



Zeggen en doen is twee
Over zeggenschap en daar voorbij

It's better to ask for forgiveness
than permission



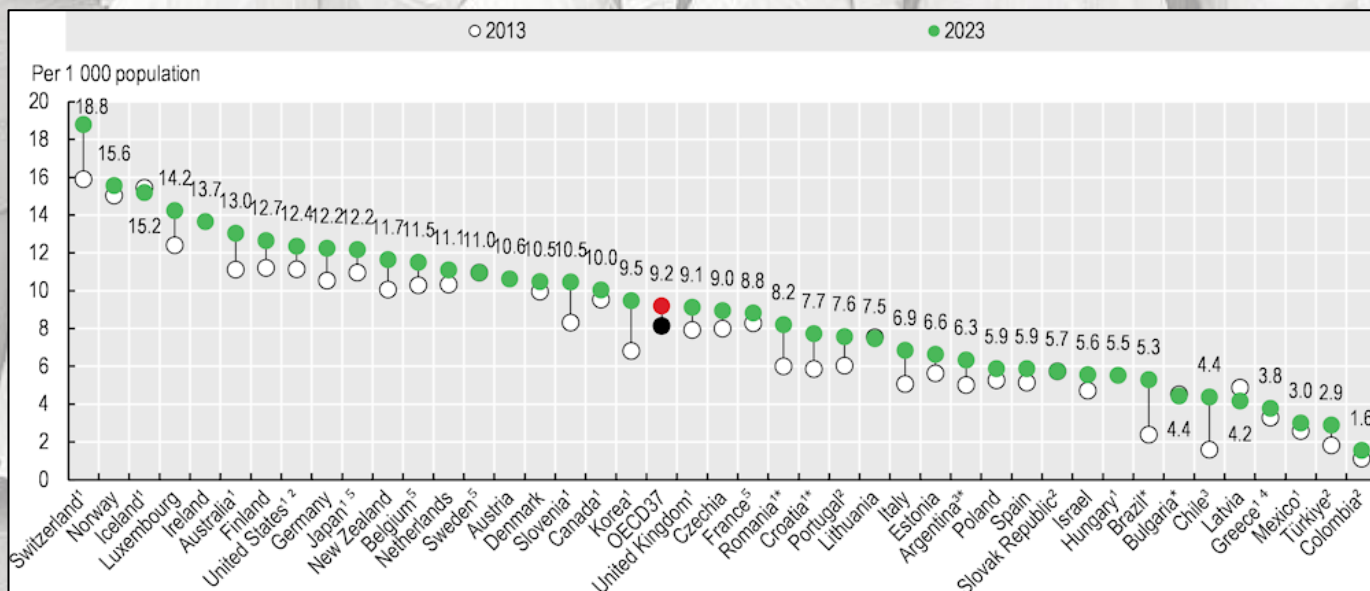
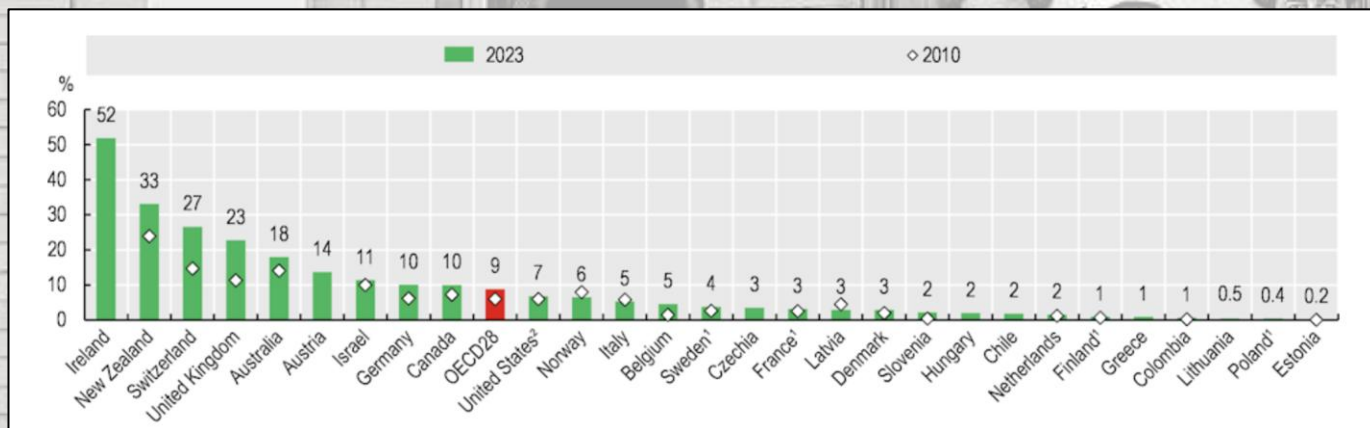
zeggen-schap



Strike



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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>

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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

ORIGINAL ARTICLE

Nursing as total institution

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

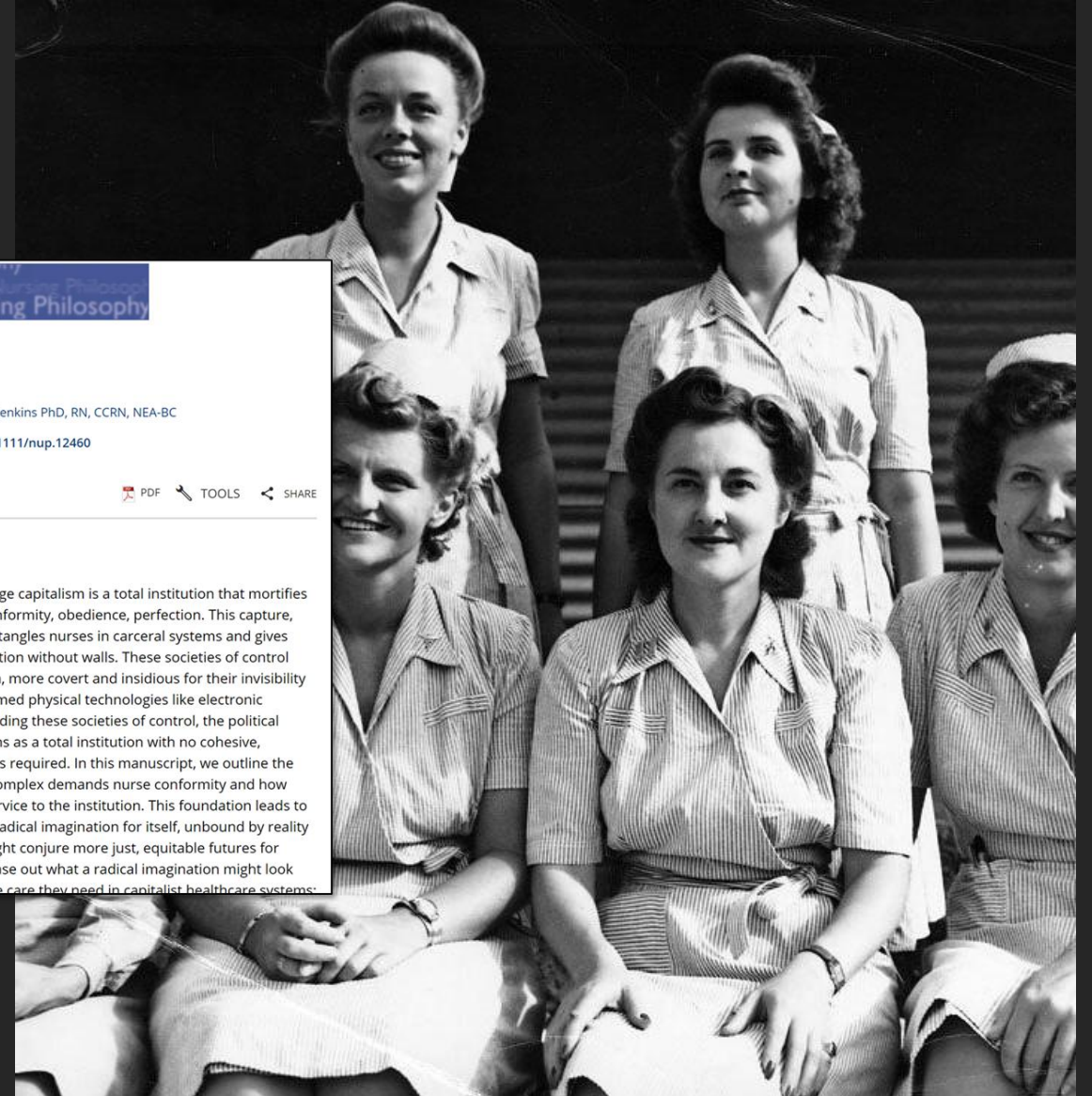
First published: 04 July 2023 | <https://doi.org/10.1111/nup.12460>

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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 Doctor-Nurse Game

Leonard I. Stein, MD, Madison, Wis

THE relationship between the doctor and the nurse is a very special one. There are few professions where the degree of mutual respect and cooperation between co-workers is as intense as that between the doctor and nurse. Superficially, the stereotype of this relationship has been dramatized in many novels and television series. When, however, it is observed carefully in an interactional framework, the relationship takes on a new dimension and has a special quality which fits a game model. The underlying attitudes which demand that this game be played are unfortunate. These attitudes create serious obstacles in the path of meaningful communications between physicians and nonmedical professional groups.

The physician traditionally and appropriately has total responsibility for making the decisions regarding the management of his patient's treatment. To guide his decisions he considers data gleaned from several sources. He acquires a complete medical history, performs a thorough physical examination, interprets laboratory findings, and at times, obtains recommendations from physician-consultants. Another important factor in his decision-making are the recommendations he receives from the nurse. The interaction between doctor and nurse through which these recommendations are communicated and received is unique and interesting.

The Game

One rarely hears a nurse say, "Doctor I would recommend that you order a retention enema for Mrs. Brown." A physician, upon hearing a recommendation of that nature, would gaze in amazement at the effrontery of the nurse. The nurse, upon hearing the statement, would look over her shoulder to see who said it, hardly believing the words actually came from her own mouth. Nevertheless, if one observes closely, nurses make recommendations of more import every hour and physicians willingly and respectfully consider them. If the nurse

is to make a suggestion without appearing insolent and the doctor is to seriously consider that suggestion, their interaction must not violate the rules of the game.

Object of the Game.—The object of the game is as follows: the nurse is to be bold, have initiative, and be responsible for making significant recommendations, while at the same time she must appear passive. This must be done in such a manner so as to make her recommendations appear to be initiated by the physician.

Both participants must be acutely sensitive to each other's nonverbal and cryptic verbal communications. A slight lowering of the head, a minor shifting of position in the chair, or a seemingly nonrelevant comment concerning an event which occurred eight months ago must be interpreted as a powerful message. The game requires the nimbleness of a high wire acrobat, and if either participant slips the game can be shattered; the penalties for frequent failure are apt to be severe.

Rules of the Game.—The cardinal rule of the game is that open disagreement between the players must be avoided at all costs. Thus, the nurse must communicate her recommendations without appearing to be making a recommendation statement. The physician, in requesting a recommendation from a nurse, must do so without appearing to be asking for it. Utilization of this technique keeps anyone from committing themselves to a position before a *sub rosa* agreement on that position has already been established. In that way, open disagreement between the players must be avoided. The greater the significance of the recommendation, the more subtly the game must be played.

To convey a subtle message of the game with all its nuances would require the talents of a literary artist. Lacking these talents, let me give you the following example which is unscientific, but happens frequently. The medical resident on hospital call is awakened by telephone at 1 AM because a patient on a ward, not his own, has not been able to fall asleep. Dr. Jones answers the telephone and the dialogue goes like this:

This is Dr. Jones.
An open and direct communication.
Dr. Jones, this is Miss Smith on 2 W.—Mrs. Brown is dead today of her father's death. It is unable to fall asleep.

[This message has two levels. Openly, it de-

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THE NEW ENGLAND JOURNAL OF MEDICINE

Feb. 22, 1990

SOUNDING BOARD

THE DOCTOR-NURSE GAME REVISITED

THE relationship between the doctor and the nurse is a special one, based on mutual respect and interdependence, steeped in history, and stereotyped in popular culture. The underlying interaction can often be characterized as a game. In 1967 one of us described how doctors and nurses related to one another at that time. In this article we address the question of change. From our observations we are convinced that there have been major changes in the doctor-nurse relationship over the past two decades. To describe these changes we will briefly review the relationship that prevailed in 1967 and contrast it with the current situation.

THE DOCTOR-NURSE GAME IN 1967

In 1967 there was clear agreement between doctors and nurses that their relationship was hierarchical, with doctors being superior to nurses. All their interactions were carefully managed so as not to disturb the hierarchy. Nurses were to be bold, have initiative, and be responsible for making important recommendations, while at the same time they had to seem passive. In short, nurses were to make recommendations, but their recommendations had to appear to be initiated by the physician.

The cardinal rule of the game was that open disagreement between the players had to be avoided at all costs. Thus, nurses needed to communicate their recommendations without appearing to make them. Physicians requesting a recommendation needed to do so without appearing to be asking for it. This technique kept both sides from committing themselves to a position before a *sub rosa* agreement on that position had already been established. In that way, open disagreement was avoided.

If the game was successful, both players were rewarded. The most obvious reward was a doctor-nurse team that operated efficiently. The physician was able to use the nurse as a valuable consultant, and the nurse thereby gained self-esteem and professional satisfaction. And through this alliance the physician gained the respect and admiration of the nursing service.

The penalties for the failure of the game, on the other hand, could be severe. Physicians who were unskilled gamblers and failed to recognize the nurse's subtle recommendations were tolerated as clods. If, however, physicians interpreted these messages as insolence and strongly indicated they would not tolerate suggestions from nurses, they had a rocky path to travel. A black cloud constantly loomed over their heads. Nurses who saw themselves as consultants but were outspoken and refused to follow the rules of the game in making recommendations had hell to pay. If they were bright and their recommendations were worthwhile, they remained employed, but they were constantly reminded in a hundred ways that they were disliked.

The game arose from attitudes shaped by doctors' and nurses' training. Unlike medical students, who usually learned to play the game after they finished medical school, nursing students learned to play it early in their training. To inculcate subservience and inhibit deviance, nursing schools were for the most part tightly run, disciplined institutions. Almost 90 percent of the nurses working in 1967 were trained in hospital-run nursing schools. Through this training nurses learned that making suggestions to physicians was equivalent to insulting and belittling them; it was tantamount to questioning their medical knowledge and insinuating that they did not know their business.

Although student nurses were told that any recommendation they might make would be insulting to the physician, they were also told that they were an invaluable aid to the physician and that they were duty-bound to contribute suggestions for the patient's benefit. Thus, when their good sense told them a recommendation would be helpful to the physician, they were not allowed to communicate it directly, nor were they allowed not to communicate it. The way out of the bind was to use the doctor-nurse game and communicate the recommendation without appearing to do so.

THE MILIEU FOR CHANGE

The doctor-nurse game has been affected by a number of important social changes since 1967. That is not to say that the game is dead; in many places it functions essentially as described. The forces at play, however, portend that change will continue and spread. Public esteem for physicians has deteriorated. Today's physicians no longer fit the image of selfless dedication to their patients epitomized in such 1950s television series as *Dr. Kildare*. The commercialization of medical care has undermined public confidence in the profession's devotion to altruistic concerns.¹ The concept of physicians' omnipotence has given way to broader recognition of their fallibility. In an era of increasingly specialized knowledge and expertise, no one can know all things about all patients. Therefore, a game based on physicians' omnipotence has an air of artificiality and quaintness.

Physicians are also increasingly likely to be female. In 1989 38 percent of freshman medical students were women, as compared with 9 percent two decades earlier.² Although female medical graduates have generally been trained to play the doctor-nurse game like their male counterparts, the demands of the game reflect stereotypical roles of male dominance and female passivity are missing. This phenomenon is accentuated by the gradually increasing percentage of nurses who are male, currently around 3 percent of the total.

In contrast to the glut of physicians in some areas, there is a nursing shortage. This has focused attention on the value of the nursing in health care. It has also emphasized the adverse conditions under which most nurses work—relatively small financial rewards, limited clinical autonomy as compared with physicians, and little involvement in hospital management.

Journal of Advanced Nursing, 1989, 22, 165-170

The nurse-doctor relationship: a selective literature review

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Accepted for publication 7 September 1989

SWEET SJ & NORMAN IJ (1989) *Journal of Advanced Nursing* 22, 165-170

The nurse-doctor relationship: a selective literature review

The disciplines of nursing and medicine are expected to work in unusually close proximity to one another, not just practising side by side but interacting with one another to achieve a common goal: the health and well-being of patients. This selective review of literature addresses some of the issues arising from the frequently controversial subject of the nurse-doctor relationship and seeks to draw out the principal themes emerging from the application of sociological theory to the nurse-doctor relationship and research into its operation in clinical settings. Particular attention is paid to the 'doctor-nurse game', a stereotypical pattern of interaction, first described in the 1960s, in which (female) nurses learn to show initiative and offer advice, while appearing to defer passively to the doctor's authority. This pattern of interaction seems less common in clinical practice today but the problem remains of each profession having ideal expectations of one another which inevitably fall short as a result of differing views of qualities of doctors and nurses to be valued.

INTRODUCTION

It is impossible to obtain a cogent understanding of the nature of the nurse-doctor relationship without an awareness of relationships between men and women in society through time, as the nurse-doctor relationship is essentially patriarchal (Gaggin & McIntosh, 1978). This is reflected in the first part of the review which comprises a sociological analysis of the nurse-doctor relationship in terms of gender roles, stereotypes and the sexual division of labour in society and the health professions (Gaggin & McIntosh, 1978). This first section includes reference to the historical development of both general and psychiatric nursing, which is inextricably linked with the sociological elements of the relationship.

The second part of the review discusses research studies that have addressed nurse-doctor interactions and relationships in an attempt to highlight changes in the nurse-doctor relationship over time. These studies form a small proportion of the available literature, most of which is prescriptive or anecdotal, based on personal opinion and the subjective experience of individuals rather than systematic and rigorous enquiry. Prescriptive literature stresses the need for certain elements in the working nurse-doctor relationship, such as teamwork (Christie, 1982), respect (Carlisle 1990) and good communication (Stuckler 1988) and outlines how individuals should behave to achieve good working relations. These prescriptions, however, are rarely supported with evidence of successful and satisfying relationships in practice.

Most research studies in the field have employed qualitative methods and the extent to which the findings are applicable to settings outside that of the study is uncertain. However, most of the research is comparatively recent,

Nursing Practice Discussion Professional

Keywords: Professional relationships/ Game theory/Multidisciplinary working

*This article has been double-blind peer reviewed

The doctor-nurse game first described 40 years ago is still relevant to modern nursing, despite many changes to the profession. Is nursing partly to blame?

Is the doctor-nurse game still being played?

This article...

- How the doctor-nurse game was first described 40 years ago.
- Why some believe changes to the nursing profession have rendered the game obsolete.
- How the game between medicine and nursing may still be very much on.

Author Dean-David Holyoake is a senior lecturer in the School of Health, University of Wolverhampton.

Abstract Holyoake DD (1989) Is the doctor-nurse game still being played? *Nursing Times* 107, 43, 165-170. Forty years ago Leonard Stein outlined his theory of the doctor-nurse game. In 1990, he revisited his theory and found that the game he had described no longer existed, mainly because nurses were no longer willing to play.

Since the publication of the original theory, attempts have been made to professionalize nursing and to negotiate a sense of identity within the conventional patriarchal doctor-nurse relationship.

However, despite demands from the nursing establishment, the doctor-nurse game continues, and changes to the profession have not been as far-reaching in this respect as hoped.

In 1951, Leonard Stein wrote an article called 'the doctor-nurse game' discussing the relationship between the professions (Box).

The nursing establishment also promotes the idea that 'the game' is over and no longer relevant in modern clinical practice as a metaphor for understanding the role. Nursing has become more educationally focused, politically aware and eager to raise its perceived status.

According to Christ (1990), Stein et al's revisiting of the doctor-nurse game in 1990 showed nursing had substantially given up the game in what is described as a 'hostile' and 'subservient' manner. This suggests the nursing professional did some kind of following the rules to riches turnaround. But get educated and refused to play.

Many patients and nurses I have spoken to do not feel this to be an accurate description. For them, the denial of multi-disciplinary conflict conceals the more experienced of many front-line nurses when it comes to the nature of the doctor-nurse relationship.

The history of relational games During the 1950s, there was an increasing belief that social psychology could offer insights into the way human beings behave in groups. Game theory is an approach used to try to understand how individuals and groups of people relate. Its principle focus is competition and cooperation in game theory, participants or groups (called players) engage in some sort of theoretical conflict such as a shortage of resources or an ethical dilemma. This conflict sets up opportunities for chance occurrences, but mostly players make choices that then affect the outcome or payoff. This sort of analysis has been used to explore aspects of nursing practice (Jones et al, 1989; Stein et al, 1990; 1995). Game theory has also been used to explore how people are motivated to make a choice (Axelrod, 1984), and

12 *Nursing Times* 0131/17 Vol 107 No 43 / www.nursingtimes.net

STRATEGIE

Wetenschap

Visie op verpleegkunde

Leiderschap

Technologie

Zeggenschap

NOTES ON NURSING:

WHAT IT IS, AND WHAT IT IS NOT.

BY

FLORENCE NIGHTINGALE.

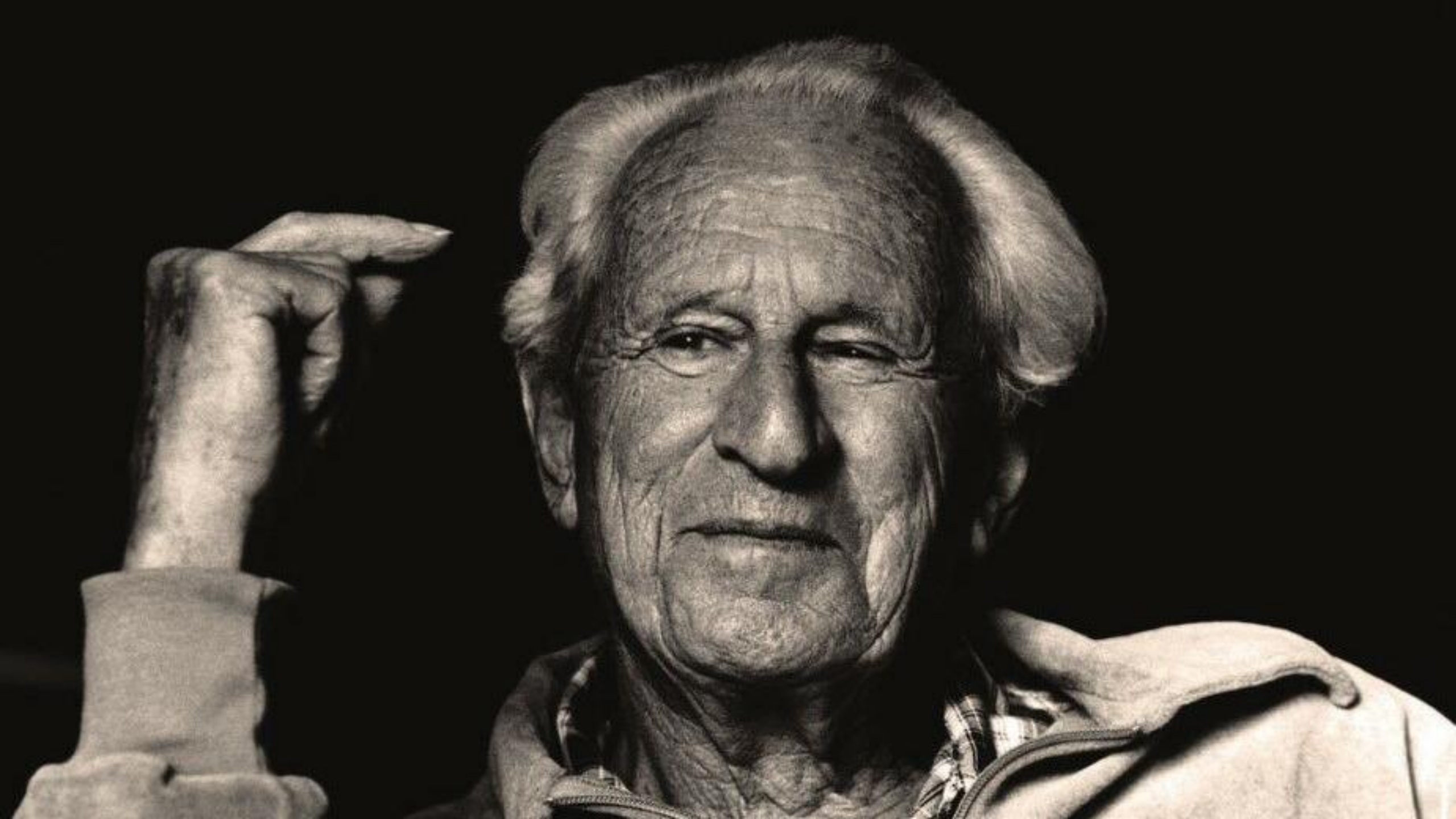
NEW EDITION, REVISED AND ENLARGED.

LONDON:

9, PALL MALL,
to the Queen.

1860.

[THE RIGHT OF TRANSLATION IS RESERVED.]



Professional Issues

Edith A. West
W.P. Griffith
Ron Iphofen

A Historical Perspective on the Nursing Shortage

Recruitment and retention problems, public image distortion, and negative work environment have been the major contributors to nursing's continual "shortages" throughout the years (Armstrong, 2002; Vonfrolio, 2006). It is not possible to isolate a single causative factor because of the problem's complexity. The literature also contains no simple description of the status of the nursing shortage. However, health care leaders agree that the current shortage has a negative impact on the nursing practice environment, nurse retention, and the profession's ability to recruit nurses; the problem is global in scope and heading for crisis if not abated (American Association of Historical Nursing [AAHN], 2001; CNN, 2001; National League of Nursing [NLN], 2002; Peterson,

2001). Most experts also agree that for sustained change and assurance of an adequate supply of nurses, solutions must be developed in areas of education, health care delivery systems, policy, regulation, and image (Nevdijon & Erickson, 2001).

The Usual Suspects: External Barriers to Change

Since the dawn of "the golden age" of Western medicine in the 1800s, the demand for nursing services has become part of a wider demand for medical care (Cooter & Pickstone, 2003; Leathhard, 2000). The evolution of medical specialization brought in its wake a host of ancillary skill practitioners, such as therapists, pharmacists, and X-ray and lab technicians. Nursing, which was never really highly prized because of its history as a "female" vocation from the start, came to be viewed as just another ancillary skill (Davies, 1980; Lancaster, 1999). When a medical model was introduced in nursing education at the turn of the 20th century, the trajectory of nursing changed from that of a "vocation" essentially providing comfort to dying, hopeless cases, to one of a trained, highly skilled profession (Abel-Smith, 1960; Lancaster, 1999). The application of science to medicine (and nursing), coupled with immense technical advances in the treatment of sickness over the

years, have made an increasing demand on the intellectual and technical skills of nurses. As medical mastery of techniques in the cure and treatment of disease progressed, and an array of specialty areas arose, a great deal of what was once considered exclusively medical practice became a routine part of nursing practice. For instance, skills such as intravenous therapy, blood transfusions, nasogastric intubations, medication administration, and multiple sterile procedures once were performed exclusively by physicians. The increase in clinical responsibility has led nurses to give most custodial patient care, once considered the center of nursing practice by Florence Nightingale, to unlicensed nursing assistants and domestic and housekeeping staff (Appiebee, 2006; Wilson, 2006).

Health care delivery systems also evolved to keep pace with advances in medical science and technology by shifting focus from community (public health) roots to a more institutionalized model for the provision of care (Connolly, 1998). This shift was driven by the mostly male medical community whose phenomenal achievements in the war against disease, made possible in large part by major discoveries in the biological and physical sciences, gained them powerful political allies and unprecedented

NURSES, PATIENTS, AND POCKETBOOKS

Report of
A STUDY OF THE ECONOMICS OF NURSING
CONDUCTED BY THE
COMMITTEE ON THE GRADING OF
NURSING SCHOOLS

MAY AYRES BURGESS, Director

NEW YORK CITY
1928

Communication Quarterly
Vol. 00, No. 00, 2016, pp. 1-25

Routledge
Taylor & Francis Group

An Examination of Nurses' Intergenerational Communicative Experiences in the Workplace: Do Nurses Eat Their Young?

Lindsey B. Anderson & Melanie Morgan

The modern workforce is becoming increasingly older, and because of this demographic shift, intergenerational interactions are more common. However, these interactions are often described negatively and could be exaggerated when housed in a workplace setting. This study explores intergenerational communication in the increasingly diverse nursing profession through the lens of communication accommodation theory. Specifically, 32 nurses were interviewed in order to understand how they experience and describe intergenerational communication in the healthcare context. Through an abductive approach to data analysis, we found three interrelated findings: (a) intergenerational hostility is commonplace, (b) intergenerational hostility is socialized, and (c) nurses are viewed as a dispensable resource. These findings were communicated and justified through the colloquialism "nurses eat their young." Theoretical implications related to communication accommodation theory and the Communication Predicament Model of Aging were developed along with practical suggestions that focus on ways to disrupt the acceptance of intergenerational hostility, enhance intergenerational communication in the workplace, and create a space for structural change.

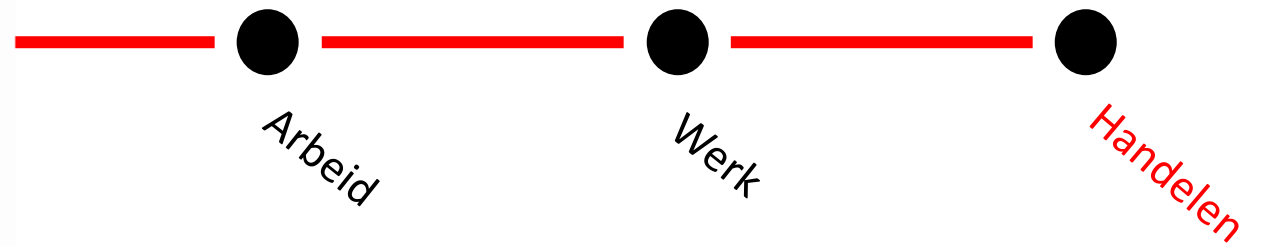
Keywords: Communication Accommodation Theory; Communication Predicament Model; Intergenerational Communication; Nursing

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zeggen-schap

Federal Government's Growing Banned Words List Is Chilling Act of Censorship

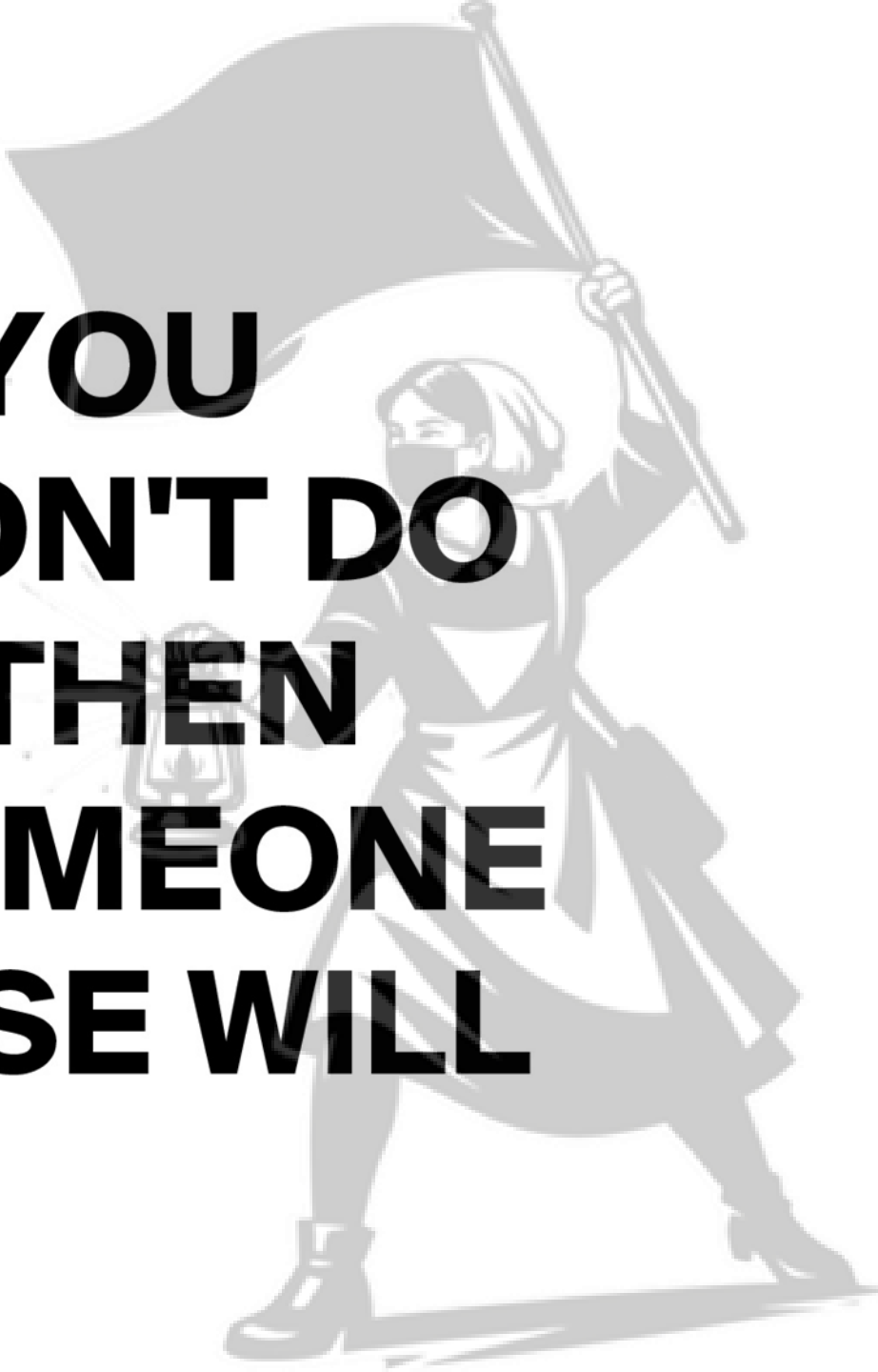
A growing list of words and materials are being scrubbed from government websites and documents in an attempt by the Trump administration to remove all references not only to diversity, equity and inclusion, but also to climate change, vaccines, and a host of other topics.

abortion
accessible
accessibility
activism
activists
advocacy
advocate
advocates
affirming care
all-inclusive
allyship
anti-racism
antiracist
assigned at birth
assigned female at birth
assigned male at birth
at risk
autism
barrier
barriers
belong
bias
biased
Biased toward
biases
Biases towards
biologically female
biologically male
bipoc
Black
black and latinx
breastfeed • people
breastfeed • person
Cancer Moonshot
chestfeed • people
chestfeed • person
clean energy

climate crisis
climate science
commercial sex worker
community
community diversity
community equity
confirmation bias
continuum
Covid-19
cultural competence
cultural differences
cultural heritage
Cultural relevance
cultural sensitivity
culturally appropriate
culturally responsive
definition
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DEIA
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DEIJ
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ultraprocessed foods
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discriminated
discrimination
discriminatory
discussion of federal
policies
disparity
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diversity and inclusion
diversity/equity
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enhancing diversity
environmental justice
environmental quality
equal opportunity
equality
equitable
equitableness
equity
ethnicity
evidence-based
excluded
exclusion
expression
female
females
feminism
fetus
fluoride
fostering inclusivity
GBV
gay
gender

gender based
gender based violence
gender diversity
gender identity
gender ideology
gender-affirming care
genders
Gulf of Mexico
H5N1/bird flu
hate
hate speech
health disparity
health equity
hispanic
hispanic minority
historically
identity
ideology
immigrants
implicit bias
implicit biases
inclusion
inclusive
inclusive leadership
inclusiveness
inclusivity
Increase diversity
increase the diversity
indigenous community/
people
inequalities
inequity
inequitable
inequities
injustice
institutional
intersectional
intersectionality



IF YOU WON'T DO IT THEN SOMEONE ELSE WILL

START PLEASing



Professionalisme

Leiderschap

Eenheid

Actie

Successie



The hopeless don't revolt, because
revolution is an act of hope.

Peter Kropotkin

“ quotefancy