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Tender loving care is back in nursing

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takes the responsibility for inspecting the results, one of the best diagnostic products of the human body. A nurse's aide, for instance, might just shove the thing under a patient, then empty it without looking."

According to Manthey, a primary nurse won't find herself overextended because she is responsible for the care of only four to seven patients.

However, a smaller patient assignment isn't a luxurious, restful situation. Aside from doing all the tasks for her patients, the nurse is accountable for a plan of care for each of her patients 24 hours a day, seven days a week. She is assisted in her off hours by an associate primary nurse, usually another registered nurse or licensed practical nurse (with additional certification in pharmacology), who carries out the primary nurse's instructions and informs her if problems arise.

"It's not like picking up her tools at 7, and putting them away at 3," Schaffrath says.

BECAUSE OF this new accountability, the primary nurse has a more dominant role in the hospital. She works with the physician in planning the care of a patient.

And with this closer partnership, Manthey insists that the name of the primary nurse be put on the front of each patient's chart — right next to the name of the attending physician. "The women's movement lent impetus to that," explains Manthey. "It means recognition and power."

Carol Davis, a young registered nurse, has her name on the charts of four patients as she reports for work on the 10th floor at Rush-Presbyterian-St. Luke's Medical Center.

Another nurse, Janet Brose, hands Davis the charts and gives her detailed progress reports on each patient.

"This is such a liberating thing," Davis says about her name on the charts. "Nurses used to be so anonymous."

Brose Tells Davis who's depressed, who was transferred, who had visitors and who they were, who keeps asking questions, who received what medications, who needs assistance going to the bathroom, who didn't sleep last night, who had a bowel movement, who was alert and feeding himself, and on and on.

"Charlotte Johnson in 1003 has been kicking up quite a fuss," Brose says, completing her report. "I think she's lonesome."

Davis, 30, nods and heads down the hall for 1003. En route she hears the squealing of Mrs. Johnson, 86, who is recovering from a stroke. As soon as Davis enters her room, she bends over the frail, white-haired woman, takes her hands, and asks softly, "Charlotte, what's the matter?"

"I WANT TO go home," Mrs. Johnson says.

"Well, you have to get better first," the nurse says.

"I wish my daughter was here," Mrs. Johnson says. "I've got to have somebody to talk to. Can you stay with me?"

An understanding Davis smiles. "I'll stay as long as I can, Charlotte," she answers. "I'll take care of you."

Mrs. Johnson's wrinkled face comes alive as Davis assures her that her daughter and granddaughter are coming to visit in a few hours. Then the nurse dries the patient's tears, helps her sit up, combs her hair, and talks to her.

DAVIS TAKES Mrs. Johnson's blood pressure before moving on to the patient in the next bed. "Mrs. Santini likes a pillow under her right shoulder as she sleeps," Davis whispers. "She broke her shoulder and hit her head when she fell at home in the shower."

Out in the hospital corridor, it's calm and peaceful, even though it's midafternoon. Only a few registered nurses are padding about. One imagines that with the assembly line nursing there must be a beehive of activity with the nurses and all their aides weaving their way past each other to get to patients' rooms.

"Yes, the noise is greatly reduced," Davis agrees.

On her way to the medicine room, Davis talks to a middle-aged woman who is suspected of having a heart malfunction. Davis takes her time counseling the patient. There's no point in worrying, she says, until lab tests have confirmed the diagnosis.

LIKE THE family doctor of long ago who looked at Grandma's sore toe or Sissy's cut finger, Davis provides plenty of warmth and sympathy.

"It's the laying on of hands," says Davis. "This is *real* nursing." Her views echo the sentiments of about 40 nurses who were interviewed at random at various hospitals.

It took Davis 10 years to learn what being a registered nurse really meant. Until primary nursing, she didn't know the difference. She studied assembly line nursing when she was a student at Rush-Presbyterian-St. Luke's School of Nursing. And when she was graduated, she became a "foreman" at the hospital.

"I was the kingpin who cracked a whip over a crew of people who were unskilled, making sure they got their tasks done," Davis recalls. "That kept me running around like a chicken without a head."

SHE MANAGED about a dozen or more aides, assigning them to various tasks for 25 to 45 patients. Davis made sure the chores were completed on schedule and recorded on patients' charts, and that her workers went to lunch and returned on time.

Having her own "team" was unheard of. Her aides, like chessmen, were constantly shifted around to other registered nurses, new patients, new units, and new tasks. She didn't have time to get to know her helpers and their abilities.

Furthermore, she had no time for interacting with patients except at pill time. "We were caught in a system that put procedures ahead of patients' needs," Davis says. "Nursing didn't have much of a human face; yet none of us knew how to correct that."

The result of such frustration was a turnover rate of registered nurses at Rush-Presbyterian-St. Luke's of 48.7 per cent each year, and recruitment was very difficult, according to Dr. Luther Christman, the hospital's vice president of nursing.

"NURSES DIDN'T like being beset with administrative chores and paperwork," he says. "They didn't like transmitting their competency to less skilled people."

Christman became involved in the hospital's nursing quagmire when he went to work there in 1972.

"Everyone was greatly dismayed at the high transiency of nurses," he recalls. "My job was to sort through all the confusion and take some bold new actions to correct the situation."

Like Manthey, he felt the switch to primary nursing would reverse the trend. He started the system in four units in 1972, while the rest of the hospital adopted a "wait-and-see attitude." The plan proved successful; so all units changed over by 1973.

"MOST NURSES were enthusiastic about the change," Christman says. "But a few, who were too accustomed to the assembly line method, left."

Christman believes he has created a working environment in which his nurses can thrive. "The nurses discovered that by giving primary nursing care, they can reverse the dehumanizing experience of institutionalization," he says. "They can treat the patients as guests in their professional homes. As a result, we find that all staff members now take a new pride in their work. They realize they are growing and developing and that they have a level of job satisfaction they never had before."

Since the change, the turnover rate has fallen to 29.1 per cent, and those nurses are leaving for "normal reasons," like childbearing, Christman says.

"Primary nursing, as it turns out, is a great recruitment tool," Christman says. "We're getting 10 times the number of job applications for each available position — that despite the nursing shortage."

THERE ARE now 897 registered nurses at the hospital compared to the 400 or so before the primary nursing period.

The new system also uses the head nurse better; her job previously was attending meetings, ordering supplies for a unit, receiving and transcribing physicians' orders, and making rounds with individual attending physicians. She is still the "problem solver," but she turns over her nonnursing tasks to a "unit manager," a trained lay person.

The new system doesn't mean higher hospital costs. "Actually, it saves us money," Christman says. "I figure we were paying a whole bunch of aides about $4 an hour, compared with the average $6 an hour we were paying nurses. The aides' salaries in the medical budget now go to the new nurses." Nurses' salaries, however, have not increased with the added responsibilities of primary nursing: The average salary is still $12,000 a year.

Dr. Joseph Muenster, a senior attending physician in the hospital's cardiology department, recalls the assembly line days. "You know that old expression, 'That's not my job'? Well, I heard that so many times. I remember almost tearing my hair out because I couldn't find which nurse was in charge of my patients. After all, her name wasn't on any chart. So first I'd go from aide to aide, then from nurse to nurse, only to be told, 'Sorry, he's not my patient.' Then, I'd try to seek out the head nurse who, by the way, was always at a meeting. Finally, I'd end up walking up to the nurse's station and saying, 'Does anybody work here?' "

MUENSTER, WHO has been a physician at the hospital for 24 years, now sees the nurse as "just like me, because she has accountability. That makes her more of a colleague instead of just a nursemaid or body servant."

Some nurses, however, are finding that accountability hard to accept, Manthey says.

"Primary nursing brings all the risky and scary elements of the women's movement into a nurse's professional life. It means she accepts responsibility for being a decisionmaker and that she will live with the results of her nursing practice," Manthey says. "Some nurses don't have the self-confidence for such a radical change in roles. They feel, 'Gee, that's an awful lot of responsibility. Do I know enough to handle it?' They're also terrified of what will happen if they make a mistake."

"Some nurses prefer the perfect anonymity they have with the other system of nursing," adds Rita Froelich, vice president of nursing at Grant Hospital, which plans to experiment with primary nursing in some units. "Some nurses don't like the idea that the buck stops with them. Some would rather direct other people to do the tasks, thereby diffusing the accountability."

FURTHERMORE, Froelich suggests that some nurses may find that exposure to the same patients day after day is "boring" or "like being married." Or some nurses, particularly if they have acutely ill or dying patients, may feel "so emotionally drained that it's hard for them to be objective," she adds.

"Some nurses protect themselves from getting involved with their patients by coming across as sterile but very efficient nurses," Froelich says.

But most nurses are like Carol Davis, who went into the nursing profession because they wanted to help sick people.

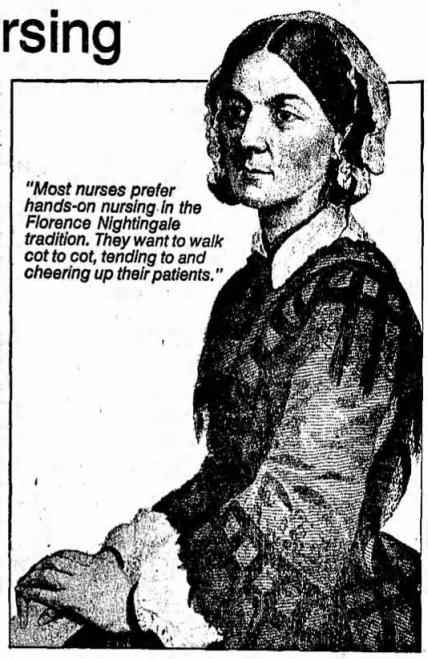
"I remember I was hit pretty hard when a leukemia patient of mine died," Davis recalls. "For two months, I had been his primary nurse. And during his last few days, I sat in his room, trying to do what I could for him and his grieving family.

"I WOULDN'T have had the time to do that in assembly line nursing," she adds. "He would have been known simply as 'the dying man in 1007,' and he would have died with his family at his side and that would have been it.

"My presence was a comfort to him and his family. I can still hear the family's words of gratitude that I cared for him as if he were my own father.

"We're not just dealing with inert lumps of flesh that hurt," Davis says. "We're dealing with people's emotional well-being, too. And that's what makes nursing exciting again."

"Registered nurses have become faceless people, and it's the system's fault," says Marie Manthey. "Nurses are supposed to be in the thick of things."



"Most nurses prefer hands-on nursing in the Florence Nightingale tradition. They want to walk cot to cot, tending to and cheering up their patients."

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