calculate the percentage of different types of vegetation found underfoot. Biogeography, by this textbook understanding, is a branch of geography concerned with the spatial distribution of plant and animal life and the interaction of this flora and fauna with its wider environment. Put baldly, biogeography is concerned with life in place.

But, in the time since all of us left school, biogeography has evolved. In an important 2001 editorial, Tom Spencer and Sarah Whatmore called for a different “bio-geography [that] invests attention in rather different assemblages of phenomena and modes of enquiry than those of the plant and animal geographies associated with the Hartshornian project of mapping patterns of spatial distribution and areal differentiation” (p.140). Part of this project of ‘putting life back into the discipline’ was a recalibration of the relationship between “human society’ and the ‘natural world”’ (Spencer and Whatmore, 2001: 140). Later, in her seminal paper heralding ‘more-than-human’ approaches to understanding the world, Whatmore remarked that “the vital connection between geo (earth) and bio (life) [is] amongst the most enduring of geographical concerns” (2006: 601). She continued:

“The durability of these concerns bears the hallmark of geography’s history, which (like anthropology and archaeology) took shape before the division of academic labours into social and natural sciences became entrenched. It is a division with which these disciplines have never been entirely comfortable, and with which they continue to wrestle more self-consciously, and sometimes productively, than others.” (Whatmore, 2006: 601)

Nursing too wrestles with this division. Even a quick sprint through its disciplinary history reveals that nursing has variously (and sometimes simultaneously) been positioned as a natural (bio-medical) science, found a home in the humanities or considered a social science. We contend that our concept of biogeography provides a path – theoretically, and, perhaps more importantly, pedagogically – across an impasse that, we suggest, has
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Hampered nursing’s emergence as a truly academic discipline. Taking our cue from Whatmore (2006) and drawing on Patchett et al’s (2008) "malleable use" of the term, we propose that the two constituent parts of biogeography – *bio-graphy* and *geo-graphy* – are both vitally connected and, combined, bring renewed vitality to nurse education.

**Biogeography as critical nursing pedagogy**

Biography is inherent to nursing practice. Daily nurses ‘take patient’s histories’, listening attentively, probing appropriately, jotting down significant events and circumstances in order to accurately re-tell the story of an individual’s illness or injury to colleagues, relatives, or, indeed, patients themselves. Nurses are already *biographers*: authors of accounts of individuals’ lives. However, rarely are they *biogeographers*: chroniclers of individuals’ lives in place. To be sure, the concept of lived experience looms large over nursing practice, research and education. Students are encouraged to attune themselves to others as part of a process of attaining an empathetic understanding by *exploring* lived experience through their conversations, engagement with qualitative research, or, indeed, autobiographical accounts of living with illness. However, so often this exploration is *aspatial*; students’ sojourns into experience occur *on* a sanitized, tidy, almost abstracted plane of reflection, rather than taking place at the nexus of the bio and geo *in*, what Whatmore calls, the “livingness of the world” (Whatmore 2006: 602).

Recognition of the inseverable link between biography and geography, for example, brings scandals such as the lottery of life expectancy at various geographical scales sharply into view. That a child born in 2012 in the UK will have a life expectancy of 80 and a child born in Sierra Leone will likely live to just 45 (UNICEF, 2014). That for every two stops travelled east on London’s Jubilee Underground line from Westminster to Canning Town over one year of male life expectancy is lost (London Health Observatory, 2008). That a man living in Merkinch just four miles West of where the opening *Social Science and Nursing* seminar takes place will live 14 years less than a man living four miles south in Lochardil (NHS Highland, 2012). To be sure, these are well-known and easily grasped observations, but nevertheless they highlight the inextricable interplay between people and place.

But it is only by extending the concept of biogeography incrementally beyond this textbook understanding of the spatial patterning of individuals’ lives (and deaths) to fully embrace the ‘livingness of the world’ (Whatmore 2006: 602) that nurse education will be emancipated. Certainly, as Andrews (2006) also acknowledges, increasing awareness of areal differentiation in health *outcomes*, such as life expectancy, is a helpful pedagogical entry point. But it is, we suggest, only by putting the concept of biogeography centre-stage in nurse education that student nurses will gain an appreciation of the crucial and complex ways through which place shapes individuals’ health *experiences, behaviours, and opportunities*. In so doing biogeography – as a critical pedagogy (Friere, 1968) – attunes students to others’ lives and simultaneously sharpens a critical, and indeed, radical edge to their nursing praxis. At the same time, as we go on to argue, through this educational intervention, patient/nurse dualisms are shattered, the theory/practice gap is closed, and the discipline of nursing fully and finally emerges to occupy its place in the academy and embrace its status as an academic discipline.

Andrews (2006) has previously stressed the vital importance of nurse education to nursing’s disciplinary development:

"Arguably, as the starting point of all nursing, nursing education is a particularly important field that demands more sustained attention, Indeed, any emerging disciplinary field – social scientific or otherwise – has to be anchored in, and articulated at, the education level so that generations of new practitioners and scholars will be familiar with it, and some able to apply it.” (Andrews, 2006: 547)
We suggest that biogeography has potential to revitalise nurse education and invigorate student nurses. So, let us now take just one example of how this critical pedagogy can be realised in the classroom by engaging with a live debate in what appears, at first, the tangential field of urban studies: neighbourhood effects research.

The central premise of neighbourhood effects as critical urban geography Tom Slater notes "stems from an understanding of society that adheres to one overarching assumption, that ‘where you live affects your live chances” (2013: 2). However, the problem, as Slater continues, is that this idea:

"...is seductively simple, and on the surface, very convincing. Somebody growing up in, say, a seven-bedroom mansion in a leafy residential suburb surrounded by golf courses in the stockbroker belt of Surrey, England, will have far more chances in life than somebody growing up in a stigmatized social-housing estate less than 30 miles away in the London borough of Tower hamlets (for decades one of the most ‘multiply deprived’ parts of England, with high levels of unemployment, poor health outcomes and little green space. Who could argue with that?” (2013: 2)

Slater does. He proposes an alternative take on the thesis that is pertinent to our unfolding argument. Slater proposes:

"...an absolutely fundamental structural question that is rarely, if ever, tabled at virtual or actual gatherings of those concerned with neighbourhood effects. That question is: why do people live where they do in cities? If where any given individual lives affects their life chances as deeply as neighbourhood effects proponents believe, it seems crucial to understand why that individual is living there in the first place. [...] If we invert the neighbourhood effects thesis to your life chances affect where you live, then the problem becomes one of understanding life chances via a theory of capital accumulation and class struggle in cities.” (2013: 3; original emphasis).

For our purposes here we need not move Slater’s argument to its final analysis informed by Marxist thought (although there is clearly much more room for the Marx in nursing praxis). What it reveals for us, is the vital importance and potential of biogeography as a lens through which to address the key challenges to nurse education outlined earlier. Slater’s (2013) inversion of the neighbourhood effects thesis reveals the proposition that lies at the heart of our concept of biogeography insofar as it invests agency in each of its constituent parts. Biography and geography actively and continuously rework each other; biogeography is not only inseverable it is co-constitutive. Put another way (and let us now explicitly substitute the term ‘life chances’ for ‘health’), an understanding that where you live affects your health only takes us so far. An explicit acknowledgement that your health affects where you live, and that health in this formulation is “an absolutely fundamental structural” (Slater, 2013: 3) concern – both an asset (to use the common public health parlance) and constrained by capital.

Arriving at this realizing of the wider structural process that constrain people’s lives – and, more importantly, that such processes can be challenged – has, we contend, considerable potential for biogeography as a critical pedagogy to inspire, what we call, spirited student nurses, as we go on to explain. Before doing so, however, it should be acknowledged that the call for nurse education (and its educators) to sharpen a radical edge and connect more explicitly with issues of social justice is not new. Almost 20 years ago, with Project 2000 looming large in nurse education, Jane Harden, drawing on the writing of Habermas and Friere called for nurse education to become enlightening, empowering and emancipatory and noted: “It’s time to get radical” (1996: 36).

Two decades later, we struggle to find evidence of this radical movement in nurse education. But we believe that this remains a noble aim – and, as we will see, our students feel the same. The reasons such ideas – just as those of the social sciences more generally – have intervention after intervention failed to take route is because
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they are arguably rather abstract: we get as far as why, without full examination of how. Biogeography provides an answer to both questions providing a practical approach to push as far as Harden hoped (if students so wish), while moving through and instilling (or distilling) equally vital and vitalizing qualities of a nurse en route.

Inspiring spirited nursing

We now move to describe what we call three ‘spirits’ of nursing that we believe pedagogy built around the concept of biogeography can inspire in our student nurses: a spirit of enquiry, spirit of empathy, and spirit of engagement. Our use of the term spirit here is not meant in an ethereal, otherworldly sense, but rather to trace the etymology of the term to its Latin root ‘breath’: that which animates and is vital to life. Hence, we suggest that combined these inspire ‘spirited nursing’ among our students which, ultimately, reinvigorates and revitalizes nurse education.

Spirit of enquiry

To kindle the spirit of enquiry students requires that we actively engage them. Doing so involves ideas being made accessible such that they can grapple with them rather than getting lost in technical detail or bamboozled by beguiling language. The challenge of utilising the social sciences in a way that is meaningful to students is not straightforward. The ideas of the social sciences are difficult to grasp as any geography, sociology or anthropology undergraduate will willingly attest, and arguably more so for nursing students for whom the subject will, at best, form only an element of their studies (although we argue this should be a core component).

One strength of biogeographical approaches is that by being rooted in practice they are made meaningful to nursing students. Clear links can be drawn between theory and practice. For example, as we hinted earlier, the taking of patient histories becomes a biogeographical exercise. Conversations that develop between student and patients (or their relatives) enable students to discover how individuals’ lives have been shaped and structured by circumstance to genuinely understand their health, health-related behaviours, or their engagement (or lack of) with health services.

Take that final point – the lack of engagement with healthcare. The interaction between structure and individual agency becomes utterly meaningful and personally relevant to students; for example, we have in mind here teaching around the inverse care law (Hart, 1971; Mercer and Watt, 2007; Jones, 2010). This 'law' essentially states that those who most need health care are the ones least likely to utilise services and support. The reasons why those in living in marginalized circumstances are less likely to engage with health services are legion: lower literacy rates; ability to negotiate increasingly bureaucratic systems; high levels of morbidity that place demands on finite appointment times and so forth. The central point here is that individual nurses may unwittingly contribute to this wider structural malignancy. Biogeographical approaches potentially reveal to students that their role may be far from benign. Reflecting on implications for nursing practice encourages students to connect the day-to-day reality of their nursing practice to theory.

Take another example – the tumultuous response to Paley’s (2013) controversial editorial (Darbyshire 2014; Rolfe and Gardner 2014). Here he proposed an alternative take on the tragedy of care failings at Mid-Staffordshire NHS Trust informed by social psychology. Quite aside from the light this sheds on the reception of ideas from outwith nursing within its disciplinary walls, the outworking of the structure/agency debate through the pages of Nurse Education Today can also be made transparent through biogeographical approaches. By reformulating this debate as the interplay between people (nurses) and place (hospital), rather than providing resolution to such debates, biogeographical approaches may effect their escape from nursing
journals and their entry into pre-registration programmes. They do so by inspiring students to wrestle with ideas and recognise the need to hold them in tension, to revisit, and reappraise over time. Releasing the spirit of enquiry excites our students such that the want to grapple with those wicked issues within current nursing; those issues for which there is no straightforward resolution.

**Spirit of empathy**

A spirit of empathy is stirred by seeing ourselves in others and recognizing the way our lives have been and are constrained and enabled by wider social circumstances troubles the simplistic notion of ‘them and us’. Students can very easily reflect in class how their own live chances have been influenced by where they have lived (geo) and opportunities through their life courses (bio). In so doing, biogeographical pedagogy breaks down the patient-nurse dualism holding the potential to facilitate empathy. Recently, Rolfe (2014) perceptively observed that it is much less likely a nurse will leave a patient in need at the end of his or her shift if there is insight into their experience.

“I care about my children because I love them and they are my children which motivates me to care for them. I care about strangers whom I encounter in hospital because I am able to imagine myself or my children in their situation. Without this empathic imagination, we have only our training and our duty to fall back on.” (Rolfe, 2014: 1459; original emphasis).

Challenging students to consider their own lives, and specifically how their own biogeography has shaped their lives – their experiences and attitudes, even their prejudices – can actively challenge those preconceptions (however subconsciously held) through recognition that the similar influences may have shaped their patients’ attitudes and experiences and effect a shift away from individual blame (as is arguably fostered by a biomedical approach that still permeates the nursing profession).

**Spirit of engagement**

The explicit focus for the structural constraints on individual’s health that come sharply into view through a biogeographical approach might also release a spirit of engagement. By this we mean a desire to not only understand but to change the (nursing) world and the lives of those for whom nurses care so deeply for and about (Rolfe, 2014). Nurses are already advocates (NMC, 2008). They are already encouraged through the 6Cs to be courageous on behalf of their patients and profession. But recognition of structuring circumstances – and that these structures might be changed – might encourage a spirit of engagement, born of keen sense of social justice sparking activism. This is best expressed by one of our students. In response to a disheartening placement experience that started with the staff nurse’s lament with which we opened – “I don’t understand why anyone in their right mind would want to do nursing nowadays, all the paperwork, chronic understaffing, and poor pay” – James Shewan wrote ‘from the heart’ in the RCN Bulletin:

“As nursing students we can play a unique role in bringing positivity, freshness and enthusiasm into placements. By embracing this, expressing ourselves and speaking up, we may just empower others to be the change they want to see.” (Shewan, 2014: 5)

Replace ‘placements’ with ‘campuses’ and our job as nursing educators is exactly the same. It is to inspire spirited students who enter a battered and bruised nursing profession bold and brave.
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References


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