**How taking on a mothering role can lead to less effective care and advocacy for patients**

The treatment of a patient and attitudes towards him raised questions about the nursing role, and gender and age differences between nurses and patients.

Meningococcal septicaemia had left 19-year-old Robert Jones with necrosed feet and widespread scabbing of necrosed areas on his arms and upper legs. After a spell on the intensive care unit, he was transferred to a general ward then moved to a 30 bed GP-led community hospital.

The rationale for transfer was to allow the body’s natural healing process to salvage as much viable tissue as it was able, to allow the toes to disengage from the foot before any surgical intervention and thus save as much of the patient’s extremities as was possible.

Using the activities of daily living nursing model (Roper et al, 1996) the nursing team composed a care plan for Mr Jones which included participation in rehabilitation.

Changing dressings on the scabbed areas of both arms, from elbows to fingers and from thigh level to toes occurred daily. This caused excruciating pain and took two nurses a minimum of 80 minutes to complete. His wounds were viewed by the tissue viability specialist nurse every month.

Inadequate analgesia at dressing change was solved by using Entonox (50% nitrous oxide and 50% oxygen), which necessitated specialist training by the ward nursing staff. Mr Jones preferred Entonox to opioid analgesia as it provided swifter pain relief, and background levels of analgesia were maintained with fentanyl patches (150mg) and Oramorph (morphine sulphate) given as needed.

**DIETARY REFUSAL**

Mr Jones’s wounds appeared to be taking an inordinately long time to heal or show improvement. On investigation, his albumin level was discovered to be 21.6g/L, possibly due to large amount of wound exudate and in some part to malnourishment.

Initially, Mr Jones would miss breakfast as he preferred to sleep late; after explanation of the role of nutrition in wound healing he committed to eating two forkfuls of bacon or sausage or scrambled egg at breakfast. He also agreed to eat cheese and biscuits in the late evening to increase ingested protein. Food in the hospital was home cooked, and protein was present in every meal with the exception of scones at afternoon tea. The sandwiches offered at 5pm for the evening meal contained cheese, tuna, egg or meat.

Mr Jones did not like the hospital food and refused dietary supplements despite explanation that increasing protein intake would result in faster healing. He later agreed to an orange flavour supplement twice a day with crushed ice. His parents occasionally brought him steak or fish and chips.

A food chart to monitor Mr Jones’s intake was initiated. The dietitian recommended supplements and overnight nasogastric feeding. However, we could not gain Mr Jones’s consent for the latter.

**MOTHERING ROLE**

I believe as a team we participated in what I refer to as “reverse ageism”. The nurses were women aged 39-55. Mr Jones was the same age as our children. Nurses took up more of a mothering role than the fathering role would seem that the nurses (mother role) and nursing staff (female (mother)). The subject was broached by a male GP – at which enquiry the nurses left Mr Jones’s room without being asked. It would seem that the nurses (mother role) found it embarrassing to acknowledge the patient’s (son role) sexuality.

As his illness was traumatic and sudden, nurses acquiesced in his refusal to partake in rehabilitation without trying to persuade him of the benefits of treatment and compliance. It was deemed that he had “been through enough”. Photographs of his wounds were not taken on his arrival nor at any other time as it was not thought seemly and possibly too distressing for him, yet every other patient had their wounds photographed (always with consent of course). Nurses would spend spare moments chatting to him as though he were a grown child of theirs.

Had he been an older patient we would have strongly advocated the insertion of a nasogastric tube and overnight feeding. Of course, this would never happen without a patient’s permission; yet I feel we would have tried harder and succeeded in gaining consent from older patients, perhaps because of their understanding of the expertise of nurses and medical staff in wound care and the management of patients following such a devastating illness.

**BEING OBJECTIVE**

As a good rule of thumb when dealing with an older patient, I ask myself: “Would I like this to happen to my mother?” We treated Mr Jones as we would our children but without asking ourselves: “Would I like this to happen to my child?” We gave him the mothering without the objectivity that should be inherent in the nurse role.

Ultimately, we let Mr Jones down by letting our parenting instincts come to the fore, forgetting that nursing is not solely about nurturing – it includes assisting the patient to face up to and learn to adapt to changes in their health. Sometimes this can be a hard lesson to learn.

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**REFERENCE**


**WRITING CASE STUDIES**

- Have you been involved in a new treatment or therapy?
- Have you been involved in a situation that has made you think about or change your practice?

If you would like to share your experience, email your suggested case study to ntk@emap.com, putting ‘Case study’ in the subject box.