Lisbeth Hockey Lecture 2021

The Power of the Nursing Narrative

It was when I was learning to be a HV in the 1970's that I first encountered the work of Lisbeth Hockey. At that time I knew little about her – I had moved from a clinical nursing setting to health visiting because I recognized that there was a lot more to recovery and wellness than could be understood by focusing solely on the clinical condition of the person in the bed. Health visiting opened my eyes – and my mind – to the influence of social determinants of health – though we did not call them that at the time. Dr Hockey was way ahead of me of course. Her book on *Primary Care Nursing*[1] inspired me for many years; it highlighted the critical importance of primary health care with its notion that health went beyond the physical to 'a state of complete physical, mental and social wellbeing'. It seemed to me then that nursing was finally going to see its day in the spotlight as the key health worker who had a holistic approach to health and wellness. How optimistic I was – I believe, 40 years later, that our day is still to come!

Professor Dame Anne Marie Rafferty in last year's Lisbeth Hockey lecture described Dr Hockey as a 'whole person person' which truly sums up her philosophy. Dr Hockey became a District Nurse because, to quote her: 'Suddenly patients became human beings with families and with their unique problems as well as joys…..'[2] What Lisbeth Hockey is describing here, I believe, is the power of the nursing narrative which, in essence, always reflects what it is to be human, dealing with illness and recovery, birth and death, happiness and despair, wellness and flourishing. The nursing narrative captures the imagination of the listener because our stories are of hearts and minds – not only the science of coming to the diagnosis but the art of finding and understanding the *meaning* of the diagnosis to the person – and their family - who has received it.

Never has the nursing narrative been more powerful than in 2020 as nurses faced the impact of the devastating pandemic. But it was also noticeable that nurses featured so often in the media as heroic carers but hardly ever as scientists. Yet nurses are safety critical in preventing infections and ensuring that highly dependent patients come to no harm – two aspects of nursing science that were essential for life through the early days of the pandemic. There was a compelling irony in 2020 being the WHO year of the nurse and the midwife, with nurses so highly visible, while the State of the World's Nursing report was largely ignored by the media (Holloway et al 2021). Nurses are often cited as the most trusted

[1] Hockey, L. (1983). *Primary care nursing*. Edinburgh: Churchill Livingston.
[2] Hockey L., (1985) Frontline to Spectators Gallery. Nursing Mirror Vol 160, no 21, May 23rd.

profession but they struggle to be influential (Godsey et al 2020), being viewed by the media as dependent on physicians for their practice. Images of nurses influencing important decision-making have been noted to be absent from media portrayals of nursing (Girvin et al 2016) and this certainly played out in the pandemic.

So the nursing narrative is powerful, it seems, in capturing the imagination of the listener, but not so much in being valued for its science or shaping important policy decisions. Hockey's own struggles to get nursing research recognised echoes this, and *still* as a profession we struggle to get nursing recognized as a subject that embraces science, technology, engineering or mathematics (STEM). Framing nursing as a 'soft' skill – not truly scientific – means that nurses are always going to be uncertain when asserting the value of the profession and claiming a fair salary and decision making power (Salvage and Stilwell 2018). Discussing the nursing contribution to care in 1975, Hockey wrote: 'I tend to agree with the American nurse, Frances Storlie, who is quoted as having said: 'The glorious thing about nursing is that it can never be defined…. The irony that we never stop trying…….' (Hockey[3] 1975). Capturing the breadth and depth of the art and science of nursing is what often continues to challenge us, so we use the narrative of what we do and what it means to us – which is so powerful and captivating. But hard nosed politicians are generally looking for a different sort of narrative – centred on economics and cost-effective health outcomes – on which to base their strategic decisions including salaries.

Thanks to Lisbeth Hockey, and other giants of nursing research, we have wealth of rich data that shows safe, effective and efficient nursing practice from well designed studies (WHO 2021) but the challenge remains for nursing to get these studies noticed outside our profession and then translated into policy and investments in nursing (Salvage and Stilwell 2018). As already discussed, although nurses see themselves as well-trained professionals, the public (and probably politicians) views nursing as a low-status profession that is subordinate to the work of physicians and is oblivious to the different levels of education and professionalism involved in nursing (ten Hoeve et al 2013). The absence of nurses from media briefings and interviews during the pandemic strengthens the public perception that nurses are not health leaders (Mason 2020).

[3] Hockey L, (1975) The nurse's contribution to care in Health Care in a Changing Setting: The UK Experience edited by Ruth Porter, David W. FitzSimons Ciba Foundation https://www.google.co.uk/books/edition/Health_Care_in_a_Changing_Setting/74IvErpuMH4C?hl=en&gbpv=1&dq=Health+Care+in+a+Changing+Setting:+The+UK+Experience+edited+by+Ruth+Porter,+David+W.+FitzSimons&printsec=frontcover

Power and nursing

From inside our nursing profession we see clearly that without nurses there would be no health systems: nurses are the biggest professional component of the global health workforce. Nurses are in every setting where health care takes place, from homes through pharmacies, school, community clinics to hospitals via urgent care, rehabilitation and end of life care. Nurses are to be found at every stop along the care pathway. No nurses, no health care – it really is that simple. But nurses have not historically demonstrated great capacity to build the bridges between nursing research and policy, with the result that nursing research findings that could be hugely useful to inform policy development are not known in the worlds of politics and economics.

This was one of the reasons that the Nursing Now campaign was established. The Triple Impact Report (All Party Parliamentary Group (APPG) 2016) showed that nursing research studies demonstrate considerable benefits from nurse-led care, which include 'reduced costs, higher patient satisfaction, shorter hospital admissions, better access to care, and fewer hospital-acquired infections' (p34). This is echoed in the State of the World's nursing report of 2020 (WHO 2020) which reports on the substantial evidence supporting the safe and effective practice of nurses and advanced nursing practice around the world. But the Triple Impact report also highlighted that much of what nurses do is invisible outside nursing and that their collective impact has to be much better understood by politicians, who need to work as partners with nurses because: 'nurse leaders alone do not have the power and influence to make the changes needed, in light of the lower status of women and the dominance of the medical profession and the bio-medical model of health care' (APPG, 2016, p50).

With my colleague Constance Newman (Stilwell & Newman 2022) I have written about the complex and deeply significant links between nursing as a gendered profession and nurses as influential leaders that have to be both acknowledged and addressed before real change can happen in the way that nursing is perceived and valued. We suggest that gender influenced stereotypes tend to limit the power of nurses as policy influencers, and these stereotypes are not amenable to "quick fixes" but require a rebranding of nursing. Developing a robust brand image for the 21st century has to be part of the nursing research and strategy agendas as a matter of urgency if nurses are to be influential leaders.

Mary Beard, in *Women and Power* (2017), suggests the many ways that power is constructed and conveyed as masculine and makes a compelling case that women are still marginalized from sites of power. We now know that 90% of nurses identified as female in the data collected for State of the World's Nursing report (WHO 2020) and from other studies we see that women are less likely than men to be in leadership positions in the health sector (WHO 2019), despite comprising the majority of the workforce. Beard goes on to say that while there are many

workplace policies—childcare, maternity and paternity leave, family-friendly hours—that have a positive effect on opportunities for women, there cannot be real change in women's profile and status unless they reject societal power norms and change their understanding and practice of power. I contest that the same is true for nursing and nurses. Mary Beard says: "If women aren't perceived to be fully within the structures of power, isn't it power that we need to redefine rather than women? You have to change the structure. That means thinking about power differently...above all thinking about power as an attribute or even a verb ('to power'), not as a possession: the ability to be effective, to make a difference in the world, and the right to be taken seriously, together as much as individually" (Beard, 2017). The frame for nursing leadership development has been one of fixing nurses as flawed players instead of changing the gender-biased systems in which nurses are seen as unequal and inferior, bound by a straitjacket of stereotypes (Salvage and Stilwell 2018).

The 2019 global survey of nurse leadership(Newman et al., 2019) that Nursing Now partnered in – and in which International Collaboration for Community Health Nursing Research played a significant role - found that the majority of nurse respondents felt unable to speak out in a large meeting or in a group of senior managers; felt they needed skills to effectively advocate for a position or formulate a policy; and lacked self-confidence in the exercise of power and when they assumed leadership roles. The survey also found that nurses were often promoted without adequate resources, such as money or staff, and then felt unable to advocate to change this situation. Nevertheless, the nurse leaders interviewed for the global survey described achievements in health systems reform despite gender bias and discrimination (Newman et al. 2019).

This was the experience of Nursing Now too. Our final report is called 'Agents of Change' (Holloway et al 2021) to reflect the innovation and resilience of nurses everywhere in the face of under-resourcing, low pay and sometimes terrible working conditions, but still not noticed by the media, often not thanked and certainly not getting adequate pay rises to reflect the complexity and worth of their roles.

Our powerful nursing narrative is largely hidden outside nursing and only we can change this. To do so means taking a look at ourselves, how we derive our power and how we can use our power strategically to raise the profile and status of nursing.

Working together *to power*

VeneKlasen and Miller (2007) emphasize three core points in the conceptualization of power that are useful to nurse leadership. First, power exercised in professional relations between individuals and groups can be thought of as *power over* people and resources. *Power over* can be structural, such as being employed by an individual or group who is then 'the boss'. Nurses often have *power over* other nurses, but not so often are they the boss in a multi-professional

team nor in a team of policy makers. Second, an analysis of power must include an understanding of social reality that we often recognize through stereotypes. This is how *power over* is associated with masculinity and men, and how there is a 'glass escalator' effect that helps men rise to leadership positions even in a female dominated profession (Punshon et al 2019). Third, and critically important, there are sources of power other than *power over*. According to Eisler (2015, p. 6)**,** *power to* and *power with* derive from partnership models rather than hierarchies. It is these partnership models that gave nurses a more powerful voice during the Nursing Now campaign. They were globally linked and could articulate together their powerful narratives. This is a different non-hierarchical power structure and one which nurses are comfortable to belong to. Used strategically *power with* can become *power to* change health policies and strategic directions, decisions, and resources.

The Nursing Now campaign had global influence and at the same time brought nurses together in new ways as grass roots groups to advocate for local action. The campaign caught the attention of politicians by having two political leaders as board co-chairs (Lord Nigel Crisp from the UK and Dr Sheila Tlou of Botswana), and of the media by having a high-profile patron (HRH The Duchess of Cambridge). In effect the campaign bridged a number of worlds – one of nursing another of high level politics and another of the media. Once the Nightingale Challenge was launched and there was a focus on young nurses, another network was created (Holloway et al 2021). The campaign acted as a convening platform for many networks, connecting groups that might not have previously been connected. Bridging networks are important as they give access to new knowledge and people, allowing the different networks to hear novel ideas (Battilana and Casciaro 2013). The numerous networks that linked through the Nursing Now campaign were able to power together and enable nurses to be advocates for nursing.

Nursing Now had characteristics as a campaign that were unique: it functioned like a start-up business, being small and agile and so could embrace unexpected developments – which included a pandemic, but also the formation of global groups, which was never anticipated. The campaign was, I believe, the first global social movement in nursing. Social movements share a collective identity (nursing) and, though organized, are linked as an informal network (Nursing Now groups) and are engaged in bringing about a change either in policy or in culture (advocacy for investing in nursing) (Christiansen 2009). Although social movements differ in size, they result from a spontaneous coming together of people whose relationships are not defined by rules and procedures but who share a common outlook. This was the nature of both the campaign (not rule defined or procedure governed) and of the groups (spontaneous and each one responding to its wider environment).

What Nursing Now did that was different was to bring the voices of national and local groups to the international arena in a way that had not previously been done at such a scale through creating a bridging network. The campaign was asked repeatedly (and especially during the

pandemic) to identify nurses who could speak to particular subjects, often with high level speakers from other contexts. One notable example took place in 2021 when the campaign was asked to identify two nurses to participate in a global press conference with Dr Tedros Adhanom Ghebreyesus, the Director-General at the WHO: a nurse from Pakistan and one from Uganda told compelling stories of their experience during the pandemic and advocated for vaccines for health workers. This was a new and important opportunity for nurses to use their powerful narratives at the highest levels with international media present. It is this exposure for nursing that will begin to change the fixed stereotypes of nurses that the public, the press and politicians often hold. To be truly influential, the powerful narratives of nursing have to be shared widely and strategically.

One critical lesson learned through the Nursing Now campaign is that the nursing profession has more to learn about strategic advocacy and ways to disrupt the status quo, if nurses are to take on more powerful leadership roles. Media and public images of nurses are outdated. The nursing profession has struggled to communicate a brand image that conveys its complex role in a changing healthcare landscape (Godsey et al 2020) and so others are able to portray other images, which may be based on their own agenda.

We are at a pivotal moment in health history and thus in nursing. If we do not seize this moment we will remain in our rut for the next 50 years and someone else will be writing pretty much the same as I am in 2055. The future is different from the past – but the signs of what it will be like are visible, so I now want to turn to what I and others see ahead and how we meet those challenges.

Into the Future

Zayna Khayat is a 'Future Strategist'[4] working at the Rotman School of Management in Toronto, Canada. She has published widely on drivers of the future of health care and Table 1 sets out the way that Khayat conceptualizes the changes that are already coming about.

Khayat has also pointed out that the pandemic increased the speed at which many people were willing to adopt change. One striking example is the use of internet and telephone based consultations, another is the use of data and analytics especially in public health but also in the development of vaccines. What Khayat says is that innovations that would have taken 10 years to get into accepted practice were taking 10 days, driven by the urgency of the pandemic.

[4] https://www.ispim-innovation.com/post/zayna-khayat-on-smashing-the-barriers-to-innovation-in-healthcare-does-it-take-a-pandemic

Table 1

Predicated paradigm changes in health care		
	Today: systems	**Future: person**
Timing	Reactive, sick care	Proactive, preventive, predictive
Tailoring	One size fits all	Precise, personalized
Channel	Institution centred	Care anywhere
Duration	Episodic	Continuous, team based
Power	Health worker	People powered
Business model	Volume, costs, fee for service	Fee for health, outcomes

All of the factors in Table 1 will impact nursing and if we manage the change ourselves instead of falling in with what is decided for us, then I believe it is inevitable that nursing will finally be the star of the show and no longer the supporting cast. I now set out my reasons for this belief.

1. ***Proactive, preventive, predictive***

This links closely to the person-centred nature of future health care. Most people – especially young people- now know where to look for health related information (Topol 2015). We all consult Dr Google and sometimes find out what is reliable and useful and sometimes not. In many areas of our lives we have taken control of our own behaviour – booking our own travel, banking on line, watching programmes on our TVs when we want to: health is not far behind.

Soon, Dr. Topol predicts that on their smartphones patients will have instant access to their own healthcare data combined with information from huge central databases that will explain risk and best management options. It will be in the power of the patient to share information with their medical team – hence the title of his recent book: The Patient will See You Now (Topol 2015). This is a huge power shift from medical system centred care delivery and it opens up new opportunities for nurses.

Nurses will be interpreters for people of the information they find and receive. How does someone deal with all their health information? How does it affect their physical and mental being? Nurses have always been the reliable bridge between the health services and the community because nurses are everywhere – homes, clinics, schools, prisons and even in pubs

and clubs. Lisbeth Hockey herself commented on working in a rural community as District Nurse, Midwife and Health Visitor that *'it was a wonderful life because everybody trusted you'*.[5]

In the future being the most trusted profession will become even more significant as people have to make sense of predictive information.

2. Precise, personalized

Treatments will be tailored to each person based on many individual factors – but will it be acceptable to the person? Will it be what they want as well as what the science suggests they should have? Who will advocate for the individual?

This is where the 'what matters to you' movement, that has taken off in recent years, will come into its own. Maureen Bisognano who was a board member for Nursing Now, and is a nurse and a quality pioneer, tells this story about her brother Jonny who died aged 21:

'I finally learned the power of the question from a radiation oncologist. While Johnny was in the hospital during that last year of his life, doctors would come and go from his room. They'd speak over him, and about him, but almost never to him. Finally, this radiation oncologist went into my brother's room and asked him, "Johnny — what do you want?" "I want to go home," Johnny answered. The doctor then took off my jacket, put it on Johnny, picked him up from his hospital bed, and carried him to my car. Johnny came home, and spent his final days surrounded by the friends and family that loved him.'[6]

Maureen has been inspired by this event throughout her career, and now advocates for nurses – and all health workers – to ask not only 'what is the matter with you?' but 'what matters to you?'. As we can each get a treatment tailored for us by science and statistics, how vital it will be to have a nurse by our side who will ask this important question as choices are made.

3. Care anywhere

The pandemic has accelerated what was coming: we had Covid tests in our cars, in village halls and immunizations in pharmacies and community centres. Already pharmacies have consultation rooms for minor illnesses. End of life care is delivered at home. Community nurses care for mental and physical health outside of institutions. If you can imagine places for health care to be delivered, then it will probably be so.

Nurses excel at this, for nurses have led care in the community since the middle of the 19th century when district nursing began and the Queens Nursing Institute was established. Health

[5] Mason K. Lisbeth Hockey: Full Biography. School of Nursing, Manchester UK https://www.yumpu.com/en/document/view/40373697/lisbeth-hockey-full-biography-school-of-nursing-midwifery-and-

[6] https://theconversationproject.org/about/maureen-bisognano/

visiting, midwifery, school nursing, community clinics, practice nursing, mental health nursing – all have an established history of working in communities. Here's what the QNI says on its web site:

'We see a future where more people are treated at home rather than in hospital, technology is exploited to the full, and the relationship between nurse and patient is central to quality healthcare'[7]*.*

This is where the power of the nursing narrative will be seen in the future and not only seen but valued by people as they make sense of their choices.

And as QNI points out technology is again driving these changes. Clinical decisions will be supported by long distance virtual consultations with a team. We will all be able to look for evidence in real time on our smart phones to give the best care. Big data will be collected routinely and even more exciting analysed and fed back to all of us so that we can talk about the science behind our health outcomes – how nursing care changes the course and outcome of a disease, or how costs are changed through more efficient care. The possibilities are huge and we should be excited and involved and learning the languages of economics and policy.

4. Continuous, team based

Nurses have always worked as part of a team – this mode of working will not be new. What should be changing is our understanding of how teams work. Teams should be dynamic – a matrix of many teams that we belong to that come together to support people along their care pathways. Team members will vary, team leaders will change and decisions will be taken in consultation with each other and with the person whose care we discuss. This is a different way of working, currently seen in some technology industries but not so much in health care. We have to learn to be nimble, agile and consultative in the interests of those we will be caring for.

We also have to learn to be consulted as part of a team and to be able to speak up with our science so we are properly heard and we can advocate for patients if we need to. All of these ways of working have to be included in nursing education so we are ready to be powerful professionals and no longer intimidated by speaking in a large group (Newman et al 2019).

Continuous care will focus on human flourishing rather than health alone. There are many nurses who already support people to be living their best lives (Crisp 2020). They make it their business to be part of their communities, available to be consulted, innovating so that communities really do flourish. This has to be our model for the future not only for the sake of communities but also because the cost of health care is ever increasing. As Lord Crisp says, we should focus on a health creating society.

[7] https://www.qni.org.uk/explore-qni/

This is where we must take a look at the social determinants of health and what we can do as nurses to influence policies for a fairer society and to reduce the health gaps between rich and poor. That is our business too and together we should be involved activists.

5. **People powered**

The power dynamics in health care have always been fascinating, and often the subject of commentary. The traditional relationship between patient and provider has been viewed as paternalistic with the provider really holding all the power to be the authority on treatment. In those relationships, the patient took a subordinate role and was often glad to. After all, the provider was the expert with years of clinical training and 'knew best'.

But society as a whole as well as healthcare professionals are now calling these power hierarchies into question, saying that they do not align with patient-centered and value-based healthcare models. Forming patient and public involvement groups has become ubiquitous in recent years though how effective they are at allowing people to contribute ti decision making remains questionable.

A 2018 survey of over 1,000 current or past intensive care unit patients showed that very few patients or family members are voicing their concerns during care encounters (Heath 2018). Between 50 and 70 percent of respondents reported hesitation when voicing concerns about possible mistakes, mismatched care goals, confusing or conflicting information, or inadequate clinician hand hygiene. About half of respondents said they did not want to be perceived as a "troublemaker," or that the team appeared too busy to hear a concern. Patients also said they did not know how to report a healthcare concern in this setting. This should be of huge concern to nurses everywhere and points to how far we have yet to travel to really change power dynamics in health care.

With healthcare priorities trending toward overall patient wellness, a more balanced partnership between patients and providers will be key, so that people can speak up as equals and truly participate in their own health care decisions. Nurses will be able to facilitate this power shift as ambassadors of health teams, learning to listen deeply to what is being said.

6. **Fee for health outcomes**

Health care is expensive everywhere but what gets paid for is in fact curing sickness rather than creating healthy communities, families and individuals. It is important of course that a society can offer treatment for illness, but there is so much that could be invested in health: good housing, green spaces, a healthier environment, food that keeps us active, safe exercise like walking and biking, access to a gym, early education opportunities – the list is long.

This list is as much our business as is the use of evidence based treatments. Nurses can be pivotal in helping people have a lifestyle that means they remain active, lessen their stress, boost their mental health and live safely. Yet we know that the budget for health care goes mainly to fund hospitals and high tech care. To be all that we should be in the future of health care, nurses have to learn about health economics and the cost savings inherent in having a healthier, happier society and advocate for different investments in community health.

As people become more health literate we will all be called to account for the outcomes of what we are doing.

The power of the nursing narrative

The nursing narrative is a powerful one, deriving as it does from our common humanity. Backed by the strong research that nursing as a profession produces, our narrative can become compelling evidence to inform policies and investments in health. To do this we need to be strategic as a profession and learn to tell our stories in new ways that show how we meet health needs, highlight our innovations, speak truth to power, calculate the cost savings inherent in good nursing, and find our allies outside of nursing who will speak with us and bridge across networks.

Florence Nightingale was adept at this. In 1856 she attacked the UK Chief Medical Officer, in print, for claiming that deaths from whooping cough, measles, and scarlet fever could not be prevented. Her strategy to sustain her influence was remarkably sophisticated, building bridges between different interest groups. It is described below by Small (2020):

'She leaked copies of her confidential report to the Minister of War, sending it to the most influential people under seal of confidentiality. She wrote for every level of society, from parliamentarians, royalty, and scientists to domestic servants. …….She organised 'health missioners' and district nurses to spread the message by word of mouth to a less literate audience…….. Her reputation among the working-class families whose sons had died in their thousands during the Crimean War, her social standing, her communication skills, and the tacit support provided by a constellation of liberal-minded politicians, enabled her to convince people from all classes of the need for better hygiene.' (Small 2020)

Florence Nightingale is not remembered for influencing policy – but for the care she provided for soldiers and for establishing a nursing school. That she did all of these things is a marvel, but it is interesting that her power in strategic influence is not what is remembered.

Nurses have long been more powerful than we acknowledge today. Centuries of professional subordination, in various manifestations, have left us with a tendency to overlook our own value. But ideas about health are changing, driven by the traumas of the pandemic and other factors too. New challenges are emerging, and technology is enhancing both the way we

educate health professionals and the way those professionals then reach patients. Nurses will be critical to how health systems are able to adapt to the 21st century. The world cannot any longer afford for nurses to be disempowered and we as nurses have to embrace and use our power for good. The great news is that nurses across the world are ready and willing to step up as we saw in the Nursing Now campaign. Nurses everywhere have started to demand their rightful place among decision makers.

This is our moment to shift the paradigm, to be taken seriously for the strength of our evidence that nursing is a sure investment for health for the future. Nurses are the key. It is the moment that we start to tell a new story of health and health care with nurses, as leading actors at the heart of sustainable health systems that meet individual and population needs, are fit for the present, and innovative and adaptable for the future.

I feel sure that Dr Hockey would be not only cheering us on but mustering the research we need to be convincing policy influencers. This moment will not come again in my life time. Real change is coming and we need to be shaping it. We have all the super-powers we need to do this – let's power together and create our own future.

Barbara Stilwell

December 2021

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