



Best Practices in Healthcare Management Begin with Self

EXECUTIVE SUMMARY

- ▶ Nurses, as natural caregivers in all areas of their lives, are ultimate patient advocates.
- ▶ Nurses are best served when heeding the lessons of self-advocacy.
- ▶ Two case studies describe how nurses personally experienced healthcare challenges and the essential importance of self-care.
- ▶ Simple measures remind us to “put our oxygen masks on first” to help others.



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LEADERSHIP BY EXAMPLE and modeling self-care are clichés with little daily application to the hustle and bustle of a busy nurse’s life. Until, that is, there is a scary reminder that even with all our understanding about healthy lifestyles, our bodies, minds, and spirits can let us down.

In this article, two exemplar cases will be described: two apparently healthy nurses relate how easily the tables turned, and how we must continuously prompt ourselves to believe that best practices in healthcare management begin with self. More women practice nursing than men, and more women go undiagnosed with cardiovascular disease than men. Either way, those living with risk factors may or may not know they have them and are likely to fail, because of

myriad obligations, to translate their health knowledge into practice. The proposed outcomes of a self-care program are to heighten awareness of our own health so we may best take care of others. While this is not a new concept (nurse, know thyself), very little funds are devoted to the concept that healthy bodies, healthy minds, and well-being of nurses are more likely to not only produce the optimal healing envi-

ronment for our patients, but improve the healthcare organization’s bottom line. However, when a medical professional seeks care it can be intimidating for both the patient and the provider, and the patient may be embarrassed asking naive questions. This article offers simple measures and easy-to-practice habits that, at the very least, provide awareness and remind us of the importance of “putting our oxygen masks on first” before we offer help to others.

Literature Review

There is an overabundance of literature about men’s cardiovascular health and a growing but less significant amount of information on the topic regarding women, suggesting cardiovascular disease is predominantly a male problem (Westerman & Wenger, 2016). Such thinking provides a false sense of security in women; especially those who may not know their risk factors and who consider themselves in good health. Cardiovascular disease (CVD) is the main cause of death in men and women; however, the prevalence is higher in women (Appleman, van Rijn, ten Haaf, Boersma, & Peters, 2015). Appleman and colleagues discuss emerging evidence regarding potentially independent risk factors for CVD exclusive to women, noting that CVD is more common in women than in men due to risk factors which vary in both sexes, especially as women have differing hormonal changes in reproductive years and early menopause, which can accelerate the development of CVD.

Winham, Andrade, and Miller (2015) add that other biological differences include smaller carotid arteries in women, which may have less plaque but a greater likelihood of stenosis. They also suggest sex differences may interfere with decisions regarding diagnosis, treatment, and outcomes. Similar findings in a study in Serbia (Jankovic et al., 2015) suggest significant differences in the prevalence of metrics for risk factors between men and women. Spence and Pilote (2015) included living environment as a risk factor, citing reports that women with a spouse and children have a higher incidence of coronary heart disease than women living with a spouse but no children.

The addition of other risk factors such as autoimmune disease in females exponentially increases the risk for CVD (Gianturco et al., 2015). Inflammation, a hallmark of autoimmune disease, contributes to plaque formation and instability. The authors describe the resulting atherosclerosis as “auto-inflammatory” injury, suggesting increasing collaboration among specialists is vital when investigating CVD in women with concurrent autoimmune disease.

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Richards, Sheen, and Mazzer (2014) described self-care as “choosing behaviors that balance the effects of emotional and physical stressors” (p. 3). They discussed the importance of listening to one’s body and using corrective measures even though we cannot control our genes. Simple but effective “rescue remedies” such as mindfulness, nutrition, exercise, and adequate sleep can be powerful remedies. Having an accountability buddy is particularly important for nurses who may find it easier to give their patients advice than follow it themselves.

Compassion fatigue and burnout are consequences for empathetic caregivers who do not make replenishment of self a priority within their professional roles. The cost of compassion fatigue and burnout extends to nurse, patient, and organizational outcomes. Nurse outcomes include forgetfulness, losing things, anger, edginess, insomnia, depression, apathy, poor job morale and performance, increased sick calls, and leaving the profession (Absolon & Krueger, 2009). As Hevezi (2016) so eloquently stated, “Recurrent generation of the energy that enables nurses to provide compassionate care is essential” (p. 346).

Figley (2002), a pioneer in the concept of compassion fatigue, described compassion fatigue as a state experienced by individuals helping people in distress; it is an extreme state of tension and preoccupation with suffering. The helper, in contrast to the person(s) being helped, is traumatized or suffers due to the helper’s own efforts to empathize and be compassionate. Often, this leads to poor self-care and extreme self-sacrifice. Figley believes this combination can lead to compassion fatigue and symptoms similar to posttraumatic stress disorder (Gould, 2005).

In 2012, Johnson conducted a study of 65 staff nurses, which showed a moderately strong negative relationship with both compassion fatigue ($r=0.60$, $p<0.001$) and burnout ($r=0.60$, $p<0.001$).

Case Study 1: Heart Health

This story gives a personal account of how a 57-year-old chief nursing officer who, despite doctoral education, resources, and access at her fingertips, nearly lost her life to mismanaged cardiovascular care.

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I made an appointment with a cardiologist at the hospital where I worked because I thought I might need an angiogram. He acted surprised and told me I looked great, and that there were many reasons for chest pain other than the heart. I had worsening chest pain, both my parents had died of cardiovascular disease, and I had a chronic autoimmune disease, often associated with cardiovascular burden (Gianturco et al., 2015). He said it was far too invasive to do an angiogram at this stage and instead asked me to smile. Thinking it was a new cardiac test I had not yet heard of, I smiled, whereupon he exclaimed that he had never “seen a Brit with such good teeth!” (my accent revealed my British heritage).

Finally, the cardiologist ordered an electrocardiogram (EKG) and booked me in for a stress test. I had an inconclusive stress test in the past, and was frustrated but agreed I should not have an invasive procedure unless necessary. Westerman and Wenger (2016) provide evidence microvascular coronary dysfunction is more common in women and may not manifest under a traditional stress test, whether or not there is coronary artery involvement. Similarly, Ketepe-Arachi and Sharma (2016) found women may not reach full exertion and symptoms during a stress test simply due to a lower exercise capacity, thus missing a potential diagnosis. That was indeed the case – I passed the stress test with flying colors.

Both the EKG and stress test were normal, which I only knew because the cardiologists’ technician called to tell me the results, and then she threw in the idea that the doctor suggested I eat a low-fat diet (my weight was 126 pounds, I exercised regularly, rarely drank alcohol, and had never smoked). In addition, I was acutely aware of recent research which suggests eating a low-carbohydrate diet may in fact reduce cardiovascular risk factors more so than following a low-fat diet (Mansoor, Vinknes, Veierod, & Retterstol, 2016).

The pain in my chest, down the left arm, up the jaw, and across the left shoulder kept getting worse, until walking 50 feet from the garage to the kitchen caused me to stop in pain. On occasion I was even awoken by the pain. Once, walking to the cafeteria at work I thought it was all over – there was that crushing, elephant-on-the-chest feeling commonly described as a heart attack. Somehow, I remained standing, extremely still, breathing deeply, and determined to make it back to my office. But the cardiologist had told me it wasn’t my heart, so, convincing myself there were other reasons for chest pain, I continued to work and stopped as often as I needed to, avoiding grocery stores and not walking any more distance than I absolutely needed to until this left “rib” pain went away.

Thankfully my nursing colleagues were not intimidated and encouraged me to return to the cardiologist, which I did. But I did not even see the doctor. The technician performed an EKG, pulled off the strip and disappeared. A few moments later she returned saying the cardiologist had looked at the EKG strip and it was fine. I could go. A few more days passed – a trip to a wedding in Europe was cancelled – my husband could not imagine getting me on a plane in this condition. He was right.

Eventually, in desperation, a nurse practitioner colleague called her own female cardiologist and I was seen in her office that day. Declining help, I drove myself 30 minutes to the new cardiologist, stopped three times from the parking lot to the office due to pain and finally presented exhausted, with a blood pressure of 220/110 mm Hg. Suddenly, everything took an urgent turn. The cardiologist asked me to call my family, a bed on the telemetry unit was being arranged (no, I could not go home and feed the dogs

first), and I was to be driven to the hospital. I was to sidestep the emergency room to be admitted directly and an angiogram was arranged – stat. The cardiologist stayed with me until my ride arrived, comforting, telling me that soon we would know for sure what was going on, and wondering why I had waited so long to get help.

That night, an exceptional interventionist somehow inserted two stents into a 99.89% blocked left anterior descending artery, avoiding by-pass surgery. A month later, due to continued (although significantly reduced) pain, two more stents were placed into the right coronary artery. At the same time, a diagnosis of pericarditis was made for continued (although different) pain, although remarkably there appeared to be no long-term damage to the heart muscle.

A few months later, having completed cardiac rehabilitation and returning to work, it struck me how lucky I was to have had caring professionals around me despite an initially disappointing encounter with the male cardiologist. Then I was mad; how dare he ignore me and tell me to eat a low-fat diet? How dare he joke about my teeth when there was such a serious health issue at stake? How different the situation was with the new cardiologist; we were on texting terms with each other (careful not to abuse the relationship but thankful for the reassurance) and, at her suggestion, I took on the crusade for women's heart health.

Case Study 2: Compassion Fatigue

On May 5, 2014 at 10:04 a.m., my world profoundly changed. My extremely healthy, former Army Ranger and Gulf War 1 helicopter pilot, significant other (SO) was diagnosed with Stage 4 thymic carcinoma, a terminal and rare type of cancer. He experienced no signs or symptoms, yet the bottom of a routine neck X-ray done to track some stenosis probably caused from his marathon running days, showed a shadow in the top of his chest. “Probably nothing,” said the thankfully aware radiologist. “Nothing” turned out to be a tumor the size of a grapefruit that wound itself around the great vessels, brachial nerve, and a portion of lung. One look at the film caused me to gasp in disbelief and become nauseated. I was positive they had mixed up the films with another patient. But no.

Ok, no worries, right? It's *just* a benign thymoma that can be excised by surgery. He was in perfect health and would be fine! We started looking at our calendars to schedule surgery at a convenient time for *us*, as if this tumor was simply an unwanted blip in the screen and we could, at *our* will, eliminate it from our lives and carry on our merry way. This would be like making a reservation for dinner, a seven-course dinner, but still, not a big deal.

I remember, like it was yesterday, sitting at my kitchen table waiting on an overdue phone call from my SO. He had texted me that the VA oncologist had asked him to stop by his office (odd, since the liver biopsy report was not due for another week). And I

wasn't there. I was *supposed* to be there; I was a former critical care nurse and I felt guilty for missing a critical moment. Completely unaware of what was happening, I had begun the journey of all knowing, strong, and in control caregiver. In my mind, it was my role to handle all things medical.

I was still scared when my SO finally called me, his voice shaking in between tears. The news wasn't good. The liver biopsy had revealed a lesion, which put this “shadow” into an entirely different category. This shadow was death, 100% of the time, even with all the options available. “I'll be treated palliatively with chemo as an outpatient at the VA,” he said, keenly aware of the ultimate outcome.

There were no words I could say other than, “I love you. They don't know *you* and they don't know *us*.” I offered to come get him, yet he declined and somehow made it home. I immediately channeled my inner warrior nurse and “oh, hell no” attitude. I located the world-renowned expert in thymic carcinoma, and by the time my SO arrived home, I secured an appointment in 24 hours to “talk to a man about a cure.” And that was that.

As I found out over the next couple of years of his treatment, and while I don't for a minute regret my support and devotion to my SO, the lessons I needed to learn about overgiving, compassion fatigue, and burnout were just beginning to rear their ugly heads. I was unaware that while my SO's disease management was mapped out perfectly, mine was not. I began sliding down the slippery slope of neglect and sacrifice of self. It was a journey I barely survived even though I have built a thriving business, published numerous articles, authored several books, and presented on self-care strategies to prevent burnout and compassion fatigue to hundreds. I learned it's easier said than done and I felt like a fraud.

In the distance, I had a feeling of becoming more detached from *my* life. I observed that even through all the busyness of battling cancer and seemingly positive progress, I became more and more lonely. I could not focus on my work, take on any more coaching clients, and the thought of writing an article or speaking on stage left me feeling overwhelmed and exhausted. Where I once leapt at opportunities, I became agoraphobic, apathetic yet easily startled. My adrenals were fried and I was numb.

I developed a checklist of sorts that allowed us something other than fear to focus on. Yet, it slowly became a one-way street with all energy flowing only from me to him. I eventually ran out of steam and selfishly felt this was becoming burdensome. At the same time, it perversely felt great to be somehow responsible for a positive outcome. I was a hero of sorts, managing all aspects of his care like an airport tower controller! But I realized I designed a toxic, unsustainable dynamic and I felt trapped.

I tried endlessly to get my SO to discuss his feelings. When I told him about my feeling of drifting apart and loneliness, he responded with indifference,

which eventually became his way of being. After his treatments ended and he was (thankfully) in full remission, this indifference turned into seething anger, which was energetically palpable across a room. When gently confronted, he recoiled, so I pushed, and he withdrew. I pushed more, he clammed up, and I (sadly) quit trying. His mostly silent anger was all consuming. My house had become a hostile environment and now I was becoming ill.

We fought together, yet now we were clearly on opposite sides of a chasm as deep and wide as the Grand Canyon. I was no longer his partner, lover, nor best friend. Now I was the caregiver. My once highly resilient self had morphed into an anxious, depressed, unmotivated hot mess. My easy laughter and zest for life vanished – I was experiencing compassion fatigue.

Lessons Learned and Recommendations

These events can happen to anyone. Know-how and sophistication as nurses are not necessarily good for us. We self-sabotage when we forge walls to protect ourselves instead of being vulnerable and open to receive the care we thirst. Is it because, when we are at our weakest we are expected to cope, be at our strongest, and not acknowledge our feelings? Moreover, how responsible are we for our own care? If cardiac care was mismanaged in a nurse with a PhD and all resources at her fingertips, what about all the other women who may be in a similar situation?

Gawande (2009) warns us failure of ignorance is one thing, failure despite knowledge is negligence. And yet, in both cases nurses allowed a situation to get the better of them. Worse still, being trim and looking well should not work against you when you are evaluated for a serious medical condition! If a patient presents complaining of pain, especially chest pain, why would she be dismissed so easily? Would a man have received different treatment, including the “smile” test?

Often people have a problem shifting their health issues into potentially helpful solutions. They await clarity amid the confusion they feel; they may be skeptical about approaches that prevent further disease, especially if they feel they have already explored all possibilities. The real lesson is how we can be led to improving decisions. Huffington (2014) calls this “course correcting” (p. 137) and describes how reaching rock bottom through sleep deprivation and stress almost cost her life until she took hold and put herself first. We must course correct before we reach rock bottom.

The practice of self-care means engaging in meaningful and nontoxic connections with others who support you, listening to your body when you feel something is awry, and knowing when you are headed toward exhaustion. Learning to self-soothe or calm your physical and emotional distress is also essential to self-care. In other words, we need to “mother” ourselves in mind, body, and spirit.

Summary

Two cases presented illustrate the importance of integrating a self-care approach with one’s own journey navigating health challenges. The authors are confident there are countless other personal examples and make suggestions on how to infuse personal and professional well-being, especially during times of crises. Nurses, as natural caregivers in all areas of our lives, are ultimate patient advocates. We are best served when we heed the lessons of self-advocacy with life, love, vulnerability, release what is not ours to fix, avoid overgiving, and accept with grace, the art of receiving. \$

REFERENCES

- Absolon, P., & Krueger, C. (2009). Compassion fatigue nursing support group in ambulatory care gynecology/oncology nursing. *Journal of Gynecologic Oncology Nursing, 19*(1), 16-19.
- Appleman, Y., van Rijn, B., ten Haaf, M.E., Boersma, E., & Peters, S. (2015). Sex differences in cardiovascular risk factors and disease prevention. *Atherosclerosis, 241*(1), 211-218.
- Figley, C. (2002). Compassion fatigue: Psychotherapists’ chronic lack of self care. *Journal of Clinical Psychology, 58*(11), 1433-1441.
- Gawande, A. (2009). *The checklist manifesto: How to get things right*. New York, NY: Picador.
- Gianturco, L., Bodini, B.D., Atzeni, F., Colombo, C., Stella, D., Sarzi-Puttini, P., ... Turiel, M. (2015). Cardiovascular and autoimmune diseases in females: The role of microvasculature and dysfunctional endothelium. *Atherosclerosis, 241*(1), 259-263. doi:10.1016/j.atherosclerosis.2015.03.044
- Gould, J.E. (2005). Compassion fatigue: An expert interview with Charles R. Figley, MS, PhD. *Medscape News*. Retrieved from <http://www.medscape.com/viewarticle/513615>
- Hevezi, J.A. (2016). Evaluation of a meditation intervention to reduce the effects of stressors associated with compassion fatigue among nurses. *Journal of Holistic Nursing, 34*(4), 343-350
- Huffington, A. (2014). *Thrive: The third metric to redefining success and creating a life of well-being, wisdom and wonder*. New York, NY: Harmony Books.
- Jankovic, J., Marinkovic, J., Stojisavljevic, D., Eric, M., Vasiljevic, N., & Jankovic, S. (2015). *European Journal of Public Health, 26*(1), 152-158.
- Johnson, S. (2012). A U.S. study of nurses’ self-care and compassion fatigue using Watson’s concepts of caritas. In J. Nelson & J. Watson (Eds.), *Measuring caring: A compilation of international research on caritas as healing intervention* (pp. 413-420). New York, NY: Springer.
- Ketepe-Arachi, T., & Sharma, S. (2016). Underestimating risk in women delays diagnosis of CVD. *The Practitioner, 260*(179), 11-15.
- Mansoor, N., Vinknes, K., Veierod, M.B., & Retterstol, K. (2016). Effects of low-carbohydrate diets v. low-fat diets on body weight and cardiovascular risk factors: A meta-analysis of randomised controlled trials. *British Journal of Nutrition, 115*(3), 466-479N.
- Richards, K., Sheen, E., & Mazzer, M.C. (2014). *Self-care and you: Caring for the caregiver*. Silver Spring, MD: American Nurses Association.
- Spence, J.D., & Pilote, L. (2015). Importance of sex and gender in atherosclerosis and cardiovascular disease. *Atherosclerosis, 241*(1), 208-210. doi:10.1016/j.atherosclerosis.2015.04.806
- Westerman, S., & Wenger, N.L. (2016). Women and heart disease, the underrecognized burden: Sex differences, biases, and unmet clinical and research challenges. *Clinical Science, 130*(8), 551-563. doi: 10.1042/CS20150586
- Winham, S., Andrade, M., & Miller, V.M. (2015). Genetics of cardiovascular disease: importance of sex and ethnicity. *Atherosclerosis, 241*(1), 219-228. doi:10.1016/j.atherosclerosis.2015.03.021

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