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Building the "Living" House of Professional Practice

Chapter 5: Skeletons in the Closet…

Every house has closets and most have a few skeletons in those closets. Unfortunately, the living house of professional practice is no different and has two skeletons that must be clearly identified so that they do not rob you of the life and passion you desire to bring into your practice. The first skeleton represents the endemic problem of unprofessional, disrespectful behaviors in nursing that goes by a multitude of names; incivility, lateral violence, horizontal hostility, and workplace bullying. The other skeleton is overt gender bias towards men in nursing that began with Nightingale and still lingers today.

Skeleton #1: Beware of Bullies

Bullying did not only happen on the playground when you were a child, but has been found to be present in all levels of primary education, nursing education, personal relationships, and in the workplace today (24). In nursing, it is commonly acknowledged and understood that "nurses eat their young," which unintentionally normalizes this destructive behavior. Bullying is defined by a consistent pattern of inappropriate abusive/aggressive behavior towards another colleague that is designed to intimidate, control, diminish, or devalue another (1). Incivility "is defined as rude or disruptive behaviors that often result in psychological or physiological distress for the people involved and, if left unaddressed, may progress into threatening situations" (35). How incivility and bullying impact another human being is what matters most. It is an assault on human dignity and self-worth and the effects can be devastating, debilitating and enduring (36).

Bullying Behaviors: In the Clinical Setting

The most common overt bullying behaviors include patterns of fault finding, intimidation, gossip, put downs and non-verbal innuendo such as raising eyebrows or sighing. More subtle bullying behaviors include isolation, exclusion, ignoring/refusing to help, and unfair assignments (1). Other categories of bullying behavior include the resentful nurse who holds grudges and encourages others to join in as well as the cliquish nurse who intentionally excludes others from their "group"(2). Other specific examples from the literature most commonly seen include:

- Having information withheld so it affects your performance
- Being ordered to do work below your level of competence
- Having your views and opinions ignored
- Being personally ignored or excluded
- Excessive monitoring of your work
- Persistent criticism of your work and effort
- Having insulting/offensive remarks made about you
- Hints from others that you should quit your job
- Repeated reminders of your errors and mistakes
- Having false allegations or accusations made against you (21)

I have experienced some of these behaviors personally in the clinical setting. The most common examples of incivility consisted of being marginalized and isolated on a unit by nurses who were unwilling to help. If I asked for help they would sigh and make it clear that I was asking too much. During report, some nurses appeared disinterested, distracted, and asked numerous questions not even relevant to the patient. When I didn't have this non-essential information, the nurse would look at me in a demeaning manner.

I have seen newer nurses break down and begin to cry when I simply asked them how they were doing as a new nurse on the unit. One nurse described the need to prove herself, feeling belittled if she asked a question because the nurse would respond, "you don't know that?" in a demeaning tone of voice. Routinely new nurses overheard gossip about them or others and did not feel safe asking questions of certain nurses.

Root Causes

One way to understand incivility is to see that bullying is relational aggression which is a feminine form of aggressive behavior. Though men are also fully capable of bullying behaviors, men most often resort to physical aggression with conflict. But because women comprise the majority of nurses, bullying as relational aggression is endemic and situated throughout the nursing profession (2). Another perspective to consider is that bullying is a learned behavior that is accepted as "normal" and expected (25). Just as relational aggression among young women is normalized in adolescence through such vernacular as "mean girls", this accepted norm then becomes a self-fulfilling prophecy of what to expect in a profession where the majority are women. This may explain in part why there is an acceptance or tolerance of bullying today. This pattern then continues

unchallenged because nurses do not challenge the status quo, but are willing to put up with it to avoid conflict at all costs (25).

Though bullying typically involves student peers or colleagues in the profession; it is also present when there is an unequal power relationship. In academia this can be typified by the dean, department chair or senior faculty who bullies a new faculty member or when faculty members bully students. In the workplace, this unequal power relationship occurs when charge nurses and nurse managers bully other staff nurses or aides.

Consequences

The consequences of a hostile work environment are devastating, creating feelings of inadequacy in a new nurse. Bullying is like putting gas on this fire of inadequacy and feelings of failure, decreased self-esteem, self-doubt, anger, depression, burnout and even post-traumatic stress disorder (PTSD) are not uncommon (1). This then leads to decreased morale, low job satisfaction, increased absenteeism and ultimately leaving the unit or even nursing entirely (4).Thirty percent of new nurses leave their first job after the first year when bullying is personally experienced (21).

Does this toxic environment impact patient care? The Joint Commission has taken the position that bullying is a safety issue and has issued a standard to that effect. It has been shown that a unit that has a prevalence of bullying behaviors can lead to increased medical errors, adverse patient outcomes, and lowers rates of nurse retention. By creating an environment that does not make it safe to ask questions, incivility poses a serious threat to patient safety and overall quality of care (5).

Though workplace bullying occurs in all work settings, healthcare occupations have the highest rates of bullying (21). Surveys have shown that 93% of nurses have witnessed bullying and 85% reported that they were victims of bullying (23). Sixty-four percent of nurses cited this as the primary reason for leaving their current job (22). New nurses as well as men in nursing (2), are more likely to experience incivility most often from other more experienced or senior nurses (3).

Be the Change!

Before we choose to act intentionally against incivility in others, purposeful SELF-REFLECTION is needed (25). Because we can fail to see our own “blind spots”, we must examine ourselves to see if we demonstrate any subtle form of bullying behaviors

in our personal relationships or in the workplace. Have you been conditioned in any way to see bullying as acceptable and the norm? Recognize the deception that is often present in your own heart, and make needed changes personally before attempting to change others.

The article ***Teaching Cognitive Rehearsal as a Shield for lateral Violence: An Intervention for newly Licensed Nurses*** (http://baylorirvinged.files.wordpress.com/2011/07/lateralviolence1.pdf) is a must read for any new nurse. It practically defines what professionalism in nursing practice looks like as well as a prepared plan to respond respectfully when bullying is directed towards you. Because bullying thrives in an environment of passivity where it has become normalized, it often stops when it is confronted in an assertive, direct, and respectful way (3). In one study where nurses were empowered by this strategy, 100% of the nurses reported that when the perpetrator was confronted, the bullying behavior stopped (23). This is the intervention that you must implement if you experience bullying personally. For example, if a bullying nurse has a pattern of raising eyebrows or other non-verbal innuendo towards you, you are prepared to respond in the following manner, "I sense (I see from your facial expression) that there may be something you wanted to say to me. Please speak directly to me" (3).

Embrace your ability to make a difference in your work environment! Influence your environment by modeling respect, embracing diversity, and forming meaningful relationships with your colleagues (3). Model and demonstrate professionalism in practice by never criticizing another colleague publicly, stand up for the absent colleague if they are not present, work as a team and accept your share of the workload (3).

If you continue to experience bullying or see it used against others and have confronted the perpetrator with no change in behavior, thoroughly document your concerns. Once adequate documentation has been collected, communicate your concerns to your nurse manager or human resources. In many cases nurse management is part of the problem by allowing bullying to continue unchallenged or may be the perpetrator of bullying behaviors. In these circumstances human resources should be involved. Most institutions have policies regarding a healthy work environment free of hostility or violence of any kind that nurses can and should be held accountable to.

I have observed from my own experience that patient care units are like families, some are healthy and functional, while others are clearly dysfunctional and in need of

intervention. Bullying is a toxic behavior that tends to be contagious and impacts everyone on that unit. Being a new nurse is like being in middle school again. You will want to do whatever it takes to fit in and be a part of the new group even if it means being passive or indifferent to bullying behaviors around you. Instead of being passive and doing nothing, you are actually part of the problem. Instead, hold yourself to the highest standards of professionalism in practice and be the change that is so desperately needed in nursing today!

Incivility in Nursing Education

Though these examples of incivility in the clinical setting are unsettling, our programs to educate nurses may also be part of the perpetuation and normalization of incivility that continues to persist today. The primary contributing factors are stress, disrespect, faculty arrogance and a sense of student entitlement. When a culture of incivility is present, it causes emotional distress in students and is an active barrier to learning (29). Incivility can be defined as a disregard for others that creates a culture of disrespect, conflict, and stress (29). . It simply boils down to which culture is dominant in your department; RESPECT vs. DISRESPECT. When mutual respect is not evident in faculty/student interactions, the bitter fruit of this seed will be incivility that begins with intense feelings of unfairness, anger, hostility, and even violence expressed towards faculty (29).

Incivility in academia has been likened to a “dance”, one leads and the other follows It is important that we do not point fingers and say this is a student or a faculty problem. In reality, uncivil behavior does not exist in a vacuum, but both students and faculty are partners and interdependent in this “dance” (29). When both students and faculty engage, communicate, and seek resolution of conflict before it digresses to incivility a culture of respect and the “dance” of civility is present. But if opportunities to promote engagement by both faculty and students are missed, the root of disrespect is established and a “dance” of incivility is perpetuated. Once this dance has begun, regardless of who may be responsible for initiating it, incivility can escalate and become a blame game with no end in sight (29). Cynthia Clark has written and researched incivility at length in nursing education and has an excellent article series **Creating communities of civility.**

http://www.reflectionsonnursingleadership.org/Pages/Vol38_4_Clark_CivilityPart1.aspx

Let’s look at the different relational contexts of incivility in nursing education; student to faculty, faculty to student, and faculty to faculty.

Bullying Behaviors: Student to Faculty

Entitlement and incivility have become increasingly pervasive in American society and contributes to incivility in nursing education (26). Unfortunately, students are not immune to this influence and reflect these attitudes as they enter nursing education. As a student or graduate nurse, did you bring attitudes that are also part of this problem? Did you come to your program with a sense of entitlement; that if I paid for an education, the college "owes" me a degree? Entitlement is expecting high grades for modest amounts of work, assuming a "consumer" mentality towards education, refusal to accept responsibility and making excuses for your failures. As a student, examine yourself to see if you are/were "uncivil" based on this list of the most common student incivility behaviors that nursing faculty identified (26):

- Disruptive behaviors in class/clinical that include:
    - Rude comments, engaging in side conversations, dominating class
    - Cell phone, texting, inappropriate computer use in class
    - Late to class and leaving early
    - Sleeping in class
- Anger or excuses for poor performance
- Inadequate preparation (29)
- Pressuring faculty until they get what they want (29)
- Bad mouthing other students, faculty and the nursing program (29)

Contributing Factors

What is it that causes caring, empathetic nursing students to turn into incivil beasts? Could the very culture of nursing education that prides itself on being highly competitive and academically rigorous be a contributing factor to student incivility? In one qualitative study the themes that students identified that contributed to their incivility included burnout from demanding workloads and competition in a high-stakes academic environment (29). I think the answer to my question is obvious and it is imperative that nursing education as a whole examine the current paradigm and determine how students can be supported and nurtured within nursing education. Cynthia Clark has done extensive research on the topic of incivility in nursing education and has an excellent article for nursing students titled: **Cindy's 'Five RITES' for fostering STUDENT-driven civility.**

http://www.reflectionsonnursingleadership.org/Pages/Vol39_1_Clark_5RITES.aspx In addition, there is an assessment tool The Clark Academic Civility Index for Students in this same article to determine if you are already or at risk for being an incivil nurse once in practice.

Bullying Behaviors: Faculty to Student

Because it takes two to tango with the dance of incivility, we must take a closer look at the role of nursing faculty in this growing problem in academia. Research has confirmed that when incivility is experienced and directed towards students in nursing education it "was often very hostile and soul destroying" (28). What is it that causes caring, empathetic nursing faculty to demonstrate incivility towards their students? In the same qualitative study, faculty identified STRESS as the primary problem. Ironically, nursing faculty are also burned out from their demanding workloads. Other causes of faculty stress include high faculty turnover, lack of qualified educators, role stress, and incivility from all sides; students, other faculty, and administration (29).

Both students and faculty identified several behaviors that communicate and demonstrate incivility as well. If you are an educator, examine and reflect to see if these behaviors of incivility are present in your classroom or clinical settings:

- Faculty superiority that is demonstrated by the following:
    - Exerting position and control over students
    - Setting unrealistic student expectations
    - Assuming a "know it all" attitude (29)
    - Being rigid, unapproachable or rejecting students' opinions (27)
- Devaluing students' prior life experiences that can include work and academic experience (29)
- Ineffective educators who cannot manage the classroom (29)
- Making condescending remarks or put downs to students (27)
- Showing favoritism to certain students
- Refusing or reluctant to answer questions (27)

There are two common denominators that both students and faculty have in common regarding the contributing factors to incivility; STRESS and DISRESPECT. Students are stressed by the juggling of many roles as provider/parent, and student as well as

financial pressures and too little time. Faculty are stressed by multiple work demands, heavy workload, problematic students, and lack of faculty and needed support (26). The lack of respect by both faculty and students creates a poisonous, downward spiraling circle. If faculty are rigid, set unrealistic expectations and do not allow open dialogue, students will inevitably respond with anger and lack of respect towards faculty and a cycle of incivility is in motion. But it doesn't have to be this way; respect begets respect. If both faculty and students respectfully and openly communicate and engage with one another a culture of civility can be nurtured instead (29).

How to Peacefully Co-Exist

Nursing academia ought to reflect the core values of the profession which include caring, compassion and nurturing of the other. Whether you are a nursing student or faculty, you can do your part to change the culture of your academic environment to make it a place where support and nurturing in a high stress/stakes environment is possible. To create a healthy culture, there must be a healthy relationship between both faculty and students. Therefore the principles that apply to a healthy relationship are relevant and apply in academia. This includes the foundation of open/honest communication, working together and establishing boundaries that are clearly defined and then enforced. If faculty implemented the following steps, civility can begin to become a reality:

1. Provide opportunities to dialogue with students in open formats such as a town hall meeting format. This can provide needed dialogue and understanding (26).
2. Establish clearly written policies or place expectations in student code of conduct that address incivility, consequences, and then consistently enforce (29).
3. Listen carefully, give students positive feedback (27).
4. Incorporate time management/stress reduction/self-care in the curriculum (26).
5. Model caring and respect in all that you do so your students can see what true professionalism looks like in practice (26)!

As a student, it is essential that you do your part, which includes:

1. Hold yourself to the highest standards of professionalism as a student which includes:
    a. Be prepared, respectful and engaged in your learning (27).
    b. Do not speak in a negative, derogatory manner openly about other students, faculty or the nursing program.
    c. Abide consistently by the standards of student conduct of your institution.
2. Communicate your needs, and what you need/expect from faculty (27).
3. Work toward a common goal of civility and respect (27).

Bullying Behaviors: Faculty to Faculty

Though this book is focused on preparing students for professional practice, it is important to address one more aspect of incivility that has relevance to nursing education. This is the incivility that is present in the majority of nursing education departments (27). In one study only 5% felt that faculty worked well together (37). In a recent national study 68% of nursing faculty reported moderate to severe levels of faculty to faculty incivility. But when mild levels of faculty to faculty is included the prevalence of incivility in nursing academia rises to 96% (37)! Leading nurse educator and scholar Patricia Benner has made it clear that nursing education is in need of a RADICAL TRANSFORMATION, but in order to see this vision realized, it must first begin by seeing our nursing departments transformed through eliminating all vestiges of incivility!

As a nurse in the clinical setting for thirty years, I have experienced episodic incivility and bullying behaviors. When I recently entered nursing academia just several years ago, I was totally unprepared for the intensity of incivility that I had never experienced in the clinical setting. These behaviors ranged from polarizing faculty attitudes towards the department chair, denigrating one another openly in faculty staff meetings and withholding information that later led to intentional sabotage. My journey in nursing education at times has truly been a “broken road.” It has been so painful that I have vowed not once, but twice to say “never again” to continue my career as a nurse educator. I can make more money and have less stress and less pain in the clinical setting!

Based on current research and the anecdotal experiences of other nurse educators, I know that my experience is not unique, but unfortunately is all too common. Incivility in

academia has been shown to lower job satisfaction, decrease productivity, and increase turnover (32). Besides the obvious negative impact that incivility produces in those who personally experience it, do we have the vision to recognize that by allowing incivility to perpetuate as it has in the past, the **anticipated nursing shortage** http://www.aacn.nche.edu/media-relations/NrsgShortageFS.pdf will be exacerbated because of the inability to retain educators who like myself have a viable plan B called clinical practice if academia remains a hostile work environment? Because of the current **nursing faculty shortage** http://www.aacn.nche.edu/media-relations/NrsgShortageFS.pdf, in 2011, over 75,000 qualified nursing students were turned away in part because of lack of qualified faculty and that 2/3 of nursing programs surveyed that this was the primary contributing factor to not admitting all qualified students (33). There is a "perfect storm" brewing as the average age of associate professors is 57 (34) and the mean age of practicing registered nurses is 46 (33).

I have been amazed at the awareness and insight that nursing students have regarding the presence of incivility among faculty. Though it may be thought to be successfully "hidden" from students' awareness, it typically is not. It is "caught" and an object of discussion among students. What is the "hidden" curriculum in our programs and what are we really teaching our students? Are educators guilty of normalizing incivility and accepting it as a fact of life of working in academia? Even if you are not experiencing incivility personally, if you are passive and tolerant when it is expressed towards other colleagues, you too are part of the problem.

Is your department part of the problem or part of the solution? Is your nursing department civil or uncivil? Incivility according to Clark is defined as rude or disruptive behaviors that often result in psychological or physiological distress for the people involved and, if left unaddressed, may progress into threatening situations" (35).Civility can be defined by "an authentic respect for others during encounters of disagreement or controversy. It involves time, presence, and a willingness to engage in genuine discourse with the intention to seek common ground (30). Examine yourself to see if any of these most commonly experienced examples of incivility in nursing education are present in you or others in your department (26):

- Persistent gossip, criticism and Insulting, demeaning remarks
- Nonverbal disapproval in staff meetings that include eye rolling, arm crossing, walking out of meetings and the use of the "silent treatment" (36)
- Avoidant, isolative, and exclusionary behaviors that marginalize

- Setting others up to fail and intentional sabotage
- Exerting superiority and rank over others/abuse of power
- Not performing one's share of the workload
- Department chair or senior faculty who use positional power to bully colleagues who are vulnerable due to their lower status in the department (32)

Transforming the culture of a department where incivility is present takes time, patience, courage and commitment to change by the entire department. The first and most effective but also the most difficult step is to respectfully CONFRONT in private an uncivil colleague. It can effectively put an end to the problem by directly addressing the behavior (36). Strong visionary leadership by the department chair or dean is also essential to lasting change. The "elephant in the room" must be identified and called by its true name. Each faculty member must make a renewed commitment to become more engaged and treat one another with dignity and respect (27). In one report, the key to cultivating civility came down to three T's, truth telling, transparency, and tending to relationships (28):

1. **T**ruth Telling
    a. Be direct and honest in all communication with both faculty and students.
2. **T**ransparency
    a. Be willing to place in writing the standards as a faculty group you want to establish regarding how to support one another during the school year or scholarly pursuits.
3. **T**ending to relationships
    a. A principle to live life by that can prevent the root of incivility from sprouting in your department is to not let the sun go down if you are still angry with a colleague. Deal with it that same day! Make the relationships in your department a priority, and nurture them so that the joy and passion that led you to become a nurse educator does not become derailed by incivility and hostile relationships.

As you look at the skeleton of incivility in all of these different contexts, there are some principles of ancient wisdom that if put into practice would work to recapture civility

in nursing and nursing education. Solomon, the wisest man of ancient history, wrote in **Proverbs** http://www.biblegateway.com/passage/?search=Proverbs+15&version=NIV, "*A gentle answer turns away wrath, but a harsh word stirs up anger*." This is so practical and effective whether it is the anger from a student or colleague. By making a commitment to the **golden rule,** http://www.biblegateway.com/passage/?search=Luke+6%3A31&version=NIV to treat others the way you would want to be treated, are a needed foundation to build the practical interventions identified in this chapter. Recognizing what is at stake, literally the ability to train the next generation of professional nurses because of the ongoing faculty shortage, it is my hope and prayer that grace and forgiveness would flow freely in our departments to bring needed healing to those we work with, those we teach as well as our profession.

Additional Resources to Promote Needed Change

Cynthia Clark, whose research is cited extensively in this section has several excellent web based articles that can be accessed directly through these links and are an excellent supplement to further your knowledge and understanding on incivility, but more importantly, be a part of the needed change!

- **Book: Ending Nurse-to-Nurse Hostility: Why Nurses Eat Their Young and Each Other** by Kathleen Bartholomew http://www.amazon.com/Ending-Nurse---Nurse-HostilityNurses/dp/1578397618/ref=sr_1_1?s=books&ie=UTF8&qid=1371184837&sr=1-1&keywords=ending+nurse+to+nurse+hostility
- **Book: When Nurses Hurt Nurses: Overcoming the Cycle of Nurse Bullying** by Cheryl Dellaseega http://www.amazon.com/gp/product/B005XD2EFS/ref=pd_lpo_k2_dp_sr_1/179-9874389-3079246?pf_rd_m=ATVPDKIKX0DER&pf_rd_s=lpo-top-stripe-1&pf_rd_r=1EQDA5706W5G1J64T6QX&pf_rd_t=201&pf_rd_p=1535523722&pf_rd_i=1935476564
- **Article: The sweet spot of civility: My story by Cynthia Clark** http://www.reflectionsonnursingleadership.org/Pages/Vol36_1_Clark.aspx
- **Article: Why civility matters by Cynthia Clark** http://www.reflectionsonnursingleadership.org/Pages/Vol36_1_Clark2_civility.aspx
- **Article: What educators can do to promote civility by Cynthia Clark** http://www.reflectionsonnursingleadership.org/Pages/Vol36_2_Clark3.aspx

- **Article: What students can do to promote civility by Cynthia Clark** http://www.reflectionsonnursingleadership.org/Pages/Vol36_2_Clark4_Cardoni.aspx
- **Article: From incivility to civility: Transforming the culture by Cynthia Clark** http://www.reflectionsonnursingleadership.com/pages/vol36_3_clark5.aspx
- **Article: Conceptual model to promote civility in nursing education by Cynthia Clark** http://hs.boisestate.edu/civilitymatters/docs/Conceptual_Model_NursingEducation.pdf
- **Book: Creating & sustaining civility in nursing education by Cynthia Clark** http://www.nursingknowledge.org/creating-sustaining-civility-in-nursing-education-5665.html
- **Website: Civility Matters: Creating and sustaining communities of civility** http://hs.boisestate.edu/civilitymatters/index.htm

Skeleton #2: Gender Bias/discrimination Towards Men in Nursing

Is there a reason why physicians have attained essentially a 50/50 gender balance in their profession, while currently 91% of nurses are women (12)? Men in nursing have had a unique experience compared to women since the reforms instituted by Florence Nightingale in 1859. This topic is personal to me as a male member of the profession. I have at times felt isolated as well as feeling "outside the bubble" in a way that I have not been able to put my finger on at times. Is it me? Is it my gender? Or is it the culture of nursing? It was these nagging questions that led me to do my master's thesis on the topic of men in nursing. I then refined my thesis to identify the disciplinary rates of men in nursing by the Minnesota State Board of Nursing.

In this research I uncovered many surprising and interesting facts about the historical role of men in nursing care, institutional gender bias towards men that began with Florence Nightingale and continued after the turn of the century. The male experience in nursing and nursing education has been very different from that of women in the modern era of nursing and barriers to men persist even today. Was it coincidental that the comedy **"Meet the Parents"** http://www.youtube.com/watch?v=XGQhCas1Tp8 was hugely successful in part because it played off the gender stereotypes of men in nursing by the lead character GAYlord Focker?

History

Would it surprise you to know that men have been caregivers throughout world history and only recently since the reforms of Florence Nightingale in 1859 have men become marginalized in nursing and become a gender minority? (6). Let's take a brief walk through history that will take us from the past to the present to put male participation in nursing today in perspective. The earliest nurses in recorded history were men. In Hippocratic writings in ancient Greece, public nursing care was provided by men (7). In India around 275 BC, public hospitals were developed where men were the primary caregivers. The early Christian church had male deacons who were responsible for ministering and caring for those who were ill (8).

In early Christian Greece and Rome, orders of monks known as Parabolani provided care for the ill (8). Historical accounts of the monastic movement show that men were responsible for the nursing care of the sick, wounded and dying as early as the fourth century. Military orders of knights were founded in the eleventh century and some orders

defended Jerusalem during the crusades. The order of the Camellians founded by St. Camillus de Lellis who served in the fifteenth century had a symbol for his order, the red cross that remains the primary symbol of health care today (9). Men also participated in non-military orders during this time up until the sixteenth century when monastery orders were dissolved (6).

When Nightingale instituted the modern era of nursing, she chose to firmly establish it as a women's occupation. To her, "every woman was a nurse", and women who entered nurse training were doing only what came naturally because it was also seen as an extension of a women's domestic role (6). Nightingale believed that men's "hard and horny" hands were not fit to touch, bathe, and dress wounded limbs however gentle their hearts may be (7). She also believed that men should have no place in nursing "except where physical strength was needed" (10). European religious sisterhoods also embraced Nightingale's reforms and by their very nature were exclusive to women (8).

At this time men who remained in nursing were excluded from general nursing and relegated to the insane asylums where men were needed because of their superior strength to restrain violent patients. Nightingale had little regard and even hostility for male asylum nurses and felt they were more like a prison warden than a nurse (7). The psychiatric education of men was considered inferior in length and quality in comparison to the women who attended Nightingale's schools of nursing (6). In the United States in the late 19th century, New York's Bellevue hospital provided a separate training course for men that was narrow in scope and one half the length of a traditional nursing education at that time. If a man wanted to expand his learning to include obstetrics and maternal-child nursing he was perceived as a pervert and threatened with expulsion (8).

Institutional/Educational Bias

By 1900 in England, general hospitals were dominated by female nurses. By 1919 the General Nursing Council (the equivalent of our current state boards of nursing), offered full membership only to women who were "general trained". Since most men were not able to even be admitted to these schools, nursing consolidated their position as the first self-determining female profession (11). Men comprised only 0.004% of nurses from 1921-1938 until the laws were changed to allow schools to accept men in 1947 (11).

In the United States, national laws that were in place between 1901-1955 prevented men from serving as nurses in the United States Army Nurse Corps. It was only after the

Korean War that this policy was changed. This continued to lower male participation in nursing in the United States. Less than one percent of nurses were men in 1930 (8). Examples of more recent gender bias include male nursing students who were prevented from taking maternal/infant classes in the 1960's (10), and as recently as 1980, some public nursing schools refused to admit male students (9). Though male participation is continuing to gradually increase and is currently at 9.6% (12). It must be recognized that the primary reason for the disproportionate male participation in nursing that still lingers today is the result of past institutional gender bias towards men in nursing.

Men & Nursing Education

Now we that we are in the 21st century and so far removed from the time when institutional gender bias towards men existed in nursing and nursing education, we can move on because it is no longer a problem, right? WRONG! Unfortunately recent research clearly communicates that we still have a problem and it is long overdue to have a crucial conversation to address gender bias that continues to persist in numerous ways in academia. Quantitative research has shown that the barriers men face in nursing education are "pervasive, consistent, and have changed little over time" (20). Though overt bias is rare, covert discrimination is much more common. One way this more subtle form of discrimination manifests is the feminine emphasis on how to provide care. The underlying message to male students is that in order to be a nurse, you have to behave like a woman (19). In addition, nursing textbooks have limited or excluded historical male contributions to nursing while emphasizing those of women. This revision of nursing history perpetuates the myth that nursing has always been a female dominated profession (17).

Nursing faculty may also be inadvertently part of the problem. Though student diversity has recently increased to include more men and ethnic minorities, the diversity of educators has not. Most educators are white, female and have become older (19). Though well intended, when nurse educators treat both male and female students the same, this fails to recognize the unique needs and lived experience of men in nursing and nursing education. This includes role and gender strain that men experience due to entering a female dominated profession (17). Men perceive an inherent bias in education with feelings of isolation and loneliness exacerbated by the lack of male faculty who serve as role models as well as the use of the pronoun "she" and assumption that

nursing is a feminine profession. In addition, the pedagogies used in education emphasize feminine learning styles, communication strategies, personal reflection and methods of caring (16).

Men are scrutinized by faculty more closely and expected to perform at a higher level in comparison to female students (16). Male students quickly realize that if they are assertive or question faculty (traditional masculine traits) they are stigmatized and recognize the need to temper their masculine behavior and act more feminine to “fit in.” Not surprisingly, the attrition rate of men in nursing education in one study was almost three times the rate of women (13). Higher rates of attrition for men have been well documented in other studies as well. Though there is an assumption by some faculty that men who enter nursing are doing so primarily for financial gain, the motivation for men to enter nursing is similar to women; the desire to help others, a sense of calling and job security (13, 15).

Barriers to Men in Nursing

If you are a woman who chose to become a nurse, did anyone suggest that you may be a lesbian or questioned your femininity because you chose to enter the nursing profession? Were you cautious in how you touched your patients while caring for them because it could be interpreted as sexual? Did you feel uncomfortable and vulnerable while caring for women on a post-partum unit? Did you experience isolation and loneliness because in clinical and in practice because there were so few women in the program? Did you feel especially visible as a student because you “stood out” and felt that faculty picked you out in class or clinical because of this? As a woman this was NOT your experience. Yet, if you are a man who chose to enter nursing, you can readily identify and have likely experienced each of these as a student and then in practice (14).

The barriers of gender role strain/conflict, sexual identity, vulnerability/sexualization with the use of intimate touch, and gender stereotyping are barriers that men routinely feel and experience. The negative stereotypes have the consequence of distorting the view of nursing and result in most men not even considering nursing as a career choice (13). Each barrier and stereotype represent a “brick in the wall” that must be brought down. Nursing would benefit from incorporating and adopting specific strategies to attract men as well as retain them. It has been reported that if men entered nursing at the same rate as women, there would be no nursing shortage (20). Men as well as ethnic minorities are an untapped resource that will be needed in the future to meet the

demands of the nursing and faculty shortage and should be embraced and welcomed to the community of caring!

What barriers were most important to male nursing students? In one study, these were the results of nurses who were surveyed after they graduated (20):

- Did not feel welcome as a student in the clinical setting
- Nervous that female patients would accuse them of sexual inappropriateness with intimate care
- Anti-male remarks made by faculty in classroom
- Program did not prepare them to work with women and no content on the differences in communication styles between men and women

In addition to what male students identified as the most important barriers, these barriers were the most commonly experienced by men in nursing education(20):

- No history of men in nursing presented in textbooks
- Textbooks referred to the nurse as “she”
- Exclusive use of lecture format in classroom
- Felt had to prove self
- No male faculty and no opportunity to work with male nurses in clinical setting

How Nurse Educators Can “Be the Change”

If you are a nurse educator you must recognize your responsibility to warm the climate for men in your program. Based on current research, the following simple steps can make a difference to transform nursing education for men in your program! The following best practices from the literature are a good place to begin this needed discussion and determine if your program is “cold” or “warm” towards men to promote their retention and success:

- Men and women have different brains and learn differently! Because of the difference in learning styles, changes to pedagogy and curricula should be considered if there is a strong emphasis on feminine styles of learning. Lecture only format was found to be a barrier by men! Mix it up with active learning strategies such as clinical reasoning case studies!
- Men benefit from the support of other men. Therefore clinical placements should be done with other male students and to place these students with a male

instructor or a male nurse on the floor if possible to promote needed role modeling and additional support.

- Provide instruction in the curricula regarding the use of touch and provision of intimate touch while providing care. Though this is needed for all students, it is especially relevant for men who report feeling "vulnerable" in this aspect of patient care (18).
- Provide instruction in the curricula to prepare men to work with women and the differences in communication styles between men and women.
- Provide instruction in fundamentals curricula regarding the history of nursing and the role of men in nursing as caregivers. Textbooks have neglected or de-emphasized this historical reality. Make it a priority to re-cover this needed emphasis to demonstrate that in the big picture of history, nursing truly is a gender-neutral profession. The role of Florence Nightingale that resulted in the marginalization of men as caregivers must also be discussed to provide needed context. The historical summary in this chapter can be a needed springboard to this needed discussion!
- Ensure the perception that nursing is a diverse, gender-neutral profession. Examine your schools recruitment material to make sure it contains both men, women and ethnic minorities. Collaborate with the guidance counselors at the high school in your community to see if they are providing accurate information to male students regarding nursing is an appropriate career choice for both men and women and that men are not discouraged from considering nursing as a career choice (14).
- Meticulously examine nursing textbooks and curricula for a "hidden curriculum" that through the use of gender pronouns such as "she" communicate that nursing is for women only. Once identified, eliminate them or use material that does not reinforce this stereotype (13).
- ALLOW MEN TO BE MEN**.** Do not take assertive or confrontational behavior personally. This is how men are wired and as long as communication is done respectfully, do not discourage or communicate that this is not acceptable.

I have addressed and documented the male experience in nursing at length because it is imperative that both men and women recognize that nursing is not a feminine profession. Men have played heroic roles as care providers over the last 2500 years.

Though bias towards men in nursing is well documented in the past and lingers today, I want to encourage men to recover caregiving and nursing as a career option. Both men and ethnic minorities are currently underutilized resources that will be needed to meet the need for nurses because of the anticipated nursing shortage in the years ahead. The profession can no longer rely on women to meet this need. Though nursing has had a strong history of discouraging men from entering the profession (20), this needs to change, and the time is now! If you are a male nursing student past or present, it is important to reflect and determine if the barriers to men that are raised in the literature were present in your program. If they were, I would encourage you to share any concerns or examples of gender bias to your faculty so that you too can be a part of the needed change to warm the climate towards men in nursing education for the next generation of caregivers!

Additional Resources:

- **Book: Men in Nursing: History, Challenges, and Opportunities**, Chad O'Lynn /Russell Tranbarger http://www.amazon.com/Men-Nursing-History-Challenges-Opportunities/dp/0826102212/ref=sr_1_1?s=books&ie=UTF8&qid=1371184775&sr=1-1&keywords=men+in+nursing

- **Book: MAN UP! A practical guide for men in nursing by** Christopher Lance Coleman
  http://www.amazon.com/Man-Practical-Guide-Men-Nursing/dp/1937554872/ref=pd_rhf_cr_p_t_3_BVFH

- **Website: American Assembly for Men in Nursing:** http://aamn.org/

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Chapter 5: Skeletons in the Closet

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