Gender influence on nursing education and practice at Aga Khan university school of nursing in Karachi, Pakistan

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Summary

Purpose: The purpose of this study was three fold: (1) increase the understanding of gender sensitivity in nursing education and practice; (2) explore male and female nursing student and faculty perceptions on effective classroom and clinical teaching; and (3) clarify the necessity of both bedside teaching and role modeling in a Pakistani nursing program.

Design: Five successive focus groups were held to explore perceptions and views of twenty undergraduate, four graduates, and five Pakistani faculty members through guided interviews. Thematic analysis of transcribed data from observation and shorthand notes reached saturation after two rounds of transcription. Triangulated thematic analysis corroborated faculty and student perceptions.

Findings: Data extracted two major categories and four themes. The classroom teaching themes emerged as (1) feeling misplaced and disapproved, and (2) gendered teaching style. The clinical teaching themes were identified as (1) feeling bewildered, and (2) preferences for bedside teaching and role modeling.

Discussion and conclusion: The findings highlighted the need for gender sensitivity and cultural awareness in teaching and practice of nursing. Innovative teaching strategies can effectively resolve the contributing barriers to learning among nursing students.

Implication for practice: Awareness of gender differences among the students in addition to faculty enthusiasm communicates positive professional attitudes. Role modeling at bedside requires balancing essential cultural issues in nursing education and practice.

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KEYWORDS
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Introduction

The three fold purposes of this study included: (1) increase the understanding of gender sensitivity in nursing education and practice; (2) explore male and female nursing student and faculty perceptions on effective classroom and clinical teaching; and (3) emphasize the necessity of both bedside teaching and role modeling in a Pakistani nursing program.

A considerable increase in male admission in to the nursing profession demands a better understanding of gender influences on nursing education and practice. Among other cultural components, gender significantly influences one’s perspective on life. Fooladi (2003) explored the gender segregation concept in Iran after the 1979 Islamic revolution, and described how male and female nursing students and faculty adhered to changes. The concept of gender sensitivity is defined as an operational term to describe an acute awareness of gender in organizing, teaching, evaluating, and practicing nursing. The recognition of this conceptual framework will assist faculty and students to teach and learn effectively.

Hemani (1996) revealed gender issues in Pakistan from social perspectives and indicated direct influences of male dominance on professional nursing progress. She argued that male interference in nursing affairs not only hindered but prohibited nurse leaders from professional advancement. Nurse leaders in Pakistan are in a constant struggle to break through the barriers as they strive for professional autonomy while facing the demands of student’s academic needs with gender sensitivity.

In Pakistan, the public sector single-sex schooling begins from early childhood to secondary education. Male and female students enter the co-education system for the first time when they enter a program such as Aga Khan University. A combined experience of sitting in a classroom with female students and learning about nursing subjects taught by a female faculty is an intense experience for the male students. A majority of associate degree nursing programs across Pakistan maintain single-sex programs. Recognizing how male and female students learn helps prepare a gender appropriate nursing curriculum.

Literature review

The web search using the terms “education” and “nursing”, as key words revealed extensive references. The paucity of references became apparent when combined terms such as “gendered nursing” or “gender in nursing education and practice” were used. Thus, related literature was reviewed to provide support for the research findings such as “gender and education”, “bedside teaching and role modeling”, “effective teaching and mentoring” and “nursing in Pakistan”.

Gender and education

Historically, academic disciplines have been designed and continue to be androcentric from social and educational perspectives. Over a decade ago, Acker (1994), Bem (1993), Gore (1993) and Jackson (1997) reported the influence of a male-authored academic curriculum and its critical effect on the way male and female students and faculty behave and perform. Morrow and Torres (1995) explored gender influences in education from socioeconomic and political perspectives using critical theory and highlighted the importance of gender-balance in the academic environment as a mobilizing force. Male and female students learn and process information differently and their educational needs can be met with gender sensitivity. Nursing curriculum presents challenges to male students and Fooladi (2003) reported how male students perceived the nursing profession in two parts as “masculine” and “feminine” based on the role components. For instance, acute care, administration, and military service were masculine nursing and labor and delivery, pediatrics, and community health were feminine nursing roles. This view may enhance the faculty understanding of student’s perception on nursing education and practice.

Bedside teaching and role modeling

Nursing students learn the clinical skills best at the bedside according to Bain (2004) and Ramani (2003) outlined a 5-steps cycle of clinical teaching which begins with an invitation and ends with a farewell.

Step-1: Using clinical course objectives and resources at the clinical site, faculty seeks suitable patients and obtains patient’s health history for bedside teaching.

Step-2: Holds a pre-conference and selectively assigns patients to the nursing students and prepares the students for bedside teaching and learning and the faculty expectations.

Step-3: Initiates communication with the patient role model proper interaction at bedside.
Step-4: Allows the bedside teaching–learning session to become more self-directed. Gently challenges the students, demonstrates and engages the patient in the discussion.

Step-5: Holds a mini post-conference to discuss what helped or hindered student learning. Summarizes and highlights new learning, ends session by farewell and gratitude.

An effective clinical teacher according to Whitman and Schwenk (1984) should assess student’s knowledge, attitudes, and skills before engaging in bedside teaching. And Quirk (1994) provided four categories for teaching practical or clinical subjects and indicated that a teacher of practical knowledge may be (1) assertive, (2) suggestive, (3) collaborative, or (4) facilitative. An assertive teacher is one who provides direction, asks direct questions, and then offers information. A suggestive teacher recommends alternatives, shares opinions, and shares personal experiences as a role model. A collaborative teacher would elicit and accepts learner’s ideas, further explores new ideas, and gives credit to personal experiences related to the topic in order to show empathy. A facilitative style of teaching elicits and accepts learner’s feelings, expresses feelings, encourages personal expressions and uses silence for heavier emphasis on teaching. Asking what is the drug of choice for Mr. X, would be an assertive teaching style. Sharing clinical experience on head massage to relieve tension headache and then asking the student’s opinion would be a suggestive style of teaching. Asking how the student feels about a conversation with Mrs. X and her terminal illness would facilitate teaching.

Students develop professional attitude by observing teacher’s behavior as a role model. Students respond to genuine interest, enthusiasm, willingness, and teacher’s approaches to challenges. The four steps to role modeling professional attitudes suggest a teacher to be: (1) your own self (2) capable, (3) sensitive, and (4) enthusiastic. Observing teacher’s competency, attitude, enthusiasm, and sensitivity at bedside helps students develop professional role over time. To emulate a principle known as “see one, do one, teach one” nursing student’s learn clinical skills by faculty demonstration of history taking, interviews, physical assessment, and other skills. Perform skills supervised by faculty until they reach competency level. And then teach other students how to perform the nursing skills. Often, peer education solidifies learning (Whitman and Schwenk, 1984).

In relation to this study, role modeling views in a social context was examined by Hussain (1994) and emphasized that for centuries young Muslim men role modeled their elders by keeping women socially secluded and subservient to the expectations of men. After centuries of living invisible, Muslim women claimed independence and examined the conflict between the ideal and contextual realities of gender roles by challenging the male interpretation of Islam on women’s social status.

Effective teaching and mentoring

Student-centered teaching and learning environment does not come with a ”to do” list. Bain (2004) took two decades to interview 63 faculty members from North America and Australia, in 24 academic institutions and in 40 disciplines, who were award recipients for excellence in teaching and nominated by the students. He simply asked the teachers to describe their courses from the student’s perspectives and found that teachers must realize their influence on personal and intellectual growth of their students and how deeply students internalized teacher’s comments, expectations, and evaluations. Teachers shape a student’s way of thinking, learning, and personal development; therefore, failure and success in a single course can elevate or devastate the student’s life.

True mentors among professors are few who defy the norm and cross the boundaries to meet the course objectives in an attempt to touch lives in a deeper way. Today, mentoring between faculty and students are rare occurrences because greater academic emphasis is placed on research and publishing. The quality of teaching has declined and the academic institutions have become commercial markets for selling education. The attributes of outstanding teachers have been described as those who (1) create a positive learning environment which sustains learning. (2) Have a substantial and positive influence on the student’s thinking, acting, and feelings. (3) Produce exceptional educational results and encourages the students to learn deeply. (4) Stimulate intellectual interests and increase student’s desire to learn more. Deep learning occurs when students say “it makes sense” or “now I understand” and such students refer to an outstanding teacher as someone who “changed my life”, “transformed my life”, “changed everything”, or “messed with my head” (Bain, 2004, p. 10).

The importance of mentoring is emphasized by Daniels (2004) as she chose to become a nurse to fulfill her inner desires for a meaningful purpose, and instead, she found no support and was faced with “apathy, exhaustion and disappointment…”
She believed mentoring was fundamental to her salvation and strongly advocates the Leadership through Inspiration and Nursing Knowledge Systems or (LINKS) for nurses where they can benefit from peer support and mentoring.

Nursing in Pakistan

Nursing profession in Pakistan suffers from significant sociocultural ailments and the unrecognized status of women in Pakistan has prohibited rapid progress in nursing. Multiple attempts to bring nursing to a respectable standing have produced faint results as the voices of prominent nurse leaders in Pakistan are silenced by male dominance (Hemani, 1996). With every forward step toward progress nurses experience exhausting obstacles as Khowaja (2005) reported in Karachi, Pakistan 23 percent of annual turn over rate involves nursing migration in search of better recognition and higher income outside of Pakistan. This study aims to explore education and practice of nursing in Pakistan.

Methodology

A cross-sectional design was adopted and focus groups formed to find student and faculty perceptions on gender influences in nursing education and practice. Freire’s (1999) critical theory provided framework for the open-ended questions to facilitate discussion. The researcher’s cultural and academic experiences helped generate data through participation and observation, using qualitative research references by Miles and Huberman (1994), Streubert and Carpenter (1995), Hall and Callery (2001) and Stommel and Wills (2004).

The setting

According to Hemani (1996) his Highness Prince Karim Aga Khan initiated the Aga Khan University in 1964. The poor public image of the nursing profession in Pakistan averted families from enrolling their children in nursing programs. His Highness endorsed nursing as an honorable profession and the Shia Imami Ismaili community embraced nursing. Therefore, in 1980 the AKUSON accepted the first class of 35 female nursing students among them 31 were Ismailis.

The AKUSON consists of a large double story building with faculty, staff, and the administration offices and classrooms distributed on both levels. There are two large auditoriums in addition to multiple well-equipped classrooms. The Aga Khan University Hospital (AKUH) is a large medical facility adjacent to the AKUSON, which serves the public needs as a private entity and community health support. This beautifully constructed campus offers education, community service, research, and is founded on religious and spiritual principles. Except for the public prayer facilities, available to men only, the medical/nursing library, cafeteria, and skill lab are open to male and female students without restriction. The BScN program at AKUSON is coed (approximately 1:5 male–female ratio) while the majority of the associate degree and diploma nursing programs across the country maintain single-sex schooling.

Sample

Serving as a nursing consultant and clinical mentor for the AKUSON in Karachi, Pakistan provided the researcher access to the graduate and undergraduate programs. The English language proficiency among the students and faculty facilitated data collection opportunities through field work, observation, small and large focus group sessions. Thus, a purposive group of twenty undergraduate and four graduate nursing students and five faculty members from AKUSON and residence of Karachi took part in this study. The faculty age ranged between 28–60 years who taught across the curriculum for 2–30 years. The 5 male and 19 female students age range were 20–40 years.

Ethical considerations

The institutional review board approval (IRB) recognized as the Ethical Review Committee (ERC) from AKUSON/AKUH was obtained and participants voluntarily engaged in dialogues in various locations on AKU premises. The participants were assured of anonymity and confidentiality. The basic human rights to privacy, autonomy and freedom from risk of injury, according to the ERC were closely observed. The written consent offered an opportunity to withdraw from the study at any point. Interviews ranged from 1 to 2 h at each setting in addition to several informal dialogues. Further networking with participants provided sufficient opportunities for clarification.

Open-ended questions facilitated gathering of individual and group perceptions of experiences in the classroom, simulation lab, and hospital units. Access to class journals and student essays
substantiated observed and short hand data. Literature was continuously and concurrently consulted and compared with fieldwork findings. Data were recorded in shorthand and later expanded in details. Transcribed data were compiled and safely stored.

Data analysis

Data were analyzed through an immediate debriefing after each focus group to compare short-hand notes with visual clues. The line-by-line review of data in each paragraph and coding of raw data reached two major categories as (1) Classroom and (2) clinical teaching. For classroom teaching two themes emerged (1) feeling misplaced and disapproved, and (2) gendered teaching style and the clinical teaching themes were (1) feeling bewildered, and (2) preference for bedside teaching and role modeling. Thematic analysis corroborated faculty views with the student perceptions on gender issues.

Findings/results

Observation

An overall gender segregation existed in classroom, clinical settings and social gatherings when students, faculty, and staff congregated in separate groups and avoided mixed interactions in the cafeteria, tearoom, hallways, and dormitories (hostels). The classroom observation at AKUSON revealed implementation of the pedagogy principles in a teacher-directed style. In contrast, the clinical components were taught according to the andragogy principles where students had to be self-directed learners without any bedside teaching, hands-on skills, or clinical mentoring.

Classroom teaching

Feeling misplaced and disapproval

When I entered the nursing program here I had to make significant emotional adjustment[s] and still feel out of place. I found this (referring to coed system) environment as intimidating and unfriendly.

I can handle any subject no matter how hard it is, but put me next to girls, I cannot think straight or focus. This is such a new experience for most of us coming from small villages to a big city and then going to school with girls.

Many of times I (female) hesitate to raise my hand or participate in class discussions because there are male students (looking at males) present and this is a new experience for me and I am usually very talkative. (Laughing) this is so true. I did not know others felt (Wiping tears) the way I did. This is getting emotional for me (students sharing glances).

Male students on class participation indicated:

Why say anything in class when faculty (female) waits until the end of class to see if we have anything to add. I feel hurt and resent the fact that only female student’s viewpoints are heard in class. That lady (the female faculty) does not even look at us or give us any time to say something. I feel being excluded and dismissed. The faculties (female) only pay attention to girls.

The faculty members on this topic corroborated student’s comments and said:

Our students should understand that there are cultural factors involved here. When a female faculty lectures she inherently looks at the female students in the audience and similarly male faculty would look at the male students. Making eye contact, showing interest, closeness, or extra attention to male or female students could be considered inappropriate. We have to be careful at all times for what we say and how we say it because any word or gesture could be misunderstood, mistaken, or perceived as inappropriate. The term “inappropriate” can be broadly interpreted with grave consequences for faculty and students.

Author’s cultural literacy substantiates the obtained data. Scientific adequacy was addressed by establishing the credibility of collected data. The inquiry audit and neutrality of data established dependability and conformity of findings. The transferability of the framework was identified among a group of nursing scholars at AKUSON and generalization of data was unanimous through personal and professional experiences on gender influences in nursing education and practice.

Gendered teaching style

Hart and Rotem’s (1994) study of college students showed a challenging transition from cognitive, psychomotor and affective domains similar to AKU students.
I (male) found female faculty mainly focused on teaching the content, covering the course objectives, and being on time.

Most of us (males) feel boxed in and just not getting the same attention or validation as female students are getting.

Many of us (males) believe that female faculty lectures are unchallenging because for example she teaches for a few minutes and then asks a question from her lecture. And then she answers the question herself (looking puzzled). As if we are not suppose to participate. There is no expectation for our preparedness in class. This [questioning] process is just useless (looking upset) because it neither tests our knowledge nor distinguishes the prepared from unprepared students (others nodding). Instead of having an interactive learning experience in class we only have a fill-in the blanks session (others in agreement). This is not stimulating us to think or be better prepared for class. She (faculty) should let us come up with the answer.

(Looking at each other for conformation) we (female) don’t see it that way. Of course, our male and female faculties have a different teaching style and expectation[s] from us.

The gendered teaching style drove a wedge among the group as male students expressed frustration with female faculty style for having "fluid expectations" on student preparedness.

We come to class, listen passively, and no one would notice if we have studied at all. Many of us are frustrated because our course assignments keep changing and we don’t know what to expect from one week to the next.

Students perceived male faculty (in nursing and non-nursing courses) as "more organized and engaging" and better receptive of student’s opinion when challenging questions were asked. Peer education seemed as an effective teaching method and students advocated teaming the "well-prepared with less prepared-students" to enhance their learning.

We (males) need a little push and faculty should put us on the spot by asking direct question[s] even if it is going to embarrass us. We would get nervous and the next time come to class better prepared to avoid embarrassment. We need to be graded for what we know through purposeful questioning and not for being favored or liked.

We (males) need a push to force us to perform well. We (looking at each other and blushing) don’t mind knowing where on the subject we are weak or strong as long as someone points that to our attention.

In pre-nursing courses such as Humanity and Islamic studies we just sit and listen because we are not allowed to ask questions. (Researcher: What do you mean?) Because questioning religious or personal views are disrespectful. In our Islamic study class specifically we (females) are prohibited from asking any questions or engaging in any class dialogue. It is not (waving hands and interrupting) necessary to argue with the teacher about the belief system. You know, you don’t have to understand to believe.

The topic of course evaluation and grading system generated much discussion and female students strongly disagreed with male student’s views.

We (females) should not have to learn under pressure. Most of us try to avoid stress to be able to concentrate on learning. Who wants to be in a class where the teaching style involves degrading and belittling the student? There is no need to feel embarrassed and be targeted in class in order to learn.

On the subject of faculty expectations and grading, students expressed unanimous views as they stated:

The female faculty grade harder. We never know what to expect because the directions are vague and frequently modified. They have higher expectations and want us to perform well in classroom and in clinical settings. The female faculties teach under the assumption that we already know some of the content and usually start somewhere above our head. May be we are suppose[d] to read before coming to class (looking around). This is not true of the male faculty because they teach as if we know nothing. This makes it easier to start from the beginning and better for those of us who come to class totally unprepared (chuckling). Some of us need to learn at the basic level.

Reflections on gendered teaching style included voice pitch and confidence.

For us (males) it is easier to understand the male faculty because they speak loud and clear. This gives us the impression that he (faculty) knows what he is talking about. While our female faculties speak softly, sometimes their message is vague and unclear. (Researcher asking for details) For example, when we ask a question, the male faculty
answers loud and clear with confidence and we believe whatever he says and sometimes we find out his answer was wrong. Our female teachers lower their voice and answer with doubt but correctly and we still think she may be wrong because she just does not show confidence. We hardly hear our male teachers say "I don't know" and they may be unsure but still continue to speak confidently.

Clinical teaching
Feeling bewildered

The gender factor was not as evident in student’s perceptions of clinical environment. The clinical learning experience indicated an overall fear and anxiety:

On clinical day I was so scared that I couldn’t think. First of all I did not understand what was expected of me. She (faculty) was with us briefly and then she was gone. The nurses were too busy to explain things for us. I was looking around aimlessly and [it] took me a while to feel safe or begin to understand where to start.

It is hard for me (male) to walk to a woman and tell her I am going to take care of you. (Female students quickly reply) the same for us, we don’t know how to approach a male patient with all his family at bedside and start to provide care for him.

In class we are told what to study and how to prepare for tests and in clinical we are left to ourselves and we feel lost and bewildered. Our teacher expects us to find out everything and we need someone to show us how and stay with us the whole time in case we have a question or need help. I think in clinical our teacher should stay with us until we feel confident to be alone. Nurses do not have time to walk us through the chart and answer our questions. I feel lost and my mind is disorganized.

Faculty views corroborated student perceptions. In the clinical setting, even well prepared and confident students show anxiety, bewilderment, and the need for direction and guidance. Faculty presence and gender sensitivity help reduce fear and anxiety among the students. Field observation identified student preferences in choosing same gender patients once permitted. The initial hesitation changed to assertive patient care after a role modeling session at bedside.

Preference for bedside teaching and role modeling

Student comments on role modeling at bedside vastly reflected their desire to learn from faculty demonstration of skills but, culturally such request would be considered disrespectful because it translates into "testing faculty knowledge". In fact, field observation verified student’s views and the need for teaching and role modeling at bedside.

Conclusion and discussion

This study concludes that classroom and clinical evaluation requires clear understanding of teacher-centered versus student-centered learning strategies. Bartels (2007) realized the need for nursing faculty teaching in the undergraduate program to have a deeper focus on productivity through teaching based on practice, service and scholarly research. Similarly, Distler (2007) emphasized the rapid pace of technology demanding some uniformity in education, training and evaluation of nursing program outcomes. Medicine and nursing are making effort to keep the promise of improved patient care quality fulfilled and yet, lack of uniformity in many areas of education has not made it easy to maintain the desired quality in patient care. Critical thinking (CT), problem-based learning (PBL), evidenced-based practice (EBP), and the student-centered teaching strategies are only a few recent approaches to improve quality of nursing education and practice.

National League for Nursing (2003) issued a position statement urging nurse leaders to evaluate what worked well in the past and change what no longer does. The suggestion was made to increase flexibility in EBP and incorporate research-based multidisciplinary pedagogy with global applicability. Critical thinking and PBL were identified as the essential elements for professional accountability. Weber (2005) wrote, knowing the importance of critical thinking in nursing education and practice requires faculty diligent to teach by promoting critical thinking. This process may include reflective learning, problem solving, active participation, and self-evaluation of learning while performing clinical skills. And finally, Distler (2007) asserted evaluation criteria used in a classroom versus clinical environment are vastly incomparable and at times unclear. It is important to use a clear and fair strategy to evaluate student achievements and not failures. Nursing faculty should aim to evaluate what has been learned and how well. Using student's past experiences to bridge the past...
to present learning would be essential in determining how much progress has been made. Once the students fully engage and participate in their own learning process, faculty will find satisfaction of observing the growth and offering rewards for effective learning strategies.

Implications for practice

The findings of this study indicate teacher-directed pedagogy in a classroom does not spontaneously transform into self-directed andragogy in a clinical setting. Although gender influenced student’s perceptions of classroom learning, the clinical setting presented a gender neutral environment hindered with fear and anxiety. Even though students expressed desire for bedside teaching and role modeling, faculty struggled with patient’s right to privacy and confidentiality. Drawn from cultural understanding and low literacy rate among the patient population, faculty resolved that bedside teaching risked the possibility of public misperception leading to lack of confidence in the nursing profession. Once more, we learn that cultural understanding has a significant influence in teaching and practice of nursing.

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