Point of View

Quality Health Care and the Professional Nurse – A Physician's Perspective

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In 1981, I testified to the National Commission on Nursing: "…doctors, health administrators, heath care planners, and resource allocators do not fully understand the roles of the professional nurse in our health care system…Society has generally accepted the…physician as the 'captain of the health care team.' It does not similarly accept the fundamental, independent and interdependent roles of the nurse in planning and implementation of health care…The general image of the nurse remains to too many an undifferentiated subordinate who follows the doctor's orders, the caring individual who charts vital signs…gives the back rub and carries the bedpan. Individual physicians, of course, know that without the nurse their work would not be possible. Doctors, administrators, trustees and health care planners clearly recognize the essential role of the nurse shortly after they or their family members become hospitalized patients." I urged "a basic change in our collective attitudes so that we do acknowledge that the nurse is an independent professional and, as such, deserves recognition and functional definition as a true partner with the doctor in medical care; and a reordering of our sensitivities, our commitments and our dedication to establish the professional nurse as a truly equal partner entitled by a long history of proven performance to equal appreciation, equal stature, equal professional standing, equal resources."

Twenty-eight years later, let me restate my enthusiasm, and respect for, the nurse.

As a medical student, I soon suspected that the seasoned bedside nurse, and the veteran emergency department nurse, knew as much as (did I dare believe even more than?) I. During my rotation on obstetrics, which involved delivering babies "on district" (in patients' homes), I offered silent thanks that the visiting nurse was always there before we arrived and, while assuring that everything went properly, graciously permitted us to feel that we had something to do with the miracle of the new life. As a sub-intern, I saw a beginning intern—reputed to be the top in his graduating class—become immobilized when faced with his first diabetic coma patient. I saw the nurse quickly sense, and correct, this.

As a resident, I learned that the "Head Nurse" frequently knew more about what was happening to my patients than I did. I learned never to go to the patient (except in an emergency) without touching base with the nurse, without first reading the often more informative nurses' notes. Years later, as a clinical investigator reviewing patients' records, I was grateful for the nurses' notes which frequently contained important documentation for my search and—besides—were usually legible. One of my deep personal regrets is that, like most of my academic colleagues, I did not list as participating author (ess) in my publications the nurses who made essential contributions to the quality of care which made my studies possible. Today—*mirabile dictu*—we have the integrated, sequential progress notes. Again, the nurses' documentation is often the most trenchant and informative.

As the Chief Resident, I valued the joint nurse-resident daily patient rounds. During one of my rare rotations to a community hospital, outside of the academic teaching orbit, I was surprised to witness quality care and satisfactory outcomes provided by "only the nurse and private physician." As a reluctant patient, I was gratified by the physician attention I received (a Chief Resident is considered an important link in the medical hierarchy) but puzzled at first by the aura of comfort and security and personal relief I felt when "my nurses(s)" entered the room. During that year, I learned more forcefully the powerful teaching role of the nurse for interns and medical students.

As I climbed the institutional ladder, I observed repeatedly the quiet, selfless contributions of the nurse in guiding interns, in discovering—and correcting—the erroneous order before its implementation, in comforting the anxious patient awed by the barrage of technology, in comforting the distraught family members, in compassionately sharing with the crying patient who had just been informed of the dreaded cancer and the need for frightening surgery, in the equal management of the agitated, or depressed, or threatening, or alcoholic, or unwashed, or senile, or incontinent, or psychotic patients. I was intrigued by the idea that every young physician might benefit from a six-week stint as a nurse's assistant early in the course of training. I gradually learned that the nurses' contributions are the essence of "quality health care" in our system. To those who know my pride in the medical professions, I need hardly add that such judgment in no way detracts from the contributions of the good and caring physicians I have known.

As Chief of Medicine at Rhode Island Hospital for 24 years, I received numerous communications from patients and families. The critical ones virtually never criticized "the nurse(s)." The grateful writers (the vast majority) invariably praised the nurse(s), often by name. I shared the frustration of the nursing supervisors in their daily, and nightly, struggles to provide adequate staffing. I witnessed the exhausting frustration of the staff nurse who finally leaves the shift knowing she could do more, should do more for her patient, but cannot, because of the overwhelming demands. And yet they do—day after day, night after night. I marveled at the abilities of both the nurse and the resident to keep abreast of the exploding technologies, despite the primary demands of the sick patients. My department increasingly asked nurses to assume procedures and roles which were "always the doctors' job." I observed the Joint Practice Sub-Committee of the Medical Affairs Committee pinpoint key patient care problems, provide realistic solutions and

spearhead the implementation of improvements such as record-keeping, DNR policy, drug usage, care of the disturbed patient, reductions in septicemia from peripheral lines, etc etc.

On a personal level, during the fatal illness of my son, my family and I were overwhelmed by the nurses' care and caring, their implementation of the medical care plan, their comfort and compassion, their meticulous attention to pain relief, nutrition and hydration, management of nausea, personal hygiene and, above all, the maintenance of dignity. After his first hospitalization, he paid nursing the ultimate tribute (voiced so often by patients and families) of requesting return to the same unit when re-hospitalization was necessary.

I shared in the developments of a new medical school, an improving Department of Medicine and its subspecialties, and growing programs in ambulatory care, in community outreach, in quality assurance, utilization reviews, discharge planning, etc. None of these could have developed to any level of excellence without the essential participation of the nurse. I am puzzled by the paradox of the frequent failure to incorporate the nurse, early and continuingly, in the planning processes. For I witnessed again and again the contribution of the nurse's expertise and perspective in the later evolution of the programs. Lewis Thomas was right: "the institution is held together, *glued* together, enabled to function as an organism, by the nurses and nobody else." To the glue, I would add: "The nurses provide the lubricant that keeps the meshing gears going, day after day, night after night."

A personal note is in order. My first wife, now deceased, was a nurse; my daughter is a nurse; my second and current wife is a nurse; our daughter is a nurse; and our granddaughter was just accepted to URI's College of Nursing. I trust that any judgment of conflicts of interest will be balanced by the putative virtues of consistency.

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