
BEDSIDE MANNERS

Play and Workbook

**SUZANNE GORDON, LISA HAYES,
and SCOTT REEVES**

Foreword by Lucian L. Leape, MD

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Introduction

Suzanne Gordon

The play *Bedside Manners* began with a conversation on an airplane. Almost ten years ago, I was flying to Seattle to give a lecture and began what I thought would be a casual chat with my seatmate. The young woman sitting next to me was a pediatric resident at Boston Children's Hospital. Along with dozens of other pediatricians on the plane, she was traveling to a national meeting in Seattle. When I told her that I wrote about nursing and health care, we launched into what became a cross-country discussion about team relationships.

She was in her second year of residency and confided that she knew nothing about what nurses did. Her medical school instruction, she told me, included next to nothing about nursing—apart from the fact that doctors “gave orders” to nurses. It certainly had no lessons about teamwork. She had little knowledge about nurses’ work or contributions and had absolutely no idea about the nursing hierarchy or nursing education. What was the difference between an LPN, RN, NP, and a host of other alphabet-soup titles, she wondered? How many shifts or hours did nurses work? When was shift change? Who was in charge of nurses? These were all mysteries to her.

She explained that in her residency program some attendings advised her to make a point of talking to nurses because they had valuable information to share. These doctors made a habit of talking to nurses before and after seeing a patient or patient's family and debriefed with nurses after their visits. Others did the precise opposite—limiting their contact to the brusque barking of orders and disappearing from the scene. In the “see one, do one, teach one” structure of the medical apprenticeship, it was pure serendipity which model of interprofessional relationship a student observed. She added that there was no mention of interprofessional teamwork in any part of her training. To doctors, the “team” constituted only other physicians or physicians-in-training. Ditto for the word “colleague.”

I explained my view of nursing and interprofessional teamwork and the importance of both. She seemed eager to learn more. I asked her if she thought residents would be interested in learning more about nursing and other members of the health care team, “Yes, absolutely,” she replied.

How could such lessons be conveyed, I wondered out loud. “Well,” she said, “the thing that had the most impact on us in medical school and our initial year of residency training was when real people would come and talk to us about real dilemmas. For example, it has been very valuable to hear parents come and talk to us about what it’s like to get bad news about a child’s illness.”

How would doctors react to nurses talking about the sometimes parlous state of doctor-nurse relationships or even what it means to nurses when doctors and nurses work well together? I considered. What would it mean to have other members of the health care team talk about their problems and concerns in an interprofessional group? Would nurses or other “lower status” team members be fearful of talking about their concerns because they might be accused of “doctor-bashing?” Nurses who are perfectly comfortable complaining about doctors’ bad behavior would hardly be happy about discussing their sometimes passive-aggressive treatment of their physician colleagues. And would nurses be willing to reflect on how they treat colleagues under them—such as LPNs and aides?

Although I didn’t see much potential in such real-life conversations, the resident’s comments percolated in my head. How can we best convey real-life situations and consequences to a health care audience on a topic that is both critical and controversial? As I pondered this question, the solution occurred to me—use theater. Write a play about health care relationships, communication, and teamwork.

Once that question was answered, the next and more challenging one emerged. How do you write a play? I’m a journalist. I know how to write magazine articles, books, opinion pieces for newspapers, radio commentaries. But a play? Me? I love theater and have been going to serious plays since I was a child in New York City. My place, however, has always been as a member of the audience and not as someone who produced the words enacted on stage.

This “how to” question seemed an insurmountable dilemma until several months later, when I went to an off-Broadway production in New York by the

playwright and actor Lisa Hayes. Hayes was acting in her one-woman show “Nurse,” about a nurses’ strike in Buffalo, New York. I was surprised to see that she’d used some lines from one of my books in the play. Emboldened by this, I approached her after the performance, congratulated her, and then blurted out, “Listen, do you think you might be interested in writing a play with me about doctor-nurse-team relationships? I know we just met, so feel free to say no. But might you consider it?”

To my surprise, she instantly replied, “I’d love to.”

“Great,” I said. “Let’s talk on the phone soon.”

I left the theater both delighted and convinced that this might one day happen. Then, about a month later, just as I was about to leave for a month-long trip to Australia, Lisa called to tell me she’d gotten a grant from the State University of New York at Buffalo. We were commissioned to write and produce our play on doctor-nurse relationships for Gender Week. We had a month and a half to write the script, get the actors, and perform the play. I was stunned. A month and a half? And I would be away for most of it. I sent Lisa all my taped interviews with physicians and nurses. She added her own research to the play and we actually finished it in time to perform it in September 2005.

Although the play was well received, that was only the beginning of the really hard work. Our job over the next several years was to write a play that addressed what we know is a very serious issue—poor communication on the health care team, particularly between its two largest professions—and to do it in a way that did not scapegoat or blame any group of professionals while simultaneously pointing toward some solutions. That took a lot of work.

In the final play, which took several more years to write, every scene is a dramatic rendition of a situation that actually happened. Some of the situations happened a decade or more ago. Some more recently. Some of its words are verbatim comments from nurses, doctors, and other health care professionals. In other instances, we have dramatized stories people have told us. The last and perhaps most powerful monologue has been included with the permission of the physician Stewart Massad, who wrote the story from which it was adapted, and by the *Journal of the American Medical Association* (JAMA), in which the story appeared.

Our goal in the play was to create a balanced work. In *Bedside Manners*, the reader will find people who communicate poorly and those who communicate well. Although the play focuses primarily on physicians and nurses and the acute-care hospital setting, we have tried to expand the cast of characters to include others on the health care team and to include other settings. As the safety literature documents, poor communication between members of the health care team is not simply an individual problem—a question of a few bad apples spoiling the barrel—but is rather a system problem that stems from how health care has historically developed. Although it is beyond the scope of this commentary to describe that historical development, suffice it to say that the problems of contemporary health care team relationships have a long history and are shaped not only by economics but also by gender, culture, religion, ethnicity, and many other factors.

Although our play is meant to stimulate discussion about health care teamwork and suggest ways that doctors, nurses, and others in health care can develop the skills necessary to create and sustain genuine interprofessional teams, it is primarily a work of theater. Its goal is to help those who work in health care approach a very hot topic in a way that is both interesting and even, dare I say it, fun.

Initially, *Bedside Manners* was performed by professional or amateur actors only. Increasingly, however, doctors, nurses, or other health care personnel or students in health professional schools who are in the institution or conference at which it is produced also act in the play along with several professional actors. We encourage this method of production because the very act of working together to rehearse and perform the play is, in itself, an exercise in teamwork. Our rule in rehearsals, which don't have to total more than a couple of hours before a performance, is that everyone is on a first-name basis and that everyone—no matter how high up in the health care hierarchy—graciously receives and accepts direction from whomever is directing the performance.

We have found that this exercise in teamwork pays off. Nurses who are used to taking orders from doctors and who may be more deferential suddenly witness chiefs of services being politely informed that they have to work on how to better deliver their lines. People separated by status hierarchies are flubbing their lines together, improving together, and then putting together a

performance that is usually very well received and that generates interesting conversations in which they take part.

We have been deeply impressed by what occurs when, for example, a chief of trauma surgery plays a nurse, and an ICU nurse plays a doctor.

One recent performance, done at a physician meeting in a community hospital system, is a case in point. We rehearsed and performed the play after several physicians involved in the patient safety movement gave a lecture to the group on patient safety and the importance of flattening the health care hierarchy. Several physicians in the group were clearly upset at this idea and made their objections known. Two of those physicians had been asked to be in the play. When I rehearsed with them, one of these physicians—who was playing a nurse—got furious. “I didn’t volunteer for this,” he said. “We have spent the whole morning doctor bashing and now here we are doing more!” he fumed.

I took a deep yoga breath and suggested that he might not find the play an exercise in “doctor-bashing” if he stood back and read it through. “You sound really angry,” I added. “The character you are playing is pretty angry too. Perhaps you could channel your anger into your performance,” I suggested.

We continued rehearsing, and he did just that. The next morning, his wife and daughter attended the performance along with his colleagues. When the actors took their bows, his colleagues congratulated him, and his family told him how proud they were of his work. He came up to me and exclaimed, “You know, I thought this was bullshit. I didn’t want to do it at all. But it was great fun. If you’re ever performing it again, I’d love to be in it.”

It has been amazing to watch the initial distance between cast members dissolve as they work together and feel satisfaction after the performance and postperformance discussion or workshop—particularly if everyone goes out for a celebration afterward.

In 2011, *Bedside Manners* was performed at the Institute for Healthcare Improvement (IHI) Patient Safety Executive Development Program. After performing in the play along with a surgeon in her large health care system, a nurse came up to me and told me how the surgeon’s behavior had changed after two one-hour rehearsals and the actual performance and talk-back. “I’m not sure he even knew my name before the play performance, but he did

afterward, and when we were talking and I called him Dr.—he said, ‘oh come on and call me by my first name.’”

Perhaps the most moving comment was made during the postperformance discussion when I asked the actors what it meant to them to be in the play. Dr. Mark Sand, a cardiothoracic surgeon and chief of staff at Florida’s Orlando Health, said movingly, “The play reinforces lessons we seem to have to learn over and over again. When we wound one another the wounds heal very slowly. When we invest in one another the rewards may come back for a lifetime. Someday, sometime, perhaps when we least expect it, we will all be patients. If for no other reason, we must unite with one another, at the bedside.”

To accompany the play and make it more user-friendly, Scott Reeves, Lisa Hayes, and I have also written a workbook, which explains the various ways it can be performed, how to mount a performance, and how to lead a discussion or workshop after the play is over. We also explain how to use the play as part of an interprofessional curriculum. Although some in our audiences have scoffed at such a “touchy feely” or unconventional way to present a serious issue, our experience has convinced us that theater is a useful tool to enhance teamwork, patient safety, and also to create more satisfying workplace relationships. Theater has been with humankind since almost the beginning of our history precisely because it is such a powerful tool. It can be used by those in health care who spend their days working with sick, frightened, anxious people, people who are, by definition, not at their best. Under the best of circumstances, their work is beyond difficult. Good communication and teamwork not only produces good patient outcomes; it helps health care professionals care for one another.

PART 1

BEDSIDE MANNERS
THE PLAY

CAST OF CHARACTERS

(in order of appearance)

Nurses 1, 2 and Doctors 1, 2: Of mixed ages and generations. Each actor plays several different nurses and doctors.

Leah Jones: Mid-to-late fifties. Narrator of the story, a wise observer of the health care system as a former nurse now experiencing the “other side of the stethoscope.”

Nurse Sally Grant: Early forties. Has been a nurse for twenty years, fifteen years on this medical-surgical (med-surg) unit. Has mastered the skill of communicating her medical assessment so that interns understand potential ramifications of decisions.

Dr. Michael Evans: Early thirties. Was an intern on med-surg unit. Has learned to listen to the nurses.

Mark King: Early thirties. Pharmacist irritated that nurses seem to think that they are the only ones who care about patients.

Dr. Carl Rogers: Mid thirties. Senior resident. Frustrated at not being able to convince a nurse to increase pain medication.

Nurse Ann Wilson: In her forties. Inflexible and unafraid to say “no” to doctors’ orders for increased pain medication.

Dr. Stephanie Long: Late forties. Recounts her experiences as an intern but is now a patient safety officer. Nurses help her get through first “code.” Good comic timing is important here.

Code Nurses 1, 2, 3: Help intern through her first “code.” (These roles can be combined into one if necessary.)

Dr. Melony Strong: Mid thirties. Tries to juggle too many patients.

Dr. Mark Cole: Mid forties. While on call, teaches new nurse even as he handles her middle-of-the-night phone call.

Nurse Miranda Clark: Early twenties. Very new nurse who is timid and nervous about calling a doctor in the middle of the night.

Dr. Jim Smith: Early thirties. He's a resident in a pediatric ICU, where he had a run-in with a nurse about getting a line in a baby.

Nurse Joan Adams: In her thirties. Is worried about the condition of their tiny patient.

Dr. Patricia Davis: Late forties. Helps with dehydrated baby.

Dr. Martha Davenport: Early-to-mid thirties. Frustrated in dealing with a nurse's "punishment."

Dr. Robert Grayson: Early fifties. Is an attending at a major teaching hospital who thinks it's important not to move on too quickly if there is something to be learned.

Dr. Abby Jones: Late twenties. Yells at nurse for screwing up blood draw that nurse had done correctly.

Nurse Carol Youngson: Early fifties. Chief OR nurse, tries to deal with new pediatric cardiac surgeon whose competence she questions.

Dr. Jonah Odum: Early thirties. New pediatric cardiac surgeon whose actions lead to the deaths of twelve babies.

Winnipeg Doctors 1, 2: Late forties or early fifties. Dismissive and condescending about nurses' concerns about Dr. Jonah Odum.

Dr. Jane Fitzgerald: Late twenties. ER intern on night shift, frustrated with nurse's refusal to get X-ray.

Dr. Raj Patel: Mid fifties. Chief of perioperative services, understands need to provide support to nurse who stops the line.

Office Nurse: Any age.

Dr. David Brown: Early fifties. Head of oncology division at teaching university, reflects on nurse who taught him to be a doctor.

LIST OF SCENES WITH CHARACTERS

<i>Prologue</i>		Nurses 1, 2 Doctors 1, 2	15
<i>Scene 1</i>	What Happens to Me?	Leah Jones	18
<i>Scene 2</i>	But Will They Need Me Tomorrow?	Nurse Sally Grant Dr. Michael Evans	19
<i>Scene 3</i>	What Just Happened?	Leah Jones Mark King	20
<i>Scene 4</i>	Frustrated Doctor	Dr. Carl Rogers Nurse Ann Wilson	20
<i>Scene 5</i>	Personal Mission	Leah Jones	22
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<i>Scene 10</i>	Ready for the Call	Dr. Mark Cole Nurse Miranda Clark	26
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<i>Scene 14</i>	Morning Report	Dr. Robert Grayson Dr. Abby Jones	31
<i>Scene 15</i>	Dr. Miller Doesn't Tell Me Squat	Leah Jones	32

<i>Scene 16</i>	How Many Dead Babies Does It Take?	Nurse Carol Youngson Dr. Jonah Odum Winnipeg Doctors 1, 2	33
<i>Scene 17</i>	A Case for No Hierarchy	Leah Jones	36
<i>Scene 18</i>	To Explain or Not to Explain	Dr. Jane Fitzgerald	36
<i>Scene 19</i>	Stopping the Line	Dr. Raj Patel	37
<i>Scene 20</i>	Last Call	Leah Jones Office Nurse	38
<i>Scene 21</i>	Stay and Watch	Dr. David Brown	39

ABOUT THE STAGING

The play is performed reader's theater style, with actors reading from scripts at music stands facing the audience. The actor playing "Leah" should be at a music stand stage right, slightly apart from the others, because she is the narrator of the story. There are two other music stands—one is stage center and has a sign that says "MD" and the other is stage left with a sign that says "RN or Other Team Member." When an actor is playing a doctor, he or she moves to the stand that says "MD." When an actor is playing a nurse or other team member, he or she moves to the stand so labeled.

INTRODUCING THE PERFORMANCE

The playwrights suggest that a brief introduction be given before the performance to set the context for both the play and the performance. The person introducing the play might say the following:

We welcome you to this performance of the play *Bedside Manners*. The play is based on actual interviews with doctors, nurses, and others in the health care field. While some scenes are composites of different incidents, everything in the play is based on actual workplace experiences. Some of the things you will see in the play occurred more than a decade ago. Some occurred just several months ago. Many similar encounters are taking place in health care institutions all over the globe while we sit here watching or discussing the play.

Although the play focuses primarily on physician-nurse relationships, it includes some encounters between other health care professionals. The encounters between physicians and nurses—whether problematic or promising—are emblematic of the communication and teamwork problems that occur in health care no matter what the professional or occupational category.

As you watch the play, we encourage you to make a mental note of any strong reactions to material in the play. We also encourage you to think about

which scenes offer you a window into the experience and perceptions of others with whom you work or mirror your own experiences or perceptions.

Because you are watching a theatrical performance, we will repeat the instructions that you have often heard in other theaters. Please turn off any cell phones, pagers, smartphones, Ipads—or any electronic devices that have been developed in the last several hours. Please unwrap any candies or other food items that you may have brought with you so as not to distract the actors.

And now, *Bedside Manners*.

THE PLAY

Prologue

*(Four actors enter and stand in a line downstage of the three music stands. They speak directly to the audience. Think of the Prologue as a series of musical phrases: “**” indicates the end of one phrase and the beginning of a new one. The “**” may also indicate that the actors become different characters.)*

Nurse 1: The human body is absolutely incredible.

Doctor 1: Being a doctor—it’s all I ever wanted.

Nurse 2: Nursing—it’s all I ever wanted to do.

All: There’s nothing else like it.

**

Doctor 2: My advice? Make nice to the nurse so she won’t torture you to death. A nurse can make your life miserable by waking you up in the middle of the night just when you’ve grabbed your only five minutes of sleep. Or she can protect you, let you get your sleep, depending on how you treat her.

Nurse 1: One physician tells you to call him for any vital sign change; another says, “Don’t call me unless such and such happens.” You wake up a doc in the middle of the night and it’s not in the ballpark of what he wants to be woken up about, he can get very testy.

Doctor 1: A nurse calls me late one night to ask for Tylenol for a patient with arthritis pain. I order it. Three weeks later the patient dies. Complications of surgery. Nothing to do with the Tylenol, but I get sued, along with everyone else who ever touched the chart or spoke to a nurse about the guy. Every single thing I say or do has repercussions. The buck stops here.

Nurse 2: Doctors are always saying, “The buck stops here,” and in a way it does. But some of them use that as an excuse not to listen to anybody else. There was a problem with a surgeon at my hospital, so the nurses

went to the chief of cardiology. He wouldn't listen. We went to the chief of surgery. He wouldn't listen. We took it all the way up to the head of the hospital. He wouldn't listen. The buck stopped with him, and twelve patients died. Shouldn't it have stopped with the nurses too?

Doctor 2: A good RN has your back. While I'm securing the airway, she's placing code paddles on the chest. She's right there beside me. . . . Without her I'd be totally out of luck.

Nurse 1: I was trying to track down this doctor about a patient. He always came by early in the morning when I was on the other side of the floor giving pain meds. I finally caught him in the hallway.

Doctor 1: One day this nurse grabs me outside of a patient's room. I have three more patients to check in on, I'm late for surgery, and this nurse insists on having a chat.

Nurse 1: I explained some problems the patient was having and suggested a change in medication. He asked me what I saw on the sign by the patient's door. I didn't know what the heck he was getting at. The patient's name? The doctor's name?

Doctor 1: I said, "You see those initials after my name—MD? You know what those stand for? Makes decisions."

Nurse 1: I pointed to the initials after my name—RN—and said, "You know what these stand for? Rejects nonsense."

Nurse 2: I brought up this thing of team communication to a nurse manager at my hospital who gave me the old, "Interesting. Oh, I'm late for a meeting." Then I brought it up to the CEO. He gave me a patronizing smile and turned to go. I stopped him. "Listen, if a doc is abusive, he isn't just going to lay into nurses. He'll go after interns, residents, pharmacists, sometimes even patients." He just shrugged and said, "What can I do? These are the geese that lay the golden eggs." He doesn't seem to realize that a lot of people have to sit on the egg if it's going to hatch.

Nurse 1: I've been a nurse for twenty years, and I'm damn good at it. I don't want to be a doctor. I like what I do. I like spending time with patients. I like being a patient advocate.

Doctor 2: If I hear one more nurse say, “I’m the patient’s advocate”—What does that make me? The patient’s enemy? Some nurses act like I’m an uncaring jerk whom they need to protect their patients from. *I’m* a patient advocate. *I’m* compassionate. Now, I know there are some difficult doctors who yell and scream and make life miserable. But they don’t just attack nurses. They go after med students, interns, residents. Sometimes I think that’s just how they learned to express authority. You know—see one, shout at one, teach one.

Nurse 2: I’m supposed to work three back-to-back twelve-hour shifts. But if you think I get out after twelve hours, you’re dreaming. In Technicolor. Sometimes they make me work mandatory overtime, which means an extra twelve-hour shift. And I’m taking care of eight patients, maybe even twelve. And then I have to go home and take care of my kids and my husband’s mother. Tired? That doesn’t even begin to describe it.

Doctor 1: Fatigue. That’s my life. I work at the clinic all day long seeing twenty to twenty-five patients. Then I’m on call that night. Then back to the clinic the next day and another twenty to twenty-five patients. Not to mention the computer charting. And everyone is bugging me all day long for orders, signatures, diagnoses, prescription refills, and more. I hate to admit it, but a lot of times my response to yet another request is colored by one fact—that I’m totally wiped out.

Nurse 2: What’s the worst part of my job?

All: STRESS!

(The dialogue from here until the end of the Prologue should build in intensity, with the “crescendo” coming on the word “CHOCOLATE.” Actors should speak together when indicated.)

Nurse 1: You want to know about stress?

Nurse 2: Don’t get me started.

Doctor 1: Stress—it’s my life.

Nurse 1: People are asking me to set up a pelvic at the same time as they’re asking me to do an EKG. And then quick, go to the next two patients who’ve already been waiting ten minutes, not to mention the doc who’s having a flip out because she needs help removing a mole.

Nurse 2: You've needed to pee for three hours, you haven't eaten since yesterday, the attending is freaking out because the X-rays she ordered ten minutes ago aren't in her hands, that witch of a supervisor is complaining that you haven't learned to use the latest "flavor of the month" computer program—

Nurse 1: And you're getting paged—

All: EVERY FIVE MINUTES.

Doctor 2: I just got back from maternity leave. Between patients I had no time to pump milk for my baby. I'm hard as a rock. I see twenty-two patients a day. Then comes answering phone calls during my supposed lunch break, and finally when I finish for the day, I get to answer all those patient phone calls that have come in while I've been seeing other patients. My husband is having a meltdown, my baby barely knows her mother. I never sleep.

Nurse 1: Is it any wonder I need—

Nurse 2: Zantac.

Doctor 1: Xanax.

Doctor 2: Zoloft¹

All: CHOCOLATE!

Scene 1 What Happens to Me?

(Leah Jones, in her late fifties, was a nurse for most of her adult life. She is now battling cancer. Leah is the narrator of the story, the voice of wisdom and experience.)

Leah Jones: Waiting. That's all I seem to do anymore. Wait for this test, that treatment. It's not so bad once I finally arrive; it's just the effort of the journey—apartment to car, car to waiting room. And everywhere I go seems to involve long, long hallways. Several people have suggested that I get a walker or a wheelchair, but I refuse. I feel like as long as I'm walking I'm not really that sick. It's strange being on the other end of the stethoscope. I'm a nurse, was a nurse. For thirty years. OR, pediatrics, labor and delivery, and finally a midwife. I had to stop working when I got too

sick. It's been interesting observing how nurses and doctors talk *to* me and *about* me, and how they talk to each other, or how they *don't* talk to each other.

You know, I've seen some great team communication. Some things have really improved since I began my career. But I've seen some other things... (*Shakes her head.*) When I was working, if the team had problems with each other, it really made everyone's job tougher. But now as a patient—if people don't consult with each other, what happens to me?

Scene 2 But Will They Need Me Tomorrow?

Nurse Sally Grant: Doctor, I just checked on Mr. Smith.

Dr. Michael Evans: (*To audience.*) Let me explain. I was an intern, and this nurse had been on the unit for fifteen years. Mr. Smith was what we called a "Triple A." He'd just had surgery for an abdominal aortic aneurysm. When I saw him in the morning, he appeared to be stable, so I scheduled him to be released later in the day.

Nurse Sally Grant: He's sweaty and pale and the EKG shows he's in A Fib. I looked at his lab work, and there is an imbalance of electrolytes. I think it's the stress from the surgery and fluid overload that's causing the problem.

Dr. Michael Evans: Let's give him Lopressor.

Nurse Sally Grant: He has COPD. Lopressor could cause serious breathing problems. Do you want to try Cardizem? That would treat the elevated heart rate without aggravating the lung disease. And what about a diuretic for the fluid overload?

Dr. Michael Evans: (*To audience.*) I followed the nurse's advice. And when the medications started to work and the patient improved, I said, "Let's discharge him."

Nurse Sally Grant: Are you sure?

Dr. Michael Evans: (*To audience.*) When a nurse says, "Are you sure," it usually means she thinks you're about to do something really stupid, but she feels she can't really say that, so she just says (*with emphasis*), "Are you sure?"

She explained that our patient was still unstable, that as the medication helped his body eliminate excess fluids, he'd continue to be at risk for low blood pressure, shock, or low blood supply to the heart, which could cause a heart attack. And very subtly, she pointed out...

Nurse Sally Grant: If any of this happens at home, the patient could die.

Dr. Michael Evans: Let's keep him here 'til we're sure he's stable. *(To audience.)* Hey, I'm not stupid. So I had the patient remain in the hospital. When the cardiologist came by to check on the patient, he said "Good call." "Thank you, sir," I said, "The nurse..." "Keep me posted," he said. Before I went off duty that day, I found the nurse and thanked her.

Nurse Sally Grant: Why is it you doctors thank us when you're interns and residents and think you need our help and then are too busy to talk to us about patients when you're attendings?

Dr. Michael Evans: *(To audience.)* What could I say? It was a fair question.

Scene 3 What Just Happened?

Leah Jones: A few weeks ago I was in the hospital, recovering from yet another surgery. I don't know what was going on with the patient in the bed next to mine, but I heard the nurse say, "I'm just trying to look out for the patient." And this pharmacist just laid into her.

Mark King: What do you think I'm doing—trying to kill the patient? You nurses take the cake—you act like you have the corner on caring about patients. Let me clue you in on something. Just because we're not RNs and only rarely see the patient doesn't mean we care any less about the patient than you do.

Leah Jones: The pharmacist walked off one way, mumbling under his breath, the nurse the other way. The patient looked over at me and said, "What just happened?"

Scene 4 Frustrated Doctor

(In this scene, the doctor's lines are directed at the audience, and the nurse's lines are directed at the doctor.)

Dr. Carl Rogers: I'm a senior resident. I have a patient in sickle cell pain crisis. He's been getting tons of Dilaudid, but it's not working. He is crazy with pain. So I told the nurse to give him more Dilaudid. She said,

Nurse Ann Wilson: I don't feel comfortable with that.

Dr. Carl Rogers: I told her I had just examined the patient and assured her that he really needed more medication. She said,

Nurse Ann Wilson: I'm worried he'll be opiate overdosed.

Dr. Carl Rogers: I explained to her that traditionally what happens is that if someone is having a lot of pain, they can handle tons of opiates. It's only if you take opiates when you're not having pain that you become overdosed. And she said,

Nurse Ann Wilson: (*Digging in her heels.*) I don't feel comfortable giving him more.

Dr. Carl Rogers: I told her I would be right there. That we could have an antidote at the bedside if she wanted, in case something happened. She said,

Nurse Ann Wilson: (*More insistently.*) No. It's just too much.

Dr. Carl Rogers: So I suggested I call the attending to ask his opinion. She said,

Nurse Ann Wilson: (*With attitude.*) Go ahead.

Dr. Carl Rogers: So I called the attending, explained the situation, and he said we should definitely give the opiate. I told the nurse, and she said,

Nurse Ann Wilson: (*Adamantly.*) No.

Dr. Carl Rogers: (*Increasingly frustrated.*) So I told her to give me the medicine, and I would inject it myself. She said,

Nurse Ann Wilson: No.

Dr. Carl Rogers: Finally, I just called admitting and said, "Can you move this patient to a floor where the nurses will give him the pain relief he needs?" We were about to move him when the man became psychotic—literally—which can happen when you're in so much pain. We had to take him to the ICU. Now I'm not saying that if we'd given him the opiate this would have been averted. There's no way to tell. But letting people stay in this much pain can lead to a psychotic break. The nurse stood in the way of giving this man the pain relief he needed. Was it something I said or didn't say?

Is there some secret code I should have used? And what do I do about it now? Write up an incident report? It's so frustrating.

Scene 5 Personal Mission

Leah Jones: When I was working in a teaching hospital, my fellow nurses used to moan and groan at the arrival of each new set of baby docs. Some of them would really give them a hard time—you know, to show them who's boss. Not me. I always felt that working with these doctors-in-training was one aspect of my job where I felt I really made a difference. So much of what doctors learn they learn at the bedside. I always made it my personal mission to help them understand what nurses do and to show them how to care for patients, not just treat them. More than once I would shame some young doc into staying in the room to watch a woman go through labor, instead of disappearing and coming back when it was time for delivery. And now? My life is all about finding a doctor who can help me.

Scene 6 Singing the First-Code Blues

(Think of this scene as a Saturday Night Live sketch—go for the comedy. The three nurses can either deliver lines from the “RN” music stand or they can be grouped around the doctor.)

Dr. Stephanie Long: I remember my first code like it was yesterday. It was the middle of the night, and I was fast asleep, dreaming about a place where I didn't have to report every change in temperature to my resident, when my beeper went off. I ran down the stairs and was told that this huge man was in V-tach. An EKG magically appeared in my hand. *(She mimes holding it up and looks puzzled.)* I had no idea what the hell I was doing.

Code Nurse 1: You want a liter of fluids?

Dr. Stephanie Long: I nodded. Another nurse hauled in paddles, glass vials, and other vaguely familiar things and said,

Code Nurse 2: Should I put some gel on his chest?

Dr. Stephanie Long: I nodded again. Another nurse began to draw some blood and after a few seconds asked,

Code Nurse 3: Would you like me to draw some blood?

Dr. Stephanie Long: I nodded. Suddenly, two paddles appeared in my hands, just like I'd seen so many times on television and once in that class we had to take a few weeks before.

Code Nurse 1: Do you want to put them on the patient's chest, to assess his cardiac rhythm?

Dr. Stephanie Long: I nodded.

Code Nurse 1: Still V-tach.

Dr. Stephanie Long: Another nurse yelled,

Code Nurse 2: Everyone stand back and let the doctor shock him!

Dr. Stephanie Long: The nurse looked at me and said,

Code Nurse 2: You're all clear.

Dr. Stephanie Long: I looked down at the paddles still clutched in my hands. I couldn't remember anything.

Code Nurse 2: Doctor? You're clear.

Dr. Stephanie Long: Clear? Clear. There was only one button on each of the paddles, so I pushed. There was this zapping sound. I looked back at the monitor and saw this spiky pattern. Spiky, I remembered, was good.

Code Nurse 3: Pressure's back to 100 over 60.

Dr. Stephanie Long: A nurse started dialing the phone.

Code Nurse 1: You want me to call intensive care?

Dr. Stephanie Long: I nodded. Another nurse handed me the chart and suggested I sign the orders.

Code Nurse 2: Great work, doctor. (*Nurses sit.*)

Dr. Stephanie Long: Throughout medical school and training, there are two rules that are constantly being pounded into each student's brain. The first is that it's OK to admit that you don't know something. This is based

on the idea that nobody knows everything, and if you don't know the answer, it's much better to admit it rather than go off half-cocked and possibly screw something up. The second rule is that no matter what, under no circumstances, should you ever, ever admit that you don't know something. The idea behind this is that we're doctors, damn it, and we need to act. After all this training, we have to know something, and it's better to take your best guess and go with it full-cocked, instead of just standing around doing nothing like an idiot.

I preferred the first rule. In fact, as Patient Safety Officer in my hospital I have tried to perfect it. Because if you don't know something as a student, you have a built-in excuse: You're still learning. But somehow, there's this idea that once you make the jump to doctor, you have all the answers. But as it turned out, I was no different the day after graduation than I was the day before. I guess the most valuable lesson I've learned is that no one can ever know all there is to know, and that it's important to listen to anyone who may have valuable information to share, whether the source is a resident, a pharmacist, or the patient's husband.

Scene 7 Being Just a Patient

Leah Jones: The day I was diagnosed—it's weird. Just because you're a nurse, people think you're somehow prepared. To be honest, deep down I probably thought that too. But when the doctor says, "You have cancer," you're not hearing it as a nurse. You're just a terrified person, thinking about the will you've never made, and the daughter who's getting married next year, and this can't really be happening, and I'm going to wake up in a minute. I guess being a nurse has been an advantage. I know how to explain my need for more pain medication. But on the other hand, you're lying in bed feeling awful, scared of dying, hooked up to all these tubes, and that nurse part of your brain is worried that the change of orders you heard an hour ago didn't make it onto the chart. And you're wondering if things go wrong tonight will your nurse call the doctor right away or will she wait because he gets nasty when she calls him. And you need to use the bedpan, but you can tell your nurse is having a very bad day, so you try to hold it 'til it looks like things have slowed down a bit.

And then something happens, and you find you've wet the bed and now just added to everyone's work, and you wish for the blissful ignorance of being just a patient.

Scene 8 Mix-up

Dr. Melony Strong: I work in an outpatient clinic. As a primary care doctor. I'm part of a dying breed. People I knew in medical school said I was crazy to become a PCP. Ophthalmology they suggested. Interventional cardiology. Radiology. But no, not me. I love what I do. But there are some days when I wonder whether I made the right choice.

Take today. My patient was scheduled for 9 am. But he was a no-show. So I did some paperwork and then saw my 9:20 patient. Since there was no one scheduled for 9:40 I took my time. At 9:56, the front desk paged me and told me my 9 am, the no show—finally showed. They told me they could put him in the 9:40 slot. It's now 10:04 and the patient is not yet in a room and I have a 10 o'clock patient scheduled. I had to explain to the front desk receptionist that I had no time to see the 9 am. They were not happy about this. They insisted that I had time to see him because—and I quote—he was only 16 minutes late for the 9:40 slot. But he wasn't my 9:40 patient, I told them. He was my 9 am patient. And I am seeing another patient in just two minutes.

"But you didn't have a 9:40 patient," they said. "So what's the big deal with seeing him?" By this time it's getting to be like who's on first.

So the receptionist sends the patient to the nurse because the patient has severe leg pain. Of course, when she examines him the nurse feels the patient has to be seen. By me or another doctor. But there are just no slots. So the nurse has to beg a resident to see the patient. The patient gets seen, and the resident calls another attending.

By now, we have a multicar crash. The receptionist is mad at me because I wouldn't see the patient. The nurse is mad at me because she had no time, but she had to see the patient. The resident is frustrated at the nurse