Do You Believe in Groundhogs?

Do you believe in groundhogs? More specifically, do you believe that they are able to predict a long winter or an early spring? The largest Groundhog Day celebration is held every February 2 with Punxsutawney Phil (i.e., the furry rodent, Marmota monax) in Punxsutawney, Pennsylvania. The day has been celebrated there since at least 1886 (Kruesi, 2007). Crowds as large as 40,000 gather to watch Phil. There are many other places in the United States and Europe where celebrations occur. Therefore, you are not alone.

If you believe in groundhogs and their predicting skills, do you know why? If you are a believer, you have probably been one since childhood. These beliefs fit within the categories of tradition, along with Santa Claus and the Tooth Fairy. Most folks do not study or research traditions, unless they are anthropologists or historical social scientists.

BEYOND BELIEF IN GROUNDHOGS

But, we are nurses. Theoretically, our beliefs, which guide our clinical practices, are based on science rather than tradition. We need to ensure that we are not unwittingly practicing traditionally, rather than scientifically.

John Kostis, MD, cardiologist at Robert Wood Johnson Medical School, New Brunswick, New Jersey, delights in challenging faculty and students to see that consensus is a form of tradition. He asks: “If 10 physicians say that something is so, what is that?” The answer is “consensus,” not science or evidence. Then he asks: “If 1,000 physicians say that something is so, what is that?” The answer is the same, no matter if the number reaches millions. He encourages patients and colleagues to always ask: “How do you know that?” or “Why are you recommending that?” (J. Kostis, personal communication, March 2015).

Interestingly, a firmly held belief of Kostis has just been disproven. Kostis heads a unit of the National Institutes of Health SPRINT study, which tests systolic blood pressure levels for various ages, but with an emphasis on older adults. He believed that the older one is, the higher the standard blood pressure should be, and that it was wrong to consider 120 mmHg normative. His rationale was that as the lumen of arteries decrease because of plaque build-up, the more power or pressure is needed to get oxygen to the brain via blood arteries. The SPRINT study ended earlier than planned because the preliminary findings clearly showed that the tested 140 mmHg was not correct, and that the clinical standards should revert to 120 mmHg (SPRINT Research Group, 2015). Participants in this randomized clinical trial were notified that the study ended, and that the systolic blood pressure portion of the study was no longer in effect. They were directed to return for monitoring to their former clinicians.

BELIEF ABOUT HEARING VOICES

What traditions, consensus, or firm beliefs do we have in our practices? When do we decide to look into these and see what changes are needed? Many psychiatric nurses believe that hearing voices (unless the stories are religious accounts) is without doubt a symptom of serious mental illness. I believed this, too, until I met Marius Romme, a Dutch psychiatrist, and some of his colleague–patients (i.e., former patients who are now colleagues). His approach was to accept the voices and help the voice hearers understand them. Louise Pembroke, a voice hearer, joined Romme and myself on a conference panel in London, England. Before beginning our presentation, Louise asked to make a disclosure. She told the audience: “Please understand that I am not a professional hearer of voices. I do not do that all day, every day. I work and have other obligations. So, please accept my part-time status” (Smoyak, 2013). Lesson learned. Before this, when working with patients with this symptom, I would tend to classify it as “atypical auditory hallucination.” But my belief has changed dramatically.

CHALLENGING CLINICAL CUSTOM

A cousin to the word tradition is “custom.” The practice guidebooks in many nursing units are really “custom.”
The processes and procedures are customs, rather than evidence or science. When newcomers to the unit ask about these, or challenge them, what often follows is defensive posturing. Years ago, when I had a rotation of junior students for a psychiatric course in a county hospital, I suggested something different. I told the 10 students that one way to earn an A for the 15-week course was to identify, with one of their patients (on a long-term chronic unit), a positive change that they would like to achieve. These ideas included learning to be more sociable, mastering table tennis, and winning at poker. Several patients wanted to get into the new in-ground pool in a recreation center within the hospital plaza. But there was nothing in the guidebook regarding use of the pool. What the students learned was how to manage the process of doing something positive, but staff were resistant and angry for their “trouble making.” Their comfortable customs had been interrupted. Nurse faculty at the college were not happy either, as their customs of teaching did not include swimming with patients in a pool in the middle of winter.

BULLYING TRADITION

Unfortunately, there is another cousin word masquerading as custom or tradition: bullying. In clinical settings, bullying happens when requests for changes of units or changes of shifts are denied and no rationale is offered. In academia, new faculty members are not provided with guidance or supervision, but are assigned courses for which they are not prepared, and then criticized when they do not do well.

Bullying is also evident in how resources are allocated or room assignments or parking spaces are acquired. Continuing education is an expectation. Yet, who pays for what is not clear. Which conferences and which journals are considered “the best” are not articulated.

When a bullied nurse tries to fight back, he or she may be accused of being a troublemaker, or not fit for the position.

VINDICTIVE PROTECTIVENESS IN ACADEMIA

With students, there is an unfortunate new culture of coddling, where the unspoken custom is now to assure that students are protected, kept safe, and do not experience any “trigger” talk in classrooms. Faculty, who had assumed that their role was to teach by challenging old beliefs and providing new ideas, are now prohibited from making students uncomfortable or upset.

Lukianoff and Haidt (2015) summarize and analyze this unfortunate new academic tradition, stating, “The current movement is now to assure that students are protected, kept safe, and do not experience any “trigger” talk in classrooms. Faculty, who had assumed that their role was to teach by challenging old beliefs and providing new ideas, are now prohibited from making students uncomfortable or upset.”

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