Thinking like a nurse: you have to be a nurse to do it

Suzanne Gordon

Before 1998, I thought I understood nursing. I had followed nurses as they cared for patients, interviewed them, read nursing texts, books, and journals, and worked with nurses to help them make their important work more visible. I understood what in Life Support: Three Nurses on the Front Lines—a book about nurses at Boston’s Beth Israel Hospital—I called nurses’ tapestry of care, the combination of domestic, intellectual, technical, social, communal and other activities that go into making the package that is nursing the sick and vulnerable. I understood the caring components of nursing work—the attentiveness to human beings who are vulnerable, in pain and suffering. I also understood nurses’ participation in the process of cure—something the care versus cure dichotomy unfortunately conceals. And, of course, I knew that nurses prevent errors, and injuries and other catastrophes.

Caring for a friend taught me that being a nurse is much, much harder than even I had assumed. It involves not only acting like a nurse, but thinking like a nurse and viewing the world through the eyes of a nurse. That different vision is critical, as I discovered the hard way.

In conversations with one of my cherished mentors, historian of nursing Joan Lynaugh, I often engaged in conversations about nursing. When Joan and I talk, she always emphasizes the role nurses play in keeping patients safe, ‘Yes, yes,’ I would always think. Of course, of course, I would agree, conjuring up images of nurses double checking dicta like ‘right dose, right time, right patient, right route’.

But in the winter of 1998, I came smack up against my own ignorance, smack up against just what it means to be a nurse and think like a nurse, smack up against the complexity of what nurses do to keep people safe from harm—something that, stupidly, I had not fully grasped before.

I learned this when I became a ‘nurse for a day’—two really—taking care of a friend who had ambulatory surgery.

In February of 1998, I went to California to give a lecture and stayed with my friend Kathy Dracup, who was at that time a cardiac critical care nurse, editor of American Journal of Critical Care, and professor at the University of California at Los Angeles School of Nursing. About a week before I arrived, Kathy called to ask me if I’d do her a favor. She had a knee injury and needed arthroscopic surgery. Suddenly, her surgeon called to tell her he had a slot open and wanted to schedule her surgery during my visit. Her husband was going to be away on a business trip. She asked if I could pick her up at the hospital, bring her home and take care of her after the operation. She would get to the hospital by cab, but she wasn’t allowed to drive or take a cab home. It would all be the proverbial piece of cake, she reassured me (and herself). All I’d have to do was get her a meal, bring her a cup of tea, or water and help her to the bathroom. Nothing to it.

Of course, I agreed. I even joked that playing nurse for a day would give her the opportunity to judge if I’d learned anything in my years studying nurses.

As instructed, Kathy had left the house that morning to be at the outpatient surgery center of a large teaching hospital by 6:30 am. Thirty minutes later, she was in the OR. At 9, a nurse called and told me to be at the recovery room precisely at 9:45. From there, I would be dispatched to the pharmacy to get Kathy’s pain medication and then return to go over the discharge instructions. We’d be out by 10, the nurse said. What brisk efficiency, I thought, as I drove to the hospital. This should be easy.

As I walked through the recovery room, I began to have second thoughts. In curtained off cubicles, I saw blitzed out, exhausted looking patients just out of the OR and still hooked up to IVs. I wondered how they, like Kathy, could possibly be well enough to go home. I hoped that I would find my friend in better shape and, sure enough, she seemed quite cheerful as she reclined in bed and gave me the good news. Her doctor had found less knee damage than expected. ‘I can’t tell you how happy I am,’ she smiled ebulliently. ‘My knee was so swollen and painful.’ I thought for
sure the surgery would be much worse and that the surgeon would find more damage. I left to get Kathy’s prescription at the pharmacy. As the pharmacist handed me the bottle of pills, I asked him if there were any special instructions I needed to know before giving them. No, he said, offhandedly. Just make sure she takes one every four hours. Back in the recovery room, I asked the nurse the same question and she repeated the same instructions. Then she went over the discharge instructions: remove the bandage 24 – 48 hours after surgery. Don’t be alarmed if there’s some blood on the bandage. Because of the danger of osteomyelitis, Kathy shouldn’t swim or take baths. She also shouldn’t try to put any weight on her bad leg for the next 10–12 hours because the nerve block used prior to surgery had completely deadened it.

The nurse asked Kathy if she’d ever used crutches before. ‘Oh, yes,’ Kathy blithely responded. The nurse probed no further. Instead, she said, ‘Okay. You don’t need a lesson in crutches’.

The anesthesiologist came in to make Kathy’s discharge official. After putting my friend in a wheelchair, the nurse and the doctor waved us out. An escort wheeled Kathy down to the parking lot where a hefty guard helped her into the car.

Great, we both said, smiling. As we drove away, I was again impressed — or perhaps I should say lulled — by my friend’s good spirits and alertness. She seemed totally herself. There didn’t seem to be any lingering effects of the anesthesia. She chirped on about how relieved she was that the surgeon hadn’t found more damage in her knee, that she wouldn’t have a lot of scarring and thus greater risk for the surgeon hadn’t found more damage in her knee, that there didn’t seem to be any lingering effects of the anesthesia. She chirped on about how relieved she was that the surgeon hadn’t found more damage in her knee, that she wouldn’t have a lot of scarring and thus greater risk for arthritis later on in life.

When I pulled up to the curb, we got her out of the car and standing up on her crutches without mishap. Rather than going up the front walk, with its numerous steps, we walked to the driveway.

Then I made my first mistake: I left Kathy alone and went up the slight incline of the driveway to open the gate that would allow her to access the front door.

After opening the gate, I turned around I saw my beau-
tiful friend lying in a heap, crutches slapped out to the side, at the bottom of the driveway. I raced down to her crumpled figure. ‘God, are you all right?’ I asked, bending down by her side. ‘Did you hurt your leg? Did you hurt your other leg?’

Completely dazed, she said, ‘I don’t know what happened. I was fine one minute and then the next I felt so dizzy. I just went down. Feeling her body, she muttered, ‘Okay, it’s okay I think I’m fine.’ I bent down to try to help her up. But she did not budge. I tried to pull her up, but she was dead weight. I’m five foot six inches and have a bad back. She’s 5’11’ and 130 pounds. She had no mobility. I didn’t have enough strength. What were we to do?

Looking for help, I raced over to the next door neighbor’s and rang the bell. No answer. I started for the next house. ‘Don’t bother,’ Kathy shouted, ‘She’s too old to help.’ In this suburb of Los Angeles, few people are home during the day.

I came back, stunned. God, what a predicament. It was her leg or my back. To try to save both of us, I crouched down carefully in between her legs and put her hands around my waist. Slowly, ever so slowly, as if I was a tree trunk, she climbed me and I supported her until she was standing.

It was now clear to me that the combination of dehydration plus the anesthesia she still had on board meant she could not be counted on to stay upright. To make sure she was safe, I would have to stick to her like glue. As we walked up the driveway, I held her waist from behind and gradually we navigated our way to the front door.

She stood at the base of the three front steps while I opened the door. Okay, I said, and went to help her up the three steps to the front door. She didn’t move. She lacked all kinetic problem-solving ability and simply couldn’t figure out how to negotiate the steps with her crutches and dead leg. I tried to support her but I just wasn’t strong enough.

I have often written that nurses help patients scale the molehills that illness has transformed into mountains. Standing there, at that front door with its three steps, thinking about going through the door and meeting the next obstacle — another step to the living room — and a flight of stairs up to the second floor and her bedroom, I felt like we were staring up at Mount Everest. The hospital had given us some climbing gear, but not the expert guides.

Just as I was contemplating the two of us standing here all day, a truck pulled up across the street and two gardeners got out and began mowing the lawn and clipping hedges. I had to risk it. ‘Hold on! I’m going to get help.’ I made sure Kathy was firmly stabilized on her crutches and begged her, ‘Please, please don’t move, don’t fall,’ and I ran across the street.

The gardeners were Hispanic and fortunately I know Spanish. ‘Please help me, please,’ I begged, pointing to the woman on crutches — thankfully still on her feet — and prac-
tically dragged one of the gardeners across the street. He accompanied me and helped Kathy up the steps and into the living room. As Kathy was hobbling across the living room to the stairway, one of her crutches hit an unanchored throw rug. The crutch started to skid out of control. By this time I was on red alert and leaped over to hold it down.

She didn’t fall again, at least here.

Kathy ascended the stairs on her bum. After heartfelt thanks, the man left the house.
Dripping with sweat, shaking with anxiety, I helped Kathy off with her clothes and into her pajamas, tucked the requisite pillows under her injured leg to keep it elevated, and went down to make her some tea. It was only 11:30 in the morning, but I felt like I needed a stiff drink.

In the afternoon, her daughter came over and I went out to do a few errands. When I came back, Kathy had some bad news. With her daughter’s help, she had gone to the bathroom. In the process of turning around to get on the toilet, she’d again become dizzy and again she had fallen.

Again, by sheer accident, she hadn’t hit her bad leg, broken a hip, cracked her head, or injured her daughter.

I immediately marched into the bathroom to survey the scene. Only then, after the fact, did I see the problem. This was no hospital bathroom, with non-skid linoleum floors, plenty of room for two people to maneuver, and grab bars near the toilet. The floor was tiled and quite slippery to stockinged feet — and she had to wear support hose for the next few days. There was another treacherous throw rug near the sink. Not surprisingly, the room was designed with fashion, not illness, in mind.

‘You shouldn’t go into the bathroom without shoes on,’ I told her. ‘You can slip too easily. In fact, when I go with you, I need to wear shoes too. We have to be careful.’ I said. ‘We can’t let you get hurt. I tried to sound calm, but inwardly I was a wreck. Too many accidents were happening.

Finally, when Kathy’s daughter left, she took a nap. As she was sleeping, her husband John called to find out how she was. Of course, I told him the operation went well, but feeling isolated and anxious, I also recounted all the rest of our mishaps in full Technicolor and stereo surround sound. Not surprisingly, he panicked. ‘Should I get on the next plane and come home? I can be there late tonight.’

I hurriedly tried to take it all back, insisting that nothing untoward would happen and that I’d call him if the slightest problem occurred. ‘All right,’ he said, and reluctantly hung up.

After putting down the receiver, I hit myself in the head with another crucial nursing skill — an awareness of the dangers of the ordinary. And they combine that educated glance, the recognition of pain, and the human vulnerability and capture, in their educated glance, with stunning clarity, is view the world through the prism of that educated glance.

I was living out that dilemma. I was asked to be a substitute nurse, we learned why. That particular medication is apparently notorious for causing nausea. Kathy needed to eat before taking it, but all she’d had since midnight the previous night was a banana. Why hadn’t anybody told me this at the hospital, I wondered. I’d asked both nurse and pharmacist if the medication had any side-effects. Neither had mentioned a word. Had I known she needed to eat to stay out of pain, I would have force-fed her like a French goose.

As I got Kathy to sleep and me into my bed, stress and worry had turned my back into a spastic knot. I felt overwhelmed by the responsibility of trying to keep my friend safe. I was also afraid that she would wake up in the middle of the night to go to the bathroom, fall again and that this time our luck would run out.

My friend Joan Lynaugh has described the dilemma that characterizes the entire history of nursing. Nurses, she says, have been given the awesome responsibility of the care of the sick, without being given the education and resources necessary to fulfill that mission. As I went to bed, I felt that I was living out that dilemma. I was asked to be a substitute nurse, the education and resources necessary to protect my friend from danger. Indeed, I was being set up to fail or, at the very least, to feel like a failure.

Although Kathy was doing much better the next day, I could not help but ruminate on what had transpired. What taking care of Kathy taught me is the enormous complexity of keeping patients safe from harm. What we so easily forget is that illness and treatment make people enormously vulnerable — not just to the side-effects of drugs, to hospital borne infections, to surgeons who may operate on the wrong limb, or to residents, and now nurses, who are overworked and overtired, but to daily life itself. Sick and infirm people — even people who are sick and infirm for only a short time — are at risk from all those things that are unproblematic when they are well. Suddenly, the normal activities and accoutrements of life become threatening, if not lethal. To nurses, I know this must sound banal. But believe me, to those who do not regularly care for the sick and vulnerable, it is not.

What nurses know and do, I suddenly realized with stunning clarity, is view the world through the prism of that human vulnerability and capture, in their educated glance, the dangers of the ordinary. And they combine that educated glance with another crucial nursing skill — the ability to protect patients from danger without making them feel endangered. I had failed utterly to do that when I talked to Kathy’s
husband. When he called, my anxiety and stress level was so great that I didn’t have the emotional energy to reflect on my actions. I did not understand that this was not the time to tell Kathy’s husband about my terrible experience and to expose the flaws of the American healthcare system — one that now routinely puts a patient and their caregivers at such risk. I did not have the professional discipline to do this, not because I am not a caring person, but because I am not a nursing professional.

Caring for Kathy also highlighted the contextual nature of nursing itself. The statement ‘a nurse is not a nurse, is accurate not only because nurses, through their education and experience, may be expert in different areas of practice. It is true because nursing is an activity that occurs in a specific context. Although many nurses, like other professionals, like to claim a special moral position that is transformative, the fact is that being a ‘nurse,’ depends on whether one is acting in the role of a nurse just as the success of nursing care depends upon the context in which it is delivered.

When I told another nurse friend about my experience taking care of Kathy, she remarked that Kathy should have better prepared and advised me. ‘After all,’ my friend said, ‘she’s a nurse’.

Well, yes and no.

The minute Kathy walked into her doctor’s office to consult about her knee, the minute the surgeon called and told her when her surgery would be scheduled, the minute she walked into that ambulatory OR, she shifted identities. She became a patient, adopting the attributes that characterize most patients. She minimized the impact of her surgery on her immediate postoperative recovery. She accepted her nurses’ cavalier comment that because she’d used crutches before; she didn’t need a run through in order to use them safely again. She was exuberant about her operation because, as patient, she was more concerned about whether or not her injury and its repair would limit her later in life than she was about the details of her home care. These concerns shifted her gaze. She was looking at the world through the eyes of a patient. Although she is extremely knowledgeable as a nurse, as a patient she had difficulty applying her nursing gaze to her own environment and could not possibly protect herself from danger.

What is even more interesting about this episode is how the nursing care she received in the hospital was also context driven. Why you might ask, didn’t her nurse insist that she have a lesson in crutches? Why didn’t she advise me about pain management, when I asked? Why didn’t she ask Kathy or me about the obstacles we would have to navigate when we were back at home? After all, one of the central characteristics of nursing care is protecting patients from harm. Why didn’t this nurse protect her patient from that harm? Was it because she was a bad nurse? An unethical nurse? Was it because she failed her moral mandate?

I don’t think so. Nurses today often work in healthcare systems that value profit, cost-cutting or efficiency more than patient safety. In ambulatory surgery centers, the imperative is through-put — getting patients in and out. Because, in reality, most nurses work for institutions not patients, the mandate to speed up the process of treatment and care may override the individual nurses’ concern for her patients. And indeed, the next day, when a nurse from the out-patient surgery center called to inquire about Kathy, that came across quite clearly. When she asked if Kathy was doing well, I told her the whole story.

About the first fall, she remarked defensively ‘But didn’t you read the discharge papers, it says patients might feel dizzy?’

‘Might feel dizzy — that’s not good enough,’ I retorted. ‘You need to tell us to stick to the patient like glue. You need to insist that patients have a lesson in crutches. You need to ask about the layout of their house — if they have steps.’ Those of us helping patients need to know how to help them maneuver up steps when they are dehydrated, have had anesthesia, and have a dead leg. You need to ask about throw rugs.

‘Well, you know, I hate to say it,’ she admitted, ‘but she isn’t the first person who’s fallen.’ Then she backtracked, insisting it was the patient’s and family’s responsibility to check the house for dangers like throw rugs. Finally, she added, ‘Maybe, we should advise patients to have two people available when they go home’. ‘That’s great,’ I thought, ‘We pay for nursing care in our healthcare premiums. Then we have to deliver that care ourselves to our loved ones at home, and now you’re asking two people to take off work. If the system isn’t going to let people recover adequately in the hospital or ambulatory surgery center, it’s the system’s responsibility to make sure they are safe,’ I wanted to shout. But I didn’t.

Why? Because I realized that despite nurses’ contention that they are patient advocates, patient advocacy is also context dependent. As much as nurses may want to advocate for patients, too many do not have the on-the-job time required for effective patient advocacy. In countries plagued by cost-cutting and shortages, many nurses are so depleted by intolerable patient loads that advocacy is a hope not a reality: at a certain point in their day, they simply don’t have the energy to fight any longer. Moreover, many nurses work in institutions that do not value their insights and concerns. Nor do some have the on-the-job protection that would encourage them to buck the system when it’s necessary.
And others are too passive or too burnt out to engage in the kind of political action necessary to change the workplace environment. Even more distressing, as Marie Heartfield’s new research is pointing out, still others have embraced the bottom-line values of their institutions and view their job not as advocating for patients, but as successfully getting patients into and out of their units as quickly as possible.

I believe the moral and political dilemmas that so many nurses face today is one of the by-products of our social failure to understand the complex nature of the work of keeping patients safe from harm. As I walked around Kathy’s neighborhood a few days after her operation, I kept asking myself why it took me so long to grasp the importance of the ostensibly trivial issues that grew to be so important when Kathy returned home from the hospital. For this failure, I think we are all to blame. Our society is to blame for its persistent inability to reckon with all the minute consequences of illness and its unwillingness to give nurses the resources they need to adequately care for the sick.

But this social problem is exacerbated because nurses are so often silent about the content of what I’ve come to think of as their safety work. When I read the descriptions of nursing work articulated by nursing organizations or by individual nurses, I find that they are long on jargon — about ‘patient advocacy,’ ‘patient education,’ ‘coordination or management of care’ ‘prevention of illness’ and ‘health maintenance’ — as well as on diffuse and vague accounts of nurses ‘caring.’ But the content of this ‘caring’ ‘coordinating,’ ‘education,’ ‘advocacy’ work is hard — if not impossible — to grasp. That’s because nurses provide very few concrete details that allow us to really understand the consequences of illness and the myriad dangers that patients face either in hospital or home. Similarly, when nurses focus assiduously on themselves as purveyors of ‘health,’ the content of the work they do when dealing with sickness (which is, after all, what the vast majority of nurses actually do in their daily work) seems to be almost entirely eclipsed.

This is unfortunate, because, as I learned the hard way, many non-nurses need to hear far more about nurses’ safety work. We need to hear more nurses explaining how they protect patients from the dangers of their vulnerability. We need to hear more of them tell us that nurses keep patients safe during illness — and how they do this. We need to hear nurses explain that they pay attention to the so-called little details (which they then describe in sufficient detail) that seem so banal but that make the difference between life and death, recovery and safety, and we need to learn what kind of resources they need to assure patient safety. We need more nurses to tell us that nursing isn’t a matter of TLC, but of life and death.

Although I have been writing about nursing for over a decade and had a very good head start, I had to wait until a friend got sick before I gained a better understanding of the complexity of nurses’ work. If our societies are to provide the resources to make nursing a long-term satisfying career, those of us who are not nurses need to learn to appreciate the facts of illness and vulnerability before we, our friends, or ourselves and relatives get sick. I was lucky. By sheer good fortune, my failure to ‘think like a nurse’ didn’t kill or seriously hurt my friend Kathy. When it comes to the care of the sick and vulnerable, luck isn’t good enough. At some point, it always runs out.