ABSTRACT

AIM: To explore the expectation that nurses should be role models for healthy behaviours.

BACKGROUND: Nurses are expected to be role models for healthy behaviours. Whether this is a realistic and acceptable expectation has not been explored.

DESIGN: Modified Policy Delphi study with two rounds of data collection.

METHOD: Purposive sampling was used to explore areas of agreement and disagreement amongst six stakeholder groups who influence nursing roles: practising nurses, student nurses, service users, policy makers, workforce development leads, and stakeholders working in nurse education. Two rounds of a modified Policy Delphi study were conducted between February and June 2015. The first round used telephone interviews for an open exploration of opinions. The second round used attitude statements to explore convergence and divergence of opinions across stakeholder groups. Responses were analysed thematically.

RESULTS: Policy and professional discourse that asserts that nurses should be healthy role models was seen as unrealistic and unhelpful. Contrary to the view that nurses should epitomise and demonstrate healthy behaviours to encourage patients and to be credible in advice, stakeholders agreed that it was more important to be seen as “human” and understand the challenges of health behaviour change. Student and practising nurses did not see role modelling healthy behaviours as a reasonable professional expectation.

CONCLUSIONS: The findings challenge the assumptions underpinning the argument that nurses be healthy role models. Further research is needed to understand the views of frontline nurses and to further explore avenues by which health services staff health can be improved.

(249 words)
SUMMARY STATEMENT

WHY IS THIS RESEARCH NEEDED?

- There is an expectation expressed in nursing policy and professional discourse that nurses should be role models for healthy behaviours.
- Little consideration has been given to the meaning attached to role modelling healthy behaviours or to how it might be realised in practice.

WHAT ARE THE KEY FINDINGS?

- There was no agreement among stakeholders that being a role model for a healthy lifestyle is a reasonable expectation for nurses.
- Practising and student nurses viewed role modelling healthy behaviours as an individual preference rather than a professional duty.
- Aside from the service user group, there was little support for intervention or regulation of nurses’ health behaviours by professional bodies.

HOW SHOULD THE FINDINGS BE USED TO INFLUENCE POLICY/ PRACTICE/ RESEARCH/EDUCATION?

- If nurses are expected to be role models for healthy lifestyles, employers should honour this expectation and make reasonable efforts to allow them to do so.
- Nurses’ ability to lead healthy lifestyles may be hindered by environmental or structural constraints. Initiatives to improve nurses’ health should consider these factors rather than focusing solely on individual motivations and actions.
- The policy steer towards nurses being healthy role models depends on its acceptability to the frontline workforce. The lack of consensus found by this study questions the likelihood of this expectation being enacted in practice.
KEY WORDS

Nurses; role model; Delphi technique; health promotion; health behaviours
INTRODUCTION
Internationally, there is an expectation in policy and professional discourse that nurses are public role models for healthy lifestyles. The International Council of Nurses (ICN) has called for nurses to make “a personal commitment to eat healthily, exercise appropriately, drink sensibly and avoid the use of tobacco” (ICN 2010, p. 37). The United Kingdom regulator, the Nursing and Midwifery Council (NMC) advises nurses to recognise that their behaviour at all times can affect and influence others (NMC 2015), and includes role modelling health-promoting behaviour as a competency standard for registered nurses (NMC 2010).

This steer towards nurses as healthy role models is also reflected in healthcare policy. In England, the chief executive of the National Health Service (NHS) has claimed that the NHS needs to “put its own house in order.” (Stevens 2015). The NHS Five Year Forward View asks all employees to “stay healthy, and serve as health ambassadors” (NHS England 2014, p.11). Although these drives target English healthcare workers, an expectation to be a healthy role model is particularly salient within nursing internationally, perhaps because nurses comprise the largest healthcare workforce globally (World Health Organisation 2014), but also because of the poor health profile exhibited by many nurses worldwide (Perdikaris et al. 2010, Lobelo & deQuevedo 2013).

BACKGROUND
The concept of the ‘role model’ is vaguely defined, commonly conceived as someone to look up to (Gibson 2004). Despite little supporting evidence, role models are assumed to affect the behaviour of other individuals (MacCallum & Beltman 2002). But what does it mean for nurses to be healthy role models? The underlying assumption behind this expectation is that one must be healthy oneself to effectively encourage behaviour change in others. This assumption has its roots in Bandura’s work on social learning and the role of observational learning (Bandura 1977, 1986). Modelled behaviours may serve as cues to initiate similar behaviours in others. Bandura argued that self-efficacy increases
when people see others similar to themselves or those they admire, succeeding. If a person sees a healthy behaviour practised by a nurse, they are more likely to want to do the same. Observation may also weaken (or conversely, strengthen) an individual’s existing restraints against the performance of a modelled behaviour such as a healthy lifestyle.

Historically, nurses were expected to be models of self-discipline and morality. Florence Nightingale argued that nurses must care for themselves to effectively care for others (Dossey et al. 2005). Later conceptualisations reflect concerns of professionalism, with nurses advised to quit smoking not for health reasons, but to avoid displeasing patients by smelling of tobacco (Delafield 1950). Since the 1990s, as healthcare policy focused more on preventive health, nurses were tasked with empowering individuals to make healthy choices and encouraging behaviour change (Kemppainen et al. 2013). Increasingly, where once nurses were expected to promote health through traditional activities such as education, there is a growing expectation that nurses should embody those behaviours they wish to promote (Hensel et al. 2014, While 2014). Some have called for greater monitoring of nurses’ lifestyles and the future inclusion of role modelling healthy behaviours as an explicit duty of nurses (Orr et al. 2014, While 2014).

Nursing policy and professional guidance suggests that the need for nurses to be healthy role models is obvious, but the expectation remains a contentious topic in the professional literature. Some frame role modelling as a professional responsibility linked to better care (e.g. Borchardt 2000). Setting a healthy example is an ethical duty for nurses to ‘practise what they preach’. A public health argument centres on credibility in promoting behaviour change. The Chief Nurse for England, Jane Cummings has noted that staff might struggle to give advice until they start improve their own lifestyles (Cummings 2015). Patients may ignore advice from nurses whose unhealthy behaviours contradict their health promotion practice (Speroni et al. 2012). Aside from being influential role models for public health messages, an economic standpoint posits that healthier nurses may reduce
the strain upon health services by evidencing significantly lower sickness absence and greater workforce retention (Blake & Harrison 2013). The counter argument is that patients may find it easier to relate to someone who also struggles with a healthy lifestyle (Aranda & McGreevy 2014). Proponents of this view argue that nurses are only human and should be free to make individual choices about their lifestyles (e.g. Cook 2010). The structural and environmental factors that influence lifestyles have also been highlighted. Many studies suggest that shift work, low pay, and the emotional labour of nursing may also make it particularly difficult for nurses to lead healthy lifestyles (Torquati et al. 2016; Fernandes et al. 2013; Nahm et al. 2012; Blake et al. 2011).

The expectation for nurses to be healthy role models has received scant research attention, with discussion often limited to commentary and opinion pieces in the professional literature (e.g. Cook 2010, Bickerstaffe 2014). Little consideration has been given to the meaning attached to this expectation or how it might be realised in practice. A Policy Delphi approach was used to explore the perspectives and attitudes of six stakeholder groups towards the expectation that nurses be healthy role models.

THE STUDY

Aim

The aim of the study was to explore the expectation that nurses should be role models for healthy behaviours.

Design

The expectation for nurses to be healthy role models is ill-defined and potentially contentious. A modified Policy Delphi study was conducted to understand if there is a shared view amongst key stakeholders by identifying the areas and extent of agreement and disagreement around this expectation. Policy Delphi designs are used when individuals from diverse backgrounds are needed
to contribute to the examination of a complex topic that is unsuited to precise analysis (Scheele in Linstone & Turoff, 2002). Unlike classical Delphi studies, Policy Delphi studies do not seek consensus, but rather explore convergence and divergence in opinion and alternate arguments from relevant stakeholders (Grisham 2009, Keeney et al. 2001).

Classical Delphi studies use structured survey rounds (Keeney et al. 2001). In contrast, studies using a Policy Delphi design typically use qualitative methods to gauge opinion (Rayens & Hahn 2000), and in this study the first round consisted of telephone interviews with online attitudinal statements used in the second round. The modification in this study from a Policy Delphi design was using open-ended interviews in the first round to avoid imposing statements on participants, allowing them to fully express their views, assumptions or supporting arguments. Figure 1 shows the study design.

The study was conducted from February to June 2015.

Participants

Unlike Classical Delphi studies, Policy Delphi studies do not recruit experts as they are not decision-making mechanisms. Instead, “informed advocates and referees” (Linstone & Turoff 2002, p.80) are recruited by virtue of their professional or educational backgrounds; they can also be individuals who contend with the end products of policies (Meskell et al. 2013). Purposive sampling was used to recruit stakeholders from six groups who influence nursing roles either through education, workforce development, policymaking and regulation, or as practitioners or service users. Table 1 indicates the rationale for including each group and the types of organisations through which stakeholders were recruited.

Group quality is more important than group size in Policy Delphi studies (Powell 2003), and the study aimed to recruit 30-40 participants to provide rich data while remaining manageable for analysis. The invitation to participate requested that participants complete both rounds, a total time commitment of less than two hours. A 50% response rate was achieved from the policy, education and workforce lead groups (see Table 1). For the practising nurse, student nurse, and
service user groups, all group members within the university were invited. Reasons for declining participation included workload, exam pressures and holiday commitments. 25 participants were recruited from the six groups.

Data collection
An interview schedule for Round One, as shown in Table 2, was developed from the existing literature. Open-ended questions allowed stakeholders greater freedom to share novel ideas or opinions in greater detail. Interviews were audio recorded and lasted between 16-98 minutes (median 42 mins). No demographic information was collected as stakeholders were recruited by virtue of their role rather than as individuals.

The literature and first round findings revealed five key conceptual themes around the expectation that nurses be role models. These conceptual themes guided the development of the online attitude statements used in Round Two. The statements reflected different arguments inherent to each theme, as outlined in Table 6. Following Policy Delphi methodology, the attitude statements were deliberately provocative and no neutral response category was included in order to force stakeholders to think about the pros and cons of the issue to a point where they were no longer neutral on the issue (Dunn 2015; Meskell et al. 2013). Participants were asked whether they agreed or disagreed with each statement and given free text to justify their choice.

The Round One interview schedule and Round Two attitude statements were piloted with a practising nurse and workforce lead, resulting in minor wording changes.

Ethical considerations
Ethical approval was obtained from a university ethics committee. All data were anonymised before analysis. To protect participants’ anonymity, quotes are identified by stakeholder group only.
Consent was obtained from participants via email agreeing to participate in the study, with oral consent obtained before each telephone interview.

Data analysis

In both rounds, thematic analysis was conducted by hand following the procedures outlined by Boyatzis (1998). The Round One data analysis comprised two stages. The interviews were transcribed verbatim and the first stage of analysis focused on the questions posed. The unit of analysis was stakeholder group. After careful reading, the key points of each interview were outlined and a list of initial codes identified. When all interviews were coded, a summary was prepared for each stakeholder group, highlighting the differences and similarities between groups based on the questions posed. The second stage of analysis used the codes generated by the first-stage analysis to look for patterns in the data. Codes within groups could then be seen as clusters. Clusters were conceptually organised into themes apparent within the whole dataset to identify underlying concepts in the data (Boyatzis 1998). On the basis of these concepts and the existing literature, a series of attitude statements were then developed for Round Two.

In Round Two, statements relating to each concept were grouped for deductive analysis (Boyatzis 1998), which focused on the arguments informing stakeholders’ positions. Frequencies were calculated to indicate levels of agreement and consensus or divergence of opinion for each statement.

Rigour

Lincoln and Guba’s (1985) criteria for trustworthiness of research (credibility, transferability, confirmability, and dependability) were followed, as these criteria are thought appropriate for studies using Policy Delphi designs (Engels & Powell Kennedy 2007, Hasson & Keeney 2011). Systematic recruitment procedures, data collection, coding, and analysis provided confirmability.
Credibility was enhanced through piloting and including diverse stakeholders. Each stakeholder group’s opinions were equally weighted and afforded equal importance in analysis to eliminate subject bias (Keeney et al. 2001). The authors, who are experienced researchers, reviewed a sample of the interview transcripts and coding definitions and emergent themes were discussed using illustrative data examples. The paper describes in detail the study findings, the analysis procedures and the authors’ interpretation of the data to enhance transferability. Illustrative quotes are used in the presentation of themes to ensure dependability (Patton 2015). An audit trail was maintained throughout the process to enhance overall trustworthiness (Boyatzis 1998).

FINDINGS

The Round One findings are presented in some detail with illustrative quotes to highlight the range of views expressed. The Round Two findings are presented as areas of convergence and divergence, with illustrative quotes used to show polarisation of opinion.

Round One

There was neither consensus on what a role model means nor whether nurses should be healthy role models. Stakeholder groups differed in their understandings of what it means to be a healthy role model (see Table 3). Tensions were evident between a perceived need to improve nurses’ health behaviours and impinging on personal freedoms or victim-blaming.

Should nurses be role models?

Stakeholders across all groups did not support the view of the healthy role model commonly presented in the nursing literature. All groups agreed that behaviour change was a more complex process than simply displaying healthy behaviours and expecting patients to follow suit. The view that nurses needed to be in perfect health to be effective role models was dismissed in favour of
being seen as human and approachable.

“If you take that idealised version, other people feel, ‘Well I’m just a million miles away from achieving that, I have a really difficult life so you don’t have an appreciation.’” (Policy)

Behaviour change was framed as a reciprocal process where nurses needed to form a relationship with individuals to effect change. Displaying healthy behaviours was only useful if accompanied by good communication skills.

“I think if nurses can’t connect with individuals, then actually it’s very difficult for them to have any impact at all. So for me, coming across as holier-than-thou, and you know that I’m completely perfect; I don’t think that’s helpful at all.” (Education)

The student and practising nurse groups differed markedly from the other stakeholder groups in that they viewed role modelling healthy behaviours as an individual preference and not as a professional duty. The student and practising nurse groups felt that personal behaviours were not necessarily important, as their professional duty was to provide evidence-based, patient-centred care.

“It’s a matter of choice because not everybody wants to be a role model” (Practicing nurse)

Stakeholders agreed that visibly unhealthy behaviours such as smoking or obesity negatively affected nurses’ credibility in health promotion. These behaviours were deemed ‘worse’ than others as they could not be concealed. Less visible behaviours were thought no less important however, although they did not impact on first impressions. The student nurse group in particular reflected this idea, as they described a role model as someone who was not seen doing the ‘wrong’ things.

“In terms of being a role model, those are the things that should be given more attention, because they’re the things that people see. They see nurses smoking outside hospitals; they see that they’re overweight.” (Workforce lead)
For the service user group, the lines between professionalism, appearance, and health were frequently conflated. Service users described negative perceptions of nurses who failed to meet an expected image of health.

“You think ‘Oh god, please don’t be the one who’s coming to look after me’. And I’m sure they’re perfectly nice people, but it just doesn’t inspire you. You think, does she know what she’s doing?” (Service user, describing an obese nurse)

**What helps or hinders nurses to be role models?**

Several factors were cited as influencing nurses’ health behaviours, as shown in Table 4. Social norms in society and the nursing community were seen as important influences on behaviour. Stakeholders speculated that nurses’ lifestyles reflected the growing social acceptability of unhealthy behaviours. The education and service user groups noted that this in turn accompanied an abdication of personal responsibility for health.

“I think we need to look at where our nurses are coming from and the sort of health behaviours rooted in that, in the communities that they’re coming from” (Workforce lead)

Social norms also operated at a micro-level in workplaces. Student nurses reported taking behavioural cues from the nurses on placement. This helped students to ‘fit in’ and feel part of the team while on placement.

“It’s who you’re working around...if there are loads of people bringing in salads for lunch, then it’s more the norm that you – if everyone else is buying sandwiches, and eating sweets and chocolate, then you’ll have it, and you’ll feel like it’s ok for you to do it.” (Student nurse)

The student and practising nurse groups described workplace cultures where unhealthy behaviours (particularly around diet and weight) were acceptable, with little pressure to change.
“It’s ok to be a bit bigger; it’s fine. Nobody ever questions eating all the chocolates, all the biscuits, or all the cake in the hospital. And in my personal life, people would never do that!” (Student nurse)

“…When there are colleagues who don’t have healthy choices, and they bring things to the workplace and want you to nibble with them…you can’t keep saying no because maybe you will offend the person” (Practising nurse)

Excepting the workforce lead group, stakeholders did not feel that individual sociodemographic or psychological traits overly influenced behaviour. Counter to policy discourse, only the practising nurses and service users cited job-related factors such as shift working as hindering healthier lifestyles.

**Should nurses’ own health behaviours be addressed?**

All groups agreed that nurses’ personal health behaviours warranted attention. Almost all stakeholder groups (bar the service user group) agreed that nurses were frequently targets for criticism. In particular the policy and workforce lead groups expressed the view that nurses were judged differently to other healthcare professionals, particularly doctors. This was thought to be due to gender and status differences between the professions.

“Often nurses are seen to be less powerful, and have less power in the system and in the health service. And within society, certainly women are regarded as; you have much less power than men. And so they’re an easy group to target and label and blame.” (Workforce lead)

The policy group challenged the perception that nurses evidenced high rates of unhealthy behaviours. This perception was heightened by negative media portrayals of nurses. The workforce lead group noted that the public struggled to differentiate nurses from other workforces such as
healthcare assistants, and judged all staff as nurses.

“You’ve got a population who call everybody a nurse and it can work quite badly”

(Workforce lead)

The service user and education groups argued that nurses should stop abdicating responsibility for their own behaviours and take personal responsibility for their unhealthy lifestyles. The education group argued that nurses should adapt a healthier lifestyle to fit around their work.

“What needs to happen is that people take some responsibility for themselves.” (Service user)

Table 5 identifies what stakeholders believed would help nurses to improve their health. Ticked boxes denote factors mentioned and empty boxes denote factors not mentioned by each stakeholder group.

The student, practising nurse, and workforce lead groups raised concerns around victim blaming, as health behaviours were often dictated by structural factors outside nurses’ control. If support was offered, it was rarely tailored to the realities of nurses’ working lives, leading to low uptake. The workforce lead group felt that employers used this as evidence that nurses didn’t care about their lifestyles, which absolved employers of their responsibilities to staff.

“It requires an awful lot more than just laying it on, like we’ve done our bit and it’s now up to them and they’re still going to be unfit and unhealthy and eat unhealthy diets.”

(Workforce lead)

Stakeholder groups differed over the level of intervention into nurses’ personal lives that they felt was appropriate. The service user and education group thought that unhealthy lifestyles should be addressed and felt that behavioural imperatives such as explicit lifestyle requirements at student
selection and regular physical fitness appraisals would improve nurses’ health and behaviours. Reference was made to renewing the health-related entry requirements of years past. Arguments for personal freedoms were dismissed as a justification used by unhealthy nurses.

“If you had a nurse who came in, and she was very overweight, it’s very much about that you’re coming into an organisation, our expectation is that you couldn’t be as big as you are” (Service user)

Conversely, the policy and workforce lead groups felt that individual choice must be respected. They acknowledged that nurses could not be made to lead healthy lifestyles if they did not wish to do so. The student nurse group shared this sentiment. They felt that nursing should not dictate their personal life, and viewed obligatory behavioural requirements as authoritarian.

“In your personal life, I think that is kind of your own space…nursing at the end of the day is just your job, it can encroach on your personal life too much.” (Student nurse)

Round two

Seven participants were lost to attrition in Round Two (one each from the service user, student, and practising nurse groups and two each from the policy and education groups). Reasons given included illness, lack of time due to student placement, and work commitments. Not all participants responded to every statement.

The online attitude statements reflected five key conceptual themes that had emerged from Round One around the expectation that nurses be role models: to be more credible in health promotion, to take personal responsibility for their health, because personal health impacts on the quality of patient care, as a professional duty, or to counteract unhealthy social norms within the workforce. Table 6 shows the percentage of agreement and the degree of consensus for each statement.

Consensus was determined following the suggestion of de Loe (1995), to be high (70% agreement or
greater), moderate (60-69% agreement), or low (59% agreement or lower), indicating the degree to which the group was agreed on each statement.

**Areas of high consensus**

Almost all stakeholders agreed that patients would find health advice from an unhealthy nurse less credible, as the discrepancy reduced the credibility of the nurse’s message. Patients’ perceptions of the nurse’s unhealthy lifestyle would negatively impact on their confidence and trust.

Stakeholders agreed that nurses’ health behaviours merited attention, but were driven by concerns for nurses’ health rather than any potential economic benefits. Nevertheless, both drivers were not thought mutually exclusive – concentrated efforts to support nurses would in turn improve absenteeism or retention. It was thought crucial to deliver messages sensitively, so that nurses felt supported rather than punished or blamed.

Stakeholders disagreed that social norms led to an unhealthy lifestyle being more acceptable in nursing than in other healthcare professions. The workforce lead and practising nurse groups remarked that in nursing, teams might be less judgemental and it may be easier to justify unhealthy choices due to the busy nature of the work.

**Areas of low consensus**

Statements related to professional duty caused the greatest divergence in opinion. Across all groups, there was little support for stricter governance of nurses’ health behaviours. Enforcing common entry requirements was thought unacceptable and possibly discriminatory; however some stakeholders deemed it worthwhile to examine if entrants valued healthy behaviours. Health behaviour appraisals at registration or revalidation were not supported, particularly by student nurses. The policy and education groups noted that fundamental principles of healthy behaviour should be encouraged, but ultimately nurses’ responsibility extended no further than meeting job
demands and fitness to practise requirements. In contrast, the service user group noted that other professions had fitness requirements and nurses should be similarly accountable.

“Nurses’ personal lives are very much controlled by their professional lives already but this is a HUGE step too far.” (Workforce lead)

“[The] sooner the better. Police force are now doing it....Too big and lose your job, obviously with a correction strategy in place first.” (Service user)

Stakeholders disagreed over whether nurses needed to take greater personal responsibility for their lifestyles. Although personal health was seen as an individual responsibility, employers were criticised for not adequately supporting staff needs. The workforce leads noted that stress and unhealthy coping mechanisms were often linked, arguing that feeling more valued by employers could improve nurses’ health. The job itself was thought inherently unhealthy. However the policy, service user, and education groups argued that this was true for all healthcare professionals and nurses needed to take their lifestyles more seriously.

“I believe that it is the shift work and stress that causes the fatigue and emotional reaction which means I make poor food choices and feel too tired after three long days to exercise on my off duty” (Practicing nurse)

“I think this is just an excuse. A healthy lifestyle is more often about willpower and discipline. And sometimes about planning ahead.” (Policy)

DISCUSSION

Despite the policy steer towards role modelling healthy behaviours, reactions to that expectation have not been explored. This study investigated the expectation that nurses be role models for healthy behaviours amongst six stakeholder groups.
The impact of the policy steer towards nurses as healthy role models will depend on its acceptability to the frontline workforce to be enacted in practice. The study found that practising and student nurses (as the future frontline workforce) did not believe that patients modelled their behaviour on that of healthcare professionals. Behaviour change was thought more complex than the process of observation and imitation described by Bandura (1977, 1986). The practising and student nurse groups viewed role modelling healthy behaviours as an individual preference rather than a professional duty. Some argued that evidencing healthy behaviours was less important than providing evidence-based, patient-centred care. The authors intend to conduct a further phase of this study with the frontline workforce to elicit the acceptability of nurses being expected to adopt healthy lifestyles.

Stakeholders generally agreed that patients would find advice from a visibly unhealthy nurse as less credible. There is some evidence that nurses who do not lead a healthy lifestyle may be less willing to raise lifestyle issues with patients (Aranda & McGreevy 2014; González et al. 2009). A recent systematic review showed that patients may be more likely to follow the advice of a healthy health care professional (Kelly et al. 2016). In this study, the service user group had negative perceptions of visibly unhealthy nurses, and argued that nurses’ lifestyles should be addressed. The voice of service users has previously been absent from debate on nurses as healthy role models, but studies of patient responses to observable health behaviours by healthcare professionals also suggest that patients’ perceptions of nurses’ professional skills and credibility are influenced by appearance (Albert et al. 2008, Puhl et al. 2013). The concerns of service users in this study reflect their perceptions of the health service. These findings may help policymakers and others to reflect on the public image of the nursing workforce and the wider health services, but also underscore the worth of incorporating strategies to support healthy lifestyles as part of initiatives to improve nurses’ health promotion practice.
This study raises the question of whether the health behaviours of nurses and other healthcare professionals are expected to be better than the general population. The nursing workforce is drawn from the public it serves, and faces the same health challenges. The implication of the expectation to role model healthy behaviours is that the job confers a status that differentiates nurses both from other healthcare professionals and the general population. If nurses are expected to be public role models for healthy lifestyles, then how this expectation might be realised must be considered. The workforce lead group thought that employers were well placed to address nurses’ lifestyles, but also perceived that currently, workplace support for healthy lifestyles was insufficient. If nurses have a professional duty to maintain a healthy lifestyle, then employers must take reasonable efforts to allow them to do so.

The nursing workplace is in itself considered inherently unhealthy (Rowe & Macleod Clark 2000, Peate 2015). This study suggests there is a shared view that societal and workplace norms negatively influence nurses’ health behaviours. Workplace cultures may be influential in reinforcing unhealthy behaviours, and could make it particularly difficult for individuals to make lifestyle improvements. Environmental and structural constraints may further inhibit nurses’ ability to lead a healthy lifestyle. Initiatives to improve nurses’ health must tackle these factors rather than focusing entirely on individuals, which could be construed as a victim-blaming approach. If students take their cues from staff on placement, healthy universities and workplaces, or team-based initiatives could also prevent students adopting unhealthy behaviours at the outset of their careers (Wills & Kelly 2016).

Limitations

The views expressed in this study are drawn from a small group of 25 participants. Delphi studies such as this do not aim to be representative and have limited generalisability (Hasson & Keeney 2011). Stakeholders are indicative of the groups to which they belonged, and their views should be considered as suggestive insights to inform thinking. This study drew from a diverse range of stakeholders, all of whom contribute to shaping nursing roles. Giving an equal weighting to the
viewpoints of each group enhanced trustworthiness. Characteristically for Delphi studies, there was some attrition between the two rounds. However dropout was distributed evenly across the stakeholder groups, with no one group particularly affected. Conventional Delphi technique aims to reduce the range of responses and the second round in this study does seem to have coalesced opinion.

CONCLUSION

This study has shown attitudes towards role modelling healthy behaviours different from the views expressed in nursing literature. Behaviour change was thought much more complex than simple imitation; contesting the assumption that role modelling can effect behaviour change. The ‘ideal’ role model proffered by stakeholders was someone who had struggled with unhealthy behaviours but eventually successfully changed the behaviour. Apart from the service user group, stakeholders felt that the healthy role model conceptualised in policy and professional guidance as best placed to encourage behaviour change was unhelpful and unrealistic.

Policy and professional discourse asserts an expectation for nurses to be healthy role models. This raises difficult questions about how much the choice and behaviours of individuals can be dictated by professional bodies or employers. Any attempt at regulation was strongly rejected by the workforce lead and practising nurse stakeholders in this study. Currently, the tenor of much of the debate around nurses’ health behaviours is victim-blaming, with an expectation that nurses should assume responsibility. Employers must be prepared to better support nurses to meet this expectation, as expressed by the workforce lead and practising nurse groups. The design of this study shows clearly that realising an expectation for nurses to be healthy role models is controversial and its implications must be carefully considered if this expectation is to become a shared and acceptable vision for nursing.

(4982 words)
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