

## **AS IF YOU KNEW HIS NAME...**

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**I**n healthcare, compassion fatigue is eradicating our passionate drive for innovation in nursing. According to Patricia Smith, "...caregivers struggle to function in care giving environments that constantly present heart wrenching, emotional challenges. Affecting positive change in society, a mission so vital to those passionate about caring for others, is perceived as elusive, if not impossible" (Smith, 2009). America's healthcare environments are inundated with barriers that prevent meaningful advances in care management. The Robert Wood Johnson Foundation cites that 1 of 5 elderly patients return to the hospital before thirty days, and "readmissions for Medicare patients alone costs \$26 billion annually" (Robert Wood Johnson Foundation, 2013). Add to this the issues of mismanagement, competition, rising costs, increase in patients who do not pay, and a nursing shortage that is quickly escalating and the end result of such frustrating challenges causes negativity and defeat within the workplace (Glabman, 2003).

Nurses across the spectrum of care strive to complete their work without incurring overtime, keeping up with the demands of their job in terms of reflecting quality, and maintaining their personal standards and art of giving care. Nurses are so busy trying to get through their day that they have little time for innovations or perspectives that could improve quality, increase efficiencies, and help to meet the goals and benchmarks of their care facilities. This environment is ripe for innovations that can and should be driven by nurses. Providing nurses with an environment that nurtures their commitment to quality and drive for improvements can produce the magic of innovation and possibly help nurses remember why they do what they do.

What comes to mind is one particular event that not only allowed me to be innovative, but also reminded me that I am not "employed" as a nurse, it is my "calling". It was early in my shift in the ED when the squawk of the radio disturbed the morning's routine with the heralding of an incoming patient. "Unidentified male, in his 50s, was found lying in a snow bank surrounded by empty beer cans. He tried to bite us so we are just scooping him up and bringing him in." was reported by the Emergency Medical Technicians (EMTs).

That particular day I was being shadowed by two nursing students who were doing their critical care rotation. As it turned out, this would be serendipitous, as I would depend on their presence and help greatly in the hours ahead.

The patient was brought into a treatment room that boasted no great amount of space or technological equipment which could be used to treat a critically ill patient. The expectation would be that this was "just another drunk homeless guy" and there was no great cry of alarm. As we transferred this man from the gurney to our stretcher his arm brushed my arm. I was amazed at how cold he felt. He looked as you would expect him to, disheveled and soaked with melted snow and probably other fluids. He was not really conscious except for the occasional groan and I did not know his name.

The EMT's left and the students and I quickly stripped him of his cold wet clothing. While turning him to accomplish this we were able to obtain a rectal temperature. Amazingly, the device read 82 degrees Fahrenheit. Since this matched my clinical assessment, I assumed it was correct. The medic's

assessment showed a change in mental status and the cause seemed apparent. The fact remains that transporting him lying flat as quickly as they did was the best thing for the patient according to hypothermia protocols (Journal of the American Medical Association, 1997). They never knew his name.

I immediately yelled for a doctor, the first sign to the students that the situation was critical. My colleague Dr. Sochat, who teaches and supports nurses, poked his head around the corner. He smiled and asked “You rang?” I reported the core body temperature and all humor drained from his face. By now, we had this man in a hospital gown and quickly moved him into a cardiac/trauma room as carefully as possible.

Severe hypothermia causes cardiac instability and the last thing that we wanted was for our patient to go into cardiac arrest. Hypothermic cardiac tissue is not easily defibrillated and will not respond to Advanced Cardiac Life Support (ACLS) interventions. To be forced to initiate ACLS protocols before properly warming the patient can be futile and cost the patient his life, I had to get this patient’s core body temperature to at least 86 degrees Fahrenheit. The clock was indeed ticking.

The students and I used warmed saline infusing through an intravenous (IV) device. In addition, with a sheet over his skin, warm bags of saline were placed on his groins and arm pits, warming blankets were placed under and over him, and the patient was quickly intubated and ventilated with warm humidified air. All was completed in a short time but the best result we could achieve was not impressive at all.

We were losing the battle, and Dr. Sochat was trying to make arrangements to take the patient to the cardiovascular operating room (OR) to place him on the bypass machine. This would allow us to warm the blood more quickly.

In preparation for the OR we placed a nasogastric tube in this patient. Which when attached to suction it drained 400 ml of gastric blood. This man had a gastrointestinal (GI) bleed (common in alcoholics) and would not be able to utilize the bypass machine as the blood thinners needed would cause him to bleed to death.

Left without any other standard options, I had to use my “Yankee ingenuity” to tip the scale in the patient’s favor. Thinking quickly, we decided to insert a 3-way catheter into his bladder rather than the basic urine draining catheter that most critical care patients use. Using this specific catheter allowed us to irrigate the bladder with warmed sterile saline furthering our efforts to warm the patient.

The problem was that these two pieces of equipment were not meant to work together. We were forced to create a connection, under sterile conditions, that would work for this application. Using various components within the trauma room we were successful in utilizing this warming method and after obtaining Dr. Sochat’s approval, we began to irrigate the warmed fluid through the bladder. The patient’s temperature began to climb more quickly.

I worked an eight hour shift that day with six of those hours caring for this man. By the time my team of students and I left for the day we had warmed the patient to 94 degrees Fahrenheit. We transferred him to the Intensive Care Unit (ICU). On my drive home I could not stop thinking about this man. He clearly had severe frost bite on both his feet and most likely would lose them. I wondered about his fate, and what his life would be like? I still didn’t know his name.

I came back to work the next day and a police officer assigned to this man’s case showed up early in the shift. He asked to speak with us and we stepped into the same room where I treated this man the day before. The officer told me the patient’s story and his name.

The man was a surgeon from a Texas trauma center. He was called to the OR one evening for a particularly gruesome multi car pile-up on a highway near the trauma center. They brought in many

victims that night, some of them unidentifiable and requiring surgical interventions. He saved all but one. The one patient he did not save turned out to be a young pregnant woman in her second trimester of pregnancy. I can only assume he did not know the patient's name.

It was not until the next morning when he arrived home, exhausted, only to realize his young pregnant wife was not there. Then, the hospital identified the one non-surviving victim as the surgeon's wife. The doctor was not able to handle his tragedy, too overcome with grief, he moved back to New Hampshire where he had family and descended into alcoholism. Eventually, he ended up in our ER and was now upstairs in the ICU where his family was finally reunited with him.

I often wonder if this man had known the name of his patient, what he would have done differently. If he had known this was his wife, would he have done something more, anything more to know that he had done all that he could. If unable to save her life, then perhaps knowing he had done everything, would that have saved his life? Would it have made a difference if he felt that he did everything in his power to save her?

This difficult and complex case and the story behind it proved that every patient is worthy of our best and most creative efforts. That perhaps by allowing compassion fatigue to convince us it is not "worth it" we miss the opportunity to appreciate the worth of always giving our best care. In the larger picture, it is not our place to judge who is worthy of the care we give, but simply to give care to the best of our ability.

Caring for others is a deeply personal commitment that nurses do not take lightly. Affecting positive change in others' lives will always be challenging. To prevent compassion fatigue from robbing you of innovative inspiration nurses should rejoice in the differences that we do make. Recall and celebrate those times when steps forward were attained. Look deeper, see more and through your caring heart, you will value the importance of the life before you and of the life you lead.

No matter how small an act of caring may seem, no matter how insignificant you perceive it to be, give your best to provide care with respect, innovative knowledge, and the same passion you might use as if you knew his name. ■

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