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Dimensions of Vulnerability in Emergency Nurses' Narratives

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Abstract

Two notions of vulnerability dominate in the nursing literature. In one model, vulnerability is equated with susceptibility to particular harmful agents, conditions, or events at particular times and is considered something to be avoided or resisted. Another view regards vulnerability as the ever-present, common condition of all sentient beings and a condition of nurses' access to understanding patients' experiences. This article uses data from an ethnographic study conducted in two hospital emergency departments to illustrate tensions between these two stances toward vulnerability as they are reflected in emergency nurses' narratives.

Many years ago, I worked as an emergency department (ED) nurse in an inner-city hospital that received many "knife and gun club" patients (as they were known in the parlance of ED bravado)-patients with injuries from shootings or stabbings. One night, I was working when a shooting victim arrived. Within minutes, the ED physician had "opened the chest": that is, sliced through the skin of the chest, pried the ribs apart, and visualized the heart to try to find the injury before the man bled to death.

Assisting, I stood with my gloved hands inside the man's bloody chest, gently massaging the heart in the attempt to maintain circulation, while the doctor prepared to defibrillate and several other nurses and technicians endotracheally intubated the patient, started intravenous lines, gave medications, and prepared equipment for use. Less than 20 minutes later we stopped; the man's injuries were too massive, the body unresponsive to all we had done. The doctor left to speak with the man's family. The other nurses and technicians moved on to care for

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other, living patients. I was left alone to prepare the room and the body and to resupply the area for the next injured person's care. I worked quickly, because while we had all been engaged in the rescue attempt, other patients had been arriving in need of care.

My eyes fell on the man's feet. Although his clothes had been violently stripped and cut away from his trunk in the resuscitation effort, his soft white socks remained on his feet where he had pulled them on when he dressed himself hours ago, at the ordinary beginning of his last day of life. One of them had a small hole in the toe. I felt a sudden lightheadedness, a tingling up the back of my neck, a rising lump of nausea. This was a person-he had an everyday life, he had pulled his socks on today as I had, never dreaming that he was doing this for the last time.

There was something profoundly shocking about having just had my hands inside the torn-open chest of a human being who still had his socks on. It suddenly felt like a kind of violation, like rape, confusing and terrible, even though I knew I had been trying to save him. Those soft socks spoke of the profoundly disturbing ordinariness of a life that had suddenly been stopped. Here, in the very heart of our collective bastion against the unpredictable and the unexpected, I found myself face to face with the way those I rescued were like me. I was, as they were, vulnerable to being irretrievably broken.

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THE HOSPITAL EMERGENCY SETTING

In perhaps no other setting in the hospital are health care clinicians confronted so frequently and violently with their own finitude and fragility as they are in the emergency setting. On inpatient units, patients are undressed and gowned; the human identity that attaches to clothing and personal items is packed away in labeled bags. In surgery, the patient's body is almost completely veiled from view except for the scrubbed, shaved operative area. But in the ED setting, people arrive with awful injuries and illnesses, snatched straight out of their everyday lives, their socks still on. Clinicians and patients in emergency settings thus meet one another within a context characterized by urgency and vigilance in which unpredictable dangers obtrude.

The ED occupies a peculiar cultural niche. It is a bastion of defense against finitude and vulnerability, and the place where these are revealed most graphically. There is perhaps no other community institution so intensely focused on the task of heroically helping. In using the term "heroic," I mean to suggest an attitude of courage and daring that characterizes the way emergency care providers dash into the very jaws of death to snatch back a fellow human being, just in time. The saving of strangers is the essence of emergency nursing, and in carrying out this role, clinicians are constantly confronted with the existential, physical, emotional, economic, and social vulnerability of their fellow human beings. However, also characteristic of emergency settings are the rapidly changing pool of patients and the temporal constraints of urgency, which may serve to shield clinicians somewhat from confronting their own vulnerability.

Patients who use EDs most frequently, the "frequent flyers," [1] are among the most vulnerable of patients in several ways. [2-4] This group of patients has been shown to be at increased risk for premature death and disability [2-4] and social distress (Okin R, Boccelari A. 1994. Unpublished data). Because their problems are often chronic and complicated by mental illness, drug or alcohol use, homelessness, and other issues, they are also among the most difficult patients for emergency nurses. [5]

The study reported here suggests that another reason nurses find these patients so difficult is because their familiarity challenges the thin protection against existential vulnerability provided by rapid patient turnover and the climate

of urgency, and it exacerbates the tension between two meanings of vulnerability that are captured in the practice tradition of nursing. In contrast to the majority of ED patients who are seen briefly once and sent onward quickly, these frequent flyers are the ones emergency nurses are most likely to know more than superficially and transiently. Knowing the patient [6] solicits a different level of engagement-and, in turn, creates a different exposure to existential vulnerability-than merely processing the patient's body. This article draws on interview, narrative, and field note data from a larger ethnographic study of ED frequent flyer patients [7-9] to describe how nurses experience and cope with such vulnerability in the emergency setting and how their experiences may inform our thinking about vulnerability as a concept.

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VULNERABILITY AS A CONCEPT

The Oxford English Dictionary defines vulnerability as "the quality or state of being vulnerable, in various senses." [10] These senses include vulnerability as military, strategic, or structural weakness and as sensitivity to disease.

Two notions of vulnerability dominate in the nursing literature. One is what might be called a public health model of vulnerability, in which vulnerability is equated with susceptibility to particular harmful agents, conditions, or events at particular times. In this perspective, vulnerability is a factor of the relationships between environmental supports and personal resources and is generally considered something to be avoided or resisted. [11] Another view regards vulnerability as the common condition of all sentient beings. In this perspective, vulnerability is a constant condition of human experience, a commonalty we share by virtue of our embodied existence and our finitude. [12] As such, it is a condition of access to understanding aspects of patients' experiences and is regarded positively. For example, Daniel [13] suggests that authentic nursing practice requires a willingness to engage with patients by acknowledging "mutual vulnerability." She challenges the notion that vulnerability is something to be avoided and protected against. Rather, she suggests that acknowledging and even embracing their own vulnerability provides nurses with opportunities for a richer and more authentic relationship with patients.

Choosing to enter a helping profession such as nursing or medicine can be a way to increase one's feelings of control and mastery-a coping strategy to reduce existential anxiety [14] over the unpredictable and capricious events of life. Yet such a choice also brings clinicians face to face with the very conditions they may find most fearsome to contemplate. The tension between these two stances toward vulnerability was reflected in the narratives of emergency nurses caring for frequent flyer patients, in which nurses used mythmaking, distancing, and existential engagement as they cared for this subgroup of emergency patients.

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METHODS

This interpretive ethnographic study was grounded in the research approach represented in nursing by the work of Benner and others, [15-21] which is based on the phenomenology of Logstrup, Merleau-Ponty, Taylor, and Heidegger. [22-29] This approach, in which narratives are primary data sources, seeks to uncover socially embedded meanings by analyzing how experiences are constituted as accounts or stories. Philosophically, the method is grounded in a phenomenological understanding of personhood [30] as embodied, meaningful, and self-interpreting. The aim of research conducted in this tradition is to capture meanings embedded in and constitutive of everyday experience.

The larger study [8] included ethnographic fieldwork and interviews in two inner-city hospital EDs (located in two Western states) over a total of 12 months during 1993 to 1994. Both hospitals are trauma centers. The primary site is a

public hospital ED with approximately 70,000 patient ED visits yearly. Fifty-five percent of the patients are uninsured or self-pay patients, 37% are covered by public insurance programs such as Medicaid and Medicare, and only 6% are privately insured.

Data sources for this article include tape recorded group interviews with 40 emergency clinicians and informal individual conversations that occurred during observation periods. Demographic data are based on the 30 staff who provided it; 10 other participants declined to provide this information. The staff averaged over 15 years of experience in clinical practice (range 5 to 35 years, median 10.5 years) and over 11 years of experience in emergency nursing practice (range 2 to 30 years, median 9 years). Seventy-four percent were female. The average age was 39 years. Most were Caucasian, reflecting the composition of the staff of both EDs, which likewise were predominately Caucasian and female; only three clinicians interviewed were not Caucasian.

During group interviews, nurses were encouraged to share detailed narratives of their experiences of caring for frequent flyer patients in the ED-patients who "visited often." Because part of the study included exploring how clinicians defined this group among themselves, clinicians were offered no explicit numerical definition of frequent flyer patients. Interviews were tape recorded and transcribed verbatim. Analysis was carried out using a hermeneutic or interpretive approach as described by Benner, 31 in which narratives are analyzed through an iterative process. Paradigm cases 31 are developed as a way of gaining access to the data from an emic or "insider's" perspective. This in-depth analysis, as SmithBattle and Leonard note, 21 "builds an account that can then be compared with other cases, not for the purpose of aggregating them to create a more general, abstract model, but to shed further light on other cases."[(p38)] The aim is to understand participants' experiences in the context of their existential worlds 30 and to give voice to those experiences. This kind of "articulation" research 32 offers the potential to empower participants by capturing aspects of their experience that may otherwise be silenced or distorted. Earlier reports from this study 1,9 described how both nurses and frequent flyer patients understood their often-strained relations in terms of a surrogate family relationship and how the emergency setting provided reassuring context in the lives of highly marginalized patients. 33 A methodological appendix published with an earlier report from the study provides more information about strategies used to enhance the rigor of this study. 9

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THE EMERGENCY DEPARTMENT AS A ZONE OF PROTECTION

Death in the emergency setting is almost always considered in some sense a tragic accident, regardless of whether it actually is caused by a cardiac dysrhythmia, a car crash, or some other catastrophic, unanticipated event. This contrasts, for example, with the microinstitutional view of death in a long-term care unit or hospice unit as a welcome relief from pain, the anticipated closure of a meaningful life, or the transition to another way of being or an afterlife. This is not to suggest that people do not come into the ED and die there quite predictably of the cancer from which they had suffered for months or years, but this is not the kind of event for the sake of which such a place exists. It is the sudden and unforeseen events that have primacy in this setting. The ED represents a kind of cultural zone of protection, the center of our collective line of defense against the terrifying arbitrariness with which misfortune is distributed among us.

In carrying out this very mission, the ED also creates a zone in which helplessness is brought to the forefront of attention, because it is the place where our ability to control and predict 34 breaks down before the finitude and the contingency that characterize every aspect of our lives. Rescue is not always possible, and the stance of omnipotent rescuer is ultimately untenable, as every one of us will die. As Hauerwas 35 has pointed out, medicine "tries to justify its power by being what it cannot be-a science that frees us from, rather than

teaches us, the limits of our bodies."(p51)

Nursing, which counts as part of its unique contribution a holistic conception of persons as more than mere body-vehicles that are objects for medical treatments, straddles a position in which practitioners are called on both to avert harm by recognizing and minimizing vulnerability, and to help patients cope, often through helping them accept and learn about their vulnerability. In the ED, the rapid flow of patients and the brief, episodic nature of the contact help clinicians focus largely on the first aspect of their mission, in which they are unabashedly combatants against vulnerability. Frequent flyer patients, however, become familiar figures over multiple visits, soliciting a deeper level of awareness and involvement that draws nurses closer to recognizing their own ever-present vulnerability by seeing it in others.

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MYTHMAKING AS A DEFENSE AGAINST EXISTENTIAL VULNERABILITY

Frequent flyer patients are the subjects of legend for emergency personnel, who recount their survival stories with something akin to awe. These patients are storied as able to withstand tremendous stressors; they take on almost superhuman characteristics in emergency nurses' narratives.

Nurse: These people are so rugged to me. You know, even though they're so unhealthy, they're so rugged. And I kind of compare it to like when I took an ecology class, they talked to you about the chaparral and the tundra, the different ecosystems. … And the chaparral is this really rugged terrain where it goes from 10 degrees at night to maybe 90 degrees during the day, out in the middle of the desert. And to be a plant or animal life in that environment, you have to be very hardy and rugged to survive, whereas [in] the tundra it's always the same temperature … you don't have to be rugged. Yes, you're living in a harsh condition, but there's no ruggedness about you. … I look at some of these street people who come in here … how many times have-I think some of them have a thousand lives. They're rugged in a certain sense that they live at such extremes in their body. They can go through tremendous trauma and insult. And still walk away from it, and check out a couple days later. But if that was you or me and we just get, maybe, hit by a car, we're very fragile and we die. Because we're not very rugged.

Interviewer: So you think that they are actually physiologically adapted …

Nurse: They're physiologically adapted to live at any extreme. So something that would kill you or me doesn't kill them. I mean, if you or I got hypothermic to the point of we were, you know, 31[degrees], we might have been in asystole and unresuscitatable. Whereas, like [female patient] … I haven't seen her in probably a year. I know last winter, they ran a code on her for 2 hours because they couldn't pronounce her because she was too hypothermic. They were trying to rewarm her, rewarm her. *Two hours*. They got a heart rate back. … She left a week later. But, I mean, 2 hours. You or I, we wouldn't come back. But these guys, I don't know what it is.

In this description of an alcoholic homeless woman's resuscitation, the patient is *not* like "us" in so many ways; the myth-making function serves to exclude these patients from the ordinary human community. Their extreme vulnerability (social, economic, physical) is transformed into a story about their ability to defy death. This allows clinicians to feel less guilty about their failure to save such patients, because the patients themselves are endowed with such powers. The power to save is attributed to the body itself, rather than to intentional mental control of behavior and the body. What such a myth obscures is questions about the absence of provision for basic, low-technology care and the social causes and meanings of alcohol and drug dependency. 9 However, it also functions to shield the nurse from recognizing aspects of her own vulnerability and commonalty with the

patient. Even as she suggests that she would die more easily given similar circumstances, the mythic stature she attributes to this homeless patient serves to emphasize distinctions between them.

However, the legends cannot be kept alive when a frequent flyer dies.

I felt really bad when he [frequent flyer patient] died. Because you always think, oh, these people are going to fall down and hit their heads all the time and live through it. … It's like they have nine lives … a lot of other people fall down and hit their head once … and they're dead! Well, we see these people again and again and again. … There was another nurse that was here, [name], who felt the same way. She said, you know, I felt really bad that he died. I said, I did, too. And she said, I know … he's not going to be here anymore. And I think it's just, [you] think of your own mortality too.

There is comfort in the myth of the frequent flyer as superhuman, resilient, and able to withstand physical, social, emotional, and economic assaults. Such a construction shields clinicians from shared vulnerability. Only those who also work in the ED can understand the strange mix of relief, guilt, grief, and fear that nurses feel at the death of a longtime frequent flyer. Because their longtime history with and knowledge of such patients provide emergency nurses with a bit of continuity and predictability in a setting in which these are rare, the death of a frequent flyer patient can precipitate reflective awareness of shared existential contingency.

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DISTANCING

More explicitly distancing themselves from patients was another strategy used by nurses to cope with the vulnerability elicited by caring for frequent flyers. This took several forms.

Nurse: She [frequent flyer patient] looked good yesterday. She came in, uh, I mean, I didn't really take care of her. I just glanced at her. And she looked good. … I didn't talk to her. I never talk to [her] unless I have to take something out of her hair, you know-

Interviewer: Why?

Nurse:-that's gotten stuck in there. She always gets things stuck in her hair. I don't know. I'm always cutting things out of her hair.

Interviewer: Why do you never talk to her?

Nurse: Why? Usually because I'm busy. You know, because I pace myself here. I mean, I don't go out of my way to, uh, (pause). But there are days … Ewhen I have energy to talk more to people. And then there are days that I just can't. I just have to wall off and, you know, I do what I have to do because you have to know … when you can put out more and when you can't deal with these people.

"Walling off" and performing nursing as a series of tasks serve here as a way to cope with the demands of bearing witness to patient vulnerability. This distancing stance acknowledges some level of vulnerability in both patient and nurse, but regards it as something to be avoided, and thus fails to make the connection between them. Each remains existentially isolated from the other.

In another form of distancing, patient vulnerability is attributed to "destiny."

Nurse: He was, he was destined. He was such a bad alcoholic, we intubated him twice this winter, I think, just for alcohol and, in fact, I took care of him the day he died. … It was destiny for him. He was so bad, and he was drinking so much that-

Interviewer: You don't think there was anything that anybody could have done?

Nurse: No. No. No. No. No, I really don't. He was beyond that point.

The nurse's emphatic, repeated "No" suggests a distancing that is self-protective. Regarding vulnerability as destiny means that nurses are relieved of their obligation to struggle against it on their patients' behalf. It also serves to assuage guilt over not having saved this patient, perhaps compounded by recalling how difficult it was to care for him.

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BEARING WITNESS TO SUFFERING

It is agonizing to bear witness to suffering. Witnessing is qualitatively distinct from mere looking; witnessing *engages* the witness as a bearer of truth that the suffering person cannot tell. 36 This aspect of the practice of nursing is largely unacknowledged, and the vulnerability it requires nurses to experience is rarely addressed. Repeatedly, nurses told me stories about how they watched as patients they came to know as frequent flyers slowly deteriorated and died. A nurse with over 20 years of experience told me the story of a patient called "Nicky."

Nurse 1: A young … fellow that I probably started taking care of 20 years ago … who at the time was employed by the post office, which is a pretty good job … and for the first several years, he was able to maintain an employment, you know, but was just a chronic alcohol abuser. And starting out it was more the weekend partying, get too drunk, fall down, get in a fight, whatever. But over a period of time, his drinking started pouring into throughout the week. So we just ended up seeing him a lot …

Nicky was … started out as a pretty nice guy. He was cute and bubbly and fun-loving, and had a tendency to get more happy and more fun-loving as he drank. And all of that changed. And after probably 10 years, he wasn't fun any more. He wasn't cute. He became obnoxious, belligerent …

Nurse 2: And then I think about a year ago his mother died. And I think that really pushed him-made him drink more, and-

Nurse 1: He was so far gone by then, though … he was dirty, he was obnoxious, he was demanding, he was mean, and all of this stuff that used to be fun about seeing him on a regular basis just went by the wayside because he was really a pill after that. He was living on the streets and filthy, and drank constantly; you'd see him just as drunk at 10 in the morning as you would at 10 at night, and he didn't really have any major health problems, but I think everything just went by the wayside. I can't remember what happened to him. … I don't think it was anything more than just an illness, pneumonia or something like that. And he died fairly recently.

As this narrative progresses, Nicky's personhood falters and fades from sight. In the beginning, there is a kind of forgiving understanding of Nicky's problem. He gets too drunk at parties because he's a very "fun-loving" kind of guy. But by the time his mother dies, his personhood is fading in the narrative; he is "obnoxious," "dirty," and a "pill." By the end of the story, he has become a dreaded burden. His personhood has been "left by the wayside." The story stands out for the nurse because of the terrible way Nicky disappeared before her eyes, leaving her feeling helpless and perhaps guilty that she could not save him. At the end, she seems to have grown weary of bearing witness, to have lost the thread that once connected her, although Nicky lives on in her narrative.

Nicky's kind of vulnerability is not the kind the ED is set up to battle. It is too slow and too fraught with contingency. Even his death is a *vague* kind of death, in contrast to the sudden, definitive death against which emergency clinicians prefer to struggle. In some ways, Nicky's death is rendered almost invisible in this setting, because it has been going on for years. But Nicky's suffering is not invisible. Clinicians watch, week after week, as patients like Nicky disintegrate before their eyes, until they can no longer bear to watch.

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EXISTENTIAL ENGAGEMENT

"Suffering must invariably involve the person," observes Cassell, 37 "bodies do not suffer, persons suffer."(pvii) When we allow the suffering of others to show up, when we do not deny or ignore vulnerability, we allow them personhood and preserve the social value of caring for others. We also expose ourselves to pain and fear. Yet there is a way in which our own humanity is diminished when we must shield ourselves-"wall off"-in order to psychologically survive. 38

It is not only the realization that rescue cannot always be successful that precipitates feelings of helplessness. It is the recognition that the rescuers themselves could just as easily be those in need of rescue. Yet this reflective recognition, when it appeared in nurses' discourse, seemed to generate compassionate engagement with patients in the work of acknowledging and coping with shared vulnerability. Nurses raised this issue repeatedly in discussing their experiences with frequent flyers.

You know, you can talk about people that are repeaters and the people that abuse the system. But in your weak moments, you can just think that-this could be you, you know … things could happen that would change our lives, that could make you be in the same situation. I mean, no one thinks it could happen to them, but it really-I mean, we see people here that are 50, 60 years old that have lost their white collar job, that have gone through all the money they have, and they end up, end up here looking for help. … It just makes you realize how vulnerable that you could be, you know. Just like any trauma patient. You could be the one that's shot. Not every person that's shot or run over by a car and stabbed is a gang member. Or doing something illegal.

Here the nurse explicitly recognizes existential vulnerability as a common human condition, not something confined to certain groups of people by virtue of their behavior or social status. This is the paradox of vulnerability; it can be either bond or barrier between nurse and patient, and it is sometimes both. Viewing the suffering one as wholly "other" helps us cope with our finitude and helplessness, but it comes at the cost of reinforcing our isolation from one another.

Nurses whose understanding of vulnerability focused on engagement spoke of specific ways they tried to preserve a human connection, even when frequent flyers were difficult.

When you see these frequent flyers-and people that just really irritate you, abusive people-sometimes I find myself just going ahead and getting irritated with them and kind of feeding into their anger, but other times … I try to think of this person as someone's child. You know, you look at them and they're saying, "F*** you" to your face. And you try to think of them as a child. And it kind of puts things back into perspective because we are pretty much-no matter if you're a frequent flyer or not, we see the worst of people. And you know they are not like this all the time. (pause) No one is.

This story contains a recognition of the inherent dependency and fragility we all share as part of being human. Thinking of patients as "someone's child" allows this nurse access to a common experience and a way to better understand the vulnerability and anger of her patient. In the same way that a parent is able to recognize that a child's anger is not wholly constitutive of the being of the child, this exercise allows the nurse to feel engaged, caring, and compassionate rather than feeling abused, angry, and helpless.

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CONCLUSION

Nursing's metaparadigm has been characterized as including the concepts of person, environment, health, and nursing. However, it is the *vulnerability* of persons or patients that gives nursing social value. If an aim of nursing practice is compassionate engagement with patients, vulnerability cannot be conceptualized in terms of patient susceptibility alone, as though it were a risk factor that could or should be eliminated. Vulnerability is an ever-present aspect of being human, and recognition of mutual vulnerability is a way to preserve on a societal level the value of caring for others. Research that further articulates how nurses successfully negotiate the tensions between different conceptions of vulnerability may help advance a vision of nursing practice as existentially meaningful work, a sorely needed counter to constricted views of nursing as a mere technical activity or commodified service line. 39

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