

2016

REFLECTIONS ON NURSING LEADERSHIP YEAR-END SAMPLER



Sigma Theta Tau International
Honor Society of Nursing®

RNL
REFLECTIONS ON NURSING LEADERSHIP

DEAR READER,

2016 is coming to a close, and at *RNL* we are looking ahead to exciting changes in 2017. As I write this we are working on the launch of a new website that promises to make your reading experience even better. The new *RNL* incorporates a design familiar to users of the main STTI website featuring a bright and inviting homepage, article pages that are cleaner and easier to read, and simplified organization. It is also responsive—a fancy way of saying it will automatically adjust itself to the device you are using, whether that is a computer, tablet, or phone. *RNL* will finally be readable on all mobile devices!

Before we ring in the new year, however, it has become our custom to look back at some of our most popular and striking articles from the current year. As usual our editors have published many outstanding pieces showcasing the diversity of accomplishments by STTI members. Narrowing them down into the few we can include here was difficult, but I think you'll be pleased with the selections we made. These represent some of our personal favorites and most popular articles from 2016. The past year saw continued growth in readership at *RNL*, and as always we are grateful for your support.

Please accept this sampler as a token of our appreciation for all you do to support STTI and our efforts to publish timely content in *RNL* as well as books and scholarly journals. Thank you for your membership and support, which allow STTI to fulfill its mission of advancing world health and celebrating nursing excellence in scholarship, leadership, and service.

We wish you all the best 2017 has to offer.



Dustin R. Sullivan
Publisher



DEAR READER,

As editor of *Reflections of Nursing Leadership* (RNL), I have the privilege of considering a wide range of articles to publish in the magazine, and I'm very pleased with the variety of content we've published in 2016. So, when it comes time to choose—together with Assistant Editor Jane Palmer and Publisher Dustin Sullivan—what to highlight in the *Reflections on Nursing Leadership* Year-End Sampler, I have to put aside my loyalty to many articles to choose just eight. This year's selections are:

In “**CONFLICT NEGOTIATION**,” Cynthia ‘Cindy’ Clark, PhD, RN, ANEF, FAAN, declares that leading with civility and kindness is not a sign of weakness but of strength, commitment to ethical conduct, and empathy for others. Read Part 1 in the sampler and then click the hyperlink to read Part 2.

In “**NURSE RECOVERS FROM SURGERY GONE BAD TO SHINE LIGHT ON DYSFUNCTIONAL SYSTEM**,” Donna Helen Crisp, JD, MSN, RN, PHCNS-BC, responds to questions about why she wrote *Anatomy of Medical Errors: The Patient in Room 2*, why she became a nurse, and why she is so committed to seeing more emphasis on ethics.

In “**I DEVELOPED LEADERSHIP SKILLS I DIDN'T THINK I'D EVER HAVE!**,” Nomvuzo Diamini, RN, RM, of Swaziland recalls the trepidation, challenges, and rewards of participating in the first cohort of Africa's Maternal-Child Health Nurse Leadership Academy, sponsored by the Honor Society of Nursing, Sigma Theta Tau International (STTI).

In “**MY RELENTLESS PURSUIT OF OPPORTUNITY**,” third of a three-part series on nurse entrepreneurship, Kenneth Dion, PhD, MSN/MBA, RN, shares lessons learned on his entrepreneurial journey.

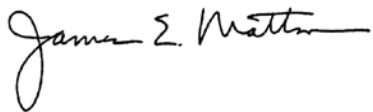
In “**HOW DO YOU SOLVE A PROBLEM LIKE MILLENNIALS?**,” Carrie Sue Halsey, MSN, CNS-AD, RNC-OB, ACNS-BC, advises nurse leaders to focus on strengths millennials bring to the workplace.

In “**GREATER AWARENESS OF SEX TRAFFICKING NEEDED**,” Kelsey Lessard, DNP, APRN, CNP, says it wasn't until she began volunteering for a local organization that offers support for sexually exploited women that she came to understand the true nature of sex trafficking.

In “**TIPS FOR NURSE EDUCATORS WHO WANT TO GO GLOBAL**,” Jan Nick, PhD, RNC-OB, CNE, ANEF, offers one tip that seems completely counterintuitive. Sometimes, she says, it's better to not know the language.

In “**A MATTER OF GENDER**,” Sarmad Muhammad Soomar, BScN, acknowledges that even though male nurses in Pakistan sometimes have to forgo in practice what they learn in the classroom, they can help clients while respecting sociocultural norms and preferences.

Thanks again for the many ways you give year-round as a nurse.



James E. Mattson
Editor, *Reflections on Nursing Leadership*



Cynthia “Cindy” Clark, PhD, RN, ANEF, FAAN, nurse consultant for ATI Nursing Education and author of *Creating & Sustaining Civility in Nursing Education*, is a psychiatric nurse/therapist and an expert in fostering civility and healthy workplaces.

Part 2: Conflict negotiation, Part 2

Published 1/13/2016, Vol. 42, No. 1

Conflict negotiation, Part 1

Civility is not a sign of weakness.

Twenty years ago, I read an excellent book authored by scholars from the Higher Education Research Institute (HERI; 1996) at UCLA. In describing a social-change model of leadership development, they identified ability to engage in “controversy with civility” as an essential element. *Conflict*, they suggested, often implies competition or disagreement that involves potential aggression, and the term frequently conjures up the notion of winners and losers. *Controversy*, on the other hand, implies disagreement that has potential for positive outcome resulting in a solution that is beneficial to all.

For controversy with civility to occur, observed the scholars, parties to the disagreement must accept two fundamental premises: 1) Differences of viewpoint are inevitable, and 2) resolution of opposing points of view requires that both positions be aired honestly but with civility and openness. Whether one uses “conflict” or “controversy with civility” when referring to disagreement, both terms, it should be noted, describe natural and normal processes which, when managed well, can lead to creative problem solving. This is particularly true when problem solving occurs in an atmosphere of civility, collaboration, and with intent to achieve common purpose. Successful negotiation of either conflict or controversy requires listening well and setting ground rules—rules of engagement—that provide a platform for acceptable conduct and interaction.

You don’t have to be mean to be a leader!

The relevance of the HERI publication I refer to above resonates even more for me today as I consider the political rhetoric surrounding the 2016 U.S. presidential campaign. I passionately believe that positive and effective leadership only occurs in a context of civility, ethical conduct, and professionalism. Some years ago, I developed the acronym PEAK—Principled, Ethical, Authentic, and Kind—to describe that kind of leadership.

Leading with civility and kindness is not a sign of weakness, nor is it a philosophical abstraction. Rather, it is living and leading by a durable code of moral and principled behavior that is applied in everyday life. True leadership calls for strong commitment to ethical conduct and ability to empathize with others. As I reflect on some of the comments made during the 2016 campaign season, I am reminded of a quote by Eric Hoffer, who said, “Rudeness is the weak man’s imitation of strength,” and another quote by Tennessee Williams, who quipped, “All cruel people describe themselves as paragons of frankness.”

Not all conflicts are created equal.

In my work as a consultant, mastering the skills of conflict negotiation often tops the list of skill-building requests. While many of us recognize that conflict can be a positive experience when it is addressed directly, we often avoid it, especially if a situation has evolved over time and bad feelings have built up, resulting

in a breakdown of communication and damaged relationships. In some cases, individuals avoid dealing with conflict because they lack the requisite skills or are unable to create the emotional “safe space” needed for effective dialogue and conflict resolution.

Other reasons for avoiding conflict include believing that mentioning the conflict or attempting to resolve it may put one’s position or job at risk. Not all conflicts are created equal. Some may be resolved with a brief conversation that clears up misunderstandings, but others require work, energy, and willingness to revisit a painful issue. It is important, therefore, to decide which conflicts to address and which ones to let go.

Effective conflict negotiation requires that you carefully analyze your level of interest in the other party, and how important it is to you to resolve the conflict. For example, if the issue is not of high interest to you or you are not deeply vested in the other party, the effort required to resolve the conflict may not be worth it. However, if the issue is of high interest to you and you are also highly vested in your relationship with the other party, it is probably in your best interest to attempt to resolve the problem, especially if both parties care about the results. It’s important to realize that some problems or issues may never be resolved.

Ask yourself these questions.

Before engaging in conflict negotiation, ask yourself the following questions: How important is your relationship with the other person? If you are able to resolve the conflict, how much will it affect your working relationship now and in the future? If you don’t address the conflict, will it negatively affect your ability to work with this person now and in the future? How likely is it that the conflict will be resolved and the relationship improved? What are the potential costs and benefits of addressing the situation?

Once you have carefully considered these questions and have decided to address the conflict, it is important to reflect and consider how you may have

contributed to the situation. Many times, people will say, “I had nothing to do with this conflict, and the other person is to blame for the problem.” In most cases, this is not a true assessment. Even when it might be true, it’s still important to consider the other person’s point of view regarding your role. Doing so will help you develop an understanding of that person’s perspective.

REFERENCE

Higher Education Research Institute. (1996). A social change model of leadership development guidebook. Version III. Los Angeles, CA: Author.





Donna Helen Crisp, JD, MSN, RN, PMHCNS-BC, took a position as an assistant professor at the UNC Chapel Hill School of Nursing in 2006. In 2012, she returned to Asheville, North Carolina, USA, where she works as a nurse and writes about nursing.

Published
10/20/2016, Vol. 42,
No. 4

Nurse recovers from surgery gone bad to shine light on dysfunctional system

My inner voice commanded me to write a book.

*The editor of **Reflections on Nursing Leadership (RNL)** interviews **Donna Helen Crisp**, author of **Anatomy of Medical Errors: The Patient in Room 2**.*

RNL: Thank you for writing this memoir. As more people are becoming aware that many patients die tragically each year from preventable medical errors and adverse events in hospitals, your book is very timely. Of your own experience as a victim of medical errors, you write: “No one would ever simply say they were sorry for what happened to me. Had this been otherwise, I probably would not have written this book.” Since you also state that you have forgiven the surgeons and others who caused you great physical and emotional pain, why *did* you write this book?

Donna Helen Crisp: Psychotic and terrified, I came back to life one weekend in a surgical intensive care unit, after being in a coma for weeks. Within a day, as my delirium began to transmute into reality, my inner voice resolutely commanded me to begin living with this truth. “You must write a book.”

But what could I write about? I had no idea why one surgery and one overnight hospital stay had turned into five surgeries and a month in the hospital. I did not know I had lost weeks of my life to a netherworld devoid of awareness. I was oblivious to the large hole in the middle of my abdomen. All I knew was that if I lived long enough, I would write a book about whatever had happened to me, once I figured it out.

It was challenging to come home and not be able to move, bathe, dress, or cook. I was in survival mode for many months. Once I was able to hold a pen and write, I began to take copious notes. I made long lists of ways I had suffered, losses experi-

enced, places my body had been damaged. I wrote down all the questions I wanted answered. And I cried—every day, usually in the afternoon. I also wrote down exactly how I remembered the first few moments after coming off the ventilator, when I had experienced inexplicable terror. Those words became the first words of my book.

For several years, as my story continued to unfold, I wrote. With time, my sense of purpose became refined and stalwart. I never doubted my resolve, especially after learning that many unsuspecting people were dying every day from unnecessary medical errors, while many more, like me, suffered serious and, sometimes, life-changing complications. I felt a turning point in July 2014, when a U.S. Senate subcommittee, chaired by Sen. Bernie Sanders of Vermont, heard testimony that preventable hospital medical errors constituted the third leading cause of death in the nation—behind heart disease and cancer.

I want to help raise awareness about a national health crisis and shine light on a dysfunctional healthcare system. I hope my book penetrates the pockets of silence that keep patient tragedies undiscovered and never mentioned, even though many hospitals want to keep it that way.

RNL: Skillfully woven throughout the telling of your story about uterine cancer surgery that went terribly wrong is your life story, which includes glimpses into a family that could be described as dysfunctional. Your “troubled childhood” led to a search for purpose and expression that included a wide variety of work experiences and a broad education, including a juris doctor degree. Why did you become a nurse? How has your law education influenced your role and perspectives as a nurse?

Crisp: In my late 30s, I realized I was not going to have a loving marriage and children, so I began to try and figure out what to do with the rest of my life. I had two college degrees and had worked as a social worker, so I considered getting a master's in social work. I also considered getting a degree in landscape architecture. My grandfather had been a botanist, and it seemed I had inherited his proverbial green thumb. While mulling over my options, I woke up one April morning and heard a voice say, "Go to nursing school." Because I had never considered working in a medical field, this was a surprise. Then I remembered how, as a child, I had told my father I wanted to be a doctor. He replied that it was not possible because I was a girl.

I called the university and learned I had just missed the cutoff date and would have to wait another year to apply. Although I figured my notion of being a nurse would eventually fade away, I began taking non-nursing courses I would need for my new degree, including five lab-science courses. By the time I finished this work, I had submitted my application for the BSN program and was accepted. After being a social worker, legal clerk/writer, singer-songwriter, poet, musician, French teacher, and restaurant waitress/manager, I spent most of the next seven years earning a BSN and an MSN in mental health nursing. Then I did a year of required supervision, sat for a national exam, and became certified as a psychiatric clinical nurse specialist.

While still in my 20s, I had earned a juris doctor degree. In nursing school and thereafter, I was often asked why I wanted to be a nurse instead of a lawyer, since most nurse-attorneys went to law school *after* becoming nurses. Apparently, my path was unique. However, I never questioned my decision. I had spent years learning about my psyche and spirituality. I even considered myself an amateur psychologist. Now I wanted to master knowledge of the physical body—physiology and pathology, health and illness. Nursing was a holistic, patient-centered practice. Nursing was exactly where I needed to be.

RNL: You observe in your book that moral distress is common among nurses, doctors, and other healthcare providers, who often "lack the ethical framework to help their patients deal with difficult decisions and life-threatening situations." How has your knowledge of nursing ethics helped you avoid moral distress in your nursing practice? What would you like to see with regard to ethics in nursing curricula?

Crisp: Many nurses graduate and begin their careers with little knowledge of ethical concepts, much less how to effectively apply them in patient scenarios. Other than learning some legal pointers for nursing practice, such as those relating to documentation and liability, nurses may not be prepared to deal with the legal and ethical issues that arise when faced with difficult life-and-death questions.

Nurses learn how to address concrete procedures, such as how to change a surgical dressing or adjust an IV pump. But without adequate training in how to work with ethical dilemmas, how can a nurse feel comfortable telling a patient's daughter: "Your mother is in pain and wants more morphine. The med order allows for a higher dose, but it may compromise her breathing." Or explaining to a patient: "No one can force you to have this surgery. However, you may die sooner if you do not have it."

A 48-year-old man with a long history of IV heroin addiction wants and needs pain medication because of internal injuries suffered in a motorcycle accident, but his wife insists he cannot have pain medicine. Without ethics training and experience, how can a nurse discern the threads of controversy and alliance in this scenario? Without knowledge or confidence to speak up for the patient, how can a nurse maintain the role of patient advocate in such difficult circumstances?

When nurses are unable to unravel their patients' ethical dilemmas, they become frustrated, especially when they witness poor outcomes. A patient receives poor or futile care, and the nurse, unable to intervene, feels worthless. A patient is not told the truth, and the nurse, unable to collaborate with the team for the patient's benefit, feels weak and ineffectual. A patient suffers from poor communication and care, and the nurse, forbidden to help the patient, feels inadequate. That is moral distress.

Every nursing program should include a required ethics course. Reading and discussing case studies about real ethical dilemmas are very effective ways for nurses to learn about these principles. This kind of learning invigorates and challenges students to think about how they will respond to patients in difficult moments. After learning about basic ethical principles, new nurse graduates are better prepared and more confident to work in hospitals and other healthcare environments. Hopefully, their workplace will honor, encourage, and support them when they identify ethical problems and collaborate with others for their patients' highest good.



Nomvuzo W. Diamini, RN, RM, practices at the Mbabane Government Hospital in Swaziland.

Other articles in
“Answering the call”
series:

Influence through policy:
Nurses have a unique
role

Influence through policy:
Four steps YOU can
take

Influence through
advocacy: Raising
awareness, advancing
change

Influence through philan-
thropy: What philan-
thropy looks like

Influence through philan-
thropy: Giving back to
pay it forward

Published 7/1/2016, Vol.
42, No. 3

I developed leadership skills I didn't think I'd ever have!

Influence through lifelong learning: Academy participant empowers others.

In her *presidential call to action* for the 2015-17 biennium, Cathy Catrambone, PhD, RN, FAAN, called all members of the Honor Society of Nursing, Sigma Theta Tau International (STTI) to “*Influence to Advance Global Health & Nursing*” in four areas: 1) advocacy, 2) policy, 3) lifelong learning, and 4) philanthropy. In this article, No. 4 in a six-part series on President Catrambone’s call, the author addresses influence through lifelong learning.

I am a registered nurse midwife currently practicing at the Mbabane Government Hospital in Swaziland. I was privileged to participate in the first cohort of Africa’s **Maternal-Child Health Nurse Leadership Academy** (MCHNLA). In cooperation with funding partner Johnson & Johnson and in collaboration with key South African nurse leaders, the Honor Society of Nursing, Sigma Theta Tau International (STTI) **adapted the successful MCHNLA model** to develop specific leadership skills for maternal and child health nurses and midwives who work in African settings.

Nurses and midwives accepted for the program were placed in collegial relationships with mentors and a faculty adviser, who guided them through their leadership development over an 18-month period. My mentor was Sakhile Masuku, BSc, and our faculty adviser was Oslinah Buru Tagutanazvo, MSc, BA Curr, DipMidwifery, DipGnlNsg, CertHIV/AIDS, of the University of Swaziland. Triads from South Africa, Malawi, Uganda, and Swaziland participated in this MCHNLA Africa. As participants, we attended workshops designed to prepare us for effective interprofessional team leadership as we strive to improve quality of healthcare in our countries for childbearing women and for children less than 5 years of age.

I did it!

I remember clearly when my mentor asked me to consider participating in this academy. I didn’t know if I should. First of all, I had just started working in the maternity labor and delivery ward. Secondly, I had never heard of Sigma Theta Tau International. And third, I saw myself as incapable of successfully leading an interdepartmental team in a ward with people I didn’t know very well. As if those reasons weren’t daunting enough, the application to participate in the academy was probably the longest application I had ever seen! However, my mentor kindly sat down with me, explained everything in detail, and gave me the courage to “try my luck” and see this as an opportunity to learn. So I did it!

She helped me select a suitable quality-improvement project to work on. She mentored me like the nurturing mentor she is. On 27 January 2014, I received an email informing me that my application to participate in MCHNLA Africa was successful. You can imagine my excitement!

I attended the first intensive workshop in March, where we basically kicked off the leadership-learning process. The leadership component of the academy was based on the research and teachings of Jim Kouzes and Barry Posner, authors of *The Leadership Challenge: How to Make Extraordinary Things Happen in Organizations*. As I’ve mentioned, we had 18 months to successfully lead a quality-improvement project with an interdisciplinary team at our respective workplaces.

Not easy!

The next year and a half was not easy, to say the least, but the results were fruitful. One challenge I faced was, after gathering the courage and doing all the hard work that my mentor and I did to seek approval from the maternity unit manager to utilize the ward and its staff members to carry out my project, I was transferred to a different ward—the trauma department. This meant I had to start anew—seek permission from the trauma department to attend the STTI workshops, but carry out my project in the maternity ward.

After successfully getting over that hurdle, we faced another roadblock. The hospital matrons would not allow us to start our quality-improvement project without clearance from the ethics board. Despite efforts by my faculty adviser and mentor to reason with board members by pointing out that quality-improvement projects do not require ethical clearance, they remained adamant. If they heard we were conducting our project without clearance, there would be serious consequences. So, for the sake of peace, we sought ethical clearance, which took quite a while.

Not alone

I was glad to find out during our second workshop in February 2015 that I wasn't the only one facing challenges in my leadership journey. The experiences and encouraging words I received at the workshop helped me to not give up and actually look forward to successfully seeing the project through. Collaborating with the Mbabane Municipality and the Swaziland Nutrition Council, we educated childbearing women on the importance of proper nutrition and also taught them how to develop backyard gardens using available resources. The municipality now recruits these women to train women in various communities on proper waste management and development of backyard gardens.

I graduated from the [Maternal-Child Health Nurse Leadership Academy Africa](http://www.reflectionsonnursingleadership.org) in August 2015 during that year's Tau Lambda-at-Large Chapter conference. What a journey it was! I developed leadership skills I didn't think I'd ever have! Secondly, through the academy, my mentor and I helped empower women by educating them about nutrition. They are using the knowledge they gained to train others, thereby providing sustainability.

I thank Sakhile Masuku for believing in me and for always encouraging me whenever I felt like giving up. I couldn't have asked for a more patient and exemplary faculty adviser than Oslinah Buru Tagutanazvo, who, throughout the project, was always willing to give advice and nurture me. Thanks, STTI and funding partner Johnson & Johnson for this wonderful opportunity, one example of lifelong learning!





Kenneth W. Dion, PhD, MSN/MBA, RN, founder of Decision Critical Inc., is treasurer of the board of directors of the Honor Society of Nursing, Sigma Theta Tau International.

Part 1: My public speaking journey

Part 2: I knew I could do it better!

Published 3/10/2016, Vol. 42, No. 1

My relentless pursuit of opportunity

Lessons I learned on my entrepreneurial journey.

The relentless pursuit of opportunity regardless of resources controlled: This **definition of entrepreneurship** has been my mantra since I first heard it from **Jeff Sandefer**, MBA, founder of the **Acton School of Business** in Austin, Texas, USA. The year was 1995, and I was attending my first meeting of the Entrepreneurship Club at The University of Texas at Austin.

A few minutes into the meeting, the lights dimmed and there, on the wall in the blinding light of the overhead projector, was my three-page résumé, which I had dropped off for feedback. The quote that still rings in my head from Sandefer's gutting of my résumé is, "Now *here* is a guy who has no idea what he wants to do."

In fact, that statement was true. However, I *did* know that I *did not* want to do what everyone else was doing. My entrepreneurial journey has been informed by many of the clichés that are strewn throughout the following paragraphs, and I'm hoping these anecdotes will serve to inform the clichés.

The holy grant

Grant writing was a required element of my dual-degree MSN/MBA program. The professor who taught the course had received a rather substantial grant, which the class got to hear about on a regular basis. I asked him if he could bring a copy of this grant proposal to class. He was elated, and the following week, my business plan and the professor's holy grant lay side by side for all to see.

We found the two documents virtually identical except for nomenclature. I told the professor there was one other difference: "My business plan will live or die by the hand of the free market." I guess they don't call it B-school for nothing, because that is what I got in that course.

The plan, the plan!

A few years after graduate school, I dusted off my business plan and set off to conquer the world. Clichés abound when it comes to planning. My personal favorite is the 5 P's of success: Proper Planning Prevents Poor Performance. The difference between an entrepreneur and a small-business owner is that the entrepreneur builds a plan that aligns resources and grows exponentially the same enterprise that a small-business owner will still be toiling away at years from now.

The business plan is a living, breathing document that serves many functions. It's the road map for the business, a benchmark for performance, a shared vision across the organization, and an investor prospectus that describes various aspects of the venture. Without a business plan, you are just someone with a cool idea.

The most important section of the business plan is the financial plan. Just as in a research study, themes run consistently from the abstract through the conclusion, so, too, many of the themes and assumptions posited in the narrative of the business plan flow through to the financial projections. The novice entrepreneur will feel pretty silly when giving a presentation in which an optimistic sales forecast far exceeds the total size of the market.

The business plan will need to be updated from time to time. There may be shifts in the market, such as new entrants. There may be changes in funding, which will result in a shift in equity distribution. These routine updates should not be confused with changes in strategy, which are also reflected in the business plan. The latter should not be taken lightly.

Legal protection

Once the plan is established, you need to protect personal assets from risks by forming a legal entity. On the advice of friends from business school, I engaged, at the height of the dotcom era, one of the top legal firms in Austin to assist me. The law firm provided me with all the boilerplate legal documents you can now get off many websites, and it filed the necessary paperwork. Believe me, this was not inexpensive!

That law firm then referred me to an intellectual-property law firm, because they were sure “I had a good idea that must be protected.” The firm was glad to help me start protecting my intellectual property by doing \$10,000 worth of ground-work and research. I thanked them for their time and devoted some of mine to finding new legal counsel, the operative word being counsel.

Good legal counsel is invaluable. These important advisers attend to one’s day-to-day legal needs and can refer you to a deep bench of specialists. The good ones will set you up with all of the standard documents you need to operate your organization and don’t nickel and dime you for little tweaks to standard documents.

What kind of structure?

Structuring the venture appropriately at the start is key. A sole proprietorship is not the favored business structure of the entrepreneur, because it limits tools for providing incentives to those who may contribute to the venture’s success. The ability to issue stock to investors and advisers, and incentive stock options to key employees, can be critical in aligning both resources and motivations. In the early days of your enterprise, when cash may be tight, stock can be useful when assembling your advisory board. A good adviser can bring as much to the table as a good investor. Always be stingy with equity in your venture.

The way you structure your organization up front will also affect the effort required to exit your venture. For example, when selling to a publicly traded company, every last share of stock must be accounted for if the company being sold is a C corporation. This could mean contacting individuals involved in the company’s startup who may have since departed under less-than-friendly terms.

The fun of funding

I launched my first venture just before the dot-com crash. In those days, money flowed like wine. So, in my copious free time, I set off to condense my business plan into a 10-minute PowerPoint pitch.

I must have given that pitch at least 20 times. A potential investor commented that I needed a business-to-consumer strategy. So, I proceeded to share my B2C strategy with him. Finally, someone who gets it! My silent elation quickly turned to deflation when he told me I had lost focus. What I had lost was my most valuable resource: time—time pitching to potential investors who funded soon-to-be-dead Pets.com with its sock puppets mascot. Remember Pets.com?

Many times, it does make sense to take investment into your venture. However, investors should bring more to the table than a checkbook. They may bring expertise and relationships that help advance your business strategy. However, even the most passive investors will need regular reporting. If not managed well, you can quickly find yourself spending more time servicing your investors than your customers.

Funding will take a venture only so far. At some point, sales must become the fuel that propels an organization forward. Salespeople: Be slow to hire ’em, quick to fire ’em. Clearly articulate metrics for acceptable sales achievement.

Where’s the exit?

The goal of successful entrepreneurs is to eventually exit their businesses. Letting go may not mean cashing in on a multimillion-dollar transaction, but it might mean stepping aside to turn the reins over to a more experienced CEO who will take your start-up through its growth phase.

In the case of acquisitions, key staff members—including founders—may be asked to stay around to facilitate knowledge transfer and customer relationships. Rarely is the new company interested in your ideas and contributions. My advice is, contribute when you can, confront as little as you can, and know when it’s time to get out. “

Many of the tenets of nursing hold true in entrepreneurship. One of the most important is the nursing process. Constantly assess, diagnose, plan, implement, and evaluate. Another is, “If you never wrote it down, it never happened.



Carrie Sue Halsey, MSN, CNS-AD, RNC-OB, ACNS-BC, is a clinical nurse specialist and natural birth and breastfeeding advocate who resides in Houston, Texas, USA. She teaches childbirth classes for expectant parents and assists mothers with breastfeeding goals.

Published 1/21/2016, Vol. 42, No. 1

How do you solve a problem like millennials?

Begin by recognizing the strengths they bring to the workplace.

On a recent trip to a Redbox movie kiosk, I parked in front of the automated dispenser of entertainment. As I began searching for the Blu-Ray DVD I wanted, my 6-year-old son interrupted my scrolling by calling to me from the open car window. I turned and told him to roll the window back up and sit down, as I didn't want his movie selection advice yelled at me from my vehicle. He stared at me with a quizzical look, so I repeated my request that he roll up the window. He continued to stare blankly at me, searching for meaning in my statement. Visibly flustered, I walked to the window and asked him why he would not do what I asked. He replied, "I don't know how to roll up the window." Finally, I understood. He has never been in a car that had a rotating handle for closing the window. So I changed my request to "Close the window." He obediently pressed the button, and up it went.

Millennials, the WHY generation

I have experienced similar interactions in the workplace. At times, I feel I am clearly communicating my expectations to a younger nurse and then discover he or she is not processing the information. I have been a leader in a variety of settings since 1998, and I can tell you from experience that **millennials—those born from 1980 to 2000, also known as Generation Y**—are not like previous generations. I hasten to add that, as with any generational cohort, generalized characteristics describing millennials are just that—generalizations—and cannot be universally applied. That said, here are things I've personally observed.

They ask why—a lot. They text my personal phone when I am not at work. They want to be friends with their boss on social media. They expect an immediate response to emails. They never put down their phones. They miss deadlines and then are dev-

astated when there are negative consequences. They challenge every direction, yet demand to be closely mentored. They think their special circumstance is more special than any other person's in the department.

While it's true that I have personally observed all of the above, it's also true that millennials are subject to many negative stereotypes—misconceptions that become universalized and regarded as truth. They are viewed as self-absorbed, shameless, pampered to, careless, selfish, screen addicts, stupid, and having a poor work ethic.

It is a lazy leader who believes these characteristics accurately describe all millennials. One only needs to think back 30 years and remember what was being said about Generation X. Generation X members were often viewed as slackers and apathetic. Think Seattle grunge, punk rock, and teens growing up in the commercialism of the 1980s. Prior to that, baby boomers were angst-filled teens riding around in Volkswagen buses and participating in love-ins. It is neither fair nor accurate to judge a generational cohort by its growing pains.

Demystifying millennials

The number of millennials in the workforce is quickly increasing. In just five years, employees born after 1980 will comprise 50 percent of the American workforce. Already, millennials outnumber Generation Xers and, by 2030, will make up 75 percent of U.S. workers.

Millennials bring a multitude of positive qualities to nursing. They are, unquestionably, the most tech-savvy generation, which is a huge asset in a constantly evolving, technological world. As early adopters of new tech, they are a natural fit to become

super-users, helping to teach others. Millennials generally place high value on education and, in years to come, will become the most educated generation. Yes, they never put their phones down, but they are incredibly connected to friends, family, and the world.

Millennials operate in multitask mode all of the time. This is a great skill for a nurse. Millennials are the most racially diverse group to date and seek social justice and complex understanding of others. They are smart and able to process information quickly. Millennials bring these qualities and more to the workplace but often struggle to fit into traditional environments. Millennial nurses are looking to their leaders for help in navigating their work environments.

Managing millennials is a challenge, one with which I have struggled. Because of this, I've had to reflect on my leadership style in recent years. I am not alone. Nursing leaders accustomed to managing Generation X and baby boomers are often mystified by millennials. It seems that leadership approaches used for other generations simply don't work when applied to Generation Y.

Working with millennials

Whether you call them millennials or Generation Y, here are some useful tips you may find helpful when working with nurses from that age group.

1. Although millennials welcome help, they do not want to be micromanaged. From their perspective, leaders are coaches, not bosses in the traditional sense. They want autonomy, to be trusted. Many grew up with attentive parents, coaches, and teachers, an orientation that necessitates an altered approach to mentoring. They need more oversight, more encouragement, more feedback, more help in goal setting, and specific guidance.
2. Providing input and working collaboratively are important to millennials. If they are not able to work as part of a team and feel ownership, burnout will follow. Unlike their predecessors, they are less inclined to settle for a job that is not fulfilling. To secure their buy-in to workplace changes and management decisions, it is important to explain the rationale behind those decrees. Millennials understand and appreciate mentorship from older nurses, but they also appreciate contributing input and possible solutions.

3. Communication expectations are quite different for members of the millennial generation. This group expects quick responses from their leaders. They are visual learners and process information best in quick snippets. They want the facts and want to be given more than the company line. They value sincerity.
4. Although millennials want to succeed in the workplace and will conform to professional expectations, they are an informal group that requires clear communication of expectations to be successful in their jobs. If a millennial nurse fails to perform a task properly, there is an excellent chance that he or she doesn't understand the assignment. It is important, therefore, that a leader views unprofessional behavior as an opportunity to mentor. When expectations are communicated clearly, millennials adapt well, especially if there are valid reasons behind expected behaviors.

Nursing needs millennials

In coming years, the profession of nursing will rely heavily on millennials to make up for retiring baby boomers, but adding to staff numbers is not their most important legacy. Millennials demand work-life balance, and they get it. They question the status quo and then change it. They expect to enjoy their work and will not settle.

Members of this new generation share many of the same goals of previous generations, but they are confident they will succeed where their parents and grandparents failed. Nursing needs these types of individuals. Millennial nurses will take our profession into the future, where healthcare teams are truly interprofessional. Nurses will no longer be invited into boardrooms as token representatives; they will be equal leaders in writing health policy, achieving scientific discovery, and determining patient care.

When I was a child, we drove to a store that rented videotapes, and we watched movies on our 19-inch analog television. We ordered pizza from a rotary phone, which was mounted on the wall. I remember watching futuristic television programs that portrayed concepts such as video chatting and thinking that maybe that would happen in my lifetime. That day is now. It is time for nursing leaders to stop managing from the past and reflect on how to become the leaders millennials need.



Kelsey Lessard, DNP, APRN, CNP, a women's health nurse practitioner, is employed at Nucleus Clinic in Coon Rapids, Minnesota, USA.

Part 2: Prison and sex-traffic victims: A place for help but not a safe zone

Part 3: Integrating sex-trafficking awareness into women's health curricula

Published 8/25/2016, Vol. 42, No. 3

Greater awareness of sex trafficking needed

Healthcare providers are among few able to identify and help victims.

As a public health nurse, I worked with pregnant teens and teenage parents who faced a multitude of health and social wellness barriers. These clients, many of whom were well below the federal government's **100-percent poverty guideline**, were not only busy navigating pregnancies and raising families, they were often simultaneously dealing with intimate-partner and family violence, homelessness, food security issues, drug and alcohol abuse, and mental health issues.

As a nurse, it was my job to guide them through pregnancy and their child's first few years of life by supplying nursing support, education, and resources. I knew these clients were at risk for all kinds of healthcare and social disparities that needed to be addressed. What I did not realize was that the daily challenges they faced often placed them at great risk for sex trafficking. Like many nurses and other healthcare providers, I was unaware that sex trafficking was probably affecting my clients, and I was not equipped to offer appropriate support or resources.

It wasn't until I started volunteering for a local organization that offers support for sexually exploited women, including survivors of sex trafficking and those trying to leave "the life," as it is often called, that I realized the true nature of sex trafficking. Hearing their stories, I began to understand how deeply my own community was affected.

Definition and scope

Human trafficking, one of the fastest growing public health concerns affecting communities throughout the United States, is often described as a form of **modern-day slavery**. People are sold

or exploited for a variety of reasons, including sex, labor, and forced engagement in criminal activities. I'm focusing here, however, solely on sex trafficking, where victims are forced, tricked, manipulated, threatened, or otherwise coerced to perform **commercial sexual acts**. Any activity involving a person under age 18 where a sexual act is traded for money or something else of value is considered to be trafficking, and it is **illegal**. Youth and adults alike are victims.

Although many think the majority of sex traffic victims in the United States are from outside the country, **83 percent** of those in confirmed cases between January 2008 and June 2010 were U.S. citizens. International human trafficking is certainly an issue that needs to be addressed, but we must not overlook the reality that trafficking happens to people who live, work, and grow up in our communities.

The reality is, the true incidence and prevalence of sex trafficking in the United States is not known. Because sex trafficking is illegal, often hidden, dangerous, and highly stigmatized, it is difficult to obtain reliable statistics. Available data are often estimates and likely underestimates. What we know is, sex trafficking is happening, and it affects the lives of many.

Health concern

Although sex trafficking has serious legal and social ramifications, it is also a major public health concern. Victims suffer from poor health caused by sexual traumas, physical injuries, child abuse, substance use and abuse, and mental health disorders. Adults and children involved in sex trafficking often endure

trauma, including rape and incest. Not having control over their own reproductive health causes them to be at greater risk for **gynecological concerns**, such as sexually transmitted infections and unplanned pregnancies.

Sex trafficking victims may suffer from **physical injuries** such as blunt force trauma, burns, firearm and knife wounds, and head injuries. Living each day in a high-stress environment of manipulation, fear, and physical and emotional abuse leaves many with **mental health disorders**. To cope with life, they often become dependent on alcohol and drugs.

These significant health consequences bring victims into contact with people working in healthcare. In fact, healthcare providers are among the relatively small group of people they are able to interact with outside the world of trafficking, and they are coming to our clinics and hospitals.

A 2014 study by **Lederer & Wetzel** of more than 100 trafficked women throughout the United States found that nearly 88 percent of victims visited a healthcare provider while under the control of a trafficker. This close contact places providers in a **unique position** to screen for, identify, and provide care and resources to these patients. Even when victims benefit from outside support and advocacy, they often lack access to needed healthcare resources.

This lack may be due, in part, to the fact that the high-risk circumstances of sex-trafficked patients often make them invisible to healthcare providers who are not trained on what signs and symptoms to look for. Because evidence-based education programs and clinical practice guidelines on screening and care of these patients are largely absent from **healthcare provider education**, sex-trafficking victims remain unrecognized and fail to receive needed care and resources.

Greater awareness needed

Healthcare professionals must know about sex trafficking and what to do when they encounter someone who is being trafficked for sex. We have a duty to ask possible victims appropriate questions, identify specific needs, and provide the best care and resources possible. To screen for trafficking, we need to watch for behavioral red flags, draw upon pertinent histories when interviewing patients, and look for physical and emotional signs and symptoms that may indicate

trafficking. Because these signals are not always evident, we must also be alert to other factors that may keep us from “seeing” traffic victims and understand why a patient is not disclosing what is really happening in his or her life.

This need for increased awareness prompted me to focus my Doctor of Nursing Practice project on implementing a program that would help educate nurses and other healthcare professionals on sex trafficking. It is essential that sex-trafficked people have a voice in that education. Working with a community partner organization, we asked women who had been trafficked or were in the process of leaving “the life” what healthcare professionals should know and do when interacting with sex-trafficked people.

They gave us all kinds of wonderful advice. They described feelings of fear—of their situations but also of visiting clinics and hospitals. They recommended that healthcare professionals be honest, ask questions that need to be asked, be open to difficult stories, and remain professional and nonjudgmental. Their pearls of wisdom were incorporated into the lesson plan we developed for healthcare providers. In addition to information, the program also provided healthcare practitioners with tools to identify, assess, care for, and support sex-trafficked patients. In evaluating the program, I found that even brief educational intervention increased awareness of sex trafficking.

Looking ahead

In my new role as a women’s health nurse practitioner, I still have the privilege of working with high-risk youth and adults. Now that I know what to look for, sex trafficking is constantly on my radar. I make sure to watch for red flags, ask more in-depth questions when I detect suspicious physical signs of trafficking, and pay special attention to the sexual, mental, and chemical health of patients who visit the clinic where I work.

My hope is that greater awareness of sex trafficking by nurses and other healthcare professionals will lead to increased identification and screening of victims, provision of better healthcare resources, and, eventually, improved healthcare management for people affected by sex trafficking.



Jan M. Nick, PhD, RNC-OB, CNE, ANEF, professor at [Loma Linda University School of Nursing](#), Loma Linda, California, USA, is dean and professor of the Department of Nursing at [Saniku Gakuin College](#), which has campuses in Otaki and Tokyo, Japan.

Published 1/28/2016, Vol. 42, No. 1

Tips for nurse educators who want to go global

Who would think NOT knowing the language can help?

If you have always dreamed of going abroad to teach or conduct faculty development seminars, I want you to know you are greatly needed! As a specialist in international faculty development, I have found that nursing schools around the globe have a great desire to receive up-to-date information on clinical trends, evidence-based practice, conducting online searches more efficiently, and implementing active learning strategies.

As a nurse leader, you have so much to offer, and sharing your knowledge globally with others aligns well with goals of the Honor Society of Nursing, [Sigma Theta Tau International](#) (STTI). Technology makes it possible to communicate with nurses on the other side of the world even when you don't speak their language, so don't let lack of fluency in another language prevent you from serving them. The benefits you receive will far outweigh the uncertainty and discomfort you may feel in a new environment.

Finding an institution to serve

There are many ways to create an international service experience. One way to find visiting scholar programs at institutions worldwide is to conduct an internet search using the term "teacher exchange." Contacting professional organizations such as [STTI](#), [International Council of Nurses \(ICN\)](#), or [International Nursing Association for Clinical Simulation and Learning \(INACSL\)](#) may be fruitful. Another option is to network at an international nursing conference, such as STTI's Biennial Convention or International Nursing Research Congress, Elsevier's [International Nurse Education Conference \(NETNEP\)](#), or the [Worldwide Nursing Conference \(WNC\)](#).

Funds are available annually through the [Fulbright Scholar Program](#) for nurse faculty members who want to work in nursing

schools internationally. Also, joining the [Consortium of Universities for Global Health \(CUGH\)](#) could open the door to fellowships and internships at one of the participating universities around the world.

Making use of church organizations and their global network of faith-based colleges and universities is a good way to build capacity in nursing schools. For the bold-hearted, identify an institution where you would like to serve, make a cold contact, and see what happens. Finally—and don't ignore this one—talk with a colleague from another country to see if he or she can help line up an international teaching experience for you. The options are many and, with a little perseverance and vision, you can create the experience you want.

Your service could be a one-time, long-term, visiting scholar assignment; a short-term arrangement; or one where, functioning as a development specialist, you return repeatedly to the same institution over many years. Typically, the host covers room and board, and either the host or the presenter pays for airfare. If you initiate the workshop, etiquette dictates that you cover travel expenses. Realize, however, that the money you spend on an overseas flight is more than compensated for by the career fulfillment and experiences that await you in the host country. Besides, depending on tax laws in your own country, expenses could be tax deductible, making the net cost even lower.

Benefits of *not* knowing the language

When considering countries in which to serve, don't limit yourself to those where your language is spoken. In fact, lack of fluency in the language of your host country may actually be a benefit as it can increase your capacity to connect at a more fundamental level. Experts say that almost half of communication is

nonverbal, enabling one to understand parts of a message without knowing the words.

I have found this to be true. Catching a single word here and there while watching body language helps convey the message and, over time, your capacity to “read” people will increase. In our own countries, where we are used to listening, we tend to get lazy and not pay attention to nonverbal cues. But visiting another country forces you to become more alert to nonverbal communication patterns, and an unexpected benefit is that you find yourself paying more attention to those cues in your own country.

Another benefit of not speaking the language fluently is that you are not expected to deal with the problems, details, committee disagreements, and other activities that typically drain the energy of nurse leaders. Excused from those distractions, you have more time to participate in visioning, collaborating in research projects, creating new direction for the department, and publishing.

Working with interpreters and translators

If you are not fluent in the language, you must work with an interpreter. Before making a presentation or other critical communication, let the interpreter know that conveying key ideas—not exact words—is best. Pause after just two or three sentences to allow the interpreter to convey the message before you begin again.

When communicating in writing, you must use a translator. While the translation won’t always be perfect, technology can do an amazingly competent job of translating short phrases. The technological tool of choice for me is Google Translate. This tool is very useful when translating bulleted words (no more than one or two words per bullet) for presentation slides. Before making the presentation, I double-check the accuracy of the translation by stating the phrase in the original language, and then I still ask someone to peruse the words for correctness.

For more complex sentences, you will need an interpreter to translate presentations. I have learned it is best to put both the English and the translated text for each bullet on the same slide. I also use this tool when sending simple messages to others (sent in both English and the other language). Again, I recommend back-translating the message before sending to make sure it conveys what you intend.

On occasion, I have also had to use Google Translate to have face-to-face communication with both students and faculty members. When they come to visit, I open the program, they type the message, I type in my response, and it translates. This goes back and forth until the requisite communication is completed. You might think communicating this way is fatiguing, but it works, and I have always felt energized afterward, knowing we have communicated!

Another tool I use to communicate is a smartphone language app. I choose my language and a second language, and the app interprets what was said and speaks the translated phrase to the other person. Once I invited Russian visitors to my home for dinner. I didn’t speak Russian, and they spoke very little English, so we used my smartphone app to communicate and get to know each other. There was a lot of laughter as we tried to speak into the smartphone as clearly as possible for optimal translation. Note: This type of app typically requires Wi-Fi to work.

Different place, same challenges

There’s no denying it; there *are* challenges when working at a foreign institution. One of them is sitting through long meetings and not being able to understand what is being said. It is hard to stay interested and look attentive. But isn’t it a challenge in your *own* country to sit through long meetings and try to appear attentive and engaged when you are tired or bored?

It is also frustrating not to be able to implement all the visions you have. Language barriers make it necessary to pick your challenges, prioritize projects, and stay focused on your vision. But that’s true even at a nurse leader’s home school!

After 15 years of working in international faculty development, the most valuable lesson I have learned is that it doesn’t matter if I am fluent or not. What matters most is my “way of being” while in the host country. Willingness to do extra presentations and be flexible, while showing humility, respect, confidence, patience, and understanding, are positive behaviors that communicate without words.

There is such a need to increase capacity globally in nursing education. I encourage *you* to go and be of service to others. The experience will stretch you and help you grow professionally. Create the professional engagement you have always desired, and don’t let circumstances or language barriers get in the way of reaching your potential.



Sarmad Muhammad Soomar, BScN, is a recent graduate of Aga Khan University School of Nursing and Midwifery in Karachi, Pakistan.

Published 4/28/2016, Vol. 42, No. 2

A matter of gender

He took her history and then asked one more question.

Because of sociocultural norms, people often feel more comfortable sharing ideas, issues, or worries with others of the same gender. Here in Pakistan, women commonly talk about household concerns, shopping, or vanity, whereas men typically discuss business, money, and the like. Similarly, in healthcare, Pakistani men and women find it easier to interact and communicate with healthcare providers of their own gender. Sometimes, when a nurse or resident of a client's gender is unavailable, compromises are made, particularly when the patient is in emergency care, a critical care unit, or a general ward. Compromises are less likely to be accepted, however, when assistance is needed in antenatal clinics, labor rooms, and postnatal care wards. Also, when it comes to breastfeeding, women prefer women for support.

When I was learning about reproductive health during my nursing program, I was taught each and every aspect of the topic—from conception to birth, from abortion to family planning, from prenatal to postnatal—but when the time came to apply theoretical concepts practically, I felt as though I was back at zero. When it comes to reproductive health in Pakistan and providing culturally sensitive care, men have to forgo in practice what they learn in the classroom.

Off limits

Stated simply, the hurdle is being a man. Men can't ask about birthing, menstruation, feeding, or other such issues and are unable to be involved in those processes because it is not considered culturally appropriate. If a man enters a ward, the women hide themselves and are apprehensive that they might be interviewed about something that is very personal. Patients in every bed refuse to answer questions or allow us to enter their spaces.

When this happened to me recently, I felt dejected and temporarily left the area. After breathing a sigh of relief, I commandeered a spare overhead table and started writing down on paper everything I knew about reproductive health that a client might want to know. After listing all the information that came to mind, I asked myself: "Why can a gynecologist in Pakistan be a male but a midwife or reproductive health nurse cannot be a male? Are nurses less knowledgeable? Don't male nurses know as much about these issues as female reproductive health nurses or midwives?"

Taking a long breath and holding my file confidently, I went to the bedside of a nearby patient, excused myself, told her who I was, and asked for permission to conduct an interview. After a bit of hesitation, the lady replied, "Yes." I assured her that, just as a female nurse would do, I would maintain her dignity. I also told her: "You have the right to not respond to questions about which you feel uncomfortable. But remember, this is about your health and the health of your baby, so it would be good if you reply to every question I ask." She smiled, and, with that, I began the interview.

I recorded the following: 1) patient's name, 2) complaint, 3) health data that ranged from preconception to last menstruation, from para to gravida, and including diet, vaccination status, and routine work habits. I tried to investigate each and every possible aspect related to her maternal health and present complaint, and she responded willingly. At the end, I summarized all of the important notes I had taken about her history and expressed gratitude for her responsiveness.

One more question

As I was moving away from her bed, a small but major thing clicked in my mind. Although I know that I am knowledgeable and prepared, even as a male, to accomplish all nursing tasks associated with an antenatal ward, my priority as a nurse is the client. Had I asked the woman if she was comfortable? Had I given her an opportunity to discuss her fears and problems? Had I adequately explored, beyond diet or exercise, what was happening with her health? No, I hadn't.

At that moment, it occurred to me why patients prefer having care provided by someone of their own gender. Women face experiences that are common just to them, and they really want to share with each other. Closing my eyes momentarily, I suddenly felt a light coming toward me, and, right then, I got my answer. Maybe I won't understand the perspective of a woman client the same way a woman can, but I can at least try. After all, a man is a human who also carries emotions in his heart and can therefore empathize with a client, whether of the same gender or not.

Turning back again toward the client, I put a smile on my face and excused myself to disturb her once again. "May I ask you one more question?" I ventured, and she gave permission. Wanting to give her the opportunity to ask or share anything she wanted, even though not on my checklist, I asked, "To be more comfortable, is there something you think you should discuss with someone?"

She stared at my face for few seconds, and, unexpectedly, I saw tears in her eyes as she replied: "No, I am feeling much better now. At last someone has asked what I think and what I actually want. I have to bear all the pain in this complete process, but everyone is thinking about *their* trouble. Everyone is instructing me to do this and do that. No one has asked what *I* feel, what *I* think." Abruptly turning her face to the other side of the bed, she stopped speaking. At that moment, an older lady, the patient's attendant, asked me to leave, and I did as requested.

Suddenly, I heard a voice behind me say: "Thank you. Thanks for your help." I turned around and saw that the client was now smiling. Returning her smile, I left the area saying, "You can call me if you need any assistance."

My takeaway

Afterward, I reflected on the experience. I reminded myself that, apart from other practical assistance, effective communication is of great help to the client. In my sociocultural context, I am not allowed to help women during the birthing process, but I can help them before they enter into that event and after they have experienced it—both prenatal and postpartum.

Male nurses *can* increase their study and research in this field, if they are really interested. They *can* help clients while respecting sociocultural norms and preferences, as I did throughout my rotation. I have determined to continually keep current on the subject while still studying other nursing fields. And in the future, I want to help male nurses, especially in Pakistan, increase their knowledge of and ability to practice in sexual, reproductive, and maternal childcare. Understanding reproductive health should not be limited to female nurses. Male nurses can also be an essential part of this important area of healthcare.





Sigma Theta Tau International
Honor Society of Nursing®