ORIGINAL RESEARCH

France's transition to academic nursing: the theory–practice gap

Odessa Petit dit Dariel[1], Mathias Waelli[1], Thomas C. Ricketts[2]

1. EHESP School of Public Health, Rennes, France. 2. Schools of Global Public Health, University of North Carolina Gillings, Chapel Hill, USA.

Correspondence: Odessa Petit dit Dariel. Address: EHESP School of Public Health, Rennes, France.
Email: Odessa.PetitditDariel@ehesp.fr

Received: June 19, 2014 **Accepted:** July 23, 2014 **Online Published:** August 13, 2014
DOI: 10.5430/jnep.v4n10p88 **URL:** http://dx.doi.org/10.5430/jnep.v4n10p88

Abstract

Nursing education's shift from vocational settings to academic institutions is a trend that has accelerated recently in Europe with the advent of the Bologna accords. France has adopted this model using a centralized, policy-driven approach. This article describes the background to this change and explores the process and impact of this shift in the lives of practicing nurses in clinical units. Between April 2011 and June 2013 nurses and students were observed using the shadowing method and were interviewed in a nursing school and four hospital units where students had clinical placements. The key interviewer elicited descriptions of the process as seen by the nurse mentors and generated themes and summary statements that encapsulated the phenomena of policy change at the individual level. The nurses expressed a broad understanding of the process, but were required to adapt the changes to their everyday professional needs under difficult time pressures. Nursing students found little sympathy and support from their mentors during the process and perceived a general lack of understanding of the goals of the reform. Three significant types of reactions were noted from new graduates: the exploitation of the hospital setting to find more rewarding work; a renewed interest in developing nursing activities traditionally undervalued; and finally, withdrawl from the profession. These factors point to the difficult future for nursing in France and globally, as systems try to reform toward greater perceived efficiency and restructuring of professional roles without providing adequate time or ressources to implement adopted policies.

Key words

Nursing education, Shadowing, Reform, Policy implementation

1 Introduction

Since the mid 1900's nursing education across the globe has shifted gradually from vocational training into post-secondary or higher education. This has been the result of both changes in nurses' expectations as well as increasing technical and cognitive demands of the health care system on its workers. The accelerated transformation of nursing and allied health education from vocational to academia essentially began in the early 1970s in English speaking countries as these professions grew rapidly and aimed to enhance their prestige and position [1-3]. The nursing profession also sought a stronger voice in health care delivery by pushing for regulatory and financial recognition [4].

The profession in France has been caught in a broader reform process. Their shift to higher education was imposed in 2009 with pressure from the European Bologna agreements, attempting to harmonize graduate education across the European Union as well as support a more rational system to accredit health professions [5, 6]. Yet the implementation of a more "academic" training system for nurses and allied health professionals in France was significantly hindered by concurrent hospital reforms that resulted in increased patient loads, turnover and administrative tasks [7-10]. While the educational reforms were driven by an aspiration by the French nursing community to gain more recognition of the profession's scientific and clinical legitimacy, the transition occurred too rapidly, without giving the actors involved time to prepare for such drastic changes.

2 Background

While nursing's transition toward an academically focused profession is not a new topic, the specific context and national culture makes the French example an informative case analysis as it highlights the way the system forced adaption and the profession followed. Indeed the situation can demonstrate how different perceptions of the nursing profession emerge in other national contexts. In France, the sudden implementation of a new nursing program transformed the roles of all the primary actors (nurse educators, staff, students…) almost from one day to the next, and disrupted both the nature and the intensity of their interactions. Indeed the push to an academic framework created a divide between theoretical knowledge and technical skills [11-13] as has been seen in other fields such as management [14]; paramedics [15]; and teaching [16].

In France the educational reform of the nursing pre-registration program began with a validation of a competency framework by all the relevant stakeholders (professional bodies, trades unions, employers, other health professions, *etc.*) [2]. Since the nursing license was to be recognized at the bachelor's level, nursing education would fall under the realm of both the Ministry of Health (MOH) and Ministry of Higher Education and Research (MoHER). The MoH would continue to certify the nursing diploma and the curriculum, while the MoHER would recognize nursing students' diploma at the same level as a bachelor's degree at the completion of their program.

Once the reform was in place, nursing schools were required to develop partnerships with universities in their region to fulfill 27% of the curriculum that had been determined would be taught by university faculty. In nursing schools, course content and pedagogical methods were revised drastically and the responsibilities relating to student supervision and evaluation during clinical placements were reallocated. In class, problem-based learning was introduced, replacing the previous emphasis on key body systems and medical pathologies. In clinical placements, the supervision of student nurses was radically redesigned. Previously, nurse mentors and educators together performed a summative assessment of the student in the clinical setting. The summative assessment has now been replaced by a portfolio kept by the student nurse that is to be updated regularly to keep track of their acquired competencies. The ongoing acquisition of competencies must be validated by the nurse mentor in charge of the student nurse [6].

The abrupt and sweeping changes in policy affecting nursing education in France emerged without a strong theoretical explanation. The policies were embedded in a larger idea of international solidarity expressed as freedom to move between EU nations and for cross-national work to be available equally. This shift away from national autonomy in the structure of professions defies the notion of "path dependency" at the national level, but affirms the idea that these policies were a "natural" consequence of the political choice to reify the European Union and to give it legitimacy. The choice to extend the idea of the EU by bringing the Bologna Accord into real effect, in turn, affected education in general, and health care only secondarily. The response in health education systems was equally without a theoretical driver other than a sense of adaptation.

For nursing in France there was acquiescence, perhaps due to the traditional power of central government and the pattern of acceptance of large-scale reforms. Those, however, are external frameworks intended to explain the policy changes. The practical changes in the application of the policy remain the province of the individuals caught in this change process.

Their explanations of the process of change and adaptations form an emergent, or grounded, theoretical background for this inquiry [17]. We seek to determine what, if any, justifications or personal explanations they would have for how they either did or did not react to the policy changes. In this sense, this work falls under those theoretical rubrics.

This article will begin by describing our data collection methods then will explain the principles and objectives of the new program, highlighting the tensions that have arisen between the academic setting and clinical practice. We will be exploring how this process has redefined the roles of all the actors involved. Finally we will present the experiences of students and new graduates taking their first steps in the clinical field, either during their clinical placements or in their first jobs as fully-fledged nurses.

3 Methods

3.1 Aims

Beginning in April 2011 we observed nursing students in their clinical settings as they implemented the new program. Based on a larger ethnographic study of the implementation of the new program in France, this paper aims to explore the tensions between the different representations of nursing work and practice and attempts to answer these questions: how has the new policy transformed practices and representations of the nurse's role? How compatible are these representations with the demands and needs of the field? What is the impact of this reform on the integration of new nurses within clinical teams?

3.2 Methodology

This research study used an exploratory approach inspired by "grounded theory" [17] to shape the data collection and analysis of the materials gathered. The investigators were immersed in the context of nursing in France and used this formative evaluation approach to test their own pre-conceptions about how the new program was experienced by practicing nurses, students and new graduates.

3.3 Participant recruitment and data collection

To explore and understand how the new program transformed nursing practices and representations in France, we employed three investigative tools: on-site observations using the *shadowing* method; in-depth interviews and focus group interviews; and documentary analysis of students' reports and assignments. The observations in the field and in nursing schools were conducted between April 2011 to June 2013 in one nursing school, and four hospital units in which nursing students regularly had clinical placements.

We chose to use the *shadowing* method in the hospital setting which consisted in following a single nurse at a time throughout an entire work-day [18]. This approach had the objective of paying special attention to elements specifically linked to the supervision of student nurses or new graduates. It allowed a better understanding of the links between mentoring and other nursing activities, whilst also facilitating the development of a relationship with the participants. The trust established allowed for better exchanges that were recorded with permission from the participants. The primary researcher immersed himself for seven weeks, eight-hours per day in a gastroenterology department in a large public hospital in Paris. He then spent fifteen days, eight-hours per day in a general surgery department (gastroenterology) within a non-teaching hospital in the south of France. Finally, observations were conducted for 8 days, twelve-hours per day in a pediatric oncology department in a prestigious cancer center in the Parisian area. Informal interviews and exchanges with registered nurses, nurse managers and nursing students were recorded and transcribed and field observations were recorded in a research diary.

On-site observations were also conducted in a nursing school attached to a large teaching hospital in Paris. The researcher spent nine days attending classes with 1st and 2nd year students. The aim was to examine the exchanges with the nurse

educators and students regarding the new program. Semi-directed, in-depth interviews were conducted (digitally recorded and transcribed) with nursing students (n = 13) followed in their first year (2010-2011) and then in their first nursing position. Nurse educators (n = 5) and clinical placement coordinators (n = 4) were also interviewed.

Finally, in the context of a follow-up program for new nursing graduates put in place by a large Parisian hospital, we collected focus-group data from new graduates having difficulty integrating the clinical setting. We conducted two focus groups lasting three hours each with a group of five and a group of six new nurses. The exchanges took place in the absence of hierarchical superiors and older colleagues.

In France, this type of study does not require informed consent or IRB clearance in the way it is understood in the United States. Clinical research, on the other hand, does require informed consent by patients, but not if the study employs the use of surveys in an administrative context [19]. Administrative review and clearance for interviews of staff and students is required by hospitals, however, and this was obtained before data collection. The researchers were particularly sensitive to issues of confidentiality, conducting interviews in private offices, providing a comfortable and informal setting. The participants were free to participate in the interviews, focus group interviews and all participants provided oral consent.

3.4 Data analysis

In order to follow an inductive process, we started our investigation in each institution with observations and informal discussions with nurses in a hospital setting. From this first set of data, some recurring themes emerged and became principal issues to be explored in our fieldwork. To explore these issues at a deeper level we included them as themes to be addressed in the interview guide. This guide only had one specific question that set the tone for the interview: “I am interested in the consequences of the new nursing education reform on your daily activity and I would like to hear about your experiences. But before can you first tell me a little bit about who you are and how you came to be a nurse?” The issues that we had identified from the initial data were then addressed in the interview, such as their nursing education experience, their first clinical placement, their relationship with their colleagues and management, their understanding of the new portfollio and their views on it and the new competencies. These themes often came up naturally during the interview suggesting that they were relevant to the participants. Interview transripts were analysed using thematic analysis and were then reexamined in light of the literature and other documents such as clinical reports and portfolios. Comparative analysis was then conducted to compare and contrast the findings from the field, the document analysis and the skills and competency framework published by the Ministry of Health (MOH). The three authors met regularly to interpret and identify emergent themes using triangulation and a structured interpretive framework.

4 Context

4.1 Nursing education in universities: a response to new health care challenges

Since the early 2000s, public authorities including the MOH, nursing and allied health stakeholder groups, health policy makers, and other professionals had been working on revamping all of the allied health professions’ education programs. The main objective pushing these reforms was the preparation of professionals able to respond to the rising growth in chronic pathologies and the ageing population in a context of medical shortages. Yet for the nursing profession in particular, the reform profoundly changed the role of both nurse educators and nursing staff who were not at all prepared for it.

The various reports suggested that moving allied health programs to higher education could offer solutions responding to a number of current healthcare challenges. In these documents it was claimed that, for nurses in particular, the Licence-

Master-Doctorate (LMD) track, recommended by the European agreements of Bologna in 1999, and Prague, in 2001, as well as the international nursing community (ICN) would:

1) Allow nurses to develop skills and competencies at a Masters level, thus giving them the title of 'Advanced Practice Nurses' (APN), able to fill the gap caused by the medical shortage and respond to growing health care demands;

2) Develop professional pathways that could rebrand the nursing profession as a more attractive option for potential students;

3) Develop an academic discipline through research in nursing and improve practice through evidence-based nursing;

4) Decrease the barriers existing between the health care professions by sharing resources in the first year, while also improving interdisciplinary collaboration.

To some the link with academia was seen as an opportunity to introduce nursing research into the curriculum thus reflecting the evolutions in clinical practice experienced across the globe. In this context, it was envisioned that nurses would increasingly be capable of questioning their own practice by comparing it to the scientific literature, thus integrating a culture of evidence-based nursing. Learning how to reflect, critically analyze their practice, and exercise clinical judgment corresponded to the desire to prepare nurses who could act autonomously within their scope of practice [20].

However, a number of factors, including strong medical resistance and internal conflict amongst the nursing profession have led the reform to not achieve these ambitious objectives. To date, the link to academia has only resulted in the recognition of the nursing degree at the bachelor level. This occurs in many cases with great difficulty since nursing schools remain geographically and institutionally separate from universities, with whom they must only sign an "agreement" engaging university academics to teach a certain number of credits (42 of 180 required). These are frequently provided using synchronous videoconferencing or DVDs of recorded classes. Clinical placements are now also longer but less frequent. Classes have been added to the curriculum such English and Information Technology (IT), and a new evaluation tool (the portfolio) has been introduced to track the evolution and acquisition of the skills and competencies as well as increase students' self-directed learning skills.

Thus the new program now has 40% of its theoretical courses offered by university professors with the remaining 60% dedicated to 'nursing science and technique' (formerly called 'nursing care'). The problem remains, as pointed out by Rothier-Bautzer [21], that the content of the latter has still not been determined: "We went from theoretical and practical care as inspired by Virginia Henderson, to "science and technique" that were not clearly outlined", thus leaving nurse educators and staff nurses in the field in uncharted territory without a map [6].

4.2 The importance of clinical placements in skill and competency acquisition

One of the main characteristics of the nursing education reform was its adoption of the "competency" model, reinforcing clinical placements as the key element in an experiential, learning-by-doing approach [22, 23]. Throughout the six semesters of the program, nursing students alternate between 2100 hours of in-class sessions and 2100 hours of clinical placements. During those clinical placements, the Student Nurse (SN) must acquire a total of ten competencies before being eligible for the national diploma. For each competency the SN must complete all the class modules associated with that competency and have acquired all the skills and knowledge representative of the competency, either during their clinical placements or through class assignments. Technical skills are primarily acquired in the clinical setting because laboratory simulations using low or high-fidelity mannequins are not common unless the nursing school happens to be attached to a teaching hospital with a medical simulation laboratory.

The earlier 1992 program had based their teaching and evaluations on a behaviorist approach focusing on measuring skill acquisition through observation. Therefore learning was considered to have occurred when the student was able to demonstrate a correct response or gesture to a given stimulus. This culminated in a final examination of clinical skills by nurse educators which closely resembled the Objective Structured Clinical Examination (OSCE). However, the new program dropped the OSCE and adopted a new experientially-based paradigm leaning primarily on a socio-constructivist process [24]. Problem-based learning is used to encourage students to work collaboratively and seek solutions to problems building on their knowledge as they formulate the problem and determine the data needed to solve it. The role of the clinical placement has thus changed drastically. It is now the dedicated space for the development and evaluation of skills under the sole responsibility of the staff nurses rather than a shared responsibility with the nurse educators.

5 Findings / Discussion

What has been the result of this transfer of responsibility to the nursing teams? The question becomes even more central in hospitals today as they experience the consequences of fifteen years of significant health care reforms and the 2009 law HPST (Hospitals, Patient, Health and Territories) that was supposed to regionalize care and promote quality while lowering costs. These reforms have led to an intensification of activities for all healthcare professionals linked in part to a demand for greater accountability and traceability, and has also resulted in a rise in turnover. The findings highlight the lack of time and preparation of the nursing teams faced with the additional responsibility of teaching and evaluating nursing students, often to the detriment of both students and nurses.

5.1 Mentoring: a time-consuming and poorly-integrated activity

Mentoring a student is considered an integral part of a nurse's mission and is clearly specified in their job description. However the new program has reinforced nurses' mentoring role without considering the context in which this would occur and without adequately preparing them. First, it was imposed on nursing staff precipitously (it was decreed in July 2009 for implementation in September of the same year). Nurse educators and staff nurses were given little time to assimilate the new program before the first students started arriving. As decribed by a nurse educator, "*It was very difficult. Within a few short weeks we had to completely revamp our system (…). We were in complete darkness as we started it. We had to learn as we went. Only today are we starting to find our feet, but it's clear that the first students suffered from our inexperience*." This feeling is largely shared by the students. Their testimonies show to what extent they participated in teaching their own mentors who were poorly prepared in evaluating a certain number of their competencies. "*During the first placement, we had to explain everything to them. For example Competence 4 (implementing therapeutic or diagnostic interventions), we would show them the description of the competency we had been given by the school. We would discuss it together and after they would evaluate us*" (RN1).

Meanwhile the different hospital reforms were contributing to shorter stays and more onerous quality assurance processes [7]. These new demands on nurse mentors were thus occurring in a context of workload intensification, increasing turnover and excessive paperwork demands. This greatly decreased the time left to spend mentoring students, creating tensions in nursing teams that were already overworked. This resulted in poor clinical experiences for students: "*On the one hand at school we were told that we would learn everything during clinical placements, yet once there we were blamed for not knowing how to do anything. We didn't feel very welcomed*" (RN5). Morever, while the responsibility of mentors has increased the activity remains largely ignored in terms of calculating patient assignments and staffing.

Obviously, the students were not alone in feeling the brunt of this inadequate reform implementation. The RNs and nurse managers we interviewed also deplored not being able to offer successful clinical experiences. Similarly Burkhart [25] found that many nurse mentors had to infringe on their personal lives to adequately complete their work: "*It's very time-consuming to fill-out a portfolio, and I often do it at home because it requires quite a lot of concentration to complete all the items. I can't do it during the day, I don't have time,*" or, "*I often stay after work to find the time to fill out the students' reports with them. It's just impossible to stop during the day to do it*".

These testimonies highlight the difficulty nurses have had in adapting to the new evaluation tool, the "portfolio". The portfolio is a reporting system used to document the acquisition of competencies and is considered time-consuming in part due to its complexity but also the difficulty nurses have had in interpreting the criteria listed under each competency. It would take an experienced nurse mentor approximately two hours to correctly fill out one portfolio [26]. Added to this is the time spent mentoring, teaching and evaluating SNs as they perform care and practice nursing skills.

Finally, all RNs are not considered equal when faced with these demands. Indeed with increased rates of turnover, certain students are assigned nurse mentors with less than a year of experience. This was the case for a new graduate working on a hematology unit in a Parisian hospital who, having barely completed her unit orientation, was given the responsibility of mentoring a student: "*I had not even assimilated the demands of the unit myself when I was obliged to take care of a student. I can't even tell you how stressful that was…*" (RN2).

5.2 Competency evaluation: unfamiliarity with the program and a great sense of responsibility

Whilst the new program details the ten competencies to be acquired, the criteria on which they are evaluated is not always clear to those doing the evaluating. The analysis we conducted on the SN's portfolios and other clinical evaluation documents demonstrates the inconsistent manner in which the criteria were interpreted. These were highly dependent on the context and the subjective opinion of the nurse mentors. The SNs portfolios confirmed these inconsistencies with certain competencies being considered as 'acquired' in one clinical placement and then needing 'to be improved', or even in some cases 'to be acquired' in following placements.

As an illustration, Competency 4's criterion: "ability to identify risks and preventive measures" in one SN's portfolio was first assessed as needing 'to be improved' during the first two clinical placements, then as 'acquired' for the following ones, and finally as needing 'to be improved' again in the last placement. These discrepancies can be interpreted in several ways. One interpretation, confirmed by students when asked to comment, is that mentors are actually validating individual clinical skills rather than transversal competencies. Each nurse mentor therefore interprets the competency differently and associates different skills to the competency that corresponds to the skills practiced on their unit.

When not related to simple resistance to the new program, these inconsistencies demonstrate complete lack of familiarity with what is being taught in nursing schools. Indeed many readily admitted not understanding the new program: "*I don't understand this teaching by "process" and to be honest, I do not know what they are learning in nursing schoo*l" (CN3-charge nurse). This unfamiliarity regarding what students are learning in class creates a significant perception gap. The nurse mentors who are supposed to be evaluating these new SNs are actually continuing to base their evaluations on the old program which in reality corresponds very little to the new one.

This was most obvious when analyzing the clinical placement evaluation forms. Indeed, a section is reserved for nurse mentors to comment on the SN they supervised. The fact that most mentors systematically noted aspects such as 'punctuality', 'kindness', 'politeness', or in another words the SNs docility, as positive characteristics suggests that the field still largely favors nurses as embracing a more traditional and 'prescribed' role, rather than the reflective and autonomous role being promoted in the new program. Student Nurses' behaviors that would be interpreted by nurse educators as more 'autonomous' are interpreted by nurse mentors as failings compared to their expectations and needs.

We also noted a certain apprehension regarding their new role as evaluators, not due to a feeling of incompetence, but rather from a heightened sense of responsibility. Indeed the validation of any competence was seen as having important consequences in terms of ethical responsibility. As pointed out by a nurse educator, "*nurses often worry about the consequences of future mistakes*". This can perhaps explain the inconsistencies noted in the portfolios regarding the acquisition of competencies for students coming to the end of their third year. It was primarily in the last semesters that competencies previously considered as having been 'acquired' were considered as needing 'to be improved'.

The difficulties encountered by mentors have since contributed to the development of welcome booklets written in collaboration with nurse educators. These initiatives show that the exchange of knowledge and know-how between clinical nurses and nurse educators can be beneficial to the students' learning process. Yet, these initiatives are not systematic since they demand both involvement of already busy nurses in the field and a good rapport between the educators and the clinical staff. If these solutions help clarify certain misunderstandings, they certainly do not diffuse all the tensions.

5.3 From unfamiliarity to resistance of the principles underlying the new program

In a predominantly hospital-based nurse education program the principles underlying the new program often appear to those in the field as very different from the actual needs of the units. Thus, tensions are not simply a result of unfamiliarity with the new program. For example, when the nurse manager on an oncology unit (quoted above) admitted her lack of understanding in terms of the new teaching approach by "processes", this pointed primarily to the gap between the pedagogical approaches and the reality of how nurses' organize their activities in a hospital setting. Indeed, according to her, discussing all 'obstructive processes' in the same class, which can include a pulmonary embolism as well as bronchiolitis in a pediatric population, does not adequately reflect the reality of the way nurses' activities are carried out in the field: "*It is only at the end of the third year that students have all the knowledge to actually understand the work of nurses. In the meantime they are totally lost during their clinical placements (…). And after three years, they don't remember what they learned in the first year*" (CN3).

As previously discussed, the lack of understanding regarding the new program is also obvious when it comes to the criteria used to describe the competencies to be attained. This is most apparent when it comes to evaluating Competency 8 as defined by the MOH Skills and Competency guideline (see Table 1), which aims to develop skills in 'Evidence Based Nursing' (EBN). The variety of interpretations noted in the criteria used to evaluate this competency points to the difficulty nurses have had in appropriating the scientific method. Even in nursing schools educators do not, for the most part, conduct or use research, and few have master's degrees and even fewer doctorates. Hence it is hardly surprising that nurses in the field are unable to evaluate this competency.

Table 1. Competency 8 Evidence-Based Nursing

Competence 8: Search for and use professional and/or scientific data
This competency demands that the SN be able to:
1. Question, analyse and use scientific and/or professional data,
2. Identify a research problem and formulate a research question,
3. Locate documentary resources, research data and use scientific databases,
4. Use data from scientific and/or professional publications,
5. Choose adapted methods and tools to research any given subject and implement them,
6. Prepare professional documents for written and/or oral communications.
The following criteria are examples of 'visible signs' of having acquired this competency:
a. Pertinent scientific data searched,
b. Pertinent elements are searched for in professional and scientific documents,
c. Scientific databases are used,
d. Explanations are given regarding the choices of the data selected in regards to the research question,
e. The methods and tools chosen are appropriate (surveys, questionnaires).

To validate this competency, the portfolio (based on the MOH's guidelines) identifies the following evaluation criteria:

- Uses scientific databases
- Searches for pertinent scientific data

- Justifies choice of data
- Adapts the methods and tools to the research problem
- Asks pertinent questions in relation to professional research questions

And yet the portfolio to be completed by nurse mentors only lists the following elements: 'Pertinence of data searched in relation to a problem' and 'Quality and pertinence of the professional question'. We can further measure the gap between the expectations of the field when questioning the students and the nurse mentors on what is actually evaluated in Competency 8. Indeed to them it reflects the students' capacity to "*research the information by asking team members*", "*searching in patients' records*", and even "*consulting the Internet*". When asked to specify the sources used on the internet the interviewees generally replied 'Wikipedia' or sometimes 'Doctissimo'.

While the content of this new competency demands greater clarification and consistency amongst nurse educators, staff nurses and students, all try their best to link it to existing practices. Yet few give it any credit, as expressed by a mentor to a student nurse during her evaluation: "*What we need are good nurses, but the new program seems to want to develop scientific nurses instead*" (RN1), demonstrating lucidity in regards to the incoherence between the discourse and the perceived needs of the field.

In this context, it is not surprising that mentors only focus on evaluating technical skills (even when they should be evaluating competencies), because these are not only easier to measure, but also are the most valued by the staff nurses in the field. Amongst these skills some are implicitly considered more important than others to master. They are typically those related to care practiced mainly in the hospital setting at the cost of those developed in other settings (community, home care, public health, psychiatry…), such as 'violence management', 'mediation techniques', or "health promotion".

This phenomenon highlights the tension provoked by the push to teach and evaluate a new type of nurse, one that is more reflective, autonomous and favors interdisciplinary dialogue in a hospital setting still greatly centered on nurses carrying out medically prescribed orders. This tension continues when new-graduates take on their first positions. Their colleagues and managers generally consider their emphasis on developing the "relational" dimension of their role as a distraction at the cost of the precision of the technical skills they consider to be lacking in new graduates.

Nursing students' integration in hospital units, especially related to their ability to provide safe patient care, is a primary source of concern for nurse managers. To address these concerns they rely on their staff nurses, which demands considerable use of energy and resources, thus becoming a great source of tension. This also has direct consequences on the working conditions of both the nursing students and those nurses graduating from the new program.

5.4 Between sharks and police squads

For the SNs and new graduates the first steps taken in clinical practice can be very traumatizing. During our immersion in the hospital setting in 2011, we met students from the old program, anxious about their upcoming OSCEs, side by side with 1st year students from the new program worried about the fact they would not have enough opportunities to validate their skills, and feeling as though they were being "*thrown to the sharks*". Each group pointed to the injustice of not being evaluated the same way as their counterparts.

Student nurses from the new program who were insufficiently prepared to perform clinical skills were often perceived as burdens to staff nurses who passed them around like "*hot potatoes*", as expressed by one student. The contradictions between the expectations of nurses and the abilities of students led to the latter feeing unwelcome in the units in which they were placed: *"During some clinical placements, I really got the impression that I was a nuisance. Every time I would ask to perform a clinical skill, it was as if I was asking for a favor. I remember one nurse in particular in internal medicine. She would glare at me every time I would attempt to start an IV. I could read in her eyes that I was simply a waste of her time. And I was so scared, it was really hard to learn under these conditions"* (RN4).

The students we interviewed identified a recurring problem they faced whilst in clinical placement. This issue was primarily linked to a lack of time and understanding of the nurses who constantly reminded them that they "*don't know how to do anything*". This resulted in quite a paradoxical situation where students either feared they would make a mistake because they have not had a chance to practice their skills under appropriate supervision, or they feared they would not be given enough opportunities to practice their skills at all.

In the first case, they felt abandoned by the nurses who were too busy with their daily work: "*They left me there, all alone in a room with a syringe and the medication, and I was to administer it through a nasogastric tube. I had never done that before, it could have gone terribly wrong*," (SN2). Such situations also resulted in them putting their own health on the line, as demonstrated by the sharp increase in sick leave noted by nurse educators who coordinated clinical placements since the new program started up. This was further illustrated by a student nurse who had a negative experience during one of her clinical placements: "*My colleague and I ended up asking a doctor to put us on sick leave for the last three days of the clinical placement. We would call each other at 5 am every day, we couldn't go on anymore, we didn't dare go there… We didn't want to risk making any mistakes, it was too dangerous*" (SN3).

On the other hand nursing students sometimes felt suffocated by their nurse mentors who refused to take any risk. One student explained that she had been systematically banned from practicing any clinical skills, and was relegated to only performing nursing assistants' duties, with no opportunity to validate any new competencies at the end of her placement.

Interestingly, as the new program began to take shape students were able to see an evolution in supervision during their clinical placements. Certain approaches, virtually non-existent in their first placements were set up little by little and became more and more formalized. A number of staff nurses began attending training sessions to learn more about the new program and the portfolio, and nurse managers began putting together evaluation forms to chart the progress of student nurses. Ironically, some of these strategies became more stifling than helpful for some student nurses who felt the nurses were constantly 'on their backs': "*It was terrible. We were five student nurses in the paediatric department, and the mentors were constantly on our backs. They were so wary of us that they were constantly monitoring everything we did. And finally, instead of helping us, it only rattled us. It was a vicious circle, the more we were under scrutiny, the more stressed and the less performant we were… and the more they monitored us. I would come home in the evenings completely exhausted from always having to watch my step… and we still had homework to do. The day after, I was scared to go back into this atmosphere, I had lost confidence in myself*" (RN6).

The experiences of three new graduates (graduated in 2013) who had followed the same clinical placements but at different times since the start of their program pointed to these drastic changes noted on one unit. Indeed one student had had a clinical placement at the beginning of the program and had experienced the lack of formal opportunities to practice skills. Her classmates who had followed in the second and third year had experienced much greater supervision, with frequent monitoring of every skill performed, quizzes on medication calculations etc.

In a context in which mistakes are inadmissible, a climate of perceived lack of skills is a double-edged sword. This climate persists even after these new graduates have taken on their first posts. In certain units, orientation programs have been put in place to prepare for them. Some new graduates are even asked to take written aptitude tests before they are hired. To rectify the shortcomings identified by nursing staff, orientation programs are prolonged (in some cases, the mentoring period has gone from one to three months), and monitoring of the new graduates has become more controlled. This merely creates a heavier workload for nurse managers and RNs, and creates a sense of discouragement for the new nurses, "*We sometimes get the feeling that we are considered as "discounted" nurses*", expressed a new graduate at her first post for three months.

This tension between working conditions in the hospitals and the assumptions made about the new program has direct consequences on both representations and behaviors. It creates a damaging image of hospital work whilst favoring new career options for these new graduates.

5.5 A new representation of hospital work

"The main thing I learned during my last clinical placement (in pediatrics) was that I absolutely would never want to work under those conditions again (…). The irony is that I was really looking forward to this placement… Today, I don't even know what I want to do. Why not work with children, but perhaps in other settings, less common, but most important, not in the hospital!" (RN8).

New graduates seem to agree on this last comment. The ones interviewed all admitted they were unsure about wanting to pursue a career in the hospital setting. What is striking is that this realization came over time. Except for two interviewees who had begun their studies with the intention of becoming mental health nurses, most of the participants we met had no particular idea of what it was to be a nurse before they entered the program. It was therefore through their coursework and their clinical placements that they built their representations of this profession, which increasingly was being envisioned outside hospital walls.

Historically nursing students were trained as handmaidens to doctors, performing delegated tasks based on medical orders. Their training evolved in response to the needs of the hospital and new medical treatments. Despite the 1992 and 2009 reforms, the development of nurses' autonomous role has not had much influence on the unit organization in hospitals [21]. For the SNs today the tensions are only too palpable. Even though nursing schools encourage the development of this "autonomous role", hospital culture has yet to catch up. On the contrary, many of the actors in the field tend to place more value on those technical skills falling under their 'medically prescribed' role than on developing their critical thinking and autonomy [27].

By placing the SNs in such an uncomfortable position in the hospital, clinical placements have contributed to reinforce a desire to express the 'autonomous role' encouraged in the new program. Indeed, with the main objective of the program being to bring the student to become an autonomous and reflective practitioner, students are being urged to detach themselves from the archaic representation of nurses as simple 'doers'. Sensing the gap between their values and those of the staff nurses they meet on the units, they are increasingly imagining their future roles away from the medical predominance so characteristic of the hospital setting.

6 Conclusion: reactions to the new program

The evolution in the representation of the nurse's role has also resulted in changes in behaviors. Our findings have pointed to three significant types of reactions from new graduates: the exploitation of the hospital setting; a renewed interest in developing activities traditionally unrecognized or undervalued; and finally, withdrawal from the profession.

The concept of exploiting the hospital setting is the current trend new graduates are demonstrating when they use the hospital as a springboard to other nursing opportunities more representative of the 'autonomous role' they seek. Many students and new graduates confided their plans to spend a few years in a highly specialized unit to achieve certain technical skills: "*I think it would be great to start with a year in a post-anesthesia unit for example. After that, I think I would feel more comfortable in doing what I want (…), because what I actually love is developing a relationship with people*" (SN3). This student's plan corresponds to an observation made by a chief nursing officer, noticing the high turnover, and associated training costs: "*Actually, today, we tend to be training nurses to work as homecare nurses rather than hospital nurses. I do not mind moving towards this evolution. The problem is that we have little return on investment in terms of the nurses we train in this department*" (CNO). In a sense this represents a positive adaptation to a difficult environment on the part of the nurses, a form of occupational creativity where they can see the utility of distasteful and stressful work in the short run as long as it generates future benefits. This may suggest a commitment to the field of nursing if not the profession itself, as the nurse sees options beyond the 'normal' progression within the profession.

The renewed interest in aspects of nursing that have traditionally lost value and recognition is a particularly sensitive gap between new-graduates and the older generation. This was particularly obvious to a nursing school director when her third

year students were introduced to 'school nurses'. School nurses in France practice with great autonomy and have a mission to promote health and prevent illness, rather than simply carry out technical skills. This type of role in the past had garnered little interest from the students but according to the nursing school director, had created great interest amongst students in the new program. The clinical placement coordinators interviewed also observed a greater enthusiasm than before for gerontology and skilled nursing facilities in student feedback. These sectors focus primarily on relational care and had previously not been particularly popular amongst nursing students.

Finally, the most disturbing reaction is one of withdrawal. Attrition from nursing, which has already been observed internationally, may have been amplified by the way in which the 2009 program was implemented. We do not have enough distance or data today to measure all its effects in France, but analyses in other countries show that we have already identified numerous factors potentially leading students to shun the nursing profession altogether [28]. The increasing gap between the reality of the field and students' representations and expectations contribute to what has been called a 'reality shock', leading to rising rates of attrition [27]. Gurbinder Kaur *et al.* and Wray *et al.* found that more than half of the SNs (52%) in their study were planning on quitting before the end of their program [29, 30]. Our findings support this in that the main factor contributing to this decision was linked to bad experiences during clinical placements. We were able to establish the effects of these bad experiences by observing the reactions of the new graduates as they hesitated entering the nursing workforce, with some delaying obtaining a job after graduation, unsure of what to do next and others choosing to pursue postgraduate studies unrelated to nursing. Whilst nursing has always had high levels of attrition after five to seven years in the workforce [31], the implementation of the new program has led to such negative experiences in clinical placements that many new graduates are choosing not to enter the workforce at all.

This paper has sought to bring to light a number of tensions that have arisen following the implementation of a new nursing education program in France, specifically highlighting the gap between the representations of the profession in the new program and the reality of the field. These observations do not necessarily question the legitimacy of the new program as much as the conditions necessary for it to successfully replace the former one. New nurses confronted by increasingly complex health care situations require adequate preparation allowing them to respond appropriately. While the study's findings are limited to the experiences of those participants who agreed to take part and as such cannot be generalizable or representative, the objective was to examine the way in which those most closely involved responded to the new nursing program as it was put in place. This was a 'snapshot' of the field five years following the implementation of the reform, and is likely to continue to shift and change. Indeed, following an evaluation of the new program [32], nursing students beginning their program in September 2015 will have a revised and simplified version of the portfolio and their competency validations are currently under review.

To conclude, the concerns of the different stakeholders identified in this study points to a growing gap between the content delivered in the new nursing curriculum and the reality of nursing practice in the field. This highlights the risks associated with the rising institutional isolation of nursing practical knowledge. It is essential to reinforce links between nursing schools, academia and the clinical setting so all the actors have access to the resources necessary to respond to both the demands of the field and their professional aspirations.

References

[1] Carraccio, C., Wolfsthal, S. D., Englander, R., Ferentz, K., Martin, C. Shifting paradigms: from Flexner to competencies. Academic Medicine. Academic Medecine. 2002; 77(5): 361-367. PMID: 12010689 http://dx.doi.org/10.1097/00001888-200205000-00003

[2] Donini-Lenhoff, F. Coming together moving apart: a history of the term allied health in education, accreditation, and practice. Journal of Allied Health. 2000; 37(1): 45-52. PMID:18444439

[3] Weithaus, B. New directions for allied health education accreditation. Journal of Allied Health. 1993; 22(3): 239-247. PMID: 8244872

[4] Institute of Medicine. The Future of Nursing: Leading Change, Advancing Health. Washington, D.C.: National Academies Press. 2011. Available from: http://www.iom.edu/Reports/2010/the-future-of-nursing-leading-change-advancing-health.aspx

[5] Andrew, S. E., Oswald, A., & Stobart, K. Bridging the continuum: Analysis of the alignment of undergraduate and postgraduate accreditation standards. Medical Teacher. 2014; 1-8. PMID: 24804919 http://dx.doi.org/10.3109/0142159X.2014.910298

[6] Debout, C., Chevallier-Darchen, F., Petit dit Dariel, O., & Rothan-Tondeur, M. International Nursing Review. Undergraduate nursing education reform in France: from vocational to academic programmes. 2012; 59(4): 519-524. PMID: 23134136

[7] Acker, F. Les reconfigurations du travail infirmier à l'hôpital. Revue Francaise des Affaires Sociales. 2005; 1: 161-181.

[8] Allen, D. Record-keeping and routine nursing practice: the voice from the wards, Journal of Advanced nursing. Journal of Advanced Nursing. 1998; 27(6): 1223-1230. http://dx.doi.org/10.1046/j.1365-2648.1998.00645.x

[9] Allen, D. Understanding context for quality improvement: Artefacts, affordances and socio-material infrastructure. 2013; 17. London: Health.

[10] Draper, D., Felland, L., Liebhaber, A., & Melichar, L. The role of nurses in hospital quality improvement. Center for studying health system change. Findings from HSC. 2008. PMID:18496934

[11] Cheraghi, M., Salsali, M., & Safari, M. Ambiguity in knowledge transfer: the role of theory-practice gap. Iranian Journal of Nursing and Midwifery Studies. 2010; 15(4): 155-166. PMID: 21589789

[12] Evans, M. Tackling the theory-practice gap in mental health nurse training. Mental Health Practice. 2009; 13(2): 21-24. http://dx.doi.org/10.7748/mhp2009.10.13.2.21.c7292

[13] Scully, N. The theory-practice gap and skill acquisition: An issue for nursing education. Collegian. 2011; 18(2): 93-98. http://dx.doi.org/10.1016/j.colegn.2010.04.002

[14] Reed, M. The theory/practice gap: a problem for research in business schools? Journal of Management Development. 2009; 28(8): 685-693. http://dx.doi.org/10.1108/02621710910985450

[15] Michau, R., Roberts, S., Williams, B., & Boyle, M. An investigation of theory-practice gap in undergraduate paramedic education. BMC Medical Education. 2009; 9(1): 23-30. PMid:19445726 http://dx.doi.org/10.1186/1472-6920-9-23

[16] Allen, J. Valuing practice over theory: How beginning teachers re-orient their practice in the transition from the university to the workplace. Teaching and Teacher Education. 2009; 25(5): 647-654. http://dx.doi.org/10.1016/j.tate.2008.11.011

[17] Glaser, B., & Strauss, A. The discovery of grounded theory: Strategies for qualitative research. Aldine: New Brunswick. ISBN-10: 0202302601; 2009.

[18] McDonald, S. Studying actions in context: a qualitative shadowing method for organizational research. Qualitative Research. 2005; 5(4): 455-473. http://dx.doi.org/10.1177/1468794105056923

[19] Durand-Zaleski, I., Alberti, C., Durieux, P., Duval, X., Gottot, S., Ravaud, P., et al. Informed consent in clinical research in France: assessment and factors associated with therapeutic misconception. Journal of Medical Ethics. 2008; 34(9): e16-e16. PMID: 18757616 http://dx.doi.org/10.1136/jme.2007.023473

[20] Perrenoud, P. Développer la pratique réflexive dans le métier d'enseignant. Issy-les-Moulineaux: ESF éditeur, coll. Pédagogies. ISBN-10: 271012145X, ISBN-13: 978-2710121459, 2010.

[21] Rothier-Bautzer, E. Entre cure et care, les enjeux de la professionnalisation infirmière. Paris: Lamarre, fonction Cadre de Santé. ISBN-10: 2757306014, ISBN-13: 978-2757306017, 2012.

[22] Balleux, A. Évolution de la notion d'apprentissage expérientiel en éducation des adultes : vingt-cinq ans de recherche. Revue des sciences de l'éducation. 2000; 26(2): 263-286. http://dx.doi.org/10.7202/000123ar

[23] Le Boterf, G. Construire les compétences individuelles et collectives. Paris: Edition d'organisation. ISBN-10: 2708137050 ; ISBN-13: 978-2708137059, 2010.

[24] Kolb, D. Experiential learning: experience as the source of learning and development. Englewood Cliffs, NJ: Prentice Hall. ISBN-10: 0132952610; ISBN-13: 978-0132952613, 1984.

[25] Burkhardt, C. Former les tuteurs de stage! Quel impact pour l'accompagnement des étudiants en soins infirmiers ? Unpublished dissertation, 2013.

[26] Argenty, J. Précis de soins relationnels. éditions Lamarre. ISBN 978-2-7573-0577-5, 2012.

[27] O'Donnell, H. Expectations and voluntary attrition in nursing students. Nurse Education in Practice. 2011; 11(1): 54-63. http://dx.doi.org/10.1016/j.nepr.2010.08.002

[28] Williamson, G. R., Health, V., & Proctor-Childs, T. Vocation, Friendship and Resilience: A Study Exploring Nursing Student and Staff Views on Retention and Attrition. The Open Nursing Journal. 2013; 7(149).

[29] Gurbinder Kaur, J. S., Hamidah, H., Blackman, I., Wotton, K., & Belan, I. Perceived stress related to nursing education and its influence on nursing students' academic and clinical performance. Medicine & Health. 2011; 6(2): 86-97.

[30] Wray, J., Aspland, J., & Barrett, D. Choosing to stay: looking at retention from a different perspective. Studies in Higher Education. 2013; 1-15. http://dx.doi.org/10.1080/03075079.2013.806461

[31] Ministère de la santé et des sports. Profession infirmier : recueil des principaux textes relatifs à la formation préparant au diplôme d'Etat et à l'exercice de la profession. Paris: Berger Levrault. 2011. Available from: http://www.bdsp.ehesp.fr/Base/433181/

[32] Monguillon, D. Enquête nationale de la réforme du diplôme d'état d'infirmier. 2013; (191): 16-17.