A conversation with Theresa Brown

Clinical Café is pleased to announce the latest in a series of conversations with newsmakers in the field of patient safety and quality. We spoke recently with Theresa Brown, RN, a hospital nurse and author who lives and works in the Pittsburgh, PA area. A former Tufts University English professor, she decided to become a nurse mid-career. Brown is a regular contributor to the *New York Times* blog "Well." Her book, "Critical Care: A New Nurse Faces Death, Life and Everything in Between," was published in June 2010.

Here are excerpts of our conversation:

Clinical Café: You talk in the book how as a new nurse you experienced disruptive clinician behavior and you mentioned the phrase, "Nurses eat their young." Have you seen disruptive behavior directly affect patient safety?

Brown: I have not seen a situation in which one nurse got yelled at and was so upset she gave a patient the wrong drug, or forgot to do something really important, but the feeling I had when I was in that environment where there was a lot of bullying was that it was an unsafe environment. That was because it took up so much of my energy worrying about who was going to be attacking me next, and what they were going to say, and I worried a lot about accidents. It also creates a situation where you don't feel safe to ask questions. For a new nurse to feel like she is not going to ask how to do something because someone is going to yell at her and humiliate her, so she's just going to make her best guess, that's a terrible environment to have nurses be starting out in.

Clinical Café: That seems to seriously undermine any effort to create a culture of safety.

Brown: The reality is that the nurse who asks a lot of questions can be looked down on and criticized and people may look on it as a check on her competence, like, "How does she not know *that*?" and I'm the kind of person who often thinks out loud, so even now I just like to think it through, and if you're that kind of person, people can often be harder on you. Thinking things through out loud in nursing isn't looked well on. I feel like I'm being too general – these are just things I've seen, so I wouldn't say it's all of nursing. But I've seen where communication really breaks down.

Clinical Café: Speaking about communication, you have blogged about communication barriers between physicians and nurses.

Brown: The thing that's missing from our education is we don't get educated about how to talk to doctors, and it can only take a few unreceptive doctors for a nurse to feel like, "Why am I trying to do this?" or if the nurse really takes a stand and the doctor doesn't agree with her, then

that can make it harder the next time. We're not taught that things in healthcare can be a negotiation. I might have an opinion about something, and the doctor might have an opinion about something, and we're not taught how to press and keep that conversation going until you're satisfied with the treatment decision. Nursing schools really need to talk to nurses about how to talk to doctors, and probably medical schools should teach doctors how to talk to nurses. Both groups come in and our communication is so important and yet there is no training or experience in how we should communicate with each other.

> **"Bullying thrives only because people collude with it . . . I did not want to work with people who would let a nurse be so cruel to one of our own, and on this floor it happened over and over again. Public humiliation by senior staff, and especially the two clinicians, was so common it was considered normal."**
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> ***-- Excerpt from* Critical Care*, by Theresa Brown***

Clinical Café: In your blog on the topic communication you mentioned how you proposed to a physician a course of treatment and came to realize later that your suggestion could have harmed your patient. Even though there was no adverse event, you seemed to be deeply affected by that event.

Brown: That's the fear that we live with because we're supposed to be the final check and then to think that I suggested something that could have been really dangerous for my patient, it's really like a violation of all of our training and why we're supposed to be there. I think nurses just live in fear of making med errors because we're taught so much how important it is to be careful. And in the nursing culture there's a lot of conversation about that issue. It's really a part of what we're going over with each other. It's good for me to remember that I'm not just giving patients their pills, but I'm also making sure what we're doing is safe.

Clinical Café: A few chapters in your book focus on your exchanges with your patients' families. Staying on the topic of communication, why aren't caregivers better listeners?

Brown: Unfortunately, we've created a system where everyone has a little bit more to do then they really can do in the time available, and it takes time to sit and listen to someone. Oftentimes, people are just in a hurry. Also, it can be very difficult dealing with families where they're suspicious of everything we are doing for the patient. It's exhausting to deal with people like that, because most of us are trying to do our best. I look at it as that the doctors and nurses are supposed to be the adults in this situation, [the good communicators], but people are human, and can get irritated and frustrated, and then there can be a true breakdown in communication, where one side is just not hearing the other. But for the day-to-day stuff, I would say just time pressure, unfortunately. That's a sad answer but I think it's true.

Clinical Café: Last fall you had the opportunity to meet President Obama as part of one of his scheduled appearances to promote Healthcare Reform. The components of safer and better

care haven't gotten as much attention as the issues of access and payment mechanisms amid the massive debate about Healthcare Reform. Why is that?

Brown: That's a good point. Safety is not given the level of attention it deserves and is not looked at as seriously as it should be. I think people aren't aware how important it is and what it means, maybe because it's scary to the general public to ask, "Hospitals are unsafe?" It's easier to focus on access or whatever else, than to actually contemplate what a chaotic system most hospitals are, and that there is a constant struggle to be safe at all times. It's really not what people want to hear in America with our healthcare system. I just finished Atul Gawande's book, The Checklist Manifesto and it's amazing why every hospital in the country isn't just embracing it. That's just a puzzle to me.

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Clinical Café: You recently wrote an op-ed piece in the New York Times nurse staffing ratios. That's a topic you obviously feel strongly about.

Brown: I wrote about the new data that showed that once you get above a certain number of patients per nurse, patient mortality really goes up. Linda Aiken at the University of Pennsylvania did the research. Her data has been out for a long time, and again, it's right there, it's obvious, the percentages are big, and it just seems that anyone who would look at that would say that we have to do this because it's the right thing to do. I'm sure a lot of it comes down to cost and nurse staffing, but it seems that it's such common sense and I myself feel frustrated that it doesn't get embraced.

(Brown is on Twitter as @TheresaBrown. Her Website is www.theresabrownrn.com. Watch for the next installment in the series of Clinical Café conversations with patient safety and quality leaders. If you'd like to suggest someone we should interview, or a topic we should cover, email me at jnovack@quantros.com. If you're not a member yet of Clinical Café, go online to www.clinicalcafe.com and click on the "Join Now" link. If you'd like to discuss this Q&A with your peers, go online to Clinical Café and post a comment in the Knowledge Share section.)