In Someone Else's Shoes

An experience of psychiatric nursing

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The relatively rigid structures of the medical and nursing professions hamper the development of an adequate mutual understanding of the experiences and contributions of each in the care of patients. It is not uncommon for medical staff in psychiatric institutions to be patronising in their attitudes to work done by nurses; and vice versa. McGuire, in her submission to the Report of the Royal Commission on the NHS (1979) commented that "decisions made by nurses may go unrecognised by doctors and even by nurses themselves".[1] Such failure to recognise decisions is symptomatic of an underestimation of the role of nurses in general.

Much useful therapy is done in the 'milieu' and doctors often fail to notice this, partly because they are occupied elsewhere with other responsibilities. Nurses become skilled in their use of the informal time with patients because they spend so much of their working day in their presence, but this is not without emotional cost. For example, the skilful handling of confrontation is potentially very helpful for patients but emotionally stressful for staff.

When working as an honorary senior registrar on secondment to the adolescent unit at Hill End Hospital, St Albans, I had the opportunity to find out more about the nurses' experience. I chose to spend three weeks working in the role of nurse, primarily because I wanted to have more face to face contact with the adolescents. I had been finding that, because of other commitments, time spent with the adolescents was being limited to formal group meetings and I wondered if in some ways this might be less stressful contact. I gave up my responsibilities as a doctor entirely and worked on three nursing shifts under the leadership of different charge nurses.

The job

My nursing responsibilities included getting the adolescents up in the morning, serving meals, supervising the performance of chores such as bed-making, tidying rooms and dishwashing, helping to lead groups and just being with the adolescents in the unstructured times. High standards of behaviour were expected of the adolescents, even though many had a history of violent behaviour towards parents, siblings or teachers. Punctuality at meals and group meetings was expected, as were reasonable table manners. Smoking and swearing were not permitted. Constructive handling of anger was encouraged but any manifestation of violence was immediately confronted in a special extra group meeting.[2] Staff sought to support adolescents who were upset and only in such meetings could a staff decision to exclude an adolescent from the group be made.

Change in status

Some of the nurses apparently trusted me in my new role right from the start. They seemed to make the assumption that if I was a doctor I could automatically do a nurse's job. I did not feel this to be the case and other nurses, probably sensing this, took longer to let me have responsibility.

Adolescents were somewhat confused about my role and increasingly dropped the title 'doctor' when addressing me. I was not aware of feeling any more threatened by this partial loss of status but had I spent longer in the role of nurse the dilution of power from this effect might have been more significant. As it was, too many of the adolescents had known me in the role of doctor prior to my changing roles. There was, however, ample opportunity for adolescents to test limits and I found my personal authority challenged in many ways.

Skills learned and developed

I observed and learned to use different ways of handling challenge and resistance. Nursing staff used paradox and humour to good effect and their example stimulated creativity in my own use of authority. At times I overlooked apparently insignificant challenges to authority but, seeing the resulting escalation of dangerous behaviour, learned to lower my threshold of tolerance and to confront earlier. Perhaps an inevitable consequence of this was that I sometimes challenged relatively innocent behaviour. However, the forum of the extra meeting always provided the opportunity to weigh up concerns with other staff before deciding what further action, if any, was appropriate. I learned much from the nurses about how to discern the essential issues and how to avoid being punitive.

Adolescents had the right to see what was written about them in reports and so entries in the nursing cardex were generally written in their presence. This was my first experience of patients having access to notes and I found it a valuable discipline. It forced me to try to use language that, although not avoiding the essential confrontation, was not unnecessarily judgemental or offensive. This is a skill which I will want to develop and use more in future.

Different emotional experiences

All staff on the shifts had coffee with the adolescents. The only break during the eight and a half hour shift was a half hour meal break. In general doctors do not experience the stress of constant exposure to patients because they can more easily get 'time out' from particular patients. Nurses

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have little choice but to face them, especially if the ratio of patients to nurses is high.

I experienced the group process which continues after the formal sessions end and doctors go home. Feelings not resolved earlier had to be coped with throughout the evening. I lived with hostility directed my way for sustained periods and experienced the emotional cost of confrontation when it is not possible to 'escape' for hours. Consequently I found myself becoming more angry with patients than I had as a doctor and found it harder to be objective about what was going on.

I enjoyed playing various games and having informal conversations with the adolescents, getting to know them better in the process. I got closer to them and felt fonder of them than I would have in the doctor role; but I had to put more effort into maintaining the balance between a professional and more personal relationship. I was quite surprised by the stress that the less formal boundary brought and took time to adjust to it. The opportunity that nurses have to form closer relationships with patients may have therapeutic potential but the inherent stress of such closeness should not be minimised.

I learned what it was like to be on the receiving end of telephone consultations with someone outside the 'system' which helped clarify the issues at stake. This different perspective on what is usually my role heightened my awareness of the value of the consultation process.

Conclusion

I experienced a different type of contact with patients and learned much that will be useful to me. My understanding of what nurses do has, I hope, increased and I am grateful to the nursing staff who made the experience possible. At times I felt jealous of their skill. It is relatively easy to speak of the importance of 'the complementary role' of the nurse in patient care but when the work that nurses do comes closer to what doctors do, it is hard not to feel threatened. If doctors allow themselves to be threatened, they and their teams will be the losers. Would that a nurse could be a doctor.

REFERENCES

[1] *Report of the Royal Commission on the NHS* (1979). London: HMSO.

[2] O'BRIAN, C., BRUGGEN, P. & DUNNE, C. (1985) Extra meetings: a tool for decisions and therapy. *Journal of Adolescence*, **8**, 255–261.

Audio-Visual Aids to Teaching

Videotape Reviews

Self Esteem and Personal Safety (UK, 1986, 55 mins)

Sexual abuse in children is a common problem. The Department of Psychological Medicine at Great Ormond Street Hospital, London, have developed a treatment approach based on six sessions of small group work with sexually abused young children. It is evident that they have considerable experience and have produced a training package to help other professionals working in this field. The package consists of a video, detailed manual and flashcards. The video begins with a brief introduction to the whole subject. The major portion of the tape is given over to clinical illustrations from sessions and these are briefly commented on. The tape shows the children progressing and the staff coping with problems such as shyness. At the end of the tape there is a discussion between the presenter (Dr E. Vizard) and Dr A. Bentovim about the project and its successes, failures and limitations. They also discuss how the group work fits in with other treatment strategies.

The videotape does not recap on information covered in the handout, and assumes the viewer has read it first. The tape and handout are successful in presenting other workers with their views and advice for setting up a similar scheme. The package would be of value to child guidance clinics and child psychiatry departments. The tape was not designed or intended to comprehensively convey information on child sexual abuse, thus it is not really suitable for medical students.

The presenter notes that video recording is an integral part of the sessions, indeed we see the children use it for video feedback. It appears that this programme was made as a result of requests to the department: the clinical recordings were not originally made for the video programme. As a consequence, we are asked to accept the poor quality of the recording. Even allowing for the limitations imposed by the clinical situation the camerawork could have been much better. In addition, no serious thought appears to have been given to recording the presenter and the discussion at the end of the tape.

In summary, a video about an important subject which has been let down by poor technical presentation. The overall impression is very disappointing.

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