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Meaningful inclusion of diverse voices: The case for culturally responsive teaching in nursing education

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ABSTRACT

Communication and diversity are essential features of safe and effective health care and of a safe and effective nursing workforce. Fostering diversity and meaningful inclusion of diverse perspectives in nursing school classrooms, labs and clinical learning environments are important steps toward building a stronger nursing workforce and health care system. This paper presents an argument for the importance of replacing the single, dominant voice in nursing education with culturally responsive teaching and offers strategies nurse educators can use to encourage students to share alternative perspectives and engage in alternative methods of discourse and communication. This essay reflects a review of the theoretical background to culturally responsive teaching and discusses how this method connects to nursing education. By engaging in culturally responsive teaching, nurse educators will prepare a nursing workforce that is ready to add multiple diverse voices to the health care team and contribute to the redesign of a safer and more effective health care system.

Introduction

Since the Institute of Medicine (IOM) published the sentinel document, *To Err is Human: Building a Safer Health System* (Institute of Medicine Committee on Quality of Health Care in America, 1999), it has become common knowledge within health care and nursing education that effective communication within interprofessional teams is essential to safety and improved patient outcomes (Foronda, MacWilliams, & McArthur, 2016; Hannawa, Wendt, & Day, 2018). Nurses and nurse educators know that diversity coupled with effective communication is a critical step toward a stronger health care system that delivers high quality health care for individuals, families, communities, and populations. Diversity is defined by the National League for Nursing (2017) as "affirming the uniqueness of and differences among persons, ideas, values, and ethnicities." A diverse workforce populated by nurses who employ strong communication skills as valued members of interprofessional teams is a key component of the best health care system. Yet, efforts to eliminate communication failures and create space for the meaningful inclusion of diverse voices have not been adequate and breakdowns in communication, misunderstandings and assumptions remain key reasons for errors in patient care (D'Agostino et al., 2017).

Fostering nurses' abilities to recognize the value of diversity and respond with communication styles that respect and support differences in thought and ideas and promote their meaningful inclusion is essential to building a stronger health care system. In its call to both create and foster a more diverse nursing workforce, the Campaign for Action (Campaign for Action, 2015) acknowledged that it is not enough simply to add a diverse array of individuals to the pool. To have a positive impact on health, the nursing workforce will not only have to look diverse, but also speak with multiple voices in order to communicate and support diverse perspectives and experiences (Irby, 2018). Nurse educators who intentionally encourage students to share different viewpoints and provide opportunities for students to communicate their unique perspectives confidently and effectively are essential to improving the safety and quality of health care.

Despite the support for the idea of diverse perspectives found in the Campaign for Action (2015) and other publications (National League for Nursing, 2017; American Association of Colleges of Nursing, 2017; Interprofessional Education Collaborative, 2016), the norm in many healthcare institutions is still to privilege the western medical/scientific perspective and facilitate practices that openly dismiss or subliminally suppress alternative voices. Indeed, the silencing of health care team members - including the patient and family - in the presence of the single dominant voice of western medicine is still too common in U.S. healthcare settings. This de facto endorsement of a single view jeopardizes patient safety by limiting communication and suppressing diversity of expression. The single voice grounded in a western

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biomedical perspective and reliant on empiricist and positivist methods is also dominant in nursing education (Day & Benner, 2014).

In this paper, we argue for the importance of replacing the single, dominant voice in nursing education with culturally responsive teaching that invites and encourages students to share alternative perspectives and engage in alternative methods of discourse and communication (Aronson & Laughter, 2016; Gay, 2000; Kim & Slapac, 2015). By engaging in culturally responsive teaching, nurse educators can prepare a nursing workforce that is ready to add multiple diverse voices to the health care team and contribute to the redesign of a safer and more effective health care system.

The consequences of a single dominant voice

The silencing of health care team members in the presence of a single dominant voice is common in U.S. healthcare settings where the status hierarchy ranks western-trained physicians over other health professionals, and professionals over patients and family members (Foronda et al., 2016; Hannawa et al., 2018). Nurses who have seniority or are in higher positions can also mute the voice of their younger, less experienced colleagues.

It is widely accepted that the presence of a hierarchy, in which status and authority mute differing perspectives and where those in higher positions are not challenged, compromises patient safety (Brown, Roediger, & McDaniel, 2014; D'Agostino et al., 2017; Maxfield, Grenny, McMillan, Patterson, & Switzler, 2005; Moorman, 2007). When the institutional culture fosters a single, dominant western medical perspective and does not invite multiple perspectives to contribute to the treatment plan, some team members are conditioned to believe that their voices are irrelevant. Hence, dialogues which are critical to patient safety are less likely to occur.

The muting of diverse thoughts can occur even when all team members, including the patient and family, share similar cultural, educational and practice backgrounds. Lauren Bloomstein's story provides a compelling example of what can happen when one dominant voice suppresses diverse perspectives during the delivery of patient care. Ms. Bloomstein was a neonatal nurse who died from an intracranial hemorrhage less than 48 h after giving birth (Martin & Montagne, 2017). Initially, Ms. Bloomstein reported epigastric pain and subsequently displayed clinical manifestations consistent with eclampsia and subsequently hemolysis, elevated liver enzymes and low platelet count (HELLP) syndrome. The obstetrician diagnosed gastric reflux and treated her with an intravenous opioid analgesic (hydromorphone) and a proton pump inhibitor. Ms. Bloomstein's nurse administered the medications even though intravenous hydromorphone is not a standard treatment for gastric reflux. The nurse did not question the order or was not heard if she or he did express a concern. Although Ms. Bloomstein's husband, a physician, attempted to challenge the diagnosis, his opinion was dismissed.

In the above example, multiple communication-related factors appeared to have contributed to the tragic outcome. Ms. Bloomstein's medical record suggests that the healthcare team (obstetrician, nurse, pharmacist, & gastroenterologist) collectively supported the obstetrician's error in diagnosis, engaged in poor communication and failed to recognize and/or report changes in Lauren's condition (Martin & Montagne, 2017). Other critical aspects of this event are the nurse's failure to effectively support the alternative perspective voiced by the patient's husband or voice his or her own alternative perspective regarding the use of an opioid analgesic to treat gastric reflux. These factors, combined with the team's commitment to the exclusive perspective of the obstetrician, most likely contributed to Ms. Bloomstein's tragic and preventable death.

Indeed, when the outcome is known, hindsight bias could overinflate predictive powers. In Ms. Bloomstein's situation the obstetrician, nurse, and the patient and her husband all shared understandings of science, methods of discourse and explanations of causation; they also shared similar experiences as health care professionals. Yet, even with this level of collective understanding, one voice dominated and created a barrier to alternative perspectives that the nurse was unable to overcome. The question for the nurse educator is to what extent do teaching and learning strategies better prepare nurses to speak up and challenge the single, dominant voice and possibly prevent this kind of communication error?

The educational climate

Unfortunately, current patterns of nursing education may not equip students with the tools to mitigate the circumstances and errors in communication that contributed to Ms. Bloomstein's death. Students come to nursing already possessing diverse knowledge, skills, and values from their personal histories and cultures. Nurse educators recognize student diversity as essential to creating learning environments that encourage all learners to cultivate broad, inclusive perspectives (Institute of Medicine, 2004). Yet, even though nursing students have diverse perspectives to contribute, nurse educators often speak from a single, empirical perspective focused on content delivery and multiple-choice testing. Discussions of diversity often take the form of lectures or textbook readings that present cultural taxonomies and epidemiological statistics that – at best – provide students with more content to memorize, and – at worst – contribute to the reification of stereotypes.

In the teacher-centered learning environments described above, students have few opportunities to draw on their personal backgrounds and express their unique perspectives. When teaching students to think like nurses, the teacher's voice/ideas become dominant in the classroom, lab, and clinical settings and students' success is measured by how accurately and completely they can frame their thinking according to the prescribed nursing perspective. Emphasizing the nursing process, nursing diagnosis, and evidence-based nursing interventions can contribute to this single voice - that of analytic, reductionist Western science delivered via Caucasian American English and situated in Caucasian American culture. This process of testing and reinforcing a single point of view and a single style of discourse risks conditioning students to exclude their own and others' alternative perspectives in favor of the one presented by the teacher – the one they will be held accountable to on exams and other forms of learning assessment.

Based on a review of the research on interprofessional communication in healthcare, Foronda et al. (2016) recommend that nursing and interprofessional education move "…beyond communication techniques to address the broader related constructs of patient safety, valuing diversity, team science, and cultural humility (p. 1)." One way to move nursing education toward valuing diversity and cultural humility is through culturally relevant teaching in settings that promote authentic education.

Authentic education

Paulo Freire (Freire, 2000), in his now classic work, *Pedagogy of the Oppressed*, posited that when individuals come together to dialogue, "… there are neither utter ignoramuses nor perfect sages; there are only people who are attempting, together, to learn more than they now know" (p. 35). He goes on to add:

> "authentic education is not carried on by "A" *for* "B" or by "A" *about* "B," but rather by "A" *with* "B," mediated by the world- a world which impresses and challenges both parties, giving rise to views or opinions about it."
>
> (p. 93)

Building on Freire's ideas, culturally responsive teaching (CRT) can be used as a guide to create empowering learning environments that cultivate respect for different perspectives and encourage all participants to share what they know. When students are told what and how to think they begin to reduce or cancel out the cultural knowledge they

traditionally use to inform their practices. Conversely, culturally responsive teachers facilitate and integrate multiple, diverse perspectives in classroom, lab, and clinical learning environments and use culturally responsive pedagogies to strengthen the voices of all students and affirm global identities. A culturally responsive learning environment invites teacher-student and student-student dialogue and recasts the traditional roles of teacher and student. In the culturally responsive classroom, teachers and students are all challenged to broaden their perspectives thus refuting the notion that only students should be challenged.

Culturally responsive teaching is an umbrella term for pedagogies that prepare students to support social justice in and beyond the classroom. Gay (2000) describes CRT as a pedagogy that is committed to collective empowerment whereby students gain "…personal confidence, courage and the will to act" (p. 32). She asserts that CRT exposes the faulty presumption of a single, monolithic reality put forward by a single dominant voice, and opposes the transmission of decontextualized facts. With CRT, students find their voices and contribute valuable new knowledge that may challenge both the teacher's understandings and the explanatory models of western biomedicine. Culturally responsive educators raise "the veil of presumed absolute authority from conceptions of scholarly truth typically taught in schools" (Gay, 2010, p. 38) to make space for mutually respectful dialogue.

The term CRT originated from, and has been used mainly by, K-12 educators (Gay, 2000). However, CRT is relevant to nursing education because it provides nurse educators with tools to operationalize the profession's value of diversity and meaningful inclusion. Culturally responsive learning environments encourage and support students as they develop the confidence and skill to share counter-narratives and different approaches to new material that emerge from their prior experiences. As a result, students are more likely to graduate with the requisite attitudes and confidence that allow them respectfully to challenge the authority of the single dominant voice with ideas derived of their own insight and experience. Also, students who have learned that their experiences, perspectives and approaches are valuable will be more open to hearing, and perhaps advocating for, voices different from their own. With CRT, conversations can move beyond the unilateral distribution of epidemiological data, or rote memorization of concepts, to more meaningful, diverse, and deeper discourse.

Tools for encouraging diverse voices in nursing education

Ladson-Billings (1994), who originated the term culturally relevant pedagogy and is widely recognized as a pedagogical expert, identified eight principles that are essential to empowering students emotionally, politically, and socially; of these eight principles, three are particularly relevant to nursing education: culturally mediated instruction; teacher as facilitator; and empowering environment (Table 1). Although Ladson-Billings (1994) used the term culturally relevant pedagogy to emphasize the effects on attitudes and dispositions, her work also has been used to illustrate teaching practices. These principles form the foundation for specific practices nurse educators can use to integrate diverse student voices into classroom, lab and clinical learning.

Culturally mediated instruction

Culturally responsive teaching is an umbrella term to describe pedagogical strategies that seek to strengthen the learner's ability to recognize and respond in an inclusive way to diverse perspectives and voices. Culturally mediated instruction as described by the Education Alliance at Brown University.

> incorporates and integrates diverse ways of knowing, understanding, and representing information. Instruction and learning take place in an environment that encourages multicultural viewpoints and allows for inclusion of knowledge that is relevant to the students. Learning happens in culturally appropriate social situations; that is, relationships among students and those between teachers and students are congruent with students' cultures.
>
> (The Education Alliance at Brown University, 2018)

Using culturally mediated instruction, educators create opportunities for students to connect new learning, specific to nursing practice, to their lived experiences. The nursing process and the Western biomedical understanding of disease and treatment continue to ground nursing practice; but the culturally responsive educator also encourages students to share what they know from their own experiences.

Culturally mediated instruction is accomplished when the learning session opens with a review of internal prompts that students are encouraged to share during discussion. The student and teacher develop a list of examples for students to use as guidelines. For example, during a discussion or lecture on cerebrovascular disease and stroke, the teacher provides a list of prompts: "That's not how my grandmother was treated when she had a stroke" or "This is not how I understand the concept or cerebral perfusion," or "My family would respond differently to these symptoms." If the student has ideas like these, she or he is encouraged to take them seriously and share them. Then the teacher might open the discussion by asking students to share what they know about stroke and why cerebrovascular disease might be more prevalent in some groups and than in others. Welcoming alternative perspectives into the discussion and encouraging students to frame concepts based on their life experiences creates a respectful dialogue that links cultural references to nursing concepts. In addition, students come to understand their experiences, ideas and voices as meaningful and relevant (Aronson & Laughter, 2016). In this way, faculty can use CRT to invite discourse on what a disease means and how it is treated in different cultural groups. Exploring their existing knowledge and understandings and connecting these to new, nursing-specific knowledge also facilitates retention and concept mastery (Brown et al., 2014).

Teacher as facilitator

As facilitators who intentionally encourage students to voice alternative ideas that challenge the authority of a dominant view, nurse educators support students in developing an appreciation for diverse perspectives. Culturally responsive learning environments allow students to share what they know and think, question and analyze given concepts and assumptions, and reflect on, share, and act on their own beliefs and feelings (Gay, 2000). Culturally responsive educators, acting as facilitators, ask questions that challenge assumptions, suggest

Table 1
Encouraging diverse voices with culturally responsive teaching principles.

Culturally responsive teaching principles	Practices
1. Culturally mediated instruction	Opportunities exist for students to connect nursing concepts to their lived experience so that learning is relevant. Educators use constructivist methods to facilitate conversations that affirm one's identity.
2. Teacher as facilitator	Questions that challenge assumptions and create alternative realities are intentionally raised. Students are given opportunities to reflect and insert different beliefs.
3. Empowering environment	Learning environments reflect how cultural differences are valued and can be used to broaden perspectives and improve academic success.

alternative perspectives and affirm the students' inner voices.

Culturally responsive educators facilitate discourse that supports interactive collaborations and encourages students to explore how their collective responses could be used to ensure safe practice settings. Using the story of Lauren Bloomstein, the teacher can pose questions like, "*In your experience, what sociopolitical or cultural factors have you seen influence health care delivery? Which of these factors might have influenced the care Ms. Bloomstein received? When have you seen power dynamics influence care delivery or outcomes? In Ms. Bloomstein's situation, what assumption might have been made and how could the nurse have respectfully challenged what might be considered the dominant belief?*" These questions each have more than one answer and invite students to connect their own experiences with what they are learning.

Student responses could illuminate their own implicit biases and negative stereotypes. When these comments come up in discussion, the facilitator-teacher maintains a safe sharing environment by restating the student's words and then generalizing provocative statements to remove blame that could heighten defenses. The teacher then provides opportunities to reflect and respond to comments and asks questions to further exploration: "*What biases could be influencing your own thoughts and beliefs?*", *or* "*How could the recognition of cultural differences in how pain is experienced help mitigate these kinds of biases that threaten health care outcomes?*"

Empowering environment

Culturally responsive learning environments reflect how cultural differences are valued and can be used to broaden perspectives and improve academic success. The legitimization of each student's independent thought and unique cultural and experiential background are integral components of CRT (Aronson & Laughter, 2016). Academic settings should cultivate an ethos grounded in the belief that all students can learn from and with each other regardless of the course that is being taught (Ironside, 2015). When educators encourage and legitimize students' ideas and affirm the value of diversity, the learning environment becomes empowering. Conversely, if students' experiences and contributions to learning are devalued and only certain voices are recognized, the conditions that support academic success are hindered (Beard, 2016).

In an empowering environment, all nursing students believe they have the capacity to succeed and are motivated to engage in activities that lead to a collective gain. Group assignments allow students to identify their strengths and affirm their unique identities. Teams are designed so that each student assumes responsibility for bringing out the best in others. For example, students working in small groups share their unique experiences while considering the following questions, "*What factors could potentially undermine the quality of care that an individual receives?*"

Group assignments provide students with an opportunity to learn and embody principles of teamwork. Teams and teamwork are listed as one of the four core competencies critical to all health professions education curricula (Interprofessional Education Collaborative, 2016). To strengthen a student's confidence when working with others, educators should encourage students to reflect on individual actions that helped to strengthen the team and consider, what if anything, they will do differently in the future. All members of a team should believe that they can learn from each other.

Summary and conclusions

When students transition into the nursing role, they have already internalized rules and procedures that direct how they respond to others. A license to practice is not enough to ensure that nurses will offer an alternative perspective. Because students are socialized in a hierarchical system, a certain level of anxiety and lack of confidence can influence their ability to interrupt situations/scenarios instigated by those perceived to be in higher positions, more knowledgeable, or with more experience (Noland & Carmack, 2015). More must be done to empower nurses to communicate their unique perspectives more effectively.

Nurse educators are in a unique position to create safer, more effective health care systems. However, this journey requires that educators cultivate a voice of dissent and empower students to contribute diverse perspectives. By encouraging students to share their various experiences, languages and methods of discourse, and then integrating these diverse perspectives into teaching and learning assessment methods, and into their own understandings of nursing practice, nurse educators have the potential to transform nursing education, practice and health care (Kim & Slapac, 2015).

With CRT, students are better positioned to graduate with the knowledge, attitudes, and skills to work toward creating a socially just culture. Thus, they are better positioned to engage in practices that, albeit difficult, foster an ethos of cultural humility that could translate into an empowering voice and safer work environments. The authors assert that the principles of CRT, adapted from teacher-education, are intuitive and can be used to empower students to voice different perspectives. However, evidence-based studies that measure the effectiveness of CRT on improving communication practices are needed.

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