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Review Article

Transforming Nursing Education: Inclusion of Marginalized Groups

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Abstract

Nurse educators are charged with developing students who can function using nursing values in today's healthcare system. Just as the population has grown in diversity throughout the past decades, so has the student body. Educators are no longer only addressing cohorts with singular viewpoints and shared cultures. This diversity must not only be welcomed, but it must be purposefully supported and nurtured within the nursing community and institutions of higher learning. When addressing diversity in students, many viewed as outliers to the norm are marginalized and forgotten when developing curricula. In order to address this issue in the future, it is first essential to identify groups at risk to be victims of marginalization and to better understand the needs of those individuals. For purposes of this discussion, four groups have been selected. It should be noted many more groups are also at risk and should be included in any institutional discussion on diversity and inclusion. The outcome of any nursing program must be to develop future practitioners who, regardless of background or personal belief systems, can provide care based on nursing principles and values. The aim of this work is to identify ways to achieve that goal for four groups of marginalized students by educating faculty on the barriers facing these students and methods proven to promote success within these populations.

Keywords: Agnostic; Atheist; Bias; Culture; Diversity; Disability support services [DSS]; Gender; Inclusion; LGBTQ+; Marginalized students; Minority; Muslim; Nontraditional; Race; Religion

Introduction

"I want to develop keels for them. . . they come oftentimes with pretty flat-bottom boats and the trouble with a flat-bottom boat is, when the wind blows, you just scatter across the water". This compelling example was used by Sarah Shannon, a nurse ethicist, to provide a description of how she assists nursing students in their formation of moral keels and is referred to in Benner, et al. [1] as an exemplar for nursing faculty. As nurse educators, faculty are charged with developing students who can think with depth and breadth in future situations that cannot often be predicted today. The thought processes students use to make decisions must be founded upon the ethical principles of the nursing profession and often require students to bracket personal feelings. Benner, et al. [1] associated these ethical principles with a "Moral Imagination"

and defended it as a guiding principle in the decisions that nurses make and as essential for the formation of new nurses.

Hills and Watson [2] called on faculty to acknowledge that an individual's knowledge and understanding are based largely on lived experience. This is of particular importance considering today's nursing students are coming from a growingly diverse background. This diversity produces students who present to nursing programs with value systems and world views often differing from their predecessors. Many faculties are limited in their understanding of the effects of diversity's influence on how students view the world. It is essential for nursing educators to acknowledge and address this issue in a proactive manner in order to meet the demands of the future. The purpose of this discussion is to provide insight into growing diversity in students entering programs of nursing, argue the need for increased diversity in students, and assist faculty in their understanding regarding many of the barriers that may present themselves when assisting these students during their formation as nurses.

Background and Statistics Regarding Student Diversity in Nursing

The American Association of Colleges of Nursing [3] called on institutions to not only welcome, but to seek out members of diverse populations for programs of nursing in order to care for a growingly diverse patient population. According to the United States Census Bureau [4], when considered as a whole, beginning in 2045, non-Hispanic white individuals will no longer make up the majority of the country's population. Nurses with diverse backgrounds reflecting this shift are required.

In the 2017 National Nursing Workforce Survey, when addressing the population of registered nurses, 80.5% of respondents identified as Caucasian, 5.5% as African American, 6.6% as Asian, 5.5% as Hispanic, and 0.4% as American Indian and Alaskan native, 0.4% Native Hawaiian and Pacific Islander, and 0.8% other [4]. The NCSBN [4] also reported 6.6% of RNs are men. Taking into consideration statistics among nursing faculty specifically, the findings are troubling as well. In 2017, approximately 15.9% of faculty came from minority backgrounds and only around 7% are male [5,6].

The AACN [6] also expressed concerns that the lack of diversity in nurse educators has the potential to leave the students in these groups feeling they are not valued and there is not an opportunity for advancement in the profession. This led the organization to develop the Diversity, Inclusion, and Equality Group (DEIG) in order to address this issue and provide leadership to educators and administrators. This effort was in addition to other previous endeavors to advance diversity in nursing faculty including the Holistic Admissions Review and the All of Us Research Program [7]. While these programs are significant, there remains a lack of diversity within nursing faculty, especially when considering groups who are not the focus of these efforts.

When considering the need for diversity in nursing education, one must recognize today's minority populations are growing in nature. In addition to differing races and cultures, groups such as the Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTQ+) community, increasingly diverse religious and non-religious groups, and other populations are becoming increasingly influential in the country. The AACN [3] reported on the growing gap between diversity in the general population when compared to that in healthcare. They argued the result has been, and will continue to be, isolation of minority groups within the country and poorer healthcare outcomes for those populations. It is of highest priority to proactively make strides in order to close this educational gap now to promote high quality healthcare for all patients.

When addressing the education of these populations, evidence shows faculty are not appropriately educated in their roles. The 2004 groundbreaking report, *Missing Persons: Minorities*

in the Health Professions, released by the Sullivan Commission on Diversity in the Healthcare Workforce, sparked a widespread debate in educators regarding how to address the growing need for faculty education in this area. While research indicates that nursing faculty feel confident in their attitudes towards students of other backgrounds, they lack confidence in the cultural knowledge needed to support these groups [8]. In order to attract students and maintain enrollment, administrators must take active steps to identify the needs of underserved groups and to educate faculty regarding working with these individuals.

Conceptual Framework

When addressing this issue as faculty, it is essential to have a consistent conceptual framework. This provides a guide for interacting with students, both for well-established faculty, and for novice members struggling to develop consistent behaviors. It is also imperative this framework be a working tool for faculty and not viewed as an abstract thought handed down by members of the colloquial "Ivy Tower." A conceptual framework must represent the values and beliefs of those being represented [9]. In this case, the values and beliefs reflected by the institution should be incorporated. Without this consideration, there is little chance faculty will view themselves as having ownership in the framework's creation and utilization.

These authors argue the conceptual framework used to assist marginalized groups in their formation as nurses should be based on an emancipatory relational pedagogy [2] and promote transformational learning. An emancipatory relational pedagogy approach requires four components [2]. In the first component, creating collaborative caring relationships, safe trusting relationships must be fostered over time and shared power between faculty and students is essential. The second component, critical caring dialogue, allows participants to learn new knowledge based on their inner understandings and life experiences [2]. This is imperative when considering the differing world views today's students carry as part of their identity. Hills and Watson [2] also stressed that this form of dialogue allows for differences of opinion while maintaining a safe and caring environment. The third component of this approach requires learners to reflect on actions while decisions are being made and to alter behaviors in real-time. It enables learners to do more than simply state what should be done in a given situation and requires active mental processing when making choices. Finally, a caring culture must be established and fostered for students to become future practitioners of care. Caring is a moral obligation for nurses and should not be viewed as simply a feeling but as purposeful action in daily practice [2].

A conceptual framework reflecting a shared belief system has been selected to meet the needs of diverse student populations. Considering personal belief systems regarding faculty and student relationships and roles is required prior to addressing the issue

of assisting these marginalized students. The selected conceptual framework acknowledges the impact of differing backgrounds on learning and understanding. It welcomes questioning in order to assist with formation and reformation as student's transition into the role of nurses. This framework also provides a method for faculty to assist learners with contrasting belief systems to develop a consistent moral guide based on nursing ethics.

Diverse Populations

Due to limitations of length in this discussion, all groups in need of attention for inclusion in nursing education will not be discussed. However, several diverse populations have been chosen in order to provide insight into this current problem. An overview of these groups will be imparted and suggestions for methods to promote success within nursing education will be offered.

Religion

Religious diversity within the country is consistently rising [10]. Members of the population identifying themselves as Christians have decreased by approximately 8% in seven years while numbers of the non-religious population have increased to over 20% of Americans. Numbers of non-Christian persons of faith have increased from 4.7% to 5.8% in that same period of time, with the largest growth being in the Muslim faith [10].

Non-religious students. According to Downey [11], the number of college students holding no religious affiliation tripled between 1986 and 2016. Considering such a large percentage of the population now identifies as having no religious affiliation, it is important to acknowledge this group. Views of atheist and agnostic students should be included in class discussions and faculty must be educated regarding the differences in the two groups. Information and guidelines for educating faculty are extremely limited in this area, largely because there is a lack of research into atheist and agnostic nursing students. In one recognized work, while older in nature, Goodman and Mueller [12] provided a detailed synopsis of the need for faculty education. Because there is no clear definition of the delineation between atheism and agnosticism, they noted many students may struggle with identity within these groups. Students who do not identify with having a religion often do not share this information with others for fear of being stigmatized by both faculty and other students, and can become isolated due to this [12].

Goodman and Mueller [12] also provided guidelines for faculty and administrators to promote inclusion of non-religious students on campus. Because so many of them may not be willing to identify themselves to faculty or other class members, ensuring supportive student services on campus is essential. Assessing the atmosphere of one's institution towards these students is also required. Faculty must talk openly and nonjudgmentally about

this group when discussing spirituality and ethics. Universities should make atheist and agnostic faculty visible to students (when institutional environments allow for this), provide information regarding scholarships and opportunities for group members, and help students to engage in national organizations in order to network with others. Faculty should also be proactive in conducting studies within this under-researched population [12].

It should be noted that the guidelines discussed here are focused on higher education in general and do not address nursing specifically. They provide an excellent general topical outline for nursing educators. However, because nursing involves a great deal of focus on spirituality and end-of-life issues, additional care should be taken to include atheist and agnostic students in these conversations. The significant gap in literature provides an excellent opportunity for future studies.

Muslim Students. Within minority religions in the United States, Islam is the most rapidly growing faith. This religion is also a current topic of political debate and controversy. A 2019 Pew Research study found 63% of Americans perceived being recognized as Muslim in the United States made it more difficult to succeed in the country. A series of travel bans from 2017-2020, recently reversed [13], reflected the tone towards the group held by many Americans. While there are no current statistics on the numbers of Muslim nurses or nursing students in the country, research shows that of the over 3.5 million Islamic residents, 31% are college graduates [14]. This demonstrates a growing need for institutions of higher learning, including colleges of nursing, to purposefully find methods of including and accommodating these individuals in programs. This requires making adaptations, when possible, to fit their needs.

Gender coordinated care is important for both students and patients of the Muslim faith [15]. However, many healthcare related activities require students to complete assessments and interventions for patients of the opposite sex. One recommendation is to consider allowing Muslim students to practice on members of the same sex in the lab setting with the understanding that, when in the clinical setting, skills must be performed of members of both sexes. Guidelines set by surgical associations also now allow for accommodations for hijabs in the operating room [15]. The invention of disposable hijabs in 2020 by a Muslim medical student, which are now in production, will allow more options for nursing students and practicing nurses of the Muslim faith in the future [16]. In addition to these issues, it is important to note the need for long sleeves as a requirement for many Muslim students [15]. Clinical policies should be written carefully in order to delineate which activities will and will not allow for this. It is important to note the above guidelines are in alignment with Title VII of the Civil Rights Act of 1964 which protects religious clothing and grooming not causing undue hardship to employers [17].

Environments for daily prayer, which is essential for many members of the faith, should be considered both on campus and in the clinical setting. When on campus, consider setting aside comfortable areas for this, so that students feel welcomed and included. Holidays and fasting are also issues to be addressed proactively, so that they do not become a reactive situation. The issues discussed here should be well established and developed with the assistance of the institution's legal counsel and with accrediting agency standards in mind.

Race and Ethnicity

The need for more diversity in race and ethnicity of the student body in nursing education remains an ongoing topic for discussion in higher education. In 2003, the Institute of Medicine warned of the differences minority populations faced in the healthcare system at the time and challenged academic administrators to begin promoting and implementing greater diversity in healthcare education. In a nationwide study involving national hearings from various stakeholders, the Sullivan report expounded on this topic and presented three principles to guide the future of transitioning healthcare for minority groups. First, the culture in schools of health professions must change. Next, non-traditional education paths must be utilized. Finally, support must be present from institutional leaders [18]. The report also argued many of the problems resulting in a lack of diversity stem from the lack of success minority students experience in the lower levels of education. Students who are not successful prior to graduating high school are unlikely candidates for acceptance into challenging and competitive university healthcare programs [18].

While this data was published more than a decade ago, today's nursing education system has made little progress towards reaching those goals. When the National League for Nursing (NLN) compared the numbers of minority students enrolled in basic RN programs in 2004 with those in 2014, Black students decreased from approximately 13% to around 12% [19]. During the same time frame, the percentage of Hispanic students increased slightly from 5.6% to 8.1%. Asian students changed little, with enrolling increasing from 5.2% to 5.9%. Although minorities identified as "other" represented the largest increase, statistics prior to 2005 were unavailable. However, beginning in 2005, minority groups identified as "other" showed an increased enrollment from 4.6% to 7.5 % in 2014 [19].

While more ethnic and racial diversity has clearly been needed and supported by professional groups for well over a decade, the trends discussed here do not reflect the rapid changes required. Factors affecting this lack of growth are briefly discussed here. When addressing the first composite of the Sullivan report [18], a shift in the culture of healthcare academe, one clear issue arises. The AACN found a lack of diversity remains in education, with less than 13% of nursing faculty consisting of minority

groups. Similar evidence from the NLN supported and expounded on this, finding even less diversity in education than in clinical practice [20]. While the majority of nursing faculty are likely well-intended in supporting diversity, this lack of minority inclusion hinders future progress.

The second requirement of the Sullivan report [18] was to increase new and non-traditional education paths. This must start with connecting to students in both middle school and high school [21] and continue into higher education by alleviating the financial burden inhibiting many minority students from being successful in obtaining a degree [22]. In 2010 over half of successful high school graduates did not meet the standards required for college to begin studies without some form of remediation [23]. In 2015, standardized testing scores reflected little change over the past decade in college readiness [24]. Results also reflected lower scores for most minority students and those from poorer families [25]. When these students reach the college and university systems, the challenge shifts to reducing work hours in order to promote academic success [22]. However, the percentage of undergraduate students working over 30 hours remains at approximately 40% [26]. More needs to be done to support these at-risk students in order to be competitive in rigorous nursing programs.

Finally, the Sullivan Report [18] called for support from institutional leaders. This requires both dedication from administrations and funding. Federal funding, such as the Nursing Workforce Diversity Grant program, targets recruitment and retention of minority individuals. In opposition to recommendations for increase, funding for this program has been cut by almost a million dollars since 2006 [6]. As resources become more limited, proactive approaches on the part of administrators is more critical than ever.

Gender

According to the U.S. Bureau of Labor Statistics [27], male nurses represent approximately 12% of the nursing work force, which is a significant increase from 2.7% in 1970. Prior to the modern era, it was more common for men to be nurses than women due to the belief that men were purer than women [28]. In the 1800s, the trend shifted to using uneducated prisoners and prostitutes as nurses simply because they were cheap labor [29]. Walt Whitman, famous American poet, was well known for volunteering as a nurse during the American Civil War [30]. During the early 1900s, the role of nursing evolved into a primarily female dominated profession due to the perception of their natural ability to nurture the sick and be more caring [29]. In Florence Nightingale's time, men were intentionally excluded from nursing due to misconceptions surrounding their lack of caring and compassion [31]. Although opinions concerning gender and stereotypes in nursing have changed throughout the years, the foundational concept of providing care to the sick has remained the same.

Gender stereotypes in nursing warrant examination in order to promote equal opportunities. Many cultures believe that men in nursing are stereotyped and treated differently on the job. Previously in certain areas “Male nurses [have been] perceived as deviant, odd, med school failures, or homosexual” [32]. The reality is that men have been successful and discovered nursing can provide a healthy demand, high salary potential, advancement opportunities, and flexibility [33]. Men are often rejected from specific areas in nursing, such as maternity wards, due to traditional gender roles thus creating a situation of gender discrimination. As a direct result, it is rare to find male lactation consultants, nurse midwives, and obstetric and maternity nurses due to the legal implications as well as the societal rules [34].

The use of touch in nursing is requirement of nurses but it can become problematic because of preconceived ideas regarding gender and social rules [35,36]. According to Zhang & Liu [36], the use of touch by males has also been associated with a means to sexually abuse clients. Male nurses can find themselves in vulnerable conditions due to gender stereotypes that men are not caring, and touching is an unnatural act for them. The differentiation between masculinity and femininity are concepts derived based on gender. It is assumed women will naturally be feminine and males masculine [36]. Bem’s psychological androgyny theory [37] challenged traditional thought by supporting the idea of an individual having both masculine and feminine qualities simultaneously, allowing men to function in protective roles while providing for individuals [38]. Nursing faculty must respond by recognizing the importance of removing stereotypes regarding the feminine image of nursing in this modern era.

Male nurses can bring a unique perspective and diverse skill set to the nursing profession, but may also have a much different experience when caring for patients than their female counterparts [39]. They are often encouraged to be cautious when touching female patients as to not display any vague sexual behaviors, have their sexuality questioned, or possibly even feel isolated and surrounded by females.

It is important to recognize males and females have different personality types. With a growing number of male students entering nursing programs, an evolution of change must occur. A common misconception is the natural assertiveness of the male personality [40-42]. This behavior may be perceived as aggressive and be un-welcomed by female educators or co-workers. Women in the nursing profession should be aware of their interpretation of interactions with men in order to prevent misunderstanding of masculine behaviors. Awareness of this issue occurs through education. Men must be allowed to behave naturally, though respectfully, and should not be discouraged from doing so [43].

Traditionally, women are relational learners and prefer more reading assignments, while men are more independent learners

[43]. Changes to teaching delivery methods might require more hands-on learning with varied activities utilizing clinical reasoning and application strategies. Finally, it is essential for male students to have other male role models [43]. Active recruiting strategies should be employed to create diversity and emphasize the need for males in a predominantly female job market. Bringing male educators to nursing programs and clinical settings provides additional support for male students to form a connection and model positive qualities not otherwise available from a female mentor Robert Wood Johnson Foundation [44]. With these simple changes, a long-standing barrier can be removed, trusting relationships can be formed, and faculty can dismiss the historical image of the white woman in a white dress and nursing cap.

Sexuality

In nursing education sexual orientation has traditionally been overlooked or simply ignored [43]. As faculty struggle to understand differences in care for lesbian, gay, bisexual, transgender, and intersex (LGBTQ+) patients, they have failed to acknowledge and include this population as nursing professionals. Unfortunately, homophobia, an irrational fear or hatred of the LGBTQ+ population [45], continues to be a worldwide problem [46]. Many Americans believe that the LGBTQ+ community members are protected from discrimination; however, they are often not [47]. While legislation protects many traditional minority groups from discrimination, this population has historically been excluded [48]. This presents an issue for recruitment and retention in higher education. Unfair admission processes in nursing education were highlighted on a national level in 2016 when a young African American transgender student was denied access to a school of nursing in Mississippi allegedly based on her transgender status [49]. Institutions should be cautious regarding unfair denial of these individuals when developing policies and screening admission requests. In order to adhere with nursing principles, institutions must aim seek out caring and nurturing individuals, regardless of personal sexual preferences. Faculty must abandon the concept of heteronormativity to prevent LGBTQ+ members from being marginalized, considering the possibility that heterosexual relationships may not be the norm [45]. This population must be recognized for their contributions to academia and healthcare not provided by other groups.

There is limited research involving teaching strategies for the LGBTQ+ community, thus making it difficult to recommend specific content delivery methods. It is possible they may fit into other categories such as age, gender, or religious preference. However, faculty cannot be tempted to simply “Make Them Fit” into a group for convenience. Further research is warranted to discover specific needs of LGBTQ+ individuals in teaching and learning.

While there is very limited information concerning teaching strategies for LGBTQ+ in academia, there are a number of social considerations for this population. Educators must recognize, as a whole, LGBTQ+ students experience high rates of depression, suicide risk, substance abuse, and sexually transmitted diseases [50]. We must also be aware of the potential for discrimination and harassment both inside and outside of the classroom [51]. Students should not feel the stress of trying to hide their identity for fear of retribution or exclusion in the presence of their peers or faculty. Faculty should promote a comfortable learning environment by not practicing avoidance in discussing specific gender needs. In order to dispel preconceived ideas creating a barrier to learning, faculty might consider incorporating active strategies such as case studies or simulation with LGBTQ+ patients. This provides a means to demonstrate support and inclusion as well as expose other students to the needs concerning gender identity and sexual orientation.

In order to support this vulnerable population, educators must stay current with available resources and referral options such as counseling services, support groups, or information about campus ministries. Students and faculty must set aside biases and be open to accepting ideas outside of the norm of the general population for a revolution to occur. By making a few substantive changes in the nursing curriculum, students and patients will reap the benefits of a more culturally diverse and competent nursing profession.

Conclusion

This discussion has addressed only a few of the evolving marginalized groups within the growing nursing community that have limited resources and need more support and in higher education. In addition, it has provided readers with a better understanding of barriers impeding learners being successful in nursing education. If faculty are to succeed in creating a diverse learning environment where formation of these unique nurses is possible, immediate change is warranted.

From a global standpoint, considering issues such as the continued lack of ethnic, racial, and gender diversity in nursing education, despite large amounts of research and funding, and the continued lack of research into non-religious, non-Christian, and LGBTQ+ students, the task of developing this diverse population may seem overwhelming. However, if considered first on an institutional level, change becomes more foreseeable. When institutions provide solid evidence of change based on carefully and mindfully developed programs and true faculty support, global progress becomes less monumental.

Schools of nursing must be proactive in providing avenues for diverse students and consider barriers such as financial limitations, prejudice, lack of preparation prior to entering secondary education, and a multitude of other hidden issues. Creating a

culture that makes discussing and celebrating diversity in the classroom must become the norm. Students should be encouraged to keep their identity as non-believers, Muslims, members of the LGBTQ+ community, or other groups. These qualities set them aside from what is viewed as the traditional nursing student and must be welcomed for the next generation of American nurses.

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