

# I Don't Have Time to Think

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**T**his issue features an interview with Dr. Carole Estabrooks, director of the nurse-led research unit KUSP, an acronym for the University of Alberta's Knowledge Utilization Studies Program. KUSP's focus is to develop the science of knowledge translation and its uptake. I have some thoughts on the subject. Nurse researchers in Canada, in a relatively short period of time, have established a reputation for excellence in their work that has gained them entrance to and acceptance by the national and provincial research enterprises. There are many indicators of this success: for example, Dr. Nancy Edwards, of the University of Ottawa School of Nursing, is the chair of the Governing Council of the Canadian Institutes of Health Research (CIHR), the leading health research funding body in the country; Dr. Joy Johnson, of the University of British Columbia, has been appointed the new scientific director of the CIHR Institute of Gender and Health, replacing Dr. Miriam Stewart of the University of Alberta Faculty of Nurses. Many nurse researchers hold personnel awards, as research chairs, research scholars and new investigators, among others; they are successful in grant competitions

and are members and chairs of peer review committees that adjudicate grant applications. The research these scientists conduct is informing clinical practice, bringing clarity to patients' reactions to their health situations and explicating the factors in nurses' work environments that enhance or diminish the quality of care provided. The research that has been generated by these researchers, and from nursing and other health researchers across the world, has created an unprecedented source of knowledge on how to improve practice and the information available to inform nursing practice will only continue to increase.

Research has complicated nursing's future. On the one hand, it has established the profession as science-based and contributed enormously to our understanding of how to enhance patient care. On the other hand, unless we can figure out how front-line nurses who work in hospitals, nursing homes, clinics and home care can use it routinely in the daily care of patients – including being able to turn to research to help answer unique patient care challenges – it is of theoretical value, but of little practical use.

Nursing has been constructed as a “doing” profession. But using research is much more about thinking than doing – that is, thinking, reflecting and determining, for a given patient, what guidance the research provides. The doing comes after the thinking. Nursing is not different from other health professions: the findings from research have to be tempered, adjusted to and moderated by the particularities of the individual patient. Fortunately, as a result of a lot of nursing research, we have learned what matters to patients and what factors must be taken into account when caring for individuals. In a recent *Globe and Mail* interview, Malcolm Gladwell, of *Tipping Point* and *Blink* fame, says that the mental demands of the workplace are increasing and that the next leap forward in work is “going to come from creating a more thoughtful workforce and giving people the opportunity to be thoughtful” (Dube 2007).

But let me tell you what I am hearing from nurses, and about nurses from patients and their family members. Recently, as a friend took her sister home after a six-day hospital stay, the nurse to whom they were saying good-bye lamented, “I’m sorry that we don’t have time to get to know our patients.”

In another, quite different situation, one of my doctoral students, Mary McAllister, is conducting a study comparing the relationships that acute care nurse practitioners develop with their patients to those developed by the patients' physicians and staff nurses. The data demonstrate that the staff nurses essentially function as shift nurses: they get the patient through the shift, not the hospital episode, not even a set of days. She writes: "Nurses seemingly focus on what needs to be done for the patients rather than on patients themselves, and when nurses interact with patients, their focus is on the needs that they must meet for that particular patient at that specific moment in time" (McAllister 2007: 168). In this study, "busyness" and lack of time permeate the remarks of nurses and patients, and their observations are tinged with regret, on both sides, for the way it is. Nurses are, indeed, so busy that they don't have time to get to know their patients. Further, continuity of nursing assignment is such that nurses, at least in many of our acute care hospitals, do not count on caring for patients for more than one consecutive day.

Research utilization takes knowledge of relevant research and of the person being cared for and the time to think in order to put these two together. In terms of knowledge translation, I believe we have gotten it fundamentally wrong because we started at the wrong end: we began with research, undertaking critical appraisals, developing best practice guidelines and creative schemes for bringing research to practising nurses. But if they don't have time to think, and don't care for a patient for more than one day at a time, when are they going to use research, no matter how well it is packaged and delivered? We need all the tools that we have developed; but we also need an environment that gives nurses the opportunity to reflect upon what an individual patient needs, to consult the best practices guidelines or to seek out the latest research on a topic, and then apply it in response to that patient's needs. Of course, not all patients require this level of investigation.

In fact, probably the majority of patients, if their nurses have the opportunity to get to know them, can be well cared for by nurses who know what the evidence suggests for patients with their condition. But what about the patient who doesn't respond to the care, or who has one or more confounding conditions? This patient's nurses must have time to think, and to access the research, in order to develop alternative approaches to care.

Time, and the lack of it, may be the greatest challenge facing nursing. It stands in the way of evidenced-based care, safety and compassionate nurse-patient relationships – and, in turn, nurses’ job satisfaction, retention and ultimately, the ability to recruit the best candidates into the profession. People thinking of becoming nurses want to know that they will be able to be the best nurses they are capable of being, not with the caveat “If I have time.” The lack of time is fuelled by a number of forces, the shortage of nurses being perhaps the greatest. According to the Canadian Nurses Association, we are facing a shortage of 100,000 nurses within five years, so we should be very afraid. I am not typically a pessimist, but I don’t see any way that we can bridge this gap. That tells me that we have to find other ways to give the nurses we have, and those whom we will educate in the next five years and thereafter, the time to think, every day of their working lives. We must rethink how we use this wonderful but limited resource: nurses. We must use the ones we have to the maximum of their thinking, rather than doing, capacity. Perhaps others can do more so that nurses can think more.

## **References**

Dube, R. 2007 (October 1). “Malcolm Gladwell Talks about Our Working Future.” *The Globe and Mail*. Retrieved December 11, 2007. <<http://www.reportonbusiness.com/servlet/story/RTGAM.20071001.wrgladwell1001/BNStory/robNews/home/?pageRequested=all>>.

McAllister, M. 2007. *Patients’ Relationships with Acute Care Nurse Practitioners, Physicians And Staff Nurses: A Descriptive, Comparative Study*. Unpublished doctoral dissertation. University of Toronto, Toronto.