PARTNERSHIPS IN PRACTICE: PARTNERING WITH THOSE WE SERVE

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THE CONCEPT OF COMMUNITY AND THE COMPLEXITY OF PARTNERING

Kathleen S. Fries, PhD, RN
Julie G. Stewart, DNP, MPH, MSN, FNP

In this year of Creative Nursing’s focus on partnerships, an introduction to the new paradigm of partnering was followed by an exploration of the ways in which nursing education systems and faculty can prepare students to partner with peers and colleagues. Now we turn our attention to partnering with those we serve.

Health care professionals use various terms to refer to the recipients of their care: patients (connoting the presence of illness and a dependent or reliant relationship), clients (connoting a professional transaction and perhaps a more autonomous or self-sufficient relationship), consumers (connoting a business relationship), or residents (connoting a long-term relationship). The “partnering balance” in these relationships is based on the needs of the recipients and their ability to contribute to the partnership.

Those who accompany and support the recipients of care also have many names: partner, father of baby, significant other, friend, birth mother, health care power of attorney, labor coach. Laurence A. Savett, author of “I Am the Professor of Myself: How Our Patients and Their Loved Ones Become Our Teachers and Models,” explained an updated draft of his article by saying, “I substituted ‘loved ones’ for ‘family,’ being sensitive to the diversity of important relationships.”

We partner in a myriad of environments: hospital inpatient units, emergency departments, primary care clinics, a wheelchair center in Guatemala. At Massachusetts General Hospital in Boston, Todd Hultman, Amanda Coakley, Christine Annese, and Sharon Bouvier explored the sleep experiences of hospitalized patients. They identified themes of hospital ambience, symptom management, and routine nocturnal cares—all opportunities for partnering to help patients rest and heal. And at the University of Rochester in New York, nursing professor Lisa Norsen and professor of emergency medicine Linda L. Spillane describe interdepartmental partnering in the development of a resuscitation simulation program that prepares students for the close collaboration that will be needed to provide the highest level of care in code situations.

Health care professionals also partner to provide care for and with families and communities. Our article on experiential learning to support community nursing practice presents various definitions and configurations of communities,
Theoretical frameworks for providing care to communities, and the concept of service-learning as a “teaching and learning strategy that integrates meaningful community service with instruction and reflection to enrich the learning experience, teach civic responsibility, and strengthen communities.” In this arena, faculty, students, educational providers, and communities partner to provide care that meets the needs of those with whom we serve.

Individual self-determination should be the paramount value in our partnering. In “What’s in a Name: A Question of Patient Autonomy,” Marcus Engel, in his story of beginning his recovery from a devastating automobile accident, shares examples of actions by his nurses that gave him back the control over his body, his choices, himself. And Sarah DeFlon, who practices nursing at University of Michigan Health System in Ann Arbor and volunteers in a clinic in Detroit, describes opportunities for clinical nurse specialists in primary care clinic settings to advocate for those they serve.

The political and economic implications of partnering with those we serve require close examination. In an interview with nursing professor Teddie Potter, sociologist Riane Eisler (cofounder and president of the Center for Partnership Studies) discusses the gender equality and flattened hierarchy she advocates in her book, *The Real Wealth of Nations: Creating a Caring Economics*, which is also the object of a concise book review by Robin Squellati, a chief nurse at the 6th Medical Group at MacDill Air Force Base in Tampa, Florida. Debra Zamora, clinical nurse manager in the Veterans Affairs Health System and an adjunct nursing faculty member at the University of San Francisco, explores the political, financial, and philosophical implications of using patient satisfaction as a basis for reimbursement.

Finally, partnering is about relationships. Staff nurse and poet Connie Coyner speaks with the voice of those we serve in “See Me as a Person.” And nursing students Molly MacLean and Katie Theisen share with us what they have gained from attending Nursing Salons: “Salons have opened my eyes to a whole new community of people who are as excited about nursing as I am.” “Salons have given me clarity about school, life, priorities, and my future.”

This edition focuses on partnering with those we serve as well as partnering with those with whom we serve. The term *partnering* is synonymous with joining, associating, connecting, or uniting with. The needs of health care recipients, combined with the complexity of our health care delivery systems and settings, highlight the need to value partnering. The articles in this issue of *Creative Nursing* thoughtfully inform the concept of community and the complexity of partnering to provide care with our health care recipients as patients, families, and communities.

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The concept of community is multidimensional and may include geographical boundaries and/or the shared interests of its members. Community nursing practice involves nurses, patients, and families who collaborate to address health issues and to promote positive health initiatives. Informed by community health theorists, experiential learning activities provide the structure to promote partnering in community nursing practice to achieve outcomes that benefit those who serve and those who are served.

Community is a concept that is defined in many ways. Taken in totality, community can be defined as a group of people who share common interests, resources, needs, and environment who also relate and interact as a result of shared needs and interests (Harkness & DeMarco, 2012). This definition is further supported where community is defined as a territory or place “where people have something in common, and this shared element is understood geographically” (Infed Community, 2012).

An alternative definition of community, geopolitical community, includes members who live in the same area, such as neighborhoods, towns, or parishes (Harkness & DeMarco, 2012). Settings for geopolitical communities include “homes, ambulatory care settings, schools, occupational health settings, residential institutions, and the community at large” (“Theories Applied in Community Health Nursing,” 2012).

Members who share an important feature or common interests also define the concept of community (Harkness & DeMarco, 2012). The term phenomenological community (Maurer & Smith, 2009) includes members who share interpersonal and intrapersonal connections.

In interest or “elective” communities people share a common characteristic other than place . . . They are linked together by factors such as religious belief, sexual orientation, occupation, or ethnic origin. In this way we may talk about the “gay community,” the “Catholic community,” or the “Chinese community.” (Infed Community, 2012, p. 7)

Although the definitions for geopolitical communities are more concrete than for phenomenological communities, which involve the principles of solidarity, commitment, mutuality, and trust (Adair, as cited in Chinn, 2012), both definitions...
The concept of partnering with community members implies mutuality and trust as nurses and patients, their families, and communities commit to collaborate to address health issues.

GIVING CARE TO COMMUNITIES

Based on the principles of trust and support undergirding the concept of community, nursing professionals, in collaboration with community members, identify health needs and concerns along with the services to help manage or eradicate targeted problems. The concept of partnering with community members implies mutuality and trust as nurses and patients, their families, and communities commit to collaborate to address health issues. Numerous elements are incorporated into this form of reciprocal and collaborative practice, including health promotion, prevention, disease management, and rehabilitation.

Several nursing theorists have written about community, community health nursing, or population-focused care. Nancy Milio identified concepts of community-oriented care and posited that unhealthy behaviors resulted from a lack of knowledge (as cited in “Theories Applied in Community Health Nursing,” 2012). Salmon White constructed a framework to prevent disease, protect against disease, and promote health through education and regulation (as cited in “Theories Applied in Community Health Nursing,” 2012). Block and Josten’s ethical theory of population-focused nursing included an obligation to the population, prevention, and centrality of relationship-based care (as cited in “Theories Applied in Community Health Nursing,” 2012).

A more recent model of community nursing, the community nursing practice model (CNPM), reflects a commitment by the Florida Atlantic University College of Nursing faculty and students to using four nursing concepts (nursing, person, community, and environment) to guide nursing practice, education, and scholarship while also promoting collaborative practice with a community health care system that is affiliated with their college (Parker & Barry, 2010). The CNPM has also been used to frame curricular development in Thailand and Uganda. Parker and Barry describe the model as an evolving one that captures a commitment to community partnerships, community health policy development, and community improvement. The CNPM reflects nursing as “nurturing the wholeness of persons and environments through caring” (Parker & Barry, 2010, p. 452).
The concept of community is multidimensional and includes a concrete definition of community in the geopolitical, logistical sense, and a phenomenological definition in which members are defined and connected by interpersonal and intrapersonal links. Both definitions guide the delivery of community-based nursing care. The definitions of community and the concepts outlined by community health theorists support nurse educators who seek to develop experiential learning activities to promote the provision of community health care experiences across multiple program levels. The values of mutuality, commitment, and solidarity are educational outcomes that support the tenets of community health nursing.

Barbara Anderson (DeChesnay & Anderson, 2012) discusses the context of vulnerability in healthy and unhealthy communities, offering a valuable new paradigm for promoting healthy communities as part of population-based nursing curricula. Healthy People 2010 and 2020 (Department of Health and Human Services [DHHS], 2011) and the Institute of Medicine (IOM; 2003) have laid the foundation for understanding the complex, interwoven determinates of health, which include biological, sociocultural, and environmental aspects. One of the identifiers of unhealthy communities is a lack of support, or even outright targeting, of vulnerable populations within them. Anderson posits that assisting a community in helping its vulnerable members become more resilient by including all members of the community in addressing poverty by providing adequate housing, healthy food, job opportunities, clean air and water, and proper sanitation are vital to the health of the population. Focusing first on the strengths within a community instead of its problems is truly a novel approach.

Dossey (2008) developed the theory of integral nursing, which embraces a holistic view of nurses as healers and emphasizes the interaction of the person and the world. This grand theory has many facets but can easily be used by those seeking to study and understand nursing and the community. The theory of integral nursing is based on integral theory developed by Ken Wilber in 1977. Integral theory is a metatheory composed of significant threads from the arts and social sciences (Integral Institute, 2009). Dossey’s intent is to encourage us to “engage in health care reform to address the challenges in these troubled times—local to global. This is not a matter of philosophy, but of survival” (Dossey, 2008, p. E72).

**SERVICE-LEARNING: EXPERIENTIAL EDUCATION FOR STUDENTS**

According to the National Service-Learning Clearinghouse, “Service-learning is a teaching and learning strategy that integrates meaningful community service with instruction and reflection to enrich the learning experience, teach civic responsibility, and strengthen communities” (Education, Training, and Research Associates, 2012, para. 1). Service-learning is more than just volunteering and is a mutually beneficial process that affects both the recipients and the providers of care. Academic courses with clear objectives are matched with an experience in a community that provides service to people in need of such services.

Examples of service-learning include partnering with senior centers, health care clinics, and community centers to provide diabetes and hypertension screenings, influenza vaccinations, and healthy lifestyle education. These activities benefit those who attend the programs, and they help the students meet objectives of specific coursework.

International partnering through mission trips has enabled registered nurse and nurse practitioner students to learn how to provide sensitive, culture-specific health care and education. In addition to setting up and working in makeshift
health care clinics providing needed services to the people in communities, students learn how to incorporate clinical skills and patient education in collaborative and supportive ways. By incorporating needs assessments in international and local communities into curricula, service-learning can be woven into the objectives of nursing courses from the undergraduate to the doctoral level.

An example of experiential learning to support community health initiatives involves a partnership between Sacred Heart University (SHU) and a nondenominational church in Guatemala. Students and faculty partner with church volunteers to provide supervised health care to marginalized Guatemalan women, men, and children. The partnership began with groups of nursing faculty and students traveling to Guatemala each year and has grown to include interdisciplinary groups of nursing, occupational therapy and physical therapy students and faculty who travel to Guatemala three times each year to provide collaborative care and follow-up services. On the most recent trip, small interdisciplinary teams measured and assembled wheelchairs at a center in which all the employees were in wheelchairs because of physical disabilities. Although the goal of this mission trip was to promote interdisciplinary collaboration and enhance awareness of each other’s roles, an unexpected benefit was being invited into a community that shared not only geopolitical attributes but also phenomenological ones as well.

In another learning experience, SHU has joined with a volunteer organization that travels to provide medical care in Jamaica. The medical mission health care team consists of nurses, physicians, and nurse practitioners working alongside nursing faculty and undergraduate and graduate nursing students.

Both the Guatemala and Jamaica experiences of SHU students support the IOM’s hallmark report entitled “Health Professions Education: A Bridge to Quality” (IOM, 2003), which posits that health care professionals who communicate well and provide an effective team approach to patient care are more likely to provide safe and quality care. Therefore, a focus on interprofessional communication and collaboration is one of the main themes of these international experiences. Nurse practitioner students are able to provide culturally competent primary health care, including physical exams and chronic disease management. These types of service-learning improve nursing students’ ability to communicate with other members of the health care team and ultimately to develop into professionals who are active members of safe and quality health care teams. The mission projects are supported by the administration of the university because they are in harmony with the core components of the university’s mission statement, which advocates responsibility for the common good of society and recognition of the dignity and worth of every human being. Service-learning and cultural awareness are also objectives of this community practice experience.

SUMMARY

Helen Forsey describes community as

a word of many connotations—a word overused until its meanings are so diffuse as to be almost useless. Yet the images it evokes, the deep longings and memories it can stir, represent something that human beings have created and recreated since time ourselves and with Mother Earth. (Forsey, as cited in Chinn, 2012, p. 1)

Margo Adair describes a community for the future in terms of belonging in and honoring the concept of “diversity in people because they know that is what gives community its richness, its strength, its cohesion” (Adair, as cited in Chinn, 2012, p. 31).
The concept of community is indeed multifaceted, broad, and all-encompassing. The multidimensionality of the concept allows for openness in defining the partners we serve and the ways in which we deliver our care. To deliver high-quality, ethical care to patients, families, and communities, nurse educators are challenged to develop experiential learning opportunities that promote partnering among nursing students, faculty, and, most importantly, the patients and populations we serve.

Nurses are members of their own nursing communities as well as members of various other types of communities as depicted in this article. In addition to the theories and examples of community health care presented in this article, there are many more resources, models, and stories to be explored. It is within the basic context of caring that nurses are encouraged to assess, plan, intervene, and evaluate in all aspects of our work in order to promote healthier communities and decrease health disparities.

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“I Am the Professor of Myself”: How Our Patients and Their Loved Ones Become Our Teachers and Models

Laurence A. Savett, MD, FACP

As health care professionals, we commit ourselves to lifelong learning. In that quest, wise professionals know that our patients and their loved ones become our most important teachers.

In no uncertain terms my new patient, who also was a long-standing friend, challenged me and put me in my place as I continually urged her to change her previous antihypertensive medicines that just weren’t working. Finally closing the discussion as she declined to make a change, she said, “Larry, I am the professor of myself.”

I tell this story often. During the course of our first appointment, when my 90-year-old patient disagreed with me about whether to change her medication, she settled the argument with the words stated above. She had tried various drugs; none was especially effective, some made her feel worse, and she had become expert—the professor—on personal medical matters. In this succinct statement she declared, I’m no doctor, but I clearly know what drugs haven’t worked or have given me unacceptable side effects and what’s important to me at my age. At the same time, her stance told me where she was in her understanding of hypertension: that “feeling okay” was equivalent to “being okay,” and that she was unaware that the risks of poorly controlled blood pressure were substantial for this woman who continued to be vital and engaged despite her age.

In another moment in my practice, the wife of a 50-year-old patient, a man of long-standing surly demeanor who had insulin-dependent diabetes and was recovering from surgery in the hospital’s intensive care unit, taught me another lesson. He was giving me an especially hard time in his wife’s presence. I thought I knew him well enough to tell his wife as we left the room, “I guess Phil is being his usual contrary self.” She corrected me, “He’s having an insulin reaction.” An immediately checked blood sugar confirmed her diagnosis, and he received the appropriate—and urgently needed—remedy, sugar.

These and similar events challenged me to figure out in even more detail the nuances of the doctor (read “health care professional”)—patient (read “patients and

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their loved ones”) relationship and to enlarge my awareness of its potential for collaboration and professional growth.

More recently, coauthors and physician/teachers Jerome Groopman and Pamela Hartzband wrote that “...Sir William Osler, an eminent physician of the last century . . . said that when trying to unravel a complex medical diagnosis, you should listen carefully to the patient, because he is telling you the answer” (Groopman & Hartzband, 2011, p. 7). And one of my students once wisely observed, “The interaction between physician and patient is the interaction between a generalist and a specialist: the doctor is the generalist, and the patient, the specialist.”

From these stories and many more, I have grown. I have recognized that collaboration is essential to any health care practice; that the product of genuine collaboration is professional growth, learning, and maturing; and that our most important teachers are often our patients and their loved ones. These lessons are worthy of learning early in our careers and transmitting to them so that we encourage them to be ongoing collaborators in their care, along with the professionals—physicians, nurses, social workers, clergy, and therapists of all sorts. In this article, I detail how I teach—and model—these lessons.

TEACHING COLLABORATION BY MODELING IT

In an undergraduate course I have taught for nearly two decades entitled, “The Human Side of Medicine: Learning What It’s Like to be a Patient and What It’s Like to be a Physician,” I devote one 2-hour session to the subject, “Medicine is a collaborative profession.” During this session, we explore ways in which various professionals involved in the care of patients collaborate among themselves and with the patient and the patient’s family. In front of the class, I interview a patient. An invited nurse, social worker, and clergyperson help clarify and enlarge the medical history and identify the issues. We all collaborate in exploring the patient’s story and ways to interact with and care for the patient and his or her family.

This session occurs in the context of previous sessions during which the students and I have discussed the importance of the patients’ stories—of their illnesses and what’s going on in their lives, uncertainties related to their illnesses, how they cope with illness, and how physicians and other professionals address the core issues of diagnosis, treatment, and prognosis. Ahead of time, I have had a phone conversation with the patient, and I summarize that conversation in a handout to the class members so that they can review it before class. I give the students the following assignment: As we all collaborate during the class, consider

- the impact of the illness on the patients and their loved ones, and the importance of considering the psychological, social, and spiritual issues;
- what patients and their loved ones are entitled to expect from their health care professionals and a medical system;
- ways in which patients, their loved ones, and physicians and other professionals can enter into genuine collaboration (Savett & Savett, 1994, p. 11–13);
- ways in which this patient’s care can run amok; and
- what we can learn from this patient and this illness that has application to other patients and illnesses.

We start with a brief history of the patient’s illness and then we explore all these other dimensions of care. Here’s an example.
The patient is the source not only of many of the clues to diagnosis but also of the information about the impact of the illness on himself and his loved ones, his income, his emotional status, and availability of support from friends and community.

The History

A 64-year-old married man had surgery to remove a malignant tumor of the small intestine, discovered because he became short of breath and severely anemic. A year later, he is doing well.

Separate questioning of the patient by each of the professionals obtains a more nuanced story. Parts of the interaction with the patients are often in the realm of the primary professional caregiver—physician, nurse, physician’s assistant; other questions are often part of the social worker’s or clergy’s inquiry. Sometimes, depending on one’s skills, the primary caregiver is in the best position to make all the inquiries. During this session, it becomes clear that the patient is the source not only of many of the clues to diagnosis but also of information about the impact of the illness on himself and his loved ones, his income, his emotional status, and the availability of support from friends and community. There is more to providing complete care than simply making a diagnosis and prescribing treatment, and the patient and his loved ones are important partners in these efforts.

The Story

He had been in good general health. In November 2010, he and his wife were traveling in Germany. Toward the end of their 3-week trip, he noticed fatigue on mild exertion; “I couldn’t walk 200 yards.” When they returned to St. Paul, he noticed that he was short of breath on hiking—his usual recreation. The following day, his symptoms caused him to leave work early. He visited an acupuncturist who had previously treated him for joint pain. After examining him, the acupuncturist told him, “You’re bleeding internally.” The following day, he saw his physician who told him that his hemoglobin level was 5.5 (normal is in the 14 range).

He was immediately hospitalized, given three blood transfusions, and had endoscopic examinations of his upper gastrointestinal tract and colon with no definite findings other than signs of blood in the gastrointestinal tract. Additional studies suggested “a leak in the small intestine.” He was referred to the Mayo Clinic in nearby Rochester, was seen the following day, and additional studies including computed tomography (CT) scan of the abdomen were done. He was told that the bleeding source was in the small intestine and that it was “cancer.” Surgery was scheduled for the following day. He told his surgeon to “be as creative and aggressive as you can be.”

At surgery, “11 inches of small intestine were removed” and three nearby lymph nodes showed metastatic tumor. The oncologist recommended chemotherapy; told him that even with treatment, there was “an 85% chance of recurrence in one year”; that the potential side effects of the drugs included neuropathy, with numbness of the hands and feet; and that the treatment was sufficiently toxic that even his expired breath would be toxic to those physically close to him.

He declined the proposed treatment, reasoning that the choice was between “being ill or very ill” and that he did not want to keep himself away from his grandchildren because of the potential toxicity to them. “If it’s not my time, God will keep me around a little longer.” He attended church daily. He took 6 months off from work and began a “juicing” regimen 13 times a day of a 6-oz drink of juice blended from fresh carrots, apples, and greens, followed later with limited quantities of chicken and fish and no salt. On his own, he began home “fever treatment” in which his
body temperature was raised between 102 and 105 degrees for 35–40 minutes once a week for 6 months.

Many friends set up prayer groups in his behalf. Of his wife, he said, “It was probably worse for her than it was for me.” Of his illness, he said, “Cancer was for me a gift. . . . My spiritual life has gotten stronger.” He declared, “I am not going to negotiate out of fear . . . My wife and I are both living with a lot of hope and expectation.”

Now, a year following surgery, he is without symptoms, working full time, and feeling well. He continues to see his oncologist every 3 months.

**The Lessons: So Much to Learn About—and From—Patients**

Each year, I invite a different patient to the class. Their illnesses are diverse and of varying complexity: for example, multiple myeloma, mitral insufficiency, colon cancer, acoustic neuroma, normotensive hydrocephalus, diabetes, chemical dependency, or dementia. The patients are diverse in age and gender, people of faith or of no faith, well informed or not so well informed or medically sophisticated, and more—or less—involved in the important decisions regarding their care. Careful reflection on this patient’s story—and the stories of those patients who have come in other years—and the interaction in front of the class between the patient and the visiting professionals, and among the professionals themselves, teaches a great deal. All these lessons apply to most illnesses and patients, hospitalized or not.

We learn about concrete matters, such as diagnosis. Short of breath? Consider anemia. Anemic? Consider blood loss and look for a source, including gastrointestinal blood loss. Gastrointestinal blood loss? Consider tumor.

We learn about easily overlooked subtle expressions of clinical problems, such as insulin reaction (see the story at the beginning of this article) and congestive heart failure. We learn that not all patients with right lower quadrant abdominal pain have appendicitis.

We learn about treatment options, and to consider “complementary” therapy. If a treatment has meaning to the patient, even if its efficacy is questionable, don’t rule it out if it does no harm.

We learn lessons that go beyond diagnosis and treatment and what we learn from physical examination and tests.

Especially when the patient is not getting better as quickly as expected, a review of the patient’s story can tell us why, as we discover that

> . . . separation, relief, guilt, and financial cost are among families’ concerns; that losses include independence, companionship, emotional support, and dignity; and that patients and their families fear a long illness that is “out of our control,” invasive tubes and other uncomfortable treatments. We learn the danger of making invalid assumptions, the need to respect the patient’s right to take some risks, the importance of providing a safe environment for a person to express himself, and the need for someone to oversee the overall care. (Savett, 2002, p. 103)

There are no laboratory tests for this information, and without it, we may compromise care by not attending to important needs and by making inappropriate decisions.

If we are open to our patients as teachers, we learn how to question, interview, and engage. Given a welcoming atmosphere, the patient can easily enter into an easy and productive conversation and collaboration with complete strangers.
Patients need not be required to speak our language. Rather, it’s our obligation to keep the conversation open by avoiding jargon and speaking with clarity, putting ourselves in the patients’ shoes, and asking the right questions in ways that invite honesty and reflection.

Although most of the patients invited to the class have previously known me, they have never met the nurse, the social worker, and the chaplain. A “welcoming atmosphere” means asking open-ended questions, allowing the patients time to respond without interruption, and being open to considering more than one alternative to diagnosis and treatment.

From our patients, we learn about language and communication—that patients need not be required to speak our language. Rather, it’s our obligation to keep the conversation open by avoiding jargon and speaking with clarity, putting ourselves in the patients’ shoes, and asking the right questions in ways that invite honesty and reflection.

We learn how to explore ways to inform patients that their views of their illness are not only welcomed but also encouraged, for they enhance the accuracy of diagnosis and the effectiveness of treatment. In front of the class, we comfortably ask the patient, “What has this illness been like for you? For your loved ones? What has been the hardest part of your illness? How have you handled it? What else is going on in your life?” (Stuart & Lieberman, 1986, pp. 102–103). Especially with a patient with long-standing symptoms, we can say, “You must have given some thought to what’s going on. What are your views?” In that way, we can address otherwise unstated fears, often about a serious illness, and either validate them or dismiss them from consideration.

We explore ways in which each of the professionals can be of help and how we can collaborate with each other and with the patients and the their loved ones to achieve not only the best outcome of the illness but also the best process of care.

We learn to explore and honor the patients’ values and recognize the collaborative partnership between equals. We learn that it’s okay for patients to decline treatment, but that we must help them make an informed choice.

We learn that serious illness is a family experience.

We learn, as in the case presented, the importance and application of the principle of nonabandonment (Quill & Cassel, 2004). Even though this patient declined chemotherapy, his oncologist maintained contact with him with periodic appointments and assurance of ongoing accessibility. We learn that, with our pledge of ongoing support, patients and their families can handle uncertainty and bad news.

We learn to explore the patient’s support system—to find out if it’s strong or if he or she is alone. Does he or she have a community that will respond?

If we accept our patients as teachers, we enhance our appreciation of diversity. The chaplain during this exercise is often from a faith tradition different from the patient’s, and sometimes the patient is unconnected to a faith. This difference never gets in the way of a rich interaction. Hardly ever is “God” mentioned as the patient and clergy together explore what the illness means to the patient and how the patient seeks meaning, comfort, and guidance. There is a spiritual side, the search for meaning, to almost everyone.

Our patients teach us that it’s important to continually validate our understanding of their stories and their understanding of our recommendations. We do so by reflecting back to the patient by saying, “As I understand it...” In describing our decisions and making recommendations, one can say, “Let me tell you what I think... and then we’ll negotiate” and “Do you buy this? Does this sound reasonable?”

Recognizing patients as our teachers provides a model for our interactions with fellow professionals. Our relationships with patients should be based on
reciprocal trust, honesty, and respect. Relationships among professionals should be no different, regardless of one’s credentials and length of experience. Health care professionals work best together when they exchange information that helps each other and when they learn from each others’ professional approaches.

Over and over, we learn that the sign of a fine professional is the ability to reflect and keep an open mind. After one has made a decision about diagnosis and treatment, an important question remains: “Is there yet another way to look at this?”

CONCLUSION

In the end, it’s all about relationships—one of the most important lessons we learned in our training. Pirke Avot, a prominent second century rabbinic text, asks the question, “Who is wise?” and immediately answers, “The one who learns from every person” (Mishna Avot 4:1). Our partnership with our patients gives us an ongoing opportunity to learn not only about our patients and their families but also from them. If, as my 90-year-old patient told me, each patient is “the professor of myself,” then we should take advantage of our “faculty,” our patients and their loved ones who continue to teach us.

REFERENCES


The Role of the Clinical Nurse Specialist as Clinician and Advocate in a Primary Health Care Clinic

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The clinical nurse specialist (CNS) functions as an expert clinician to disseminate knowledge and apply evidence-based practice in his or her role. The framework of CNS practice competencies (patient, nurse, and system) reflects an opportunity to advocate for disadvantaged and underserved populations when providing care. Strategies, techniques, and tools to advance CNS practice in the primary care setting are discussed.

As advanced practice registered nurses, clinical nurse specialists (CNSs) integrate a myriad of roles in order to provide exceptional patient care. They must use their superior clinical knowledge to treat illness and disease effectively, collaborate successfully within an interdisciplinary team, and strive for continuous improvement of outcomes within an imperfect health care system. Among the four advanced practice nursing (APN) disciplines (nurse practitioner, nurse midwife, nurse anesthetist, and CNS), the CNS’s role is universal in its scope. This role offers nurses the opportunity to influence methods of care, to define an evolving practice, and to promote techniques that enhance efficiency and cost-effectiveness of processes. This article describes the unique contribution that the CNS can provide to patients with complex care needs in an underserved and socioeconomically disadvantaged population.

The CNS role in the evolving historical context of nursing defines itself by leadership, experience, and superior clinical knowledge in a specific area or areas of practice (Fulton, 2010). Although the educational mandate of CNS preparation at the graduate level is clearly defined, varying definitions and requirements of the CNS title from state to state lead to ambiguity about what can be accomplished within the role. The standard spheres of influence in which the CNS practices (patient, nurse, and system) provide an exceptional opportunity for practicing CNSs in all areas to define, nurture, and expand the role.

A key theme in current CNS practice is the emergence of advocacy on behalf of underserved populations. Muller, Hujcs, Dubendorf, and Harrington (2010) demonstrate the importance of CNS practice in earning Magnet status in the tertiary setting, and Tuite and George (2010) emphasize the essential position of the CNS in establishing research-based care originating in the academic milieu.
Although literature demonstrates the role of innovative tools such as the Internet to promote advocacy (Galer-Uni, 2010), CNSs also have a foundation of rigorous academic training, specific clinical experiences, and connections to their community, which can foster positive relationships and thus encourage successful health outcomes. Mayo et al. (2010) stress the difficulty of measuring all the contributions that CNSs make to clinical practice, implying that the accomplishments of the CNS in the work environment are greater than what may be initially perceived.

From a public health perspective, Israel et al. (2010) endorse advocacy as a tool for engaging the public to formulate policy that addresses inequalities in health among various populations. Stanley, Werner, and Apple (2009) encourage APNs to gear their profession and practice toward transforming health care within the structure of the APN consensus model (Advanced Practice Registered Nurse Consensus Work Group, APRN Joint Dialogue Group, & National Council of State Boards of Nursing Advisory Committee, 2008). By doing so, CNSs can address inequalities in health care within their defined scope of practice.

The skill of applying research to the promotion of evidence-based practice provides a relevant framework for the unique contributions of the CNS to patient care. Kitson, Harvey, and McCormack (1998) developed the promoting action on research implementation in health services (PARIHS) model to evaluate successful application of research to professional practice (Hopp, 2010). Hopp argues that the components of the PARIHS model, “evidence, context and facilitation” (p. 133), comprise a construct from which all CNS competencies can be derived. Exploring these competencies from an evidence-based practice view demonstrates the strengths of the CNS as a health care provider and advocate for disadvantaged populations.

The National Association of Clinical Nurse Specialists (Lyon & Davidson, 2004) addresses the areas of expertise through which the CNS may thrive. By using evidence to advocate for each arena of care, the CNS may develop strategies unique to his or her scope of practice. Creating wellness by preventing illness in the primary care setting, the CNS can use clinical aptitude, research in specialty areas such as cardiology and diabetes management, and knowledge of disease prevention as tools to advocate for and treat underserved populations. Jones (2010) describes a model for an independent business managed by two CNSs who provide specialty services to a specific population. This scenario exemplifies the ability of the CNS to individualize treatment of adult patients; this business model can apply to clientele who are socioeconomically disadvantaged or marginalized.

By building on the competencies developed in the Statement on Clinical Nurse Specialist Practice and Education (Lyon & Davidson, 2004), the American Association of Colleges of Nursing (AACN), The Hartford Institute for Geriatric Nursing at New York University, and the National Association of Clinical Nurse Specialists (2010) have created specific competencies for the CNS in the adult-gerontological population. These competencies can be applied using evidence-based practice as a foundation in the setting of a primary health care clinic. As a member of a multidisciplinary care team, the CNS can implement plans of care that improve patient outcomes within the APN scope of practice. A successful CNS can employ cost-saving methods that improve efficiency and promote health as part of his or her composite role.

During patient visits, the CNS can address patient questions and concerns to coordinate all aspects of care. Using advanced practice competencies, the CNS may, for example, make recommendations to the physician for medication regimens.
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best suited for the patient who may have no or very limited insurance coverage. Scheduled telephone consultations with patients may prevent unnecessary clinic visits and promote compliance with assigned treatment regimens. The CNS who builds on core competencies with a specialty such as cardiology can provide education on heart failure, hypertension, and heart disease to identify clients at high risk for these conditions, perhaps by designing pamphlets on lifestyle habits such as diet and exercise to promote wellness.

From a systems perspective, the CNS can promote change to facilitate better health care delivery through strategies to foster efficiency in the health system construct. Situated at the forefront of health care in the vital role of health care provider, a CNS in the primary care setting can assess health status and coordinate referrals for more complex needs. For example, the CNS who leads the case management of a patient undergoing dialysis may collaborate with the medical team to determine if inpatient hospitalization for progression of acute kidney disease is warranted. Using evidence-based practice to decrease cost, the primary care CNS can evaluate available information technology resources to optimize storage of patient data; coordinate care between primary, secondary, and tertiary care settings; and manage client information to best coordinate care for his or her patients.

Proficiency in the AACN adult-gerontologic competencies demands that the CNS be culturally competent, sensitive to the complex needs of patient populations, and skilled in delivering appropriate treatments for illness and disease. At the advanced practice level, the CNS must therefore institute and follow processes and protocols that advocate for successful client-focused care. For a socioeconomically disadvantaged population, this means creating an environment favorable to patients’ active participation in their treatments. For example, a CNS may choose a clinic located in a neighborhood close to grocery stores, places of worship, or schools to demonstrate a vested interest in the well-being of the population he or she serves. This places the CNS in the primary care setting as the prime point of service for patients and demonstrates the value of the holistic nursing perspective employed by the CNS.

The strength of the CNS role lies in the ability to translate evidence-based research into action that benefits the patient and improves the delivery of care from the patient and systems perspectives, respectively. However, the AACN Adult-Gerontology Clinical Nurse Specialist Competencies address the capability of the CNS to enhance the evolving APN role within the context of nursing practice. For example, LaSala, Connors, Pedro, and Phipps (2007) provide an example of a protocol developed by a CNS in the inpatient setting to improve the outcomes of patients by educating staff nurses to identify patients with critical or deteriorating respiratory status. In a primary care setting, the CNS not only participates on a multidisciplinary team but can also lead staff nurses and fellow APNs by assessing nursing performance and seeking teaching opportunities with facility staff. Through formalized evaluations of peers, the CNS can optimize patient outcomes and care delivery while encouraging health promotion and wellness. Written performance critiques, review of the proper allocation of resources to reduce cost and maintain efficiency, and professional support such as in-services on new care techniques or current evidence-based research issues are all examples of the ability of the CNS to transform nursing practice.

The adult-gerontological competencies provided by the AACN et al. (2010) create a foundation of APN practice for the CNS categorized by patient, nursing,
and systems perspectives. Within the context of treatment of a complex patient in the primary setting, advocacy by the CNS both for advancing nursing practice and for improving patient care is an explicit requirement of the role. CNSs can maintain ties with locally elected politicians such as the mayor of the city where they practice to maintain visibility in the public eye. Tracking the voting records of state representatives on legislation related to advanced practice nursing is critical for adhering to the APN scope of practice and expanding the role. By supporting lobbying efforts of national nursing organizations, the CNS leverages power to advocate on behalf of the underserved patient and promotes the CNS role within the context of current health care reform efforts. These examples illustrate how the CNS may use established competencies to promote political change within the health care system.

As a clinician, an advocate, a leader, and an instrument for change, the CNS champions the use of evidence-based practice to provide outstanding patient care. Although especially relevant to the setting of a primary care clinic serving a disadvantaged population, examination of the CNS’s role breeds excitement for the future of advanced practice nursing in all spheres of influence and practice.

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Partnering in Interprofessional Education to Design Simulation Programs to Promote Collaboration and Patient Safety

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Interprofessional education (IPE) using simulation strategies is a rewarding way to promote teamwork and interprofessional collaboration. The benefits of collaboration far outweigh the challenges that arise from differences in educational culture and scheduling logistics.

Interprofessional education (IPE) is a deliberate attempt to create an opportunity for two or more disciplines to learn “with, from, and about each other to improve collaboration and the quality of care” (Palaganas, 2012). Teamwork and communication are recognized by the Institute of Medicine (IOM) as crucial to developing a safer and more patient-centered health care environment (Kohn, Corrigan, & Donaldson, 2000). The Joint Commission on Accreditation of Healthcare Organizations (2005) attributes most medical errors to poor communication and teamwork and estimates that medical errors are fifth in the top 10 causes of death for all deaths in the United States.

In 2011, the American Association of Colleges of Nursing, the Association of American Medical Colleges, the American Association of Colleges of Osteopathic Medicine, the American Association of Colleges of Pharmacy, the American Dental Education Association, and the Association of Schools of Public Health endorsed a list of core competencies for interprofessional collaborative practice and noted that simulation (among other educational technologies) may provide an effective pedagogical approach to teaching teamwork (Interprofessional Education Collaborative Expert Panel, 2011). Despite the imperative to develop true collaborative opportunities for learning teamwork and communication skills, the reality remains that formal and informal opportunities to teach teamwork and collaboration present some challenges. The purpose of this article is to describe two interprofessional simulation-based training educational exercises and lessons learned from implementing them.

In the past, teamwork training initiatives evolved because one profession recognized a problem or responded to a professional training requirement. In these cases, programs are developed unilaterally, with other disciplines being invited to participate after the planning process is completed. Although this is expedient, the opportunity to establish common goals and expectations is lost.
On the other hand, true IPE programs involve all parties in the planning and curriculum development process in addition to the training itself. This process allows faculty to establish common goals, acknowledge the educational framework of each group of learners, and model the interprofessional behaviors intended for students.

In traditional teamwork training initiatives, the roles of instructor and student are often not identified, resulting in confusion and suboptimal learning outcomes. Teaching philosophies and instructional processes may differ, affecting the quality of the experience for faculty and students. However, when IPE is realized, each profession is taught within a culture of established values and expectations of both faculty and students. In true IPE team training programs, instructors from all involved professions meet to discuss the goals and objectives of the educational experience, the course content, the debriefing process, faculty and trainee expectations, and program evaluation. Ideally, course directors should also agree on a timeline for course development and discuss the logistics of scheduling students, faculty, and facilities.

**EMERGENCY MEDICINE RESIDENT AND GRADUATE NURSE TEAM TRAINING**

Initial attempts to develop interprofessional team training exercises for emergency medicine residents prompted me (LS) to develop a simulation-based team training exercise for these residents. I invited the new graduate nurses and nurse educators in my department to participate. The nurse educators and I agreed on general goals: to improve teamwork and communication skills in the care of patients who are critically ill and to foster a collaborative relationship between nurses and resident physicians. Nurse educators participated in developing general curricular goals, but the selecting of cases and the crisis resource management framework used to assess and debrief team performance was done by me. Although this was a step forward in interprofessional collaboration compared to my previous use of physician faculty to play the roles of nurses, my assumption that we shared a common framework for critical thinking and team performance was mistaken.

In 2007, the University of Rochester Strong Memorial Hospital adopted TeamSTEPPS (Team strategies and tools to enhance performance and patient safety; King et al., 2008) as a model for teamwork and communication with multiple faculty and staff training sessions. In 2009, this framework was incorporated into the emergency medicine resident/graduate nurse simulation-based team training sessions. Thereafter, simulation scenarios were designed to allow participants to practice four critical skills: identifying a team leader, shared mental models, assertion, and closed-loop communication. Residents and new graduate nurses are now assigned to teams with whom they remain throughout the training session. Teams rotate until they have completed six resuscitations. Although the content of the scenarios varies, all scenarios are designed such that the team members must communicate with each other and have an opportunity to order and/or administer medications using closed-loop communication. Each case lasts 15 minutes, with 25 minutes to debrief the team regarding teamwork skills. Instructors are prepared on how to debrief in a constructive, open-ended manner with specific feedback regarding teamwork.

This program has grown to include 36 emergency medicine residents, 8–10 new graduate nurses, and a pharmacy resident. Emergency medicine faculty, nurse educators, and an emergency department pharmacist participate as instructors.
CHALLENGES AND LESSONS LEARNED

Speaking a common language and having a shared mental model of teamwork had a significant impact on the value of these interprofessional exercises. Encouraging faculty to focus the postencounter debrief on teamwork behavior has remained a challenge because new graduate nurses and resident physicians have many technical and cognitive skills to master. In the first 3 years of the program, faculty and students received the goals and objectives for the sessions and a description of effective teamwork strategies. Adding a 20-minute didactic presentation prior to the simulation activities helped to focus students and instructors. In the future, involving instructors in a more formal debriefing training may be helpful.

Scheduling has been relatively easy with this particular educational experience because new graduate nurses and their instructors have educational time built into their schedules, as do the residents and physician teaching faculty.

NURSE PRACTITIONER STUDENT AND MEDICAL STUDENT TEAMWORK EXERCISE

In 2009, medical school faculty partnered with nursing school faculty to develop a simulation-based teamwork exercise for 100 medical students participating in an Introduction to Clinical Medicine course and 46 nurse practitioner (NP) students enrolled in their initial clinical course in the acute care and primary care programs. From the outset, our goal was to partner and model the principles of IPE. Faculty from both schools mutually agreed on the educational goals of the exercise. Each discipline brought ideas and tools to the table for review and endorsement by the group. For example, cases developed by a medical faculty member and educational evaluation tools developed by the nursing faculty were reviewed and agreed upon.

The differing cultures and traditions of each school were apparent from the outset. For example, scheduling logistics initially seemed insurmountable because NP students used a self-scheduling model and medical students were assigned to groups by the course director. In addition, because all faculty members had clinical appointments and responsibilities, choosing dates to run the exercise was a challenge. Ultimately, the commitment of the faculty to appreciate differences made it possible to overcome real and perceived barriers. Patience, persistence, flexibility, and desire to make the program work were essential to the success of the program in that first year.

Great care was taken to develop simulation scenarios of appropriate difficulty for all participants, recognizing that the NP students had much more practical knowledge and experience and that the medical students had more “book” knowledge about acid-base balance and arterial blood gas (ABG) analysis. The scenarios were designed to allow NP students to share their practical and theoretical knowledge about pathophysiology and for the medical students to incorporate more basic science and acid-base/ABG analysis into the care of the patient with a toxin-induced emergency. Although both NP students and medical students would be expected to have the clinical reasoning skills to manage a comparable patient at the end of their individual training periods, cases were chosen carefully to create a condition in which both the medical students and the NP students would have to communicate their knowledge, apply critical thinking skills, and share mental models in order to care for the patient appropriately.
Each team of one NP student and two medical students were given 30 minutes to manage a simulated patient with a toxin-induced emergency. Simulations were videotaped with the knowledge and consent of participants. The simulation exercise was followed by a three-step debriefing process. Immediately following the case, medical and nursing instructors led a 10-minute debriefing session with the entire group, allowing participants to discuss general impressions and frustrations. This was followed by a very brief synopsis of the case and reflections by the instructors about the behaviors and communication strategies that moved the case forward.

Students then watched the videos of themselves as a team and reflected on their communication strategies and roles. The team then met with additional faculty from the school of medicine and the school of nursing to discuss the different roles each student played and what they learned from the experience of working with each other. All students filled out evaluation forms at the end of the session; the responses were used to guide future changes in the educational activity.

**CHALLENGES AND LESSONS LEARNED**

Instructors met to review the course evaluations and discuss changes for the upcoming year. This level of debriefing was essential because faculty learned as much as students. Every member of the planning team gained a new respect for discipline-specific expertise and realized that the quality of the educational experience truly was better as an IPE exercise. Student evaluations of the experience were universally positive, and both medical and NP students felt that this was an invaluable experience and requested additional opportunities to engage in IPE opportunities.

Consistency in faculty assigned to IPE from year to year is recommended, especially in the early years of the program when important relationships evolve. A new NP course director arrived between years 1 and 2, which led to confusion about faculty responsibilities. Now, the IPE faculty meets by e-mail or in person months before the course begins to establish schedules and responsibilities. The medical and nursing schools run on different academic calendars, and course and program dates do not line up. In the future, we would like to see academic calendars or specific blocks of time purposely created to promote seamless opportunities for IPE.

**CONCLUSION**

The initial foray into IPE requires the right mix of faculty who are energetic, open, and committed to the process. Members must be able to balance the discipline-specific needs of their students with the imperative to engage in IPE. Every member of the planning team possesses specific expertise that has value in planning, executing, and evaluating the IPE experience. Members of all disciplines must be willing to relinquish complete control, acknowledge discipline-specific expertise, and embrace the contributions of their partners. Logistical issues are likely inevitable when trying to combine complex needs of multiple users, and the support of administrative staff in problem solving is essential.
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What's in a Name: A Question of Patient Autonomy

Marcus Engel, MS

The author describes actions by his nurses that were the beginning of his recovery from a devastating automobile accident. By offering choices and supporting his decisions, they helped him regain a sense of control over his future.

The seasoned nurse glanced again at the chart of her newest patient in the intensive care unit. An 18-year-old kid who had the misfortune to be in the path of a drunk driver who was drag racing down a busy midwestern street. She swallowed hard, thinking of her own son about the same age, and walked into the room.

“Hello,” she said softly, kindly to the mangled boy lying in the bed. “I’m Barb and I’m going to be one of your nurses while you’re here. Would you like your pen and paper?”

He held up a finger, so she carefully placed the pen in his hand and wheeled a table over to hold the tablet. This young man, with his head swollen to the size of a basketball, had had an emergency tracheostomy in the ER and now, other than finger symbols, a legal pad and pencil were his only means of communication.

“We are going to take excellent care of you here—You’re in very good hands.” She glanced again at her chart she continued. “And Marcus, we’re going to—” She stopped, looking again at the mute, blind form in the bed and posed a question.

Fresh from a 25-hour facial reconstruction surgery, the young man’s head resembled a watermelon more than a human face. Both legs hung in traction. A severed ear canal meant his hearing was diminished. His flesh was missing in hunks due to road rash. The tiniest movement caused excruciating pain. And the kid was totally and permanently blind.

Glancing again at her chart she continued. “And Marcus, we’re going to—” She stopped, looking again at the mute, blind form in the bed and posed a question.
Autonomy. A beautiful word. A word we all desire for ourselves, for our children. A word that represents what our country was founded on and professes to believe is a basic human right. But not a word one typically thinks of as applying to a patient in a hospital.

Well, of course, we think of autonomy in the sense that we now recognize and respect a person’s Do Not Resuscitate directive. And yes, a patient can always check out against medical advice. But while a patient is lying in a bed, where does autonomy fit in to the picture? And what role does it play in promoting his or her recovery?

As you may have gathered, I was indeed the patient lying in that intensive care unit (ICU) bed. And even through the mountains of pain, medication, and trauma, I remember Barb’s question in vivid detail.

“Wait,” she said. “Do you like to be called ‘Marcus’ or ‘Marc’?”

Hold on! I thought. Someone is asking me a question? This was the first time in days, maybe weeks, that someone had asked me a direct question! Not since the carefree college freshmen climbed into the passenger seat with friends after a hockey game had someone asked me such a simple question that did not revolve around my pain. Something so simple, yet so powerful.

I grasped at it like a drowning man for a life raft. I was so tired of being called “Mr. Engel” and feeling like a body that singularly existed to be passed around, poked, prodded, examined, touched, and discussed. But not one to be given options.

“Either one,” I wrote slowly. And then, because I could, I expressed myself. “But it is spelled with a ‘c’,” and I underlined “c” over and over.

In retrospect, I just wanted to be me. The person I really was. The person I had been before all “this” happened. And that simple question was the first glimpse I’d been given that the “me” I used to be—young, independent individual just beginning to be in charge of his own decisions, his own life—was still inside. And would one day be “me” again.

The need to maintain order in a hospital setting is both crucial and evident. But let’s discuss what usually happens when a patient is first admitted. The standard operating procedure of the hospital kicks into high gear.

All personal belongings are removed. The patient is asked to take off his or her own clothing and put on the uniform of a patient: the dreaded hospital gown that shows off one’s backside, with oddly placed strings and snaps that identify you as a patient to anyone who happens to glance in your direction. The clothing alone stops you from freely moving around the hallways and so forth because you are immediately identified as someone who is supposed to be in bed.

Intravenous lines (IVs) are started, blood pressure is taken, questions are asked as forms are filled out. There is very little time for the patient to ask anything. Instead, he or she faces a barrage of instructions and invasive probes from strangers.

If as a patient you venture a simple question such as, “Why do I need an IV?” you might be met with a brisk and uninformative response such as, “It’s standard.” The sheer multitude of health care professionals you may see means you don’t even

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know who to ask. The intake nurse? The phlebotomist? The surgeon? The nurse anesthetist? The anesthesiologist? The operating room technician who shaves and scrubs your body?

If you think of a prisoner being admitted to a correctional facility, the parallels are strong. In both cases, individuality is stripped. Orders are given. Questions are not encouraged. Prefixed meals are delivered at prescribed times and with little variety or choices. Even visiting hours parallel “lights out.”

It’s clear and vital that routine be established in both cases. And it is the rules, safeguards, and standard operating procedures that are designed to ensure patients’ physical safety. Although we patients understand the reasons—and as patients, we are grateful for every policy that puts our physical well-being at the forefront—there is this issue of patient autonomy that seems to present a conflict with traditional protocols.

But. (Doesn’t there always seem to be a “but”?)

But, the emotional needs of patients have a strong impact on their experience, their compliance, and ultimately their health. And within the structure of procedures that must be established, we need to include the options of returning a patient to the feelings of autonomy.

Easier said than done, right? You, the health care professional, have enough to do already; in many cases, too much, perhaps. So how do we actually create an environment in which a patient feels like he or she is still an individual and has at least some semblance of control?

Think of a patient who is critically ill or injured. If he shows any desire for control, it is taking some portion of control out of the hands of the experts. That may very well feel to the patient as if he is signing his own death sentence. How do we maintain a protocol to keep the patient alive, yet let him feel as though his body is still his own?

My best caregivers provided a feeling that I was not just a body to be treated but a mind and soul to be consulted. That happened when I was asked questions about my care. The options that could be offered varied depending on the fragility of my medical condition. At times, to simply be asked in which arm I preferred the IV was enough. Because of collapsed veins and multiple “blown” IV sites, the choice wasn’t really my own, but simply being asked the question gave me the feeling of at least some degree of control.

As my health improved, so did the options I was given. “Marcus, would you like the head of your bed raised?” “Can I get you another pillow for under your hip?”

And once I was able to communicate more, my providers often asked me things that allowed me a modicum of control over my environment. “Would you like me to find your mom and dad?” “Your friends are here to visit—Would you like to see them? Or would it be better if I asked them to come back later?” Every question put me closer to being in the driver’s seat of my care.

My friends and family were my lifeline to sanity. Sometimes, when I was up to it, a group of half a dozen college guys would squeeze in around my bed, joking and laughing like one in our midst wasn’t blind and battling back to life. This was the best mental health medication I could ask for. Other days I was so out of control because of the pain and narcotics that I wasn’t able to face my best friend. When this would happen, my nurses would run interference after asking me if I was up for visitors. They stood in the gap and gave me control over when and which visitors were allowed to cross into my sanctum.
It’s a difficult thing. Unlike standard operating procedures, there is not a set of rules to govern exactly how to offer a feeling of autonomy in each individual set of circumstances. But I do know one excellent beginning. “Wait, what do you like to be called?”

Thank you again, Barb.

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Using Patient Satisfaction as a Basis for Reimbursement: Political, Financial, and Philosophical Implications

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Patient satisfaction has always been important; however, basing monetary value on patients’ perceptions is causing a strenuous debate in health care. Hospital administrators and providers alike are scrambling to implement measures to improve patients’ experiences of care and avoid cuts in revenue.

On October 1, 2012, Medicare will begin to tie inpatient Medicare reimbursement to patient satisfaction through the Hospital Value-Based Purchasing Program. Although the Patient Protection and Affordable Care Act became a law on March 23, 2010, numerous provisions were slated for implementation at a later date. Many of the provisions offer payment incentives to improve quality of care, and the Hospital Value-Based Purchasing Program is one such provision (Elmendorf, n.d.). For the first time, more than 3,500 hospitals nationwide will be reimbursed for inpatient services provided to Medicare patients centered on quality, not simply quantity, of services provided (U.S. Department of Health and Human Services [USDHHS], 2011a, 2011b).

In fiscal year (FY) 2013, the Centers for Medicare and Medicaid Services (CMS) will reduce base diagnosis-related group (DRG) payments to hospitals by 1%, then increase by 0.25% each year to a maximum of 2% in FY 2017 (Matos, 2011). The money saved from the reduction in payments will be set aside into a pool from which value-based incentive payments or bonuses will be paid to hospitals based on how well they score on 17 clinical quality measures and eight dimensions of patients’ experiences of care (USDHHS, 2011c). Although 70% of the bonus is tied to the evidence-based clinical quality measures such as treatment for myocardial infarction, heart failure, pneumonia, and surgical care improvement, the remaining 30% is tied to patients’ experiences of care (USDHHS, 2011b). With experiences of care based solely on patients’ perceptions, many in health care are questioning the rationale for allowing subjective data to influence reimbursement (Daly, 2011).

Patients’ experiences of care are determined using core elements of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, including

- how well nurses communicated with patients,
- how well doctors communicated with patients,
• how responsive hospital staff were to patients’ needs,
• how well caregivers managed patients’ pain,
• how well caregivers explained patients’ medications to them,
• how clean and quiet the hospital was,
• how well the caregivers explained the steps patients and families need to take to care for themselves outside of the hospital (i.e., discharge instructions), and
• overall rating of the hospital (McKinney, 2011; USDHHS, 2011c).

Although the measures have been espoused by national bodies of experts such as the National Quality Forum, many other groups have opposed them (USDHHS, 2011b). Hospital groups aggressively but unsuccessfully pressed federal officials to decrease the amount of the bonus tied to patient satisfaction, stating that 30% was excessive when based merely on opinions rather than facts. “Some hospital advocates and researchers have warned that the survey has undergone little peer-reviewed validation and does not account for apparent patient biases” (Daly, 2011, p. 30).

Although the current HCAHPS patient-mix adjustment includes education level, self-educated health, non-English primary language, age, and service line, it does not include all the items that have a potential impact on scores, leaving many hospitals at a disadvantage from the start (HCAHPS, 2011; Selvam, 2011). The Association of American Medical Colleges (AAMC) cited research showing that the HCAHPS survey tool does not adjust risk fairly, producing inequitable results for both urban and teaching hospitals that treat disadvantaged patient populations such as those with a lower socioeconomic status, higher severity of illness, and longer lengths of stay (AAMC, 2012).

In addition, those hospitals with lower overall margins, older facilities, and poor access to capital tend to score lower on HCAHPS (Barr, 2011). Cash-poor hospitals may lack the resources necessary to invest in improvements, aesthetics, and perks, potentially exacerbating the gap between prosperous and struggling facilities.

By differentially rewarding either achievement or improvement on measures, the Hospital Value-Based Purchasing Program may give hospitals a financial incentive to continually improve how they deliver care (Ropes & Gray, 2011; USDHHS, 2011c). The Hospital Value-Based Purchasing Program marks a shift in CMS reforms from “pay-for-reporting” to “pay-for-performance” by using payment incentives “in promoting higher quality care for Medicare beneficiaries and transforming Medicare into an active purchaser of quality health care” (USDHHS, 2011c, p. 2).

WellPoint, one of the nation’s largest commercial payers with more than 65 million insured, initiated incentive payments in 2009 that include patient satisfaction. With Medicare implementing a similar pay-for-performance program, CMS hopes that other commercial insurers will incorporate payment incentives to improve patient satisfaction as well (Torrey, 2012; “With Medicare,” 2012).

Considering the upcoming 2012 election, with Republicans trying to take control of the White House and the Senate vowing to repeal the Affordable Care Act, the future of health care reform is anything but clear (Blumenthal, 2011). Some policy makers are proposing a “pay-for-patient” model that would pay providers a flat annual fee for each patient, resulting in a financial incentive to keep patients healthy and eliminate ordering unnecessary tests and medications that are not founded on evidence-based care (Pipes, 2012).
As a budget-neutral program, the Hospital Value-Based Purchasing Program mandates that hospital personnel work harder for the same reimbursement they receive now. “Medicare makes up 43% of hospitals’ revenue on average. The cuts would be on top of the $400 billion reduction already built into the Patient Protection and Affordable Care Act” (Peters & Young, 2011, p. 1). Because overall Medicare spending for inpatient stays at acute care hospitals will remain constant, the new payment structure will benefit some hospitals while negatively impacting others.

An estimated $850 million will be allocated for the Hospital Value-Based Purchasing Program in fiscal year 2013. If patients are highly satisfied with their care, the cuts in reimbursement can turn into bonuses (Morrissey, 2011). Those organizations scoring lowest on patient satisfaction may not get any bonuses, ultimately resulting in a 2% reduction in Medicare reimbursement by 2017.

For hospitals in areas with a high population of low-income families, chief financial officers are struggling to make ends meet while providing free federally mandated services to uninsured individuals who present to the emergency department for care. Compounding penalty on top of penalty may result in failed financial viability for some hospitals over time (Daly, 2011). Organizational collapse is not unprecedented, and failure may be the norm rather than the exception for small rural facilities providing care to the poorest of the poor across the nation. Hospital closure has been shown to impact those in the surrounding community, resulting in harmful delays in care, more negative health outcomes, lack of patient education, and reduced access to specialty care (Walker, Clark, Ryan, & Brown, 2011). The ultimate effect on the already underserved poor could be truly devastating.

One thing is certain: hospital executives are faced with complex new rules, many of which could have a significant financial impact. Hospital administrators and providers alike are questioning how insurers can base reimbursement on results of a survey that has not been validated for determining patient satisfaction. After all, what makes a patient satisfied with his or her hospital care? Is it the fresh flowers and beautiful furniture that are appealing? Do patients really have the ability to determine objectively whether communication was effective or explanations regarding care were sufficient?

Health care executives across the nation are rightfully anxious about the upcoming changes. As third-party payers continue to decrease reimbursement, many in health care are struggling to reconcile their desire to care for our most vulnerable populations with the need to make ends meet. With an emphasis traditionally placed on clinical quality and patient safety measures rather than patient satisfaction, health care providers must shift from a culture focused predominantly on clinical outcomes of care to a more holistic approach. Some hospital executives have begun appealing to providers’ humanitarian desire to provide the best possible care to ensure buy-in to the importance of patient satisfaction, not because of the potential for increased reimbursement, but because it is the benevolent thing to do (Morrissey, 2011). Dr. Peter Semczuk, Vice President of Clinical Services at Children’s Hospital at Montefiore, stated, “The challenge for many hospitals is that they are not traditionally known as service institutions. They are complicated places, busy places” (Solomont, 2007, p. 1).

Despite the specific questions on the HCAHPS survey asking patients to evaluate such elements as communication practices, responsiveness of staff, and pain management, patients appear to be swayed by their overall perceptions of the facility. When New York University (NYU) Medical Center moved its cardiology unit to a renovated floor in 2008, patient ratings shot up, even though the procedures and

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employees were the same. NYU’s Chief Executive Officer, Dr. Robert Grossman, believes that although amenities provide value, insurance incentive payments should be based on evidence-based clinical quality measures (Rau, 2011). Despite Dr. Grossman’s beliefs, NYU executives are keenly aware that patients’ perceptions will affect their pocketbook and are quickly implementing changes to deter a loss in revenue. Changes such as greeting patients in the emergency room within 30 seconds of arrival, providing cell phones to maternity patients to enable them to text their nurses, and offering “happy hour” treats to family members have already been implemented, and several more are in the works (Pho, 2011; Rau, 2011).

Other hospitals have completely revamped patient rooms, adding homelike furniture, refrigerators, large-screen televisions, and other amenities to make patients’ experiences as pleasant as possible while in the hospital. “Money is spent on touches that have little to do with improving patient care” (Pho, 2011, p. 1). Gourmet meals and fresh flowers delivered to hospital rooms each day may make it difficult for patients to give a hospital a poor rating.

Many facilities are focusing on staff interactions with patients. Customer service and patient-centered care initiatives have been elevated in importance, training staff from housekeepers to physicians on such things as the importance of increasing communication, making eye contact, calling patients by name, answering call lights immediately, knocking on doors before entering, and simply being more gracious. Hourly rounds to keep patients and family members informed have become the norm rather than the exception, ensuring adequate pain management and clean rooms and connecting with patients to reassure them that staff is available and that they care (Tea, Ellison, & Feghali, 2008).

Concerns about spending money on painting walls, buying flowers, and expanding food choices in lieu of new medical equipment, staff education, and updated technology are widespread. Although having money for all of the above would be nice, hospitals typically operate on a slim profit margin, and many simply cannot afford to do it all. Hotel-like amenities, single rooms, and gourmet food are typically defined as perks rather than quality clinical care (Rau, 2011).

Hospitals working collaboratively across communities to improve patient care through committees, projects, and boards may reevaluate their participation in these activities. With the Hospital Value-Based Purchasing Program pitting hospital against hospital in a fierce competition for money, it is unlikely that best practices will be shared as freely as before (Nelson, 2012). Why would a hospital share innovative ideas that allow increased communication and better care, when they risk losing their rank on the scoreboard? After all, those with the best scores will receive the most money.

Another major concern is the potential to manipulate patient satisfaction scores—a practice that many health care providers feel pushes ethical boundaries. One hospital’s maternity ward showed marked improvement in satisfaction scores when delivery room nurses began telling patients about the great postpartum nurses who would soon be taking care of them. When the delivery nurse transferred the patient and family to the postpartum nurse, the postpartum nurse would tell the new mom how lucky she was to have that particular nurse in the delivery room (Rau, 2011). This practice is not an option because nurses are evaluated on their performance of the practice during their annual reviews. Some in health care feel that hospital executives are trying to game the system by purposefully influencing patients’ perceptions of care by using key phrases from the HCAHPS survey. Paul Alexander Clark, a consultant to health system executives, states...
“The problem of teaching the test is caregivers are more focused on the right words rather than the right care” (Rau, 2011, p. 1).

To add to questions about the worth of patient satisfaction scores, physicians and health care executives alike are worried that they will need to yield to patients’ demands, ordering unnecessary tests and more medications in order to increase the likelihood of a bonus payment. One prospective cohort study of nearly 52,000 adults found that those patients who were most satisfied with their health care used more health care services, including inpatient and outpatient visits and prescription medications, than less satisfied patients, despite being in better overall physical and mental health. The most satisfied patients incurred 8.8% more health care expenditures than did the least satisfied patients and spent 9.1% more on prescription drugs than did the least satisfied (Fenton, Jerant, Bertakis, & Franks, 2012).

Even those who support the Hospital Value-Based Purchasing Program agree that higher patient satisfaction should be rewarded with only a small portion of bonuses to prevent submitting to patients’ every request for treatment or medication despite lack of medical necessity (Press & Fullam, 2011). Tying patient satisfaction to revenue provides little incentive for providers to follow evidence-based clinical guidelines and may ultimately result in increased health care expenditures (Pho, 2011).

Despite the controversy, the Hospital Value-Based Purchasing Program is upon us. Interdisciplinary collaboration among all health care providers is essential to improving patient satisfaction scores while providing safe and quality care. Despite the turbulent political climate, it seems that the Hospital Value-Based Purchasing Program is here to stay. In a time of economic hardship, health care providers must work to provide innovative ideas on how best to improve patient satisfaction and sustain revenue.

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See Me as a Person

Connie Coyner, RN

See me as a person.
Sit with me and stay.
Provide me with encouragement
In this sacred space, I pray.

Don’t treat me as a bed number
Or an illness to understand.
I am a frightened person
Whose life is in your hand.

To me you are a voice
When I feel that I have none,
A comforter and healer
On this journey I’ve begun.

You may not know my story
From beginning to the end.
What matters most to me is
The precious time you’ll spend.

I hope that you remember
And take it all to heart –
When you see me as a person,
That is where all healing starts!

I am a member of my hospital’s Professional Excellence Council, which organizes events for Nurses Week every year, and I started a tradition of welcoming our chief nursing officer to nurses week with a poem. This year, my experience was different because of the cultural transformation of Relationship-Based Care (RBC) implemented at Muncy Valley Hospital. I recently attended a 3-day presentation of Re-Igniting the Spirit of Caring, and I truly believe that it changed my life.
So often, we focus on ourselves and on the task at hand. As nurses, we are oriented that way, but RBC changed all that and reminded us that people want to be seen and understood fully—mind, body, and spirit. Unless we understand our patients and “see them as a person,” we can’t provide them with the best patient care experience.
INTERVIEW

Shifting the Paradigm:
A Conversation With
Riane Eisler, JD

Interviewed by Teddie M. Potter, PhD, RN

Teddie Potter: Today I am privileged to interview Riane Eisler, social theorist, macrohistorian, celebrated author, and president of the Center for Partnership Studies. Riane, we at Creative Nursing are excited to have you join us for this interview. Our previous issue (Creative Nursing, Volume 18, Issue No. 2) has a review of your book, The Chalice and the Blade, as well as a discussion of your work related to the field of nursing. So we’re very interested in what you have to say.

Riane Eisler: And I’m very interested in Creative Nursing because the nursing community embodies in so many ways the principles of what I call the caring economy. As you know well, Teddie, because you wrote your dissertation on that as well as on what I call the partnership model.

Potter: Yes. You have been analyzing social organization structure for your entire career. Would you help our audience understand a bit about your personal history and how it fueled your passion for partnership?

Eisler: You’re right. I have a great deal of passion for this work, not only as a researcher and a social scientist and of course as a writer and organizer and speaker, but also as a mother and grandmother. I’m deeply concerned, as so many of us are, about what kind of world our children will inherit. The issue is human agency. We must understand where we are and what we can do to move in a more positive direction. My research came out of questions that arose very early in my life. When I was a little girl in Vienna, after the takeover by the Nazis, suddenly my parents and I became hunted. The Nazis had a license to kill, and we escaped by a hair’s breadth. I was very young on Kristallnacht, when a gang of Gestapo men barged into our home and dragged my father away.

So very early, I saw that we humans are capable of great cruelty, violence, insensitivity. But I also saw something else that night that profoundly affected me: it’s what I call spiritual courage. We’ve been taught to think of courage as slaying the dragon, killing the enemy, but spiritual courage is the courage to stand up against injustice out of love. And my mother displayed that courage. She recognized one of the Gestapo men as a young man who had once been an errand boy for the family business, and she got furious. She said, “How dare
you treat this man, who was so good to you, this way! I want him back!” Now, my mother could have been killed because many Jewish people were killed that night. But by a miracle she wasn’t—by a miracle, we escaped Vienna. My mother managed to get my father’s release; we fled in the middle of the night and I grew up in Cuba, in the industrial slums of Havana, and eventually came to the United States.

All that led to the question that many of us have asked: Does it have to be this way? When we humans have such an enormous capacity for caring, for sensitivity, for creativity; why has there been so much destructiveness, so much cruelty, and so much insensitivity? Eventually, those questions led to my multidisciplinary cross-cultural research, looking for answers.

**Potter:** You did a wonderful job describing those answers in your book, *The Chalice and the Blade*. Can you talk about the cultural transformation theory that came out of your work?

**Eisler:** I want to start by saying that I didn’t really embark on this research until another pivotal experience in my life—in the late 1960s—when, along with thousands of other women, I suddenly woke up as if from a long drugged sleep. I realized, through consciousness-raising groups, that so many of the problems that I thought were just me (You know, something’s wrong with me! We’re always told something’s wrong with me! We’re always told something’s wrong with us, right?) . . .

**Potter:** Right!

**Eisler:** They weren’t really personal problems, because I shared them with so many other women. They were social problems. So when I embarked on this cross-cultural historical multidisciplinary research, I drew from a much larger database than most studies of society. To begin with, most of these studies are quite aptly called the study of man, and we’re told, “Don’t worry, man includes woman.” In English, the word “woman” actually includes “man,” but that’s not the point. The point is that if you work with a database that leaves out no less than half the population, you aren’t going to have correct results. You just can’t. You aren’t going to be able to see the configurations, the patterns.

Once you start including women, you move from the area that most conventional studies of society focus on, which is the so-called public sphere of politics, of economics, to also start looking at where we all live, in our families, and other intimate private relationships—in other words, at the whole of our lives.

As you know from reading *The Chalice and the Blade*, I also drew from a very long span of history, not only cross-culturally but historically, that includes both our recorded history and our prehistory.

That made it possible to see patterns—configurations that kept repeating themselves that aren’t visible if you look at only part of the picture. There were no names for these patterns, so I called one the domination model and the other the partnership model. The interesting thing, that is very relevant not only to the female half of humanity but to all of us, is something that you would never know from looking at conventional studies, reading all those tomes that I read through all my years of higher education. This is: How a society constructs the roles and relations of the female and male halves of humanity not only directly affects our individual life options as girls and boys, as women and men, but profoundly affects every single social institution, from the family, education, and religion, to politics, economics, and, yes, the health care system.
If you work with a database that leaves out half the population, you aren’t going to be able to see the patterns. Once you start including women, you move from the area that most conventional studies of society focus on, to looking at where we all live, in our families, and other intimate private relationships—at the whole of our lives.

Being able to see these connections is why so many people write to me about the “Aha!” moments they have when reading my work. I had those moments in doing the research. It was fascinating, like a Sherlock Holmes experience, to see things that were always there but that were invisible looking at the world through the lenses of conventional categories like right/left, religious/secular, eastern/western, northern/southern, which don’t show the fundamental importance of construction of our primary human relations: gender relations and parent–child relations, our early childhood experiences. We know from neuroscience that those are models for all relations and that what children observe and experience affects nothing less than the neural structures of our brains. So we need to pay attention to these relations if we are going to lay foundations for the more caring and equitable and sustainable world we so want and need.

**Potter:** You mentioned sustainability, and I know in your book, *The Power of Partnership*, you discuss another relationship that is impacted by how we structure our primary relationships. It is our relationship to the land. That is so pertinent today in this time of ecological crisis.

**Eisler:** Absolutely. I was recently invited to speak at the United Nations General Assembly in a session dealing with the rights of nature. We haven’t thought of it that way in the past, but of course, human rights and the rights of nature are interconnected because nature is our life support system. But I was the only person there who talked about women, about children, about poverty, about hunger. What I said is that you can’t tack on a balanced, harmonious approach to nature to a fundamentally imbalanced system—a system based on rigid rankings, beginning with the ranking of one half of humanity over the other half. And if we associate caring for people, starting in early childhood, and keeping a clean home environment—if we associate that with women and the devalued feminine as we have been taught to do, how can you expect real change as long as women and anything associated with women and the “feminine” continue to be devalued?

I used to joke and say that women would never have created nuclear waste with no idea of where to put it, not because we’re better than men, but because both women and men were socialized with this idea that men can make all the messes and women will be there to clean up. Thankfully, this idea is beginning to change.

**Potter:** Originally, that was the thinking.

**Eisler:** Yes, that was the thinking, and we’re just barely getting out of it, aren’t we?

**Potter:** I think that mentality is a historical part of the health care system, as well.

**Eisler:** You are right, and I think that’s something that we really need to focus on. The nursing profession has embodied the power of care, at least in theory, right?

**Potter:** Yes.

**Eisler:** Not that every single nurse is going to be caring. In fact, this whole notion that women are caring and men are not is nonsense. I happen to be married to a very caring man, and we all know women who are not caring.

But women are socialized to care for others. In fact, traditionally, we’re socialized to have only a relational identity—as a daughter, a wife, a mother, a
grandmother. Those are extremely important roles, but there’s no identity for us except as we serve others. And that socialization has made us concentrate in the caring professions: nursing, child care, and so forth.

The good news is that more men are beginning to enter these professions, but there’s a part of the dynamics that we need to understand: men are socialized to be not like women. If they do things that are seen as female things, they’re wimps; they’re sissies; they’re effeminate—as if that were a terrible thing, right?

Potter: I think a lot of my male colleagues experience that pressure.

Eisler: I always want us to understand that when we’re talking about gender issues—when we’re talking about raising the status of women worldwide—we are talking about something that’s fundamental to social health and that affects girls and boys, men and women. The old socialization was like putting us in strait-jackets as women and men, as girls and boys, constricting so much of our human potential. There are traits that are stereotypically considered masculine that are great; leadership is supposed to be a male trait. Well, women can do it too. But if a woman is assertive, she’s terrible, a “ball-breaker,” and so forth. The other side of the coin is, if men are caring, if men are sensitive, they receive a lot of devaluation, not only from other men but often from women.

Potter: In light of what we’ve just talked about, I’d like to discuss what the word “partnership” means to you. In the past, partnership has been a male construct. What went into the choice of that word as opposed to any other word—for instance, the word collaboration?

Eisler: Well, I don’t use the word collaboration because, in reality, people who are in rigid domination structures also collaborate all the time: monopolies collaborate, terrorists collaborate, invading armies collaborate. So the difference between partnership and domination systems isn’t working together. What is different is the social configuration.

These new categories answer the most critical question for humanity: What kind of social configuration will support the expression of our genetic potentials for consciousness, for caring, for creativity rather than our genetic potentials for insensitivity, coercion, cruelty, destructiveness. Because we have that whole spectrum of potentials, don’t we?

I sometimes wish I hadn’t chosen the term partnership. I’ll tell you why I chose it, though. I was casting around for accessible terms. Originally, I only used the neologism gylny because gender is so central to how societies are structured. Gy is for gyne, for woman; an is for andros, for man; and l signals the link between them rather than their ranking. But it was clear that I needed a more accessible term, and I chose partnership.

You’re right, it is a male term for business partnerships. But the characteristic of a business partnership, at least in theory, is equality of voice, mutual accountability, mutual benefits, mutual respect. And those are the kinds of relations that the configuration of a partnership, rather than domination system, supports. But now in popular parlance, partnership has become a synonym for strategic alliances, for working together, and that’s why I sometimes wish I had found another term. But, you know, the meaning of words can change, so I’m hoping that people will begin to understand that to have real partnership relations based on mutual respect, accountability, and benefit, we have to build the foundations; we have to build the structures that will support them.
I’m hoping that people will begin to understand that to have real partnership relations based on mutual respect, accountability, and benefit, we have to build the foundations; we have to build the structures that will support them.

Potter: I think you’re right that we can recapture the use of the word. I’ve been teaching my graduate nursing students about your theories, Riane, and we are using a shared language of partnership and domination, and we understand each other when we use those terms, so it’s very possible to claim that as a new area. One thing I am concerned about is that it’s easy to get into the blame game of us versus them—we’re right, they’re wrong. One of the things we see in nursing—it runs through quite a bit of the literature—is this tendency toward lateral violence where, out of frustration, the nurses, instead of getting angry at the source of the oppression that they’re experiencing, lash out sideways toward one another. Do you see this in your research as well, that people who are oppressed sometimes manifest some of the same behaviors?

Eisler: Oh, absolutely. And that is one of the ways that domination systems maintain themselves. Consider that they couldn’t maintain themselves if people weren’t in denial about what’s really happening and didn’t have any outlet for their frustration. So it is not only lateral violence that you describe within organizations, but it’s racism, it’s anti-Semitism. My work shows how we acquire these patterns.

Lateral violence isn’t only situational, because not everybody does it. Some people don’t. More and more, as I look at neuroscience, I’m beginning to understand some of what we know from psychology. For example, the work of psychologist Else Frenkel-Brunswik on very prejudiced people. She found that they tend to come from what I call dominator families: very authoritarian, top-down, rigidly male-dominated (except when the woman takes the dominator role but then the husband is supposed to be henpecked, right? It’s a role reversal). These people have learned that it’s very dangerous not to listen to the voice of authority; it’s dangerous to question authority no matter how unjust. Because as children, their obedience and even their love was demanded of them.

And that actually seems to affect the brain. There are people who label themselves as conservative. I want to be very careful with this term because conservative can mean many things, but let us use the definition for people who believe that government policies should be only for police powers, for weapons, for wars, for prisons, but who disparage any kind of caring policies, as in the derisive phrase “the nanny state.” In other words, people who identify with control rather than caring. These people seem to have a much more active right amygdala, which is where a lot of our fear and our negative memories, and so forth, are stored. So this world view seems to get itself into our brains.

That’s not to say it can’t be changed. But it’s not easy.

Potter: Right.

Eisler: We need to understand that if we don’t pay attention to those primary gender and parent–child relations, we don’t have the foundations for more caring societies, do we?

Potter: And we don’t even have the idea of what a positive model would look like. As you explored history, can you share a little bit about some of the cultures that were partnership cultures and what they looked like? Or cultures today that are partnership cultures—what could we be like if we really moved in this direction?

Eisler: Let me start by saying what you already know, which is that it is always a continuum. I always speak about a partnership domination continuum because it is always a matter of degree. I’ll start with contemporary cultures. We seem to
Very prejudiced people tend to come from dominator families: very authoritarian, top-down, rigidly male-dominated. These people have learned that it’s very dangerous, very painful to question orders no matter how unjust; where they internalize this unequal model of our species; where difference, beginning with the most fundamental difference between female and male, is automatically equated with either superiority or inferiority, dominating or being dominated, being served or serving. But for many people who consider themselves progressive, these are just women’s and children’s issues.

When people want to push us back to the “good old days” when all women and most men knew their place in these rigid hierarchies of domination, a top priority for them is to go back to a “traditional family” where women are back in their “traditional place.” These are code words, aren’t they, for an authoritarian, rigidly male-dominated family, where children learn early on that it’s very dangerous, very painful to question orders no matter how unjust; where they internalize this unequal model of our species; where difference, beginning with the most fundamental difference between female and male, is automatically equated with either superiority or inferiority, dominating or being dominated, being served or serving. And the third is that abuse and violence are not built into the system, as they must be to maintain rigid rankings of domination.

What’s interesting about the Nordic nations is that they exhibit these connections; they pioneered the first peace studies. They pioneered the first laws against the use of physical discipline against children in families. They have a strong men’s movement to disentangle masculinity from its association with domination, with violence. Approximately 40% of the national legislature is female. And they have much more caring policies. Because they have more of a partnership configuration, they have also been leaving behind traditions of violence, male dominance, and the devaluation of the feminine. They have been leaving behind what I call hierarchies of domination, moving toward what I call hierarchies of actualization. Because we do need hierarchies.

Potter: Could you say more about that? The health care system has very strong hierarchal pathways and I think that when we speak about partnership, people accept all kinds of terrible things in domination systems, but if there’s an alternative system and it’s not perfect, it’s no good, right?
think, does that mean it’s a flat organization? But that’s not at all what you have in mind. You’ve talked about hierarchies of actualization. Could you describe how that might work for a nursing unit or a group of health care workers?

**Eisler:** Kurt Lewin, the father of social psychology, found that when you have a laissez-faire situation, a completely flat organization with no loci of responsibility, that’s the quickest road to the domination system.

**Potter:** Interesting.

**Eisler:** Because people need some structure. A completely flat organization is not realistic. Just as it isn’t realistic to say, “If everybody would just cooperate, everything will be fine.” We can’t just do away with hierarchies. We need parents. We need teachers. We need managers. We need leaders, right? I coined the terms hierarchy of domination and hierarchy of actualization to make a distinction that actually is beginning to be written about in the management literature: the manager no longer being the cop or controller but rather being someone who inspires others to be the best they can be, who facilitates and guides, and sometimes makes decisions. You know, sometimes someone has to make a decision; there has to be a locus of responsibility. But in a hierarchy of domination, accountability, respect, and benefit only flow from the bottom up, don’t they? In a hierarchy of actualization, they flow both ways. That’s a huge difference.

**Potter:** I have told my students that we all move ahead when no one is left behind. And that, in a nutshell, is the idea of actualization: You work together so all people benefit from a system that’s healthy.

**Eisler:** As I said, sometimes somebody has to make a decision. But what matters is the cultural climate. There are so many studies showing that organizations in which information flows both ways in the hierarchy are much more successful, where decision making is not just at the top and where caring is present. My colleague Jane Dutton did some wonderful work in organizations where caring and compassion were encouraged and modeled by the leadership. People are happier, the organization works better. It makes sense, doesn’t it?

**Potter:** Absolutely.

**Eisler:** When we talk about partnership systems, we’re talking about a very specific interactive configuration. And we always come back to gender and to the fact (as I write in my latest book, *The Real Wealth of Nations*) that as long as women and the stereotypically feminine, like caring and caregiving, are practically invisible in terms of what’s considered economically productive, as long as they’re so devalued, they get no tangible rewards—as unfortunately is still the case in most countries, including our own.

But it’s not the case everywhere. Sweden, Norway, and Finland have government-supported paid parental leave, stipends for families to help families care for the children and for elderly, and of course, universal health care. In Norway, either parent can receive a social security credit for the first 7 years of caring for a child at home. These are economic inventions, caring economic inventions, but they didn’t happen by accident. They happened because as the status of women rises, men, as well as women, no longer devalue the stereotypically feminine. They can embrace it, they can identify with it. This is not a simple cause and effect thing. It is an interactive dynamic.
Our nation is committing economic suicide today by cutting precisely the funding we need, the investment we need, to develop our people’s human capacities, or as economists like to put it, the “high-quality human capital” essential for economic success as we shift from a manufacturing to the knowledge/service postindustrial era.

Potter: The Real Wealth of Nations does a beautiful job explaining why rights and benefits that are sometimes called entitlements in our country actually improve the economy of a nation. Could you share a bit about your theory of caring economics and what you’re finding?

Eisler: Well, the findings are very simple. They are that caring pays. And it pays not only in human and environmental terms but in strictly economic terms. I’ll start with organizations. As I said, companies function better if there is caring. For example, those companies which appear regularly in Working Mother or Fortune 500 as the best companies to work for have a higher return to their investors.

But let’s talk about nations. At the beginning of the 20th century, Sweden, Norway, and Finland were so poor that there were famines. Minnesota was populated by people fleeing poverty and famine. Today, these nations are very high in both the United Nations Human Development reports and in the World Economic Forum’s Global Competitiveness reports. A major factor, which is directly related to their shift to the partnership side of the continuum, is that they invested in their human infrastructure through more caring policies. I’ve mentioned some of those policies already.

Our nation is committing economic suicide today by cutting precisely the funding we need, the investment we need, to develop our people’s human capacities, or as economists like to put it, the “high-quality human capital” essential for economic success as we shift from a manufacturing to the knowledge/service postindustrial era. I’ve written quite a few op-eds about this in addition to The Real Wealth of Nations. It is shocking that our public is not educated. This is where we can make a real difference, where nursing associations must take a stand. Throwing away people is not a good mentality. Even just within the framework of “economic success,” cutting our investment in caring for people is the wrong policy.

Potter: We might be able to push that as nurses, as the move toward accountable care organizations (ACOs) continues to gain momentum. ACOs are discovering what nurses have always known: invest in prevention; invest in care up front; upstream thinking makes sense; let’s try to figure out the issues long before people require expensive interventions and hospitalization. Care pays. Care creates sustainable systems.

Eisler: And to do this, we have to show how completely irrational the opposition to it is. That it is based on that dominator mentality that we all too often hear expressed: control people rather than care for them—it’s a nanny state if we care for people. Whoever invented that expression, nanny state, was a brilliant strategist because it feeds directly into that conscious and unconscious devaluation of women and the feminine. We have to expose it for what it is, but we also have to recognize that a lot of these people came to this mindset honestly. That’s what they were taught in their early childhood: to devalue women and “women’s work.” But we simply can’t afford that kind of thinking.

We hear all this talk about the United States being in decline—you bet we will be in decline if we don’t change these misguided beliefs! But we don’t have to be in decline. There is a great deal we can do, starting with understanding the economic value of care work. We also have to get rid of overconsumption, which is another way that people in domination systems try to meet unfulfilled needs: for caring, for connection, for meaningful work, for all the things that give people real and
lasting satisfaction. And, of course, the barrage of marketing drives people in the wrong direction.

But none of this is inevitable. That’s why we at the Center for Partnership Studies have launched our Caring Economy Campaign, and I invite the nursing associations to become part of our Caring Economy Coalition. You can do that at http://www.partnershipway.org as well as on our http://www.caringeconomy.org site which will soon be up.

Become part of the coalition, which has already been joined by many organizations representing women, children, different faiths, think tanks, sustainable businesses, and so on. We will feature the work that you are doing (like what you mentioned—the movement for accountable care). That’s part of the movement toward a caring economy, as are many other important initiatives. But what’s been missing is a unified caring economy frame so that we can build a groundswell for real change. And the first step is changing the conversation about economics by starting to talk about a caring economy instead of getting caught up in the old argument about capitalism versus socialism.

As a key part of the Caring Economy Campaign, we’re working on something very important, very basic, which is social wealth economic indicators. I think many of us are beginning to realize that gross domestic product (GDP) is an inaccurate, distorted, incomplete, and in many ways, a crazy way of measuring wealth. It includes negatives (making cigarettes, medical bills, funeral costs)—they’re all part of GDP, right? They’re great for GDP, but they’re horrible for people and for the environment and the future.

So again, I want to invite readers to join our Caring Economy Campaign, to take our online Caring Economy Leadership Program. It’s a fabulous online training at http://www.partnershipway.org. We can make a difference if we unite around a common intervention: to give visibility and value to the work of caring for people, starting in early childhood, and caring for our Mother Earth.

**Potter:** Riane, so many of your themes resonate very deeply with the profession of nursing and give us hope for a way that we can move forward because if our new systems and new health care models are based on old forms of measurement and old outcomes, we are just putting the same old problems in a different set of clothes. You have expressed so articulately in your work that one of the first things we need to do is to shift the story. Your caring economics and your partnership theory allow nurses to have a common language and begin to shift the story in health care. So I thank you so much for speaking with us and for supporting our profession—the caring profession. We look forward to working with you by connecting with the Center for Partnership Studies.

**Eisler:** I thank you too. It’s essential that we really value the work of care—the work of nursing—and, as you said, that we invest in care rather than having to deal with all of the human and economic and social and environmental costs of lack of care.

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Interruptions in sleep for hospitalized patients have been correlated with decreases in immune function, changes in mental status, and increased stress levels. The purpose of this study was to explore patients’ perceptions of their sleep experiences during hospitalization. Structured interviews were conducted with a convenience sample of patients who had spent three consecutive nights in the hospital. Data was analyzed by content analysis; three themes emerged from the data. The findings from this pilot study will lead to further research in nursing practice as it relates to supporting sleep and rest in hospitalized patients.

Sleep is a complex physiologic process that is not fully understood (Tranmer, Minard, Fox, & Robelo, 2003). However, the effects of sleep disturbance in the hospitalized population are well documented. Sleep disturbance has been correlated with decreased immune function (Palmblad, Petrini, Wasserman, & Torbjorn, 1979), changes in mental status (Krachman, D’Alonzo, & Criner, 1995), and increased stress levels (Meerlo, Sgoifo, & Suchecki, 2008). These effects may interfere with the healing process in adults who require acute care in a hospital setting (Patel, Chipman, Carlin, & Shade, 2008). Additionally, lack of sleep in hospitalized patients is considered a dissatisfier in evaluations of the hospital experience on patient satisfaction surveys (Southwell & Wistow, 1995).

To date, attempts to identify factors that contribute to sleep disturbance have focused on subjective reports by patients, nursing observations, and objective data related to sleep. To investigate environmental contributors to sleep deprivation in the intensive care unit (ICU), Freedman, Kotzer, and Schwab (1999) developed a questionnaire that asked patients to rate, on a numeric scale, the impact of discrete factors related to both environment (such as noise) and human intervention (such as diagnostic activities and monitoring vital signs) on their quality of sleep. The findings of the Freedman study confirmed the results of an earlier study conducted by Simpson, Lee, and Cameron (1996), which asked patients to rate preselected factors that impact their sleep; the results showed that patients slept poorly when they were uncomfortable, when they were awakened for procedures, and when the environment was noisy.
Nurses’ observations do not correlate well with patient’s perception of sources of sleep disruption (Southwell & Wistow, 1995). Objective data using actigraphy as a measurement of sleep, and light and sound meters to measure preselected environmental factors, have found an inconclusive correlation between sleep and environment, in part reflecting the subjective experience of sleep (Missildine, 2008).

Given the complexity and the importance of sleep to the human condition, especially while hospitalized, there is a dearth of research into the sleep experience with hospitalized patients, including the impact of strategies to promote restorative sleep (Tranmer et al., 2003). The actual relationship between restorative sleep and improved outcomes in hospitalized patients remains unclear (Redeker, 2000). Evidence suggests that maintaining circadian patterns of activity and rest are correlated with improved functional status and decreased length of stay (Redeker, Mason, Wykpisz, Glica, & Miner, 1994) as well as improved perception of the hospital experience. To learn more about how patients perceive and report their sleep experience while in the hospital, the following study was undertaken.

**SPECIFIC AIMS OF THE STUDY**

The specific aims of the study were to

- investigate the sleep experiences of patients hospitalized in an acute care setting both before and during hospitalization,
- identify factors that affect sleep in an acute care setting from the patients’ perspective, and
- identify patients’ perceptions of nursing interventions that have an effect on sleep in an acute care setting.

**METHOD**

The appropriate institutional review board approved this study.

**Subjects**

Subjects were selected from a convenience sample of patients admitted to three acute care hospital units at a large teaching hospital in the northeast region of the United States. The subjects were approached after three nights on the same unit in the hospital. This time delay afforded the patients time to experience several nights of sleep in the hospital and to reflect on the various factors affecting their sleep experience. There were 37 subjects across all three units.

**Study Questions**

1. Can you tell me about your sleep over the past week prior to this admission?
2. What do you do at home to help you sleep?
Consider the past few nights in the hospital when answering the following questions:

3. Can you tell me about your sleep while you have been in the hospital?
4. How did you expect to sleep while in the hospital?
5. What interferes with your ability to sleep at night in the hospital?
6. What helps you to sleep in the hospital?
7. If you nap during the daytime, how often do you nap and for how long do you nap?
8. Do you have any suggestions to improve how hospitalized patients sleep?

Study Design

This research study used a qualitative descriptive approach. Members of the research team conducted interviews. All responses were audiotaped and later transcribed by a graduate student assisting with this study. Members of the research team and a graduate student who did not participate in the interviews conducted the content analysis of the transcripts. Sandelowski (2000) identifies qualitative content analysis as the basic strategy for qualitative descriptive research and an important approach to understanding experiences or events.

Data were analyzed to isolate and interpret themes, issues and repeated patterns, and refine understanding as new insights emerged. Three key findings emerged and were shared with unit-based nursing staff to assess content validity.

FINDINGS

Key Finding 1: Hospital Ambience Can Aggravate Sleep Disturbance

Patients described aspects of hospitalization that impacted their ability to sleep, including the unfamiliar bed, the noise of the hospital, and the activity of the unit that kept them from sleeping. In general, patients anticipated not sleeping well or not sleeping as well as when at home because of the hospital environment. Comments included the following:

- “I can hear the noise next door, or something next door.”
- “Here, I seem to hear everything.”
- “...hospital noise, bells going off, stuff like that.”
- “Depends on the noise and what’s going on out in the halls.”

Key Finding 2: Management of Symptoms is Related to Quality of Sleep

Many patients commented on how their symptoms affected their ability to sleep while in the hospital. In particular, pain seemed to prevent patients from sleeping. Comments included the following:

- “I was in extreme pain.”
- “I was in a lot of pain in my foot that I ended up having amputated.”
- “I have a bed sore at the end of my spine.”
Key Finding 3: Patients Find Routine Nocturnal Care Such as Vital Signs Understandable but Bothersome

Many patients commented that nocturnal care kept them awake, although they understood that this care was necessary. Comments included the following:

- “Waking the patients up—the biggest complaint you’ll get, but if it’s necessary, then it’s necessary.”
- “You wake up and they take your blood, they take your temperature, and it takes an hour to get back to bed.”
- “Well, that is very difficult because that’s a part of the care—when you’re having procedures done and it’s just normal procedure.”

DISCUSSION

This pilot qualitative research study examined the phenomenon of sleep in the acute care hospital setting. In general, patients did not anticipate sleeping well because of the hospital environment, and many believed that they slept worse in the hospital than at home. Qualitative analysis of data found themes of nocturnal care, noise, and symptom distress emerged as contributing factors that negatively affected patients’ ability to sleep. This pilot work supports previous quantitative research on the sleep experience of patients in the hospital setting that identified the same themes.

The unique contribution of this study is the report of the patients’ experience of sleep. Prior research has relied heavily on quantitative data using researcher-generated standardized surveys. Qualitative data found more nuanced results, such as patients’ understanding of the importance of assessing nocturnal vital signs or being awakened for critical medications. The findings from this study lay the groundwork for future research in nursing practice, as it relates to supporting sleep and rest in the hospitalized patient.

LIMITATIONS

The limitations of this pilot study include reliance on a convenience sample with a limited number of subjects. Generalizability of results is limited because the study was conducted on three preselected care units rather than across the hospital setting. Because the hospital is a large academic center, patients choosing to access care there may not be representative of the general population. In addition, in this small sample of care units, the influence of unit-based culture and/or practices on patients’ experiences of sleep is unclear.

CONCLUSION

Nurse-driven interventions that partner with patients to develop a plan of care that reflects patient-specific needs, such as improved management of pain and symptoms and changes in nocturnal nursing practice, should be considered in future research.
REFERENCES


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THE NURSING SALON EXPERIENCE

Finding Community, Friendship, and Support

Molly MacLean, BA
Katie Theisen, AD

Molly MacLean: This is the time in my nursing program when I am beginning to feel mixed emotions about my future as a nurse. I feel anxious to graduate, excited to call myself a “real nurse,” scared to take my boards, and hopeful for my future. Unless you have been through nursing school, it is hard to understand the pressure, the excitement, and the responsibility of becoming a nurse. Nursing Salons are where I can go to find the wisdom and reassurance of nurses who have been through what I am going through now. The men and women I have met at Nursing Salons have had very different nursing careers, yet I can relate to them all.

Katie Theisen: I attended my first Nursing Salon a year ago as part of a required assignment for one of my classes. Never having gone to a salon, I had no idea what to expect when I walked through the door that night. However, I left with huge feelings of excitement that made me want to do energetic leaps down the sidewalk with my arms gracefully extended. I knew that this excitement was not only contained in myself; every single person at the salon held a certain excitement. This excitement stemmed from the one simple question asked at the beginning of every salon: “What is on your mind about nursing tonight?”

MacLean: Everyone is welcomed with open arms at Nursing Salons. Some of the nurses are retired, some do nursing research or management, some have been nurses for longer than I have been alive, and some are nursing students or new graduate nurses. At a Nursing Salon, the format is always the same, but the conversation is always different. Dinner is served. Then everyone introduces themselves and answers the question, “What is on your mind about nursing tonight?”

Theisen: Such a simple yet broad question, leaving room for a variety of topics to be discussed related to nursing. I have learned so many valuable nuggets of information that I will be able to use in my personal and professional life. I am able to gain reassurance from nurses who reiterate to me that the career I will soon embark upon will take me on an unforgettable journey—a journey in which I will touch people’s lives when they are most vulnerable, and I will hold patients’ hands when no one else is there.

Molly MacLean, BA, has a bachelor’s degree in Community Health from Bethel University and is a senior nursing student in the accelerated BSN program at Globe University/Minnesota School of Business.

Katie Theisen, AD, has an associate degree in medical administration and is a senior nursing student at Globe University/Minnesota School of Business.
MacLean: Sometimes the topics are personal; sometimes the topics are large and broad, but the conversation always stays in the room. As nurses, we understand the rules of the Nursing Salon in the same way that we understand the Health Insurance Portability and Accountability Act (HIPAA). The sense of confidentiality at Nursing Salons makes me feel comfortable to say what I really feel, to be myself, and to feel the authenticity of the whole group. The conversations are honest, exciting, motivating, and experiential. No matter the topic, the time spent at a Nursing Salon is always valuable to me.

Theisen: Along with meeting new people and forming new friendships, I treasure each salon I participate in because it presents an opportunity to network. I am able to seek valuable information from newly graduated nurses and retired nurses with expertise in a range of specialty areas. The salon graciously cultivates a format in which whatever is on one’s mind about nursing takes center stage. Some nights, there is a grab bag of both good and bad, but more importantly, there is always a positive point that can be taken from every single comment.

MacLean: Nursing Salons have given me clarity about school, life, priorities, and my future. I have found support, friendship, and community at Nursing Salons. Other nurses and nursing students who have attended have offered practical advice about school, internships, taking the National Council Licensing Examination (NCLEX), and even finding a job. I have also found great nurses to network with, and I was even able to shadow a nurse during her shift. The connections I have made both personally and professionally have had a significant impact on my life as a student nurse.

Theisen: Recently, I divulged how stressful it is to know that I will be graduating in less than one year and am unsure of where and how my new journey will begin. I cherished the advice that echoed around the room from all the nurses when multiple ideas were proposed to help form connections. I had not previously thought of the ideas given that might facilitate the goals I would like to accomplish as I make the transition from student nurse to registered nurse. How lucky was I to have this support and gain real-life advice from nurses whom I might be working with one day?

MacLean: Nursing Salons have opened my eyes to a whole new community of people who are as excited about nursing as I am. The gatherings are a refreshing way to share what really is on your mind about nursing—to find community, friendship, and support. As graduation inches closer, I can go forward with confidence that my experiences at the Nursing Salons make me see nurses, myself, and my future career in a new light.

Theisen: I know that attending Nursing Salons has not only enriched me as a student nurse but has made me more aware of issues within the larger nursing profession. I feel that I have become more aware of what is currently happening in the world and how this will impact my nursing practice. After I graduate, I know there will be bumps in the road, but no matter what direction my nursing journey will take, I know I will walk it successfully and accomplish so many great things. I can walk the journey successfully because I know I have the support of many nurses I have met through Nursing Salons, and that to me is exciting.

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BOOK REVIEW

The Real Wealth of Nations: Creating a Caring Economics

Riane Eisler’s 30 years of research in evolutionary systems science led to her 11th book, The Real Wealth of Nations: Creating a Caring Economics. Because Eisler is not an economist by training, she offers a broader societal lens for economics. She views caring for and developing human resources as an essential and fundamental component of any economic system. Eisler uses economic systems in the United States and around the world as examples of positive and negative economic factors. Reading her book with an open imaginative mind allows the reader to discover a new and improved economic system.

Eisler presents a partnership approach to an economic structure that includes a society in which caring for others is valued. She shows how caring for children and the sick leads to increased productivity and increased economic development in the society. This type of society recognizes that wealth is found among human and natural resources rather than solely financial. To nurture a people of caring and compassion requires recognition that neither socialism nor capitalism has resulted in the promotion of human welfare and happiness. These economic systems have led to environmental degradation, poverty (20% of children in the United States live in poverty), violence, and gender inequality within their societies. Women around the world are devalued, earn less than men, and are taught to serve men. In female-dominated professions, salaries are generally lower than in male-dominated professions. A problem with capitalism in the United States is that the wealthiest 1%, whose spending patterns are described by Eisler as wasteful, owns 40% of the nation’s wealth.

Traditional economics studies the market economy, the government economy, the unpaid (volunteer) economy, the illegal (drugs, arms trade, sex trade) economy, the household economy, and the natural economy. The caring view of economics is broader and also includes societal values such as respect, compassion, and caring. Instead of child care workers and nurses receiving low wages compared with many other careers, in a caring economy these services would be compensated as befits their importance to the society in supporting human survival and development. Universal health care, paid parental leave, and flexible work hours would also be valued because these benefits serve to develop society.

A shift from a dominator model (control, decreased trust, a top-down approach) to a partnership model would include cultural attitudes that value caregiving, a change in economic indicators, and partnership in which caring and nurturing are the motivators. This partnership model uses relational dynamics to realize the highest human potential instead of viewing economics solely from a profit model. The concept of time dollars represents a partnership within a community.
to provide care to those in need, in return for discounts on food or health care. Thirty-six U.S. states as well as several other countries have implemented time dollars.

Eisler focuses on the global economy, in which business owners demand productivity. Yet, no society could live without caring for the children and the sick and older people. Eisler uses Finland as an example of a caring nation that incorporates partnerships into educating its children, who perform better on measurements of literacy and math skills than their counterparts in the United States.

Several U.S. companies offer their employees unlimited sick days, exercise facilities, and paid health care and have achieved economic growth because of decreased turnover and decreased absenteeism. Telework, flexible and affordable child care, and parental leave also have been shown to lead to more productivity and happier workers. Beyond the workplace, society also realizes benefits of decreased violence, decreased child abuse, and decreased costs of health care.

The relationship between gender, politics, and economics is woven throughout Eisler’s book. Rigid domination, as in Germany under Hitler and Russia under Stalin, does not lead to happiness, health, or economic success. Nurses may wonder if a partnership society could exist. The Nordic nations are closest to this model, with less top-down power, women well represented in political positions, and better educational and health outcomes. If we set as a goal making a partnership economic system a reality, eventually our culture could be changed.

Reviewed by Robin Squellati, MSN, APRN

Instead of child care workers and nurses receiving low wages compared with many other careers, in a caring economy, these services would be compensated as befits their importance to the society in supporting human survival and development.

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