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Nurses: The First and Last Line of Defence for Not Only Patients But Physicians as Well

On June 1, 2012, several London newspapers, including the *Independent* and the *Guardian,* reported the findings of the British National Confidential Enquiry Into Patient Outcomes and Death (NCEPOD) concerning the deaths of acutely ill patients who had a cardiac arrest while in hospital. The *Independent* focused on that part of the report dealing with the general assessment of warning signs prior to cardiac arrest, the *Guardian* on that part dealing with the appropriateness of resuscitation.

The *Independent* (Edgar, 2012) reported that the inquiry found that more than 38% of the cardiac arrests could have been avoided if the junior physicians had assessed the situation and responded in a timely manner, that warning signs were not picked up in 35% of the patients, that these were not acted upon in 56%, and that junior doctors had not communicated with senior doctors in 55%. According to the *Independent*, the inquiry laid the blame on lack of skill among junior doctors and lack of communication between junior and senior doctors.

The *Guardian* (Boseley, 2012), in contrast, focused on the finding that, of the acutely ill patients who had a cardiac arrest — many of whom were nearing the end of their lives — less than a third (29%) did not receive "good" care and were subjected to what the inquiry considered "futile resuscitation attempts that prevent them dying with dignity." In nearly half of the 526 cases investigated, the patient's condition had not been properly assessed on admission to hospital. One in four patients were expected to die shortly, and of these only 44% had end-of-life directives written in their charts. The *Guardian* reported that the inquiry laid the blame on senior doctors, who should have the "expertise and experience and the ability to communicate effectively and with compassion to make these tough decisions."

In reading these two newspaper accounts, I was struck by the glaring omission of nursing's part in patient care and the role that nurses have traditionally played in the education of junior doctors. I was also struck by the focus on the junior physician-senior physician partnership, with no attention given to other partnership models, such as nurse-physician, that might make the system more responsive to the needs of patients. Let me explain.

In the United States and Canada (and, I suspect, in Great Britain and elsewhere), nurses have been the unsung teachers of interns and residents. In their book *Clinical Wisdom and Interventions in Acute and Critical Care,* Patricia Benner and colleagues describe many cases of nurses pointing out to junior physicians the warning signs of deterioration, correcting their misinterpretations of signs and symptoms, suggesting diagnoses, and an-

ticipating when and how to intervene (Benner, Hooper-Kyriakidis, & Stannard, 2011).

In speaking with experienced physicians, one often finds that they will recount some "near misses" from their internship or residency days. They will recall their failure to recognize the early warning signs of a patient "turning sour" and those almost failure-to-rescue patients — "almost" because of the competence of a knowledgeable, experienced nurse who protected them as young doctors and, more importantly, protected and safeguarded the patient. Many seasoned physicians still have a profound sense of gratitude for these nurses and may even, dare I say it, be in awe of those who "saved" them in the early years of their career when there was no time to consult with a senior physician. They depended on these expert nurses, who knew the patient and were attuned to subtle changes in his or her condition before they became fully manifest. Yet nurses have never been recognized or given credit for their role as educators of physicians in training.

Who are these nurses who serve as the first and last line of defence for both patients and physicians? They are nurses who possess a depth of theoretical and practical knowledge, acquired in the classroom and utilized, developed, integrated, and honed in care settings. Theoretical knowledge gives nurses the flexibility to understand and interpret observations, whereas practical knowledge enables nurses to "situate" that knowledge and use it in ways that are responsive to the particular patient. Theoretical knowledge *ensures* that patients and families get the best care possible. We now have a body of research that attests to the complexity of nursing care and the years of practice it takes to amass the knowledge and skills needed to achieve a high level of expertise. Those in nursing and many other professions know that knowledgeable nurses protect the system in countless ways, not least by ensuring that physicians have the most up-to-date and salient information about their patients on which to make medical judgements and take appropriate action. Unbelievable as it may seem considering all the evidence, we still hear from certain quarters, in nursing as well as in medicine, that nurses do not need the benefits of basic or advanced university education. It may be that some physicians have not had the privilege of working alongside well-educated nurses who have undergone this level of preparation and training.

We all have something to learn from the report of the NCEPOD inquiry. If the British health-care system lacks a sufficient number of university-trained nurses, it might consider investing in additional educational opportunities for nurses. If it has a sufficient number of university-educated nurses, it might consider how better to use them so that they are given the opportunity to use their training to the fullest capacity and to use all of their competencies.

Another characteristic of these invaluable frontline nurses is their years of experience in the workplace. They are professional nurses who value ongoing learning and evidence-based care and who are keenly aware of the need to spend time getting to know patients and families. They are reflective practitioners — they think rather than depend on routinized, prescriptive care.

They work in institutions and agencies whose senior administrators and nurse leaders give priority to investing in and retaining their nurses. Two decades of research has exposed the deleterious and tragic effects of devaluing and undermining nurses and nursing. The cost has been high in terms of nurse burnout and patient morbidity and mortality (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002). Research has also revealed the conditions needed to retain professional nurses (e.g., Kramer, Schmalenberg, & Maguire, 2010). Nurses who are rewarded, recognized, and respected for their expertise are those most likely to commit to a career in nursing. Moreover, when nurses are given status, resources, control over their own practice, opportunities to function autonomously within their scope of practice, and the ability to use their knowledge and skills to the fullest, they choose to stay and are satisfied with their workplace. Most intriguing in this body of research: One of the best and most consistent predictors of nurse satisfaction and good personal health (i.e., low burnout) is positive professional relationships with physicians (Laschinger, Shamian, & Thomson, 2001; Needleman, Buerhaus, Pankratz, Leibson, & Stevens, 2011; O'Brien-Pallas, Tomblin Murphy, Shamian, Li, & Hayes, 2010; Schmalenberg et al., 2005). Physicians also benefit from such relationships. Most important of all, when physicians partner with nurses and there is clear communication within the partnership, patients' voices are heard and their needs are met.

These are some of the invaluable lessons learned from the past two decades of research. Our British colleagues would do well to heed these lessons. They need to rethink recommendations that are based on a narrow focus such as the junior physician-senior physician relationship and consider the value of interprofessional partnerships, particularly between nurses and physicians. They need to consider strengthening their frontline staff — those nurses who are with the patient 24/7 and are readily available to intervene if and when necessary. However, such a transformation can be realized only when nurses are educated, are allowed to practise to the full extent of their training, and are given recognition for their unique contribution to patient care — complementary to that of their medical colleagues (Institute of Medicine, 2012). And it can be realized only when nurses are accorded the status, respect, and power accorded to any professional — that is, when they have the preparation and experience necessary to care for patients and families with dignity and

respect, promoting their health, facilitating their healing, and ensuring their safety.

Let us in Canada and elsewhere also learn from the lessons of those recent decades when nursing was devalued and even dismantled. The effects were profound and will reverberate for years to come, until we have rebuilt a profession of frontline nurses who are well educated, knowledgeable, skilled, compassionate, and committed to nursing as a career. We need to dedicate our efforts to valuing nurses and nursing worldwide, if we are to learn from the past and build a safe and responsive health-care system. Nurses will truly have the power to transform patient care and the health-care system when they become full partners with physicians.

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References

Aiken, L. H., Clarke, S. P., Sloane, D. M., Sochalski, J., & Silber, J. H. (2002). Hospital nurse-staffing and patient mortality, nurse burnout and job dissatisfaction. *Journal of the American Medical Association, 288*(16), 1987–1993.

Benner, P., Hooper-Kyriakidis, P., & Stannard, D. (2011). *Clinical wisdom and interventions in acute and critical care: A thinking-in-action approach* (2nd ed.). New York: Springer.

Boseley, S. (2012). Acutely ill patients prevented from dying with dignity in hospital. *Guardian,* June 1. Available online: http://www.guardian.co.uk/society/2012/jun/01/acutely-ill-prevented-dying-dignity.

Edgar, J. (2012). Report criticizes hospital doctors over cardiac arrests. *Independent,* June 1. Available online: www.independent.co.uk/life-style/health-and-families/health-news/report-criticises-hospital-doctors-over-cardiac-arrests-7810521.html.

Institute of Medicine. (2012). *For the public's health: Investing in a healthier future.* Washington: National Academy Press.

Kramer, M., Schmalenberg, C., & Maguire, P. (2010). Nine structures and leadership practices essential for a magnet (healthy) work environment. *Nursing Administration Quarterly, 34*(1), 4–17.

Laschinger, H. K. S., Shamian, J., & Thomson, D. (2001). Impact of magnet hospital characteristics on nurses' perceptions of trust, burnout, quality of care, and work satisfaction. *Nursing Economic$, 19,* 209–219.

Needleman, J. P., Buerhaus, P., Pankratz, S., Leibson, C., & Stevens, S. (2011). Nurse staffing and inpatient hospital mortality. *New England Journal of Medicine, 364,* 1037–1045.

O'Brien-Pallas, L., Tomblin Murphy, G., Shamian, J., Li, X., & Hayes, L. (2010). Impact and determinants of nurse turnover: A pan-Canadian study. *Journal of Nursing Management, 18,* 1073–1086.

Schmalenberg, C., Kramer, M., King, C. R., Krugman, M., Lund, C., Poduska, D., et al. (2005). Excellence through evidence: Securing collegial/collaborative nurse-physician relationships, Part 1. *Journal of Nursing Administration, 35*(10), 450–457.