

Outsiders in Nursing Education: Cultural Sensitivity in Clinical Education

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DeBrew, J.K., Lewallen, L.P., & Chun, E. (2014). Outsiders in Nursing Education: Cultural Sensitivity in Clinical Education. *Journal of Professional Nursing*, 30(2), 149-154. doi: 10.1016/j.profnurs.2013.08.005

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Abstract:

Cultural competence is a stated value of nursing and nursing education. However, some institutional and traditional practices in nursing education can unintentionally impede nurses from achieving cultural competence. Both the literature and interviews with nurse educators show that despite educators' intentions to treat all students the same, nontraditional students may feel singled out and may in fact be singled out for closer scrutiny because of their difference from the demographic norms of nursing students. To ensure that the nursing profession reflects the composition of the patient population it serves, nurse educators must first acknowledge the Eurocentric culture of nursing education and, then, work to change the environment in which students are recruited, learn, and take on the role of beginning practicing nurses.

Keywords: Nursing education | Clinical education | Cultural sensitivity | Pre-licensure nursing education | Clinical failure

Article:

The profession of nursing has made the delivery of culturally sensitive care, or cultural competence, a priority in response to the increase in diverse cultures in the United States (American Academy of Colleges of Nursing [AACN], 2011a, American Nurses Association, 1991, American Nurses Association [ANA], 1998, National League for Nursing [NLN], 2009 and Southern Regional Education Board [SREB], 2002). This can be realized both by educating nursing students in cultural competence and by increasing the numbers of culturally

diverse nurses in practice and academic settings. Increasing cultural competence has become a common goal in nursing education, and it is prominently featured in the American Academy of Colleges of Nursing [AACN], 2006, American Academy of Colleges of Nursing [AACN], 2008 and American Academy of Colleges of Nursing [AACN], 2011b. Another way to achieve cultural competence is to produce a nursing workforce that mirrors the population being served, which means increasing the number of minority students in nursing schools (McQueen and Zimmerman, 2004, Newman and Williams, 2003 and Southern Regional Education Board [SREB], 2002). Actively recruiting culturally diverse nursing students appears on the surface to be an excellent way for all students to learn cultural competence as they become a part of the community of learners. However, neither the culturally diverse students nor the faculty who teach them may be prepared for the challenges of incorporating diversity into the homogeneous culture of nursing education.

The norms of the health care system and of nursing education are Eurocentric. Puzan's (2003) provocative paper presents a compelling case that while nurses want to increase diversity, we measure others' customs by describing how they differ from those of the White majority. In nursing education, we teach the value of science and downplay the importance of custom and nontraditional health practices. We expect nursing students to respect authority, communicate with peers and superiors in a certain established pattern, and implement health care routines that may compromise personal privacy with only a passing consideration of cultural differences in these practices. As faculty, we believe that in order to be fair in student evaluations, we must treat everyone the same, and this often means holding them to the same standards that we were held to when we were nursing students (Bednarz, Schim, & Doorenbos, 2010). Because nursing faculty in the United States are White and female (American Academy of Colleges of Nursing [AACN], 2011a and American Academy of Colleges of Nursing [AACN], 2011b), this may mean that we are, perhaps unintentionally, holding all students to the cultural norms of White females. Diversity in nursing involves not only racial diversity but also diversity in gender, age, and physical/cognitive ability. Diverse students in all of these groups have reported challenges in nursing education (Bell-Scriber, 2008, Maheady, 1999, Marks, 2000, O'Brien et al., 2009 and O'Lynn, 2004).

While studying clinical evaluation of nursing students (DeBrew and Lewallen, in press and Lewallen and DeBrew, 2012), we found that faculty who reported struggling with the decision to pass or fail students in clinical frequently were talking about students who are often viewed as outsiders in nursing education. These outsiders, including foreign students, male students, older students, and students with physical disabilities, are often those who are successful in the classroom yet struggle with the demands of the clinical setting, for various reasons. This finding is particularly relevant in a time when demands are being placed on the profession of nursing to increase diversity and better reflect the population served. Nurse educators have an important role to play in efforts to increase diversity, and this may begin with a closer look at their own practice of evaluation.

Background

The most recent demographics available show that although there have been increases in minorities employed as registered nurses, the proportions are still far below those of the minority populations in the United States or, in other words, the consumers of health care. The U.S. Department of Health and Human Services reports that minority nurses represent only 12% of the registered nurse population, although minorities represent 30% of the total population (<ftp://ftp.hrsa.gov/bhpr/rnsurvey2000/rnsurvey00.pdf>). As these numbers show, the nursing profession has little racial diversity. The nursing profession also has very little gender diversity. Men comprise only 5.4% of the registered nurse population, although the number has increased by 226% since 1980 (<ftp://ftp.hrsa.gov/bhpr/rnsurvey2000/rnsurvey00.pdf>). Although males now make up 12.1% of the graduates from registered nursing programs (NLN, 2009), it remains evident that men are still underrepresented in the profession.

Struggles of Outsiders in Nursing

The most serious risks faced by students who are outsiders in nursing schools are failure from the program and failure of the licensure examination (National Council Licensure Examination for Registered Nurses). Nursing students who are outsiders in the nursing field in terms of race, ethnicity, gender, and disability face not being successful while in school. In part, this is because female-dominated and Eurocentric stereotypes of the typical or ideal nurse persist within nursing education and can influence educational outcomes.

Language barriers have been cited as the major reasons minority students are not successful in nursing programs (Anthony, 2004, McQueen and Zimmerman, 2004, Newman and Williams, 2003, Patterson et al., 2004 and Sanner et al., 2002). Lack of confidence in speaking publicly keeps students from asking questions during class (Sanner et al., 2002), affects their success on multiple-choice examinations (McQueen & Zimmerman, 2004), and creates problems in dealing with other health care professionals in the clinical setting (Patterson et al., 2004). The most common teaching strategy, the lecture, can be extremely difficult for students whose first language is not English. These students have difficulty taking notes in class because the content may be given to them so rapidly that they are unable to translate and take notes (Flinn, 2004). Language can also affect the ease in which students read prior to class and study for examinations (Newman & Williams, 2003). Language barriers also have implications for clinical learning, where the situation may not allow time for students to think and process in their first language and then translate into English for interpersonal communication (Starr, 2009).

Another common barrier faced by minority students is the feeling that they are being asked to discard their cultural practices in order to be accepted by the dominant culture. For example, students whose cultural norms do not allow public assertiveness are viewed as inadequate nursing students. Students felt conflict between pleasing their faculty and maintaining their own cultural identity. Students who try to meet the expectations of the dominant culture are further

conflicted when they feel rejected by their families, who do not approve of the changes occurring in them (Patterson et al., 2004).

While in nursing school, minority students report an overall sense of being made to feel different from the other students (Anthony, 2004, Sanner et al., 2002, Newman and Williams, 2003 and Patterson et al., 2004) through everyday occurrences such as patient assignments in the clinical setting. An example would be assigning a student of Chinese origin to a Chinese-speaking patient (Patterson et al., 2004) or assigning the obese patient that requires lifting to the male student (Anthony, 2004). Male students in nursing report differential treatment in faculty interactions because of stereotypical expectations of nurses as females. The lecture-style format of teaching has been cited by male students as a barrier to their learning (O'Lynn, 2004), as well as the textbooks used, which depict only White females as nurses and refer to all nurses in the feminine voice (Bell-Scriber, 2008 and O'Lynn, 2004). Male students, as has been confirmed by their female classmates, have found that their teachers treated them differently from female students through looks, gestures, and the continual referral of nurses as "she" rather than "he" (Bell-Scriber, 2008). Some male students report also being treated differently by staff nurses on the clinical unit, particularly in areas such as obstetrics (Cude, 2004). Finally, men felt that their education failed to prepare them to work with women, both patients and co-workers. O'Lynn (2004) found that male students desired more teaching on appropriate touch with female patients and some type of preparation on how to function in a female-dominated profession. These findings reflect the fact that the dominant culture, female, has established the norms and expectations for the profession, making it difficult for an outsider to assimilate.

Finally, the lack of minority, male, and disabled nurse role models, both in university settings as faculty and in clinical settings, represents a serious deficit in nursing education (Patterson et al., 2004). The American Association of Colleges of Nursing has reported that only 9.4% of full-time nursing faculty are minorities (<http://www.aacn.nche.edu/index.htm>), a percentage even lower than the 12% minority population of practicing registered nurses (<ftp://ftp.hrsa.gov/bhpr/rnsurvey2000/rnsurvey00.pdf>).

According to Patterson et al. (2004), the low proportion of minority faculty relative to the availability of minority nurses suggests the continuing pervasiveness of Eurocentric stereotypes in faculty hiring. O'Lynn (2004) and Bell-Scriber (2008) also cite the lack of role models as a significant barrier for male students.

Methods

The data reported here come from a larger qualitative study on clinical evaluation of nursing students, which is fully discussed elsewhere (Lewallen and DeBrew, 2012 and DeBrew and Lewallen, in press). In the larger study, faculty described, via a telephone open-ended interview, characteristics of successful and unsuccessful clinical nursing students and discussed factors that influenced their decision about whether to assign a passing or a failing grade in clinical. In the

final question of the interview, faculty participants ($n = 24$) representing differing types of prelicensure nursing programs (Associate's Degree in Nursing, Bachelor of Science in Nursing, public, private, minority) described a time when they had to struggle to decide whether to fail a student in clinical and noted in the end whether the student passed or failed. These critical incidents were collected from 24 nurse educators who described 25 incidents. Of the students described, 10 passed the course, and 15 failed; however, one of those who failed was reinstated by administrators. All of the students who failed were found not meeting the student learning outcomes of the clinical course (DeBrew & Lewallen, in press). In addition to the findings reported elsewhere, the participants spontaneously offered details that revealed that many of the students were indeed not young White females. A noteworthy finding that emerged from the retelling of these incidents was that the majority of the students who failed the clinical course were students who could be viewed as nontraditional or outsiders in the field of nursing. They included students who were foreign (5), students who were viewed as older adults (4), students who were male (3), and students with disabilities (2), such as difficulty in hearing. Some of the students described fell into multiple categories, such as an older male student from another country (see Table 1).

Table 1. Nontraditional Students Who Failed Clinical

Foreign students 5
Older students 4
Male students 3
Students with disabilities 2

Foreign Students

In the 25 incidents described, foreign students for whom English was not their native language were most likely to fail in a clinical course. Most of those students were cited by faculty as having difficulty communicating with either patients or the faculty. One faculty member said,

[This is] best exemplified by that English-as-a-second-language student. I looked at that from every possible angle and that student...held a degree...some advanced degree--in the country she was from. It was just she could not be effective in English. And that was a very difficult decision to make, because she really had all of the other components. It was just the communication piece that was missing. And that was enough that I felt she could not be safe. That was probably one of the more heart-wrenching decisions because I know that if she could just overcome that one barrier, she had all the rest of the components that I feel make a successful student and a successful nurse.

Older Students

Older students were sometimes viewed as being unable to adapt to the clinical setting, particularly with keeping up with quickly changing patient situations. The following quote refers to an older adult who failed:

And she was an older lady and she was really nice, but she just was not safe. She just could not understand--and she had multiple remediations. She still did the same exact thing in clinical when she returned.

Male Students

Poor communication skills were cited as a reason for the failure of a male student. This student was also noted to lack a caring attitude toward his patients.

He just didn't have the communication skills to deal with the patients. He was very robotic. And, a lack of empathy and privacy. He was good academically, but just not good personally with the patients.

Students With Disabilities

Some students demonstrated more than one "outsider" characteristic that placed them at risk for failure. The following quote describes an older student who had visual difficulties:

I had a student who was an older lady who was just not safe. She had no clear critical thinking. Her thoughts were always scattered. She had one patient who came from the OR, and the patient had a fever of 104.5. She didn't tell anybody for two hours. Um, when I sat down with her I said, 'You know, why didn't you tell anybody? Why didn't you document it?' 'Oh, I didn't know I had to.'and so when I told her, 'Well remember the first day that we sat down and I told you my expectations? One of the expectations is anything that changes on the patient or anything out of the ordinary, that you need to let us know right away.' She goes, 'Oh, I didn't read that.' I said, 'Well why didn't you read that?' She said, 'Because the print was too small.' And...it took more than one semester to get her out because she just wasn't safe.

These descriptions suggest that the clinical evaluation process has a potential for subjectivity that may be affected by factors such as linguistic and communication skills or disabilities. While inferences cannot be drawn from these qualitative accounts without further validation, clearly the clinical evaluation process can be influenced by stereotypical expectations. While our participants were very clear about considering the course learning outcomes in evaluation and were reluctant to assign a failing grade unless it was clear that course outcomes were not met, the incidents they chose to relate suggest that, unconsciously, we may consider demographic and cultural characteristics of students in evaluating clinical behaviors.

Discussion

Much of the current literature on minority students in nursing education programs is aimed at providing strategies that educators can use to create classrooms in which different types of students can learn (Flinn, 2004 and Guhde, 2003) or focuses on the role of the institution in increasing diversity (McQueen and Zimmerman, 2004 and Southern Regional Education Board [SREB], 2002). Little has been written on the implications of racial and gender diversity in clinical settings.

Minority students are at risk for failure in the clinical setting. Bruner's (1996) belief that learners have an ethnopsychosocial perspective might offer an explanation. According to Bruner, learners make meaning by incorporating prior cultural knowledge into the learning opportunity; therefore, learning is contextual (Ackerman-Barger, 2010). Nursing students who have never experienced the clinical setting are at a disadvantage, particularly male students and students for whom English is an additional language. The socialization process for females may have involved play acting as nurses, whereas male students did not have this experience as children, and they may have even been discouraged from playing nurse as young boys. For foreign students, the clinical setting may be a new environment. These students may not have ever had the experience of being in our health care system, as a patient or with family members, so they may not have had an opportunity to experience firsthand how our system differs from that of their native country. For both of these groups, the classroom setting is familiar to them, especially for students who have a previous degree. They understand the expectations and the culture of the classroom setting, yet they may not understand the expectations of the clinical setting because they have never been there.

Marbley, Bonner, and Berg (2008) found that *language bias* was one of the biggest barriers for students in academic settings because it is not well understood by educators how language affects academic success. This bias extends beyond interpretation from one language to another and includes colloquial expressions and nuances that are common to a culture. The clinical setting exemplifies the risk of this bias because of the insider language that is used among health care professionals.

Another explanation for the failure of nursing student outsiders lies in the structure of higher education. Marbley et al. (2008) explain that *practice bias* is prevalent in education and results in assessments and policies that discriminate against the nondominant culture. Practice bias comes from the belief that, to be equitable, all students must be treated the same. However, because all students are not the same, it would be more equitable to provide students with learning opportunities and assessments that meet the needs of the individual, rather than the cultural attributes of the dominant culture. In trying to be equitable, nursing educators appear to be engaging in cultural imposition (Ackerman-Barger, 2010); that is, the rules, both formal and informal, have been established by the majority (White women), setting up the non-White female for failure.

Older students and students with disabilities appear to be affected by practice bias as well. Ableism, or the discrimination and exclusion of people with disabilities (Castaneda & Peters, 2000), came to the fore in higher education in the 1990s with the passage of the Americans with Disabilities Act, or the ADA. The law requires the admission of qualified, disabled students to schools of nursing with appropriate accommodations to help them be successful in spite of their disabilities (O'Connor, 2006). Yet, faculty in schools of nursing have had difficulty in interpreting the ADA, primarily because of the definition of the essential skills needed to become a nurse and the accommodations required in the educational setting (Arndt, 2004).

According to O'Connor (2006), "The goal of accommodation is to create an even playing field for the disabled student..." (p. 310). Some nurse educators feel that accommodations are unfair to students without a disability and are unwilling to make exceptions for disabled students (Arndt, 2004). Their reasoning appears to be that all students, disabled or not, must do the exact same tasks in order to graduate from the program. O'Connor (2006) points out, however, that having the clinical knowledge and skill to delegate a task is more valuable than being physically able to perform the task.

The vagueness of the "essential" qualifications and skills needed to become a nurse has sparked much debate among nursing faculty and has led many schools of nursing and boards of nursing to create documents outlining the skill set necessary to become a registered nurse (Arndt, 2004 and Katz et al., 2004). Unfortunately, the emphasis tends to be on the technical skills that are often performed by nurses, rather than on the cognitive skills that nurses must possess in order to be licensed and to practice (O'Connor, 2006). In the view of some, the emphasis on technical skills is hurting nurses in their efforts to serve as equal members of the health care team, rather than as simply skilled laborers (Marks, 2007 and Sowers and Smith, 2004). Furthermore, this emphasis excludes persons with disabilities and decreases the diversity of the profession.

Recommendations

Although leadership in schools of nursing frequently emphasizes the importance of multiculturalism and diversity in the educational process, the opportunity structure for minority, male, and disabled nursing students suggests a different reality. Our findings suggest that stereotypical expectations can influence clinical evaluations and educational outcomes. While these expectations may be socially generated, they have become deeply embedded in educational contexts and are reflected in hiring patterns, curricular offerings, and evaluation practices.

Short-term fixes such as an occasional cultural competency program for nurse educators do not address the significant institutional change necessary to improve the nursing education process. It is important to hire diverse nursing faculty who not only reflect the diversity of the patient population but also the diversity of the registered nurse workforce. The lack of minority, male, and disabled role models among nursing faculty is a serious deficit. Students need opportunities

to experience different role models and prototypes for the nursing profession. The visual imagery used for course content needs to include male, minority, and disabled nurses. Nursing students need to become comfortable with diversity and practice communication patterns that reflect the norms of different cultural settings.

Campinha-Bacote (2002) believes that nursing faculty first desire to recognize their own cultural imposition. The next step is a time of self-reflection, in which core beliefs and personal biases are examined (Bednarz et al., 2010). Faculty can then demonstrate to students an open-mindedness to diversity and a desire to meet the needs of individual learners. Scheele, Pruitt, Johnson, and Xu (2011) note that there must be a strong faculty commitment to changing teaching practices to meet the needs of diverse learners.

Guhde (2003) suggests that one way to increase awareness of what minority students need is to simply ask them. Many students are reluctant to share their concerns or perceived deficiencies with their clinical instructor for fear that they will be labeled as inferior to other students. However, if the instructor is proactive and talks with the student about his or her needs and fears, the course will be started on a positive note. Gudhe also advocates for the use of student journals, which allow students to share their thoughts and feelings with faculty without fear of penalty. Instructors can then assess individual student needs through these journals.

In the clinical setting, knowing the individual needs of students is imperative. One strategy that would benefit all students would be to prepare students before entering the clinical unit. Simulation, role playing, and case studies depicting typical clinical situations can give students an idea of what to expect in a particular course, and also let faculty identify students who might need extra assistance. Another strategy is to provide students with the expectations for the clinical course in writing prior to beginning the clinical rotation. Faculty should let students know what it takes to be successful in their course while in the clinical setting.

Conclusion

The profession of nursing is said to be a “calling”: one has to feel led to become a nurse (McQueen & Zimmerman, 2004). Often, this calling comes because the person feels a deep caring and compassion for other people, and nursing allows the expression of nurturing as a vocational choice. Ironically, a profession that is based on “the art of caring” often shows little compassion when it comes to educating its future colleagues.

Nursing education is based heavily on tradition. For example, faculty require students to achieve competence on outdated tasks such as bed making. Nursing education is also based on dominance (McQueen & Zimmerman, 2004). The result of these traditional influences is an educational system perpetuated by the power structure of the dominant culture that sets the standards and accepts only those who conform to them (Patterson et al., 2004). Diverse students may choose to change their cultural practices and behaviors in order to be accepted; however, at

times, this is not possible. As a result, these students may be forced to remain outsiders, fearful of challenging the status quo and struggling throughout the course of their education.

The focus upon cultural competency in nursing education is on patient care. This emphasis does not generally extend to awareness and practice of the requisite cultural skills for interactions with students, especially in the clinical setting. Nursing students who enter a program with attributes of race, gender, or disability that differ from the majority face the challenge of not only being accepted but also of being allowed to stay. It is imperative that nursing faculty return to the core values of the profession and apply the fundamental principle of caring to all students, not just those who reflect characteristics similar to their own. The profession of nursing cannot be viewed as one of cultural competence until educators realize that their students deserve the same culturally sensitive treatment as their patients.

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