

Klinisch leiderschap:
Verandering en verbetering
van binnenuit

Simon Malfait, UZ Gent





ZORG VOOR DE TOEKOMST: OVER DE TOEKOMSTBESTENDIGHEID VAN DE ZORG

- Het tekort aan zorgpersoneel zal tot 2040 duren t.g.v. de huidige bevolkingspiramide
- Er is momenteel een **economische relance** waardoor de werkloosheid nog nooit zo laag geweest is
- Indien we alle noden in de toekomst willen invullen zullen **3 op 20 Nederlanders in de zorg moeten werken**, wat financieel niet haalbaar is



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GROOTSTE CRISIS OOIT?

- Uitdagingen zijn niet nieuw: tekorten, generatiekloven, praktijk vs. onderwijs, complexiteit van zorg, ...
- COVID als katalysator:
 - ✓ Collectief trauma
 - ✓ Essentieel belang van enkele 'basis'-gezondheidsberoepen
 - ✓ Systeemfouten

FUNCTIEDIFFERENTIATIE

GESTRUCTUREERDE
EQUIPE

MANTELZORGER &
BEKWAME HELPER

DEFINTIE
VERPLEEGKUNDE

(NIET)-DELEGEERBARE
HANDELINGEN

KONINKRIJK BELGIE

FEDERALE OVERHEIDSDIENST
VOLKSGEZONDHEID, VEILIGHEID VAN DE
VOEDSELKETEN EN LEEFMILIEU

Voorontwerp van wet tot wijziging van de wet
betreffende de uitoefening van de
gezondheidszorgberoepen, gecoördineerd op 10
mei 2015, teneinde de hervorming van de
verpleegkunde hierin op te nemen

Memorie van toelichting

Met dit ontwerp wordt de wet betreffende de
uitoefening van de gezondheidszorgberoepen,
gecoördineerd op 10 mei 2015 gewijzigd, teneinde de
hervorming van de verpleegkunde hierin op te
nemen.

Het regeerakkoord voorziet een verdere uitrol en
modernisering van de wetgeving op de
gezondheidszorgberoepen. Taken worden hierbij
toegewezen aan zorgverleners die ze op de meest
doelmatige manier uitoefenen.

Naar aanleiding van het regeerakkoord werd in
september 2021 op federaal initiatief een taskforce
betreffende het verpleegkundig beroep opgestart,
met steun van de verschillende ministers bevoegd
voor gezondheid en onderwijs van de deelstaten. De
taskforce maakte aanbevelingen omtrent het
functiemodel verpleegkunde van de toekomst.

Ten gevolge van het eindverslag van de taskforce
werden meerdere adviesvragen gesteld aan de
Federale Raad en Technische Commissie voor

ROYAUME DE BELGIQUE

SERVICE PUBLIC FÉDÉRAL SANTÉ
PUBLIQUE, SÉCURITÉ DE LA CHAÎNE
ALIMENTAIRE ET ENVIRONNEMENT

Avant-projet de loi modifiant la loi relative à
l'exercice des professions des soins de santé,
coordonnée le 10 mai 2015, afin d'y insérer la
réforme de l'art infirmier

Exposé des motifs

Ce projet modifie la loi relative à l'exercice
des professions des soins de santé, coordonnée
le 10 mai 2015, afin d'y insérer la réforme de
l'art infirmier.

L'accord de gouvernement prévoit le
déploiement et la modernisation de la
législation sur les professions des soins de
santé. Dans ce cadre, les tâches sont attribuées
aux prestataires de soins qui les exercent de la
manière la plus efficace.

Suite à l'accord de gouvernement, une
taskforce sur la profession infirmière a été
lancée en septembre 2021 à l'initiative
fédérale, avec le soutien des différents
ministres compétents pour la santé et
l'éducation des entités fédérées. La taskforce a
formulé des recommandations concernant le
modèle de fonctions infirmières du futur.

À la suite du rapport final de la taskforce,
plusieurs demandes d'avis ont été adressées au
Conseil fédéral et à la Commission technique

Personeelstekort in woonzorgcentra leidt tot schrijnende situaties: "Mijn moeder zit al uren te wachten op de wc"



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In vier op de tien woonzorgcentra werken minder verpleegkundigen dan het wettelijke minimum. Dat leidt tot schrijnende situaties, vertellen zij die er wél werken. "Ze huilt van schaamte omdat ze uren had moeten wachten op de wc."

Personeelstekort is grote constante op zwarte lijst van woonzorgcentra: "Overheid heeft probleem zelf gecreëerd"



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Een tekort aan personeel: het is voor veel zorgvoorzieningen de reden waarom ze onder verhoogd toezicht staan. De overheid heeft dat probleem zelf gecreëerd, pareren directeurs. "We doen al twintig jaar hetzelfde, maar nu is het niet meer goed genoeg."

ZORGSECTOR

51 miljoen extra voor zorgpersoneel



Flexi-jobs kunnen in de zorgsector, maar niet voor een zorgberoep als arts of verpleegkundige. — © Fred Debrock

Het systeem van de flexi-jobs werd niet uitgebreid naar de zorg. Minister Frank Vandenbroucke (Vooruit) bekampt het personeelstekort met drie maatregelen.

Jeroen Struys

Maandag 16 oktober 2023 om 03:00





Partnership for Health System
Sustainability and Resilience



BELGIUM

Sustainability and Resilience in the Belgian Health System

Muriel Levy and Lieven Annemans



February 2023

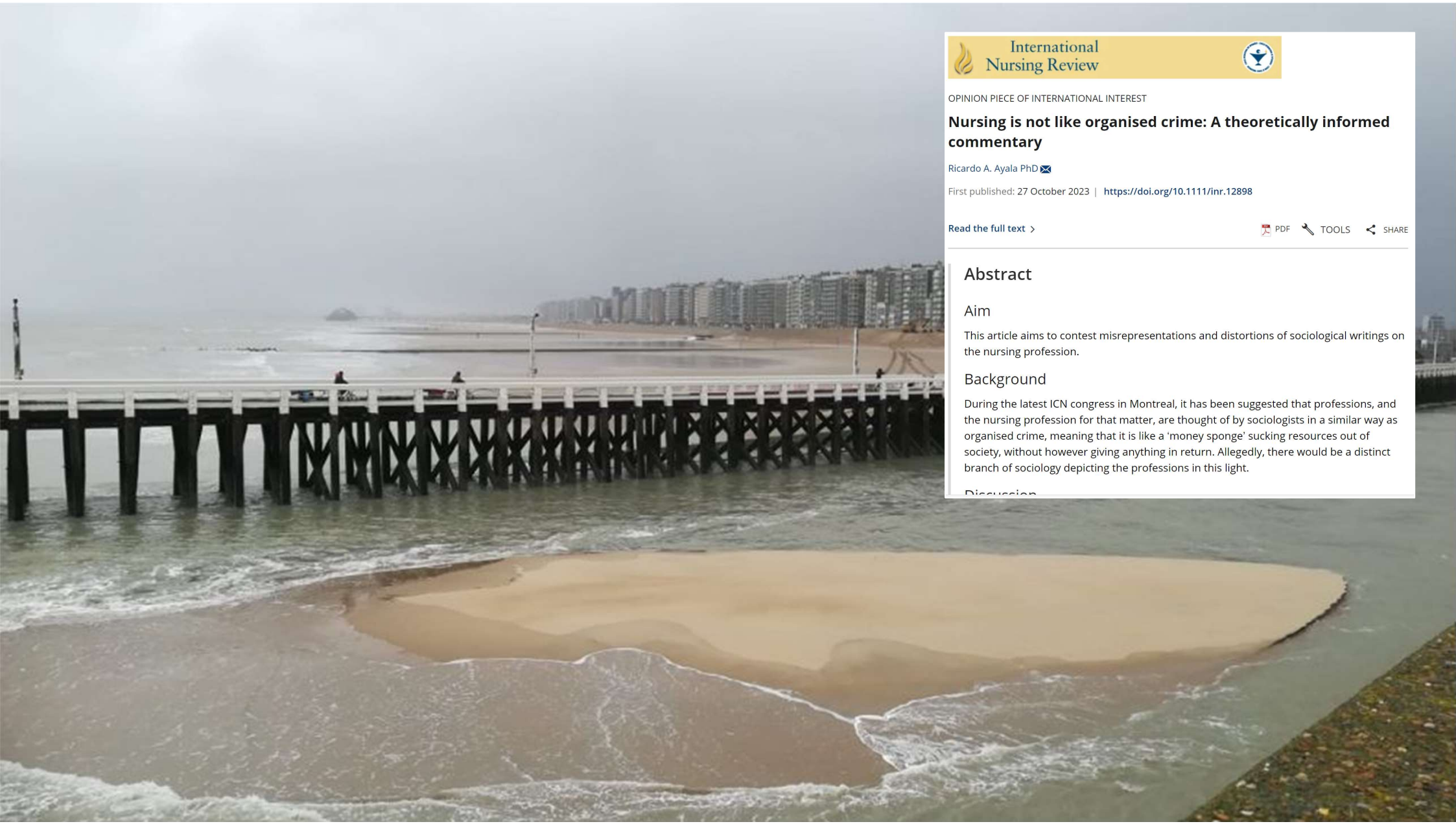
Table 6: key data about the Belgian healthcare workforce

Workforce category	Number per 1,000 population	EU-13 (2018) ^a
Practising nurses (2018)	11.07	8.69 ^c
Practising physicians (2019)	3.16	3.83 ^d
Practising midwives (2018)	0.72	0.40 ^c
Practising dentists (2019)	0.76	0.69 ^e
Practising pharmacists (2019)	1.27	0.85 ^f
Practising physiotherapists (2019)	2.04	1.98
Practising caring personnel ^b (2018)	6.29	8.30 ^g
Percentage trained abroad	%	%
Nurses (2020)	4.11	5.16 ^h
Physicians (2020)	12.70	15.49 ⁱ
Average gross remuneration (2019)	Annual income (€)	Income multiple of average wage
Self-employed general practitioners	117,110	2.49
Self-employed specialists	266,243	5.67
Salaried hospital nurses	69,537	1.48
Average annual wage	46,948	

Table 7: Evolution of practicing physicians and nurses

	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Practicing physicians per 1,000 population	2.92	2.92	2.92	2.93	2.96	2.98	3.02	3.07	3.08	3.13	3.16
Practicing nurses per 1,000 population	9.42	9.59	9.81	10.02	10.3	10.58	10.83	10.96	11.22	11.07	-

Source: OECD Statistics



OPINION PIECE OF INTERNATIONAL INTEREST

Nursing is not like organised crime: A theoretically informed commentary

Ricardo A. Ayala PhD 

First published: 27 October 2023 | <https://doi.org/10.1111/inr.12898>

[Read the full text >](#)

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Abstract

Aim

This article aims to contest misrepresentations and distortions of sociological writings on the nursing profession.

Background

During the latest ICN congress in Montreal, it has been suggested that professions, and the nursing profession for that matter, are thought of by sociologists in a similar way as organised crime, meaning that it is like a 'money sponge' sucking resources out of society, without however giving anything in return. Allegedly, there would be a distinct branch of sociology depicting the professions in this light.

Discussion





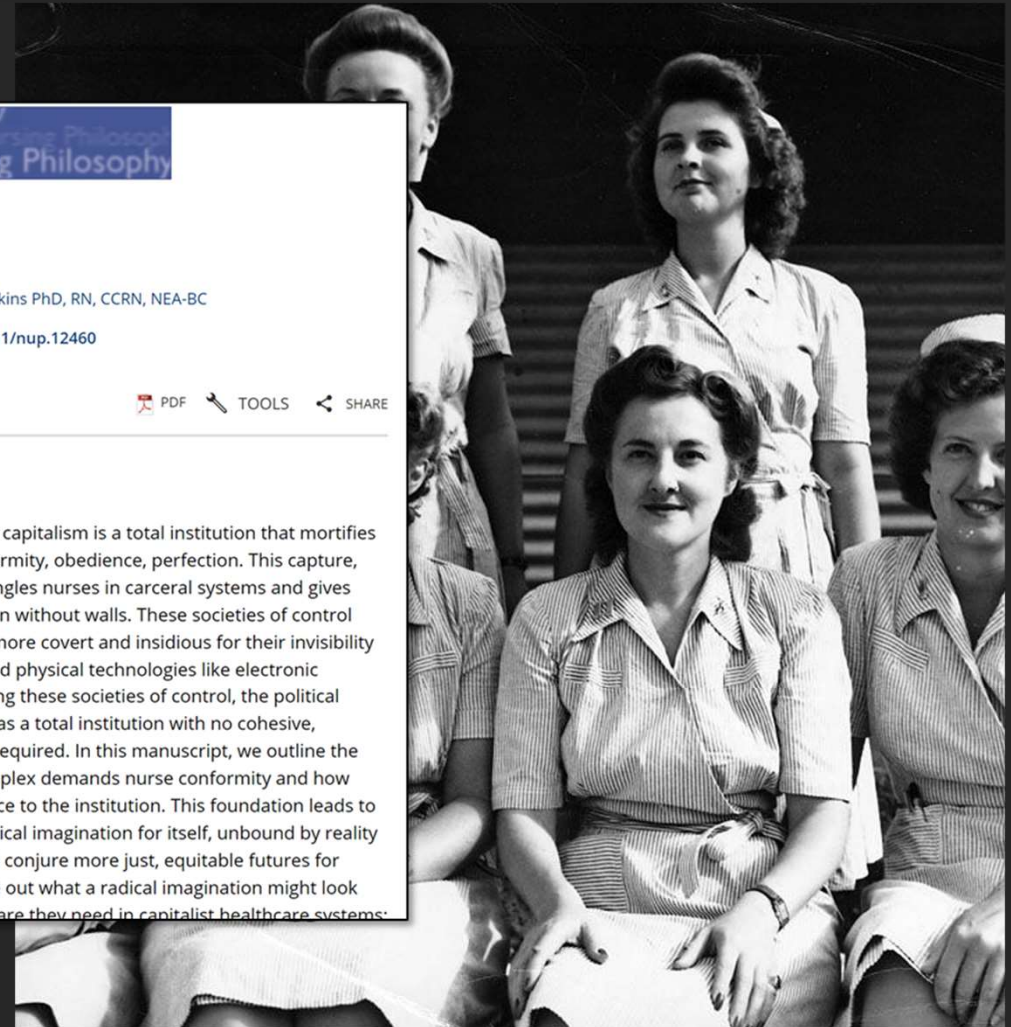












Nursing Philosophy

Nursing Philosophy

ORIGINAL ARTICLE

Nursing as total institution

Jess Dillard-Wright PhD, MA, RN, CNM ✉ Danisha Jenkins PhD, RN, CCRN, NEA-BC

First published: 04 July 2023 | <https://doi.org/10.1111/nup.12460>

[Read the full text >](#)

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Abstract

Healthcare under the auspices of late-stage capitalism is a total institution that mortifies nurses and patients alike, demanding conformity, obedience, perfection. This capture, which resembles Deleuze's enclosure, entangles nurses in carceral systems and gives way to a postenclosure society, an institution without walls. These societies of control constitute another sort of total institution, more covert and insidious for their invisibility (Deleuze, 1992). While Deleuze (1992) named physical technologies like electronic identification badges as key to understanding these societies of control, the political economy of late-stage capitalism functions as a total institution with no cohesive, centralized, connected material apparatus required. In this manuscript, we outline the ways in which the healthcare industrial complex demands nurse conformity and how that, in turn, operationalizes nurses in service to the institution. This foundation leads to the assertion that nursing must foster a radical imagination for itself, unbound by reality as it presently exists, in order that we might conjure more just, equitable futures for caregivers and care receivers alike. To tease out what a radical imagination might look like, we dwell in paradox: getting folks the care they need in capitalist healthcare systems.



THE *Nurse-leader* ANARCHIST COOKBOOK

Limburgse zorgacademie

~~Keith McHenry~~

with

~~Chaz Bufe~~
Simon

See Sharp Press • Tucson, Arizona

Klinisch expert



Evidence based medicine: what it is and what it isn't
It's about integrating individual clinical expertise and the best external evidence

Introduction
Evidence based medicine, whose philosophical origins extend back to the 18th century Paracelsus and others, remains a hot topic for clinicians, public health practitioners, purchasers, planners and the public. There are two frequent criticisms in how to practice and teach it (one sponsored by the JGMP in London in 24 April undergraduate and postgraduate 'training programmes are incorporating it' (or providing how to do it). Briefly, critics for evidence based practice have been established or planned to adult medicine, child health, surgery, pathology, pharmacology, nursing, general practice, and dentistry. The Cochrane Collaboration and British Centre for Evidence and Dissemination in York are providing systematic reviews of the effects of health care. New evidence based practice journals are being launched and it has become a common topic in the lay media. But enthusiasm has been muted with some negative reports. Criticism has ranged from evidence based medicine being old hat or it being a dangerous innovation, perpetrated by the

supposed to serve cost centres and suppress clinical freedom. An evidence based medicine continues to evolve and change, now is a useful time to refine the discussion of what it is and what it isn't.

Evidence based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research. By individual clinical expertise we mean the proficiency and judgment that individual clinicians acquire through clinical experience and clinical practice. Increased expertise is reflected in many ways, but especially in more effective and efficient diagnosis and in the more thoughtful identification and compassionate use of individual patients' preferences, rights, and preferences in making clinical decisions about their care. By best available external clinical evidence we mean clinically relevant research, often from the

basic sciences of medicine, but especially from patient centered research that focuses on the accuracy and precision of diagnosis (including the clinical examination), the power of prognostic markers, and the efficacy and safety of diagnostic, rehabilitative, and preventive regimens. External clinical evidence both involves previously accepted diagnostic tests and treatments and replaces them with new ones that are more powerful, more accurate, more efficacious, and safer.

Good doctors use both individual clinical expertise and the best available external evidence, and neither alone is enough. Without clinical expertise, practice risks becoming tyrannical by evidence, for even excellent external evidence may be inapplicable to or inappropriate for an individual patient. Without current best evidence, practice risks becoming rapidly out of date, to the detriment of patients.

This description of what evidence based medicine is helps clarify what evidence based medicine is not. Evidence based medicine is neither old hat nor impossible to practice. The argument that "evidence already is doing it" fails before patients who miss out on clinical behaviour and the best results which clinicians provide interventions to their patients.¹⁴ The distinction that clinicians face in keeping abreast of all the medical advances reported in primary journals are obvious from a comparison of the time required for reading the general medical literature (to examine 10 articles per day, 35 days per year) with the time available (well under an hour a week) to British medical consultants, even on self-report.¹⁵

The argument that evidence based medicine can be replaced only from busy towns and academics is refuted by calls from many of our colleagues who are in their own inpatient clinical teams in general medicine,¹⁶ psychiatry (J R Giddens et al., Royal College of Physicians, 1998; January 1998), and surgery (P McCulloch, personal communication) have provided evidence based care to the vast majority of their patients. Such studies show that busy clinicians who devote their scarce reading time to selective, efficient, patient driven searching, appraisal, and incorporation of the best available evidence can practice evidence based medicine.

Evidence based medicine is not "cookbook" medicine. Because it requires a bottom up approach that integrates the best external evidence with individual clinical expertise, the literature does not allow itself to deliver, cookbook approaches to individual patient care. External clinical evidence is not a substitute for the best available individual clinical expertise, any more than it is the expertise that decides whether the external evidence applies to the individual patient at all and, so, how it should be integrated into a clinical decision. Similarly, an external guideline may be integrated with individual clinical expertise in deciding whether and how to match the patient's clinical case, preferences, and needs, and thus whether it should be applied. Clinicians who fear no down cookbooks will find the advances of evidence based medicine joining them at the barricades.

Some fear that evidence based medicine will be attacked by purchasers and managers to cut the costs of health care. This could not only be a misuse of evidence based medicine but suggest a fundamental misunderstanding of its financial consequences. Doctors practicing evidence based medicine will identify and apply the most efficacious intervention to maximize the quality and quantity of life for individual patients, this may raise rather than lower the cost of their care. Evidence based medicine is not restricted to randomized trials and meta-analyses. It involves thinking about the best external evidence with which to answer our clinical questions. To find out about the accuracy of a diagnostic test, we refer to full proper cross sectional studies of patients clinically

Autonom

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ORIGINAL ARTICLE

The relationship between self-efficacy, malicious or benign envy in nurses: A cross-sectional study

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Abstract
Aim: To determine whether nurses' self-efficacy affected envy levels and to develop the necessary strategies.
Background: Envy is a widespread global phenomenon. Envy can harm the individual, the work environment, and nursing care. However, the relationships between self-efficacy and envy have not been adequately explored in the nursing context.
Methods: This study was conducted as a cross-sectional descriptive study. The study sample consisted of 361 nurses working in a university hospital in a province of Turkey. The research model was analyzed using structural equation modeling. The participants were selected using convenience sampling. This study was reported using the STROBE checklist for cross-sectional studies.
Results: Nurses' educational status affected their self-efficacy. No other personal characteristics influenced self-efficacy and envy. There was a positive relationship between malicious and benign envy. As nurses' self-efficacy increased, malicious envy decreased and benign envy increased.
Conclusions: The results of this study showed that nurses' education level affected self-efficacy, and self-efficacy level affected envy, and malicious envy could be reduced by improving nurses' self-efficacy.
Implications for nursing and health policy: Nursing managers and policymakers should support nursing education at the minimum undergraduate level, encourage nurses to continue their professional education to improve their self-efficacy, and provide training to increase their self-efficacy.

KEYWORDS
benign envy, hospital, malicious envy, nursing, self-efficacy, structural equation model

INTRODUCTION
The dynamic nature of the work environment causes employees to experience complex emotions. Emotions and feelings play a role in the overall productivity of both employees and the work environment (Achhann & Gupta, 2022). Envy, one of the emotions felt in the work environment, has also been reported to affect the functioning of organizations (Li et al., 2023a). In a systematic review, workplace envy was also associated with dysfunctional outcomes for both individuals and organizations (Zurriaga et al., 2020). Workplace envy influences the occurrence of counterproductive work behaviors, abusive supervision, ostracism, social undermining, and incivility (Li et al., 2023a). In addition, envy can have an impact on job performance and turnover intentions (Achhann & Gupta, 2022). It has been mentioned that the energy that nurses spend on sabotaging the envied person is the energy they should spend on patient care (Gan, 2022). Envy in nursing may

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Ondernemen

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EDITORIAL

JAN WILEY

Advancing nursing entrepreneurship in the 21st century

Nursing entrepreneurship represents an important, developing role for nursing that inspires innovation and advances scientific knowledge. In the 21st century, a growing aging population, prevalent chronic illness, advanced technology, higher demands for quality health care, limited resources, healthcare workforce shortages, inequities and disparities in healthcare delivery, as well as the COVID-19 pandemic challenge healthcare systems and impact population health. Nursing entrepreneurship offers an opportunity to respond to these trends, expand healthcare services and enhance health globally (Vannucci & Weinstein, 2017). Nurses often work on the front lines of healthcare delivery, including health promotion, disease prevention, treatment, and rehabilitation to meet the demand for safe, high-quality, patient-centered, and accessible care. Nurses are also becoming the drivers and leaders in population health management, helping to facilitate equal access to healthcare services and therefore well-positioned to consider new businesses, technology initiatives, and ways of working and thinking to support the healthcare system (Jakobsen et al., 2021). By using their nursing skills, knowledge and experience to start healthcare-related businesses, nurse entrepreneurs can be empowered to take on these leadership roles. However, the development of this important area of nursing practice and science currently needs more rigorous research evidence and nursing curricular content.

1 | THE IMPORTANCE OF NURSES BECOMING ENTREPRENEURS

The global healthcare industry is massive and continues to grow, with its market expected to reach to over \$7,500 billion in 2022 and over \$10,000 billion in 2026 (Reportlinker, 2022). Accordingly, entrepreneurship in healthcare plays a significant role in the economy, with healthcare businesses having a prominent role in the transformational changes taking place in the public and private healthcare sectors and many new start-ups being established. However, the prevalence of entrepreneurial nurses is only 0.5%–1% of all working nurses globally, which means there is an enormous potential for entrepreneurship in the nursing profession due to people's need for healthcare services and the capability of nurses to address these

and can include the establishment of their own businesses or development of new equipment for patient care.

2 | NURSE ENTREPRENEURS AND NURSING ENTREPRENEURSHIPS

A nurse entrepreneur is defined by the International Council of Nurses as "a proprietor of a business that offers nursing services of a direct care, educational, research, administrative, or consultative nature" (Sanders & Kingma, 2012, p.7). Nurse entrepreneurs can play an essential role in the healthcare system by supporting the development of targeted services such as nursing entrepreneurship or nursing businesses. Nurses can also enhance businesses to develop and distribute medical products or devices, offer direct patient care or patient advocacy, educate or train other professionals or community members, and provide healthcare-related consultations, among other functions (Vannucci & Weinstein, 2017). From a review of the existing literature, nurse entrepreneurs currently operate nursing businesses in the public and private healthcare sectors. Several types of nursing businesses exist, such as independent nursing practices, nurse-owned skilled nursing facilities, and consultancy agencies (Sanders & Kingma, 2012). Self-employed nurse leaders, focusing on establishing their businesses, are usually motivated by opportunity and need, as well as by profit.

3 | WOMEN'S EMPOWERMENT IN NURSE ENTREPRENEURS

The challenges that nurse entrepreneurs face are essential to understand how nurses have shifted their perspectives to a nurse entrepreneur role, particularly in terms of empowering women to be nurse entrepreneurs in business. Nurse entrepreneurs, most of whom are women, argue that they can run or manage healthcare businesses, traditionally a man's enterprise, such that gender should not be a barrier to entrepreneurship. The empowerment of nurse entrepreneurs, particularly as women, has contributed to status change and business improvements in the healthcare industry and system, promoting positive health outcomes for patients, and nursing

Visionair

by EDWINA A. MCCONNELL, SUSAN SUMMERS OSHEA and KARIN T. KIRCHHOFF

RN Attitudes Toward Computers

Nurses tend to be somewhat undecided in their attitudes toward computers.

Today nurses use computers to perform myriad functions in all areas of the profession including practice, education, administration and research. Despite the increasing application of computers in nursing and healthcare, however, at the time this study was undertaken only one study had focused exclusively on registered nurses (RNs) attitudes toward computers.¹ A variety of other healthcare personnel have been studied, including licensed practical nurses (LPNs), staff nurses, head nurses and supervisors, as well as physicians, medical and nursing students and ancillary personnel.^{2,3}

Participants in these studies used computers to perform many different functions, and the number of these functions has expanded as computers have become more common in healthcare. For example, staff in an early study used computers to admit, transfer and discharge patients, as well as to identify empty beds on a unit and to report chemistry lab tests.⁴ Computer

usage in a later study included all these functions plus radiation therapy, cardiology, computer-assisted instruction and interactive applications in patient admitting and in business and financial affairs.⁵

Attitudes of some healthcare personnel toward computers have changed over time. Participants who were long-term, loyal employees did not believe that technical devices would result in a more efficiently run hospital.⁶ Furthermore, some employees did not view computers favorably, agreeing overwhelmingly that they posed a threat to individuality.⁷ However, nurses in a later study believed that computers assisted in providing nursing care and that automation of nursing information increased both productivity and effectiveness.⁸

Most participants in an early study indicated that computers are important and that their use has facilitated great scientific advances.⁹ However, both staff and student nurses were among those least willing to participate with or use computers. This reluctance was attributed to nurses' perception that computers were a threat to their jobs and to their belief that computers cannot help alleviate a hospital's problems.¹⁰ Similarly, staff nurses in a replication of this earlier study evidenced somewhat negative attitudes towards computers.⁴ Of all groups of personnel they were most threatened by computers.⁴

Background factors, such as age, level of education, experience with computers and length of employment at the hospital show conflict-

ing associations with attitudes toward computers. Many who did not view computers favorably were more than 40 years of age and had worked at the same hospital at least eight years.⁹ Yet, other studies showed correlations between positive attitudes toward computers and length of employment at the hospital and in healthcare.¹¹

Generally education has been found to foster a positive attitude toward computers.^{12,13} However, Krampf and Robinson found no association between attitude and education.¹

Study of attitudes

Nursing staff at a large university teaching hospital in the Midwest use the Technicon Medical Information System (TMIS), an on-line computer information system. It took two and one-half years to complete the implementation of this system on all nursing units. They use this patient-record-based system to document nursing care, enter nursing orders and create nursing care plans.

In this study three questions were considered: 1) What is the degree of utilization of computerized functions by different categories of nursing personnel? 2) What are the relationships between demographic variables and current usage? and 3) What are the staff's attitudes about computers? The last question is addressed below.

A total of 313 questionnaires were distributed to a random, stratified sample consisting of 202 RNs, 47 LPNs and 64 other nursing service personnel. Completed, usable ques-

Trots



The "nurse as hero" discourse in the COVID-19 pandemic: A poststructural discourse analysis

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ABSTRACT

Background: Nurses have been labelled "hero" to describe their commitment to providing exposure and lack of clinical resources. Few to nurses' professional, social, and political Objective: To critically examine the effects of ongoing COVID-19 crisis and to consider discourse on nursing work. **Methods:** A poststructural discourse analysis subjectivity, and normalization, was conducted here in the contexts of COVID-19. Media of August 1, 2020 to locate newspaper and media postings, and institutional/corporate website. **Setting:** Data sources included English language and the UK. **Results:** Three main elements of the heroizing nurses as selfless, sacrificing, and doing adequate protective gear and other clinical as compliant, hardworking, and obedient in more or less COVID-19 public health making hero worship as a fitting reward for supporting long-term policy change, and its mundane and ordinary to the exciting and **Conclusions:** The hero discourse is not a new tool employed to accomplish multiple and enforcement of model citizenship, and the ability of front-line nurses to determine if approaching the collective political response the ongoing emotional, psychological, ethical,

What is already known about the topic?

- Nurses have been publicly labelled "heroes" to describe their commitment to providing care to people with COVID-19, despite the risks of front-line practice and the lack of clinical resources such as adequate personal protective equipment.

- Few studies identify

What this article adds

- The heroizing nurses' responses

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The Woodhull Study Revisited: Nurses' Representation in Health News Media 20 Years Later

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Key words:
Media, Woodhull study, health journalism, nursing, policy

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Abstract

Purpose: To determine if nurses are represented in health news stories more frequently today than 20 years ago when Sigma Theta Tau International Nursing Honorary Society published The Woodhull Study on Nursing and the Media, which found that nurses were cited as sources in only 4% of the stories.

Design: Content analysis of health news stories for the month of September 2017 in the same publications used in the original Woodhull study. **Methods:** Searches with Nexis and Webhost identified 2,243 articles related to health care published by the news outlets in September 2017. A random sample of 537 of these articles was obtained: 258 from seven newspapers, 127 from three weekly newsmagazines, and 152 from three health industry publications. After removing irrelevant articles or those with only passing references to health, 365 articles were reviewed and coded, using the original study's coding schema.

Findings: Nurses were identified as the source of only 2% of quotes in the articles and were never sourced in stories on health policy. When quoted, nurses mainly commented on the profession itself. Nurses or the nursing profession were mentioned in 13% of the articles. Nurses were identified in 4% of photographs or other images that accompanied the articles.

Conclusions: Nurses remain invisible in health news media, despite their increasing levels of education, unique roles, and expertise.

Clinical Relevance: Nurses' clinical expertise is accompanied by unique perspectives on health, illness, and health care; but the public is not benefiting from the wisdom and insight that nurses can provide in health news stories.

In 1998, Sigma Theta Tau International (STTI) Nursing Honorary Society published *The Woodhull Study on Nursing and the Media: Health Care's Invisible Partners* (STTI, 1997), examining nurses' representation as sources in health news stories in leading print publications of the day. The study found that nurses were identified as sources in only 4% of quotations and other sourcing. Nurses were invisible in public news media.

Thirteen years later, the Institute of Medicine's (IOM's) report on *The Future of Nursing: Leading Change, Advancing Health* (IOM, 2011) brought attention to the importance of nurses in transforming health care and improving the health of the public. The Campaign for Action was launched at the same time to generate strategies for ensuring movement on implementation of the report's recommendations. Progress has already

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Leider

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COMMENTARY

WILEY

Nursing's future? Eat young. Spit out. Repeat. Endlessly

They say there is nothing new under the sun. More's the pity. Nursing's "dirty little secret" (Brunworth, 2015) is no secret to anyone involved in our profession, in any country and at any level of seniority (Birks et al., 2017; Johnson, 2009).

Recently on twitter, a UK nurse tweeted about her first ward experience as a newly qualified RN:

Very disheartened after my first day. Five newly qualified nurses on the same ward doesn't suggest good support. Also been told cannot guarantee I'll be allowed time off for my graduation next month. Advised I should already be competent and not require any supernumerary time...

Adding that at this time, she had "no contract" hardly seems surprising.

Another student posted that:

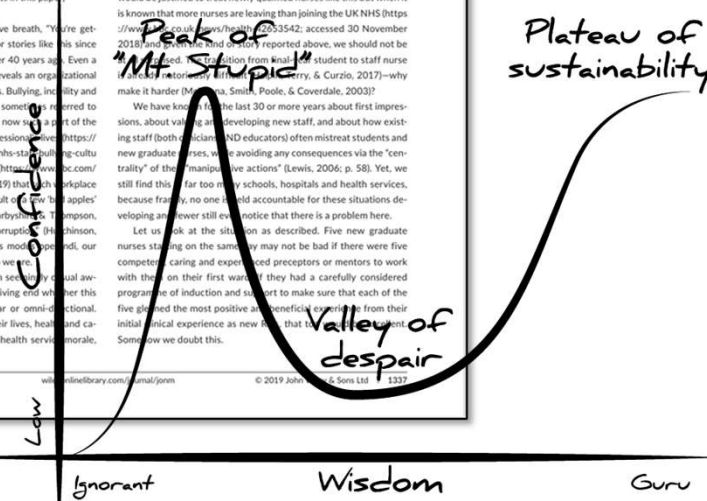
I'm getting tired frankly of hearing of student nurses pushed to the brink by members of our caring profession (Permission from both tweeters was obtained to use their tweets in this paper)

We could only mutter under our collective breath, "You're getting tired of it?" We have been hearing horror stories like this since 2018 and the number of such reports above, we should not be surprised. A random selection from Knall's student to staff nurse research report (Knall, 2017; Currie, & Currie, 2017)—why make it harder (Mason, Smith, Poole, & Coverdale, 2003)?

We have known for the last 30 or more years about first impressions, about valuing and developing new staff, and about how existing staff (both clinicians and ND educators) often mistreat students and new graduate nurses, while avoiding any consequences via the "centrality" of the "manipulative actions" (Lewis, 2006, p. 58). Yet, we still find this "far too many schools, hospitals and health services, because frankly, no one would accountable for these situations developing any fewer still even notice that there is a problem here.

Let us look at the situation as described. Five new graduate nurses starting on the same day may not be bad if there were five competent, caring and experienced preceptors or mentors to work with them on their first ward. If they had a carefully considered programme of induction and support to make sure that each of the five gleaned the most positive and beneficial experience from their initial clinical experience as new RNs, that they would be content. So how do we doubt this.

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Positief ongehoorzaam

KRITISCH BEKEKEN

Rebels verpleegkundig leiderschap

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CONTEXT

Leiderschap van verpleegkundigen is cruciaal om de kwaliteit van zorg te bewaken en verbeteren. Daarnaast laat onderzoek zien dat wanneer verpleegkundigen leiderschap (mogen) tonen, zij meer werkplezier ervaren en minder de intentie hebben om het vak te verlaten.^{1,2} Allemaal belangrijke zaken om te zorgen voor de *quadruple aim*: het streven naar betere zorgresultaten tegen lagere kosten met positieve ervaringen van patiënten en professionals.³ In 'het verpleegkundig hart' zit de beste zorg aan patiënten verlenen volgens professionele standaarden, maar soms hebben verpleegkundigen daarbij last van regels en voorschriften van de organisatie. Een discrepantie tussen regels en professionele normen/waarden daagt verpleegkundigen uit rebels leiderschap te tonen en weloverwogen af te wijken van deze regels en voorschriften.^{4,6} Concepten die dit weloverwogen afwijkende gedrag van verpleegkundigen beschrijven, zijn *positive deviance*, *healthcare rebels* en *tempered radicals*.^{4,6} In de scoping review van De Kok, Weggelaar, Schoonhoven & Lalleman (2021) zijn deze theoretische concepten onderzocht om inzicht te geven in het rebels leiderschap van verpleegkundigen.⁷

DOELSTELLING

Het onderzoek geeft inzicht in de genoemde concepten, de eigenschappen van rebelse verpleegkundig leiders en factoren die de ontwikkeling van rebels verpleegkundig leiderschap stimuleren of belemmeren.

METHODE

Met behulp van de *Joanna Briggs Institute Reviewers' Manual* is een scoping review uitgevoerd.⁸ Eerst is een beperkte zoekopdracht gedaan om relevante trefwoorden en synoniemen te identificeren. Vervolgens zijn de gevonden woorden ingevoerd in vier databanken: Scopus, CINAHL, PubMed en PsycINFO.

Er werden 2705 artikelen gevonden. Na screening van de artikelen en de literatuurlijsten zijn 25 artikelen geïncludeerd.

RESULTATEN

Beschrijvingen

Van de 25 artikelen beschrijven er 23 het concept *positive deviance*, één het concept *healthcare rebels* en één *tempered radicals*. Alle drie de concepten beschrijven het positief en weloverwogen afwijkende gedrag van verpleegkundigen. Dit doen de verpleegkundigen om zowel goede zorg voor de individuele patiënt te kunnen geven als duurzame veranderingen in de eigen organisatie te initiëren en bewerkstelligen. De artikelen beschrijven verder dat deze verpleegkundigen betere zorguitkomsten behalen ten opzichte van hun collega's, terwijl ze in dezelfde soort werkomgeving werken.

'Vooralsnog lijkt vooral sprake te zijn van een theoretisch concept'

Er zijn ook verschillen tussen de concepten. Zo waren in de *positive deviance*-artikelen deze professionals vaak zichtbaar in de organisatie, terwijl ze in de artikelen over *healthcare rebels* en *tempered radicals* juist 'onder de radar' bleven.

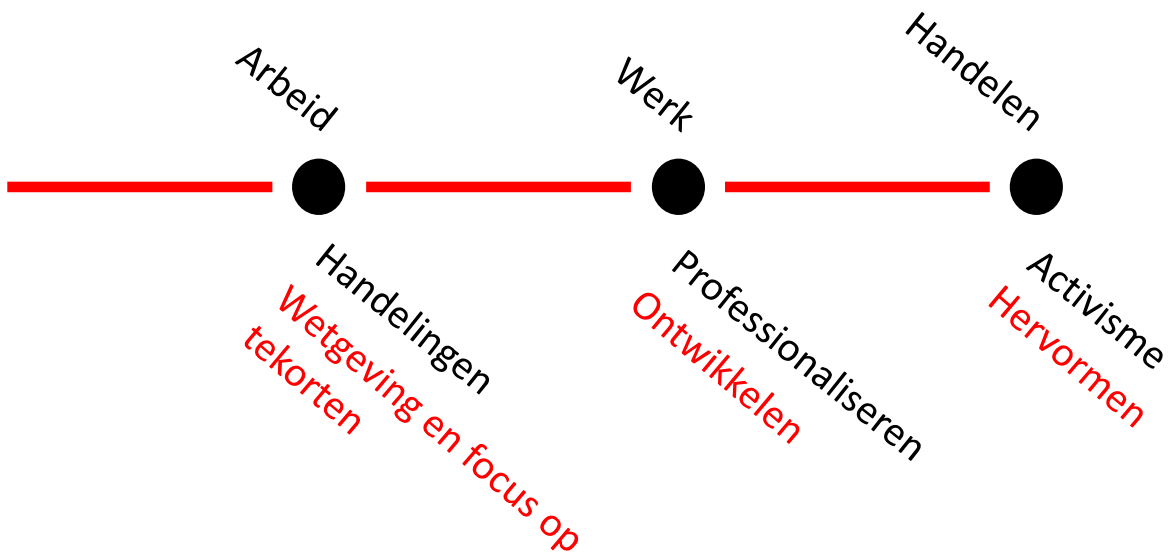
Eigenschappen

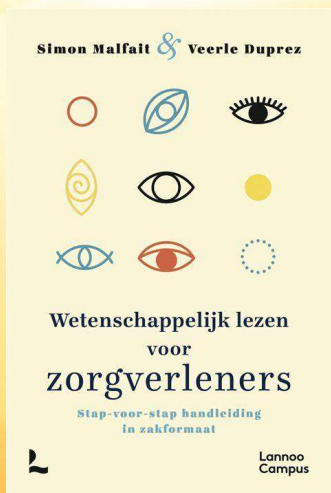
Er zijn vier rebelse gedrageigenschappen gevonden voor deze positief en weloverwogen afwijkende verpleegkundigen. Allereerst kunnen zij samenwerken en netwerken met professionals en management binnen én buiten de organisatie. Ze weten bij wie ze terecht kunnen wanneer zij hulp nodig hebben. Ten tweede moedigen zij collega's aan eigenaar te worden van een

"Het is een uitdrukking van het idee dat de bewijslast altijd ligt bij degenen die beweren dat autoriteit en overheersing noodzakelijk zijn. Ze moeten met krachtige argumenten aantonen dat die conclusie juist is. Als ze dat niet kunnen, moeten de instellingen die ze verdedigen als onwettig worden beschouwd"



Klinisch leiderschap: Verandering en verbetering van binnenuit





Leadership is an
action, not a position

Donald McGannon



quote fancy



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