Is there a perceived tribal culture within the nursing profession?

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People are naturally tribal and tend to form solid societal connections with specific groups whose members share similar interests. This is not surprising and applies to both personal and professional relationships. It is natural to feel connected to people who share a professional background and have similar goals within the workplace. In the context of nursing, this enriches our experiences and helps us achieve our goals and visions. For many, these will be around innovation and evidence-based practice, with the goal being to enhance the quality and efficiency of care delivery.

The author has been privileged to work with many smart, ambitious and impressive colleagues who have a very strong sense of professional identity. However, as in any profession, conflict and tensions among colleagues can occur when obstruction is perceived as animosity, especially where nurses align closely within certain specialties and with fellow nursing colleagues. Yet tribalism in the nursing profession can also cultivate a supportive network where individuals are encouraged to feel empowered and motivated to establish an environment where colleagues collaborate, share knowledge, and collectively work towards a common goal.

In today's current climate there is no doubt that the NHS is faced with an enormous challenge of delivering the highest quality of care while striving to improve efficiency and save money. The nursing profession itself is undergoing significant changes and clinical teams are being challenged to develop new ways of working. At the same time, they are expected to take on extra roles, for example, in long-term-condition management.

In the author's opinion, attaining these goals while maintaining the fundamental principles of the NHS, such as equity of access to healthcare resources, represents a significant challenge to the nursing profession. Therefore, it is essential that the NHS provider service looks at different ways of making efficient services available for the future while still maintaining service quality, equity of care, acceptability, and accessibility.

The psychosocial Leg Club model for lower limb care

To address the NHS provider service, the nursing profession is expected to cope with additional demands due to the change in demographics, an ageing society, and the prevalence of long-term disorders such as problems of the lower limb/foot. Adopting a positive cohesive culture in nursing will be rewarding. When nurses come together within their respective units or departments, there is a real opportunity to support each other, collaborate effectively, and provide the best possible care for their patients. This approach fosters a sense of belonging, teamwork, shared purposefulness and establishes a culture of mutual respect.

Community leg ulcer clinics emerged several years ago as a new approach to leg ulcer management. The general belief was that the provision of leg-ulcer care within a dedicated clinic increases both ulcer healing rates and patients' quality of life (Moffatt et al, 1992; Harrison et al, 2008) when compared with individualised nursing care. However, a randomised controlled trial (Mölnlycke and The Patients Association, 2022) concluded that no difference was found between healing rates provided by specialised individuals at home or in a clinic. This may reflect that it is the organisation of care that may be more important than the location in which the care is delivered. In an ageing society, communities must cultivate their social fabric to maintain health and wellbeing, with one alternative to either home or a non-medical social clinic approach being the psychosocial Lindsay Leg Club® model.

Embracing new models of nursing care requires clear evidence of their effectiveness and safety. The author has observed that, despite recent data published on the psychosocial Leg Club model for lower limb care relating to cost-effectiveness (McIntyre et al, 2021) and the benefits of the Well Leg Regime (McIntyre et al, 2023), many readers and practitioners remain unaware of the rationale, aim, belief, and concept of the Leg Club model. The concept is based on a framework and rationale to develop a social model to provide community-based care for individuals with leg-related problems that emphasises a holistic approach, including wound management, social support, wellbeing and public health promotion.

Leg Clubs are a research-based initiative grounded in Becker's Health Model (Becker and Maiman, 1975), which argues that people's health behaviours are driven predominantly by psychosocial considerations. To address this, the Leg Clubs provide community-based treatment, health promotion, education, and ongoing care for people of all age groups experiencing leg-related and foot problems.

The Leg Club nursing teams are employed by NHS local provider services, community trusts, GP consortia or individual practices and the nurses incorporate the Leg Clubs into their everyday practice, working in a unique partnership with patients (members) and the local community. Working to best-practice guidelines, they provide a high standard of care in a social and friendly setting that promotes understanding, peer support and informed choice.

The Leg Club model provides options in liaising with practice and community teams, and the integrated model can help to facilitate 'neighbourhood working', as it saves their teams time from travelling between houses. Often housebound individuals can get out of the house with assistance and some Leg Clubs

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provide a minibus to transport people (key criteria is that people can walk with a walking aid or, if in a wheelchair, can use the toilet independently), enabling people to attend who would otherwise be labelled as housebound.

Healthcare systems, however, may give precedence to resources for traditional care settings, leading to a lack of investment in community-based models such as the evidence-based Leg Club model. Addressing the persistence of resistance or animosity towards the psychosocial Leg Club model requires a multifaceted approach that includes:

- Encouraging open communication and collaboration
- Addressing concerns about risk and resource allocation, engaging nursing leadership
- Gradually implementing changes while acknowledging and respecting the existing culture
- Recognising that concerns about professional status, autonomy, and patient safety can further fuel resistance.

Overcoming this resistance requires understanding and addressing underlying fears and misconceptions, fostering open communication, and involving nurses in the process of implementing the introduction of the Leg Club into the community they serve. This model was conceived to support people with leg problems 'owning' their clinic, which is set in a non-medical environment such as a community hall or day centre. Working with NHS staff, the Leg Club generates a unique partnership between integrated nursing teams and the local community. The clubs provide person-centred management with a 'well-leg' programme of care for those vulnerable to lower limb problems in a social environment, where members are treated together.

Healthcare systems are often slow to change due to complex bureaucracies, entrenched policies and resistance to change. The author acknowledges that if nursing management and healthcare organisations do not actively promote or champion the adoption of new care models such as Leg Clubs, frontline nurses may be less likely to embrace them. Without adequate support and resources, nurses may be reluctant to fully engage with the Leg Club model.

Many forward-thinking colleagues have experienced strong resistance to change simply because it is different from the norm. For many practitioners there is a strong professional culture rooted in traditional healthcare settings such as hospitals and clinics. There is clear evidence of a dichotomy within the profession between the medical and non-medical approaches to lower limb care. Some nurses may view the community-based Leg Clubs as a departure from their professional identity, leading to resistance. It is not necessary or possible to understand all the nuances of a non-medical social approach to lower limb care. However, for some colleagues and management, acquiring some knowledge goes a long way when confronting uncertainties associated with adopting new care models.

Removing barriers from tribalism

Since 1994, the author and motived proponent nursing colleagues have encountered 'tall poppy syndrome'. Unfortunately, many have experienced verbal confrontations, resentment, and direct criticism for proposing the introduction of the model.

There are numerous exemplary nurses who excel in their careers or receive recognition for their accomplishments but sadly will face resentment from their peers. Hence, the term 'tall poppy syndrome' where people are criticised, resented, or verbally confronted because of their achievements or success, particularly when this success stands out within a group or community. This is the opposite of the culture of support and collaboration that can foster amazing results. When nurses celebrate each other's achievements and work together towards common goals, the possibilities are endless.

Nurses can explore ways that services can be delivered more effectively to manage the modernisation and development of community nursing services, while recognising financial restraints. It is believed that NHS expenditure is close to £10 billion a year; therefore, the potential cost effectiveness to the NHS of the Leg Club model, which requires little investment, is substantial. In addition, it addresses a key aim of the NHS, which is to provide accessible services locally whenever possible.

In the current healthcare climate, it is important to demonstrate how the Leg Club services within the UK are driving up quality, increasing productivity and patient satisfaction. The three domains of quality are safety, effectiveness, and patient experience. Leg Clubs address the quality agenda and demonstrate that taking a different approach to the delivery of care can improve patient outcomes and experience.

Conclusion

The two articles published by McIntyre et al (2021; 2023) demonstrate that the Leg Club model is more economically efficient than traditional or usual home visits. This is because of the excellent health outcomes of the model. Other health and social benefits of the Leg Club are also important for providers to acknowledge. For members, improved quality of life, enhanced functionality, greater socialisation, and choice are the main benefits. Giving people more choice is a priority of the modern NHS. Research shows that treatments are more effective if patients choose, understand, and control their care (NHS website, 2024). The Lindsay Leg Club model is an example of members choosing to receive care in a local environment that helps them to better understand their problems and become involved in their care. This successful partnership between the Leg Club, service provider, members, and the community, represents an excellent public health model.

The focus of the psychosocial Leg Club model is to remove a tribal culture and strive for collaboration. Change can be challenging but unless we collectively reshape care delivery in the modern NHS, we will not be able to resolve the issues discussed in this article. With innovation and change comes uncertainty, of course, and for some practitioners this can feel overwhelming. It is important that we not only respect and value the patients and their families, but we also facilitate and support our colleagues as we implement these reforms. We must strive to break down barriers to positive change by working in partnership with our own and other disciplines, not against them. **BJN**

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