Why do nurses sometimes ask the wrong questions?

In this article...

- Instances of neglect and a discussion of the issues
- Psychological factors that affect a nurse’s ability to meet a patient’s needs
- How deep personal reflection can improve practice

Keywords: Neglect/ Psychology/ Reflection

This article has been double-blind peer reviewed

When nurses fail to ask the right questions, the results can be dire, as the case of Kane Gorny shows. Nurses have to face some uncomfortable psychological truths.

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Abstract


The recent high-profile case of Kane Gorny highlighted a number of systemic and individual failures that led to his death by dehydration in a hospital bed. This article asks how it happened and presents some psychological, “human” aspects that may have contributed to the tragic outcome.

In looking for ways to prevent this happening again, the author suggests that nurses should first understand and accept their own psychological prejudices that may cause them to make the wrong choices or fail to ask the right questions.

Reflective practice can help with this issue and perhaps offers the only route to change our own practice and ultimately the healthcare system as a whole.

Kane Gorny died of dehydration in a hospital bed in 2009. His notes made it clear that without his medication and adequate hydration, his health was at severe risk. His condition caused him to become aggressive. Because of this he had been put into a side room and his pleas for water were ignored.

By now most of us know this story well, and since the coroner’s report and widespread media coverage, are probably aware of the issues, arguments and justifications. As nurses who are concerned about the wellbeing of those we care for, we probably have opinions and solutions to the deficiencies this case exposed.

My response includes a feeling of empathy with the nurses involved. We have probably all missed things in practice that only become obvious in hindsight but through good fortune there were not such devastating consequences. Perhaps we could all be there but for the grace of God?

The deputy coroner, Dr Radcliffe, said: “Kane was undoubtedly let down by incompetence of staff, poor communication, lack of leadership, both medical and nursing, a culture of assumption” (Press Association, 2012). The emphasis appears to be on processes, environment, knowledge and skills. These are clearly all issues that need to be addressed.

The summary at the beginning of this article reduces Kane Gorny’s story to the bare facts. This makes it appear stark and shocking. We can, however, reduce the story even further:

- A nurse chooses to respond to a man’s behaviour and ignore his life-threatening health needs. The health condition is known to cause aggressive behaviour if untreated. The man dies as a consequence.

There is a shocking simplicity about this statement. The coroner described a “cascade” of problems that accounted for Mr Gorny’s death. We might raise another issue. Why was it that no individual asked the correct question? What happens to nurses, from all branches, who appear to miss the point entirely?

Katherine Teal, a consultant anaesthetist, made the following point: “this probably wasn’t a simple case of ignorance of physiology. I would bet that the ward doctors would answer a multiple choice questionnaire (MCQ) on the pituitary axis reasonably well. What it does reveal are

5 key points

1. The case of Kane Gorny is one of many instances that have come to light in recent years where a patient’s needs have been neglected.

2. When a patient is aggressive, a nurse can either seek a reason for it and act on this, or respond to the aggression directly.

3. Nurses should always ask “Why is this person behaving like this?”

4. Nurses can improve their responses to “difficult” patients by becoming aware of their deeper cognitive processes.

5. When nurses see patients as “others”, they are less likely to meet their actual needs.
Attribution

First, this event can be seen as a classic example of attribution taking place. It appears that we all need to attribute causality to behaviour. One common dimension to attribution is dispositional, in that the behaviour is seen as resulting from the nature of the person; another is situational in which the behaviour is seen as resulting from the situation the person finds themselves in (Heider, 1958).

In this case, it is possible to see the aggression as a result of sudden health status change (situational) or as a result of the person’s natural aggression (dispositional). Some of the staff thought Mr Gorny was dependent on alcohol, which again suggests a dispositional attribution. If a person is seen as responding to a dispositional drive then they are likely to be given globally negative attribution and by seen, for example, as “uncooperative”.

There is a substantial body of research (Dagnan and Weston, 2006; Dagnan and Cairns, 2005; Weiner, 1985) suggesting that professionals will give more help to patients/clients who are seen as not responsible for their actions. A patient seen as being deliberately aggressive or choosing to drink excess alcohol is less likely to get the required support than one seen as very unwell.

Schemas

We all hold mental representations of the world. These are known as schemas. They enable us to make sense of and function in a complex reality. They enable us to operate on “autopilot” for much of the time, which allows us to avoid being overwhelmed. (Augostinos and Walker, 1995). These mental representations are activated whenever we experience something for which we hold a schema.

If we think of, for example, “social worker” – and I suggest anyone reading this article tries this – we immediately have available the following four types of schema (Fiske and Taylor, 1991):

- Role schema – what do they do?
- Person schema – what sort of people are social workers?
- Event schema – when am I likely to work with one?
- Self schema – am I as a nurse better or worse than a social worker?

This also allows us to make a judgement, as all schemas carry information such as “I like social workers”, although feelings may be less concrete than that. They may exist as a general sense of positivity or negativity. Similarly, when working with a male patient, for example, we will unconsciously activate the schemas for “man” and “patient”. Schemas involve judgements which, in this case, might include “men are less tolerant of pain” or “men are aggressive”. If a nurse working with a patient like Kane Gorny holds such schemas, it is less likely that an explanation for the aggression would be sought – the answer is readily available in the schema.

This is, of course, a source of prejudice. It is worth pointing out that nearly all of us hold schemas so, to that extent, we are all prejudiced. What we can do is become aware of the schemas we hold and become conscious of the deep-rooted and difficult-to-move prejudices we do have.

Social representation

A collective version of a schema is a social representation (Moscovici, 1988). This is where a group of people share a collective representation of an object.

In the Gorny case, it appears that the team shared a social representation that inhibited any one member from asking: “Why is he behaving like this?” Once a social representation has been created and shared, there is tendency for individuals to accept it and stop thinking. It becomes an accepted truth that sister X is too controlling, social worker Y is impossible to get hold of or patient Z is manipulative.

The implications for these cognitive processes on nursing practice are more fully discussed in Mee (2012). All of these cognitive constructs operate at an unconscious level and it can be very difficult to become aware of them. They can be particularly difficult to access if we hold a self-schema of objective professional, because we are unlikely to want to believe that we have such judgemental cognitive constructs.

These processes are more pernicious because of their shadowy existence. They are, however, accessible to us through deep reflective practice; Johns’ model (Johns, 2000) is particularly useful. Understanding our cognitive structures offers the potential to improve our practice if we have the courage to face our cognitive shortcomings then address them in action.

A catalogue of errors

The Kane Gorny case is one in a depressingly long list of similar cases of error, abuse and neglect that encompasses all branches of nursing. The following are some examples:

- The Care Quality Commission reported that people with dementia in hospitals and care homes are routinely deprived of their liberty (Care Quality Commission, 2012);
- People with a learning disability are subject to institutional discrimination in health settings (Mencap, 2012; Department of Health, 2008);
- A Panorama programme outlined the abuse of people with a learning disability in an institution (Panorama, 2011).

An essential underpinning aspect of the
Discussion

cognitive and social representation of the individual patients/clients is that, for them to be treated so badly, they must first be “othered” (Wolfensberger, 1972). For an excellent analysis of othering in nursing settings, see Canales (2000). It is very difficult to abuse someone whom we perceive as just like ourselves. This example of othering from practice illustrates this principle well:

“I work with a client with learning disabilities who has a cataract and challenging behaviour. The GP refused to treat on the basis that ‘He can see out of his other eye’” (DH, 2008).

Othering is evident throughout practice and in ways that are unconscious. It is probably the case that most of us engage in this hidden othering. The following example is a case in point:

Four people who have been resettled from a long-stay institution live in a house, with 24-hour support from a staff team. The staff are well organised.

They keep a set of staff cups in a high cupboard. In a lower cupboard, there are client cups, which are cheaper and older than the staff cups. There is a dishwasher in the house and no one who lives there has a communicable disease.

We can, of course, substitute mental health or adult setting in this vignette; it is fairly typical to see two sets of crockery. Can nurses claim to value the people they support if they are not prepared to share crockery? If they share with other staff but not patients/clients, this is othering in practice. The use of a dishwasher ensures that there is no health threat, so why does this practice persist? If a patient/client has a communicable disease, they should have separate crockery from everyone else, not only staff.

As a manager of support services, I once challenged a group of staff about not sharing cups. One member of the team summed up his feelings by saying: “I don’t know why, but I just don’t fancy using the same cups as the clients.” This suggests that there is no rational reason for this practice, it just does not feel right to him. This justification sits at an unconscious level and is worthy of further discussion.

Conclusion

This article started with an example of severe neglect in the Kane Gorny case. He had been othered and the resulting treatment led to his death. The patients/clients in the example concerning staff cups had been similarly othered but the outcome was not as severe. The perception of the patient/client is qualitatively similar (the person has been othered) but quantitatively very different. This might be expressed as a continuum (Fig 1).

This quantitative similarity has profound implications for practice. If we make the people we care for others, the resulting cognitive processes can lead us to give negative attribution and work with schema and social representations that contain negative judgements.

When working in this way, we are less likely to meet the actual needs of our patients/clients. We run the constant risk of having an unholy alliance of conditions that lead to disaster for the person in our care and for ourselves.

The answer here may lie not in new systems, management, skills or even training. Perhaps, as Teal suggested, someone with the vision to ask the right question is needed. One way in which we can develop such vision and awareness is to become aware of our deeper cognitive processes.

The only way to approach this problem is through brutally honest deep reflection. As Johns (2000) suggests, through reflection we can learn to be different.

Steve Mee is author of Valuing People With a Learning Disability. Keswick: M&K Publishing

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