can benefit from specialized mental health care. Successful adaptations should be noted and praised as adequate "for now."

2. Motivation

The parents, and, with increasing maturity, the child, should be asked to make their own assessment of their lives from time to time. They should be asked to judge how the burn injury has affected them and in what ways they might want to change their coping styles. This is the final application of the path of encouraging activity in burn patients and their families. Referral for specialized mental health assistance becomes in this way an ongoing matter for the collaborative judgment of the burned child and his family and their medical caretakers.

8

A Systems Approach to the Emotional Management of the Burn Team

Alan Flashman

THE BURN TEAM IS A SYSTEM

A system is any group of people who interact closely on matters of emotional importance. By calling this group a system, we mean that:

1. The activities and feelings of any one member necessarily cause reactions in the activities and feelings of all the other members.
2. Any physical or emotional work required of the group will be shared in some way by all members of the group.

People whose work together involves patients with burns become a system because:

1. The care of burned patients necessarily arouses major emotional responses.
2. The care of burned patients brings these emotionally aroused people together regularly, in close interaction, to coordinate the complex treatment regimen. This is especially true in a Burn Special Care Unit.

System members react to each other and share work. When these proceed smoothly, the rules of the system are implicit. When the experiences of reacting and sharing are faced with rough spots, members of the system can best renegotiate their system's rules when these rules are made explicit. Since rough spots are unavoidable in the difficult work of caring for people with severe burns, the system's rules are best kept within easy access of explicit consideration. The purpose of this section is to help make the rules of your system explicit.

THE MEMBERS OF THE SYSTEM

The system will always include:

1. Surgical staff (senior and in-training)
2. Nursing staff (head nurse, staff nurses, and aides)
3. Rehabilitation staff (physiatrist, physical and occupational therapists)
4. Burn clinician
5. Social worker
6. Psychiatrist

The system may also include:

1. Respiratory therapist
2. Anesthesiologist
3. Medical consultants
4. Housekeeping staff
5. Dietary staff

MEMBERS OF THE SYSTEM HAVE TO MEET

One hour per week should be reserved for all members of the system—or at least members of each group involved—to meet together. This encourages system members to bring up important issues directly at the appointed time and place.

A regular meeting of any three members of the system constitutes a system meeting. Therefore:

1. If representatives of three disciplines agree to a meeting, the meeting should be held even though members of other disciplines do not attend.
2. Such small, regular meetings can often be the nucleus for occasional larger meetings at times of crisis.
3. Some system meetings take place informally without an explicit designation as a system meeting. They may be called "social service rounds," "disposition rounds," "Tuesday night poker," or what have you.
4. More formal teaching rounds rarely fulfill the function of a systems meeting in encouraging open expression from all disciplines.

THE AGENDA FOR SYSTEMS MEETINGS

A. Current crises take first priority

A crisis is a sensitive pulse of the system and usually bespeaks a need of the system for reorganization. Therefore, crises take first priority, since this reorganization will be necessary before other, more routine matters can be addressed effectively. For example, a patient refused a skin graft. It was learned that the surgeon did not communicate his plan for the graft to the staff nurse, and the patient was confused by his nurse's implicit ignorance of the plan. Until the pattern of communication between doctor and nurse is clarified, the doctor and nurse will continue to miscommunicate regarding all other items on the planned agenda.

B. Ongoing treatment plans follow

The system "gets in gear" through practice on cases already in progress. For example, a skin graft for a patient's left shoulder is planned for one week. The system members now *explicitly* negotiate plans that relate to implicit concerns: Who will inform the patient? Who does the patient like? Respect? When to tell the patient? Does the patient like or make good use of advance warnings? How to tell the patient? Will the patient respond with optimism or fear? Who, when, how to tell the family? Who has a good relationship with the family? Are there changes in current regimen related to the upcoming graft? For example, the patient is requesting more than the prescribed analgesia, mainly for debridement of the left shoulder. Since this shoulder will be grafted soon, the staff plans a temporary increase in analgesia with cooperation of the patient in planning to decrease the dose a few days after the graft. Counting down the days until the graft helps the patient tolerate the pain of debridement.

C. Planning for recently admitted patients

The team has practiced its work and now sets up a tentative plan for dividing the work regarding new cases *(see below)*.

D. Follow-up on patients who have been in the hospital for some time or already discharged

The team gains important perspective on acute, intensive management when these patients are presented. Especially important is the opportunity for more detached self-evaluation of the team's efforts and of team growth in current as compared with past regimens.

E. Finally: self-evaluation *(see section on Process for Changing Structures)*

F. Some representative issues

The following issues may be expected to arise regularly among various members of the system:

1. Personal reactions to the massive injuries of patients, especially uncomfortable feelings of threat and vulnerability.
2. Personal reactions to the patients themselves, especially discomfort at inevitable aggressive feelings toward already severely injured patients.
3. Personal and ethical responses to the work of maintaining or saving patients whose quality of life is in great doubt.
4. Personal responses to the communication of emotional material that usually is excluded from social discourse or even consciousness and that is openly stated by delirious or "regressed" patients. Most staff choose burn care more for its medical aspects and are made anxious by the openly aggressive or sexual matters expressed by patients suffering severe injuries.
5. Splitting among staff members. This is often experienced as a war between the "good" and the "bad" guys. Situations that provoke strong contradictory feelings in staff members are common. The discomfort of each person with the intensity of these feelings may lead to separate subgroups, each espousing their separate feelings. For example, each person's mixed feelings about whether

to resuscitate a patient with a very grim prognosis becomes expressed in a battle between some who say only "yes," and others who say only "no."

SYSTEMS HAVE STRUCTURE

Structures for Work

A system has a specific structure of *leadership*. It should be the responsibility of a particular team member to facilitate and expedite the business of the meeting. The "chairing" member need not be invested with special authority regarding decisions. For example, the consulting psychiatrist or social worker may serve as meeting facilitator, yet have no authority in medical decisions. A system has a specific structure of *authority*. It should be made clear which member(s) have responsibility for which final decisions, what is the mechanism for input by others into those decisions, and in what way will the team evaluate the decisions made. Authority may vary with each decision. For example, for a given patient the head nurse may have authority to decide the exact dose of each analgesic, the surgeon to choose the proper analgesic and to determine schedules for skin grafts, the physical therapists to determine the patient's level of activity, etc. It is not at first necessary that all team members *like* the authority structure, but rather that they *understand* it and know clearly where they can have input into the decision and its evaluation. This relieves much anxiety resulting from staff members feeling responsibilities that are not their own.

Process for Changing Structures

A system must reflect on itself: "How are we as a staff all doing in this most difficult task?" The team will reevaluate periodically not only its decisions, but also its procedures for making decisions. These times for self-evaluation should be planned in advance. In this way, no structure is deemed eternal and above criticism, and failings of a system are experienced as shortcomings of a temporary procedure rather than as flaws of a self-proclaimed, divine verity. Also, when mistakes are made, staff can differentiate whether the fault is in the plan itself or in its manner of implementation. For example, a patient is in her 6th day following a skin graft. She has been receiving 75 mg of meperidine as a prn dose for analgesia. The nurses note that she tends toward dependency and is frightened that her husband will not take care of her. She expresses these matters concretely in always asking for more medication from an especially anxious surgical resident. The nurses do not detect signs of excessive pain otherwise, and observe the patient is somewhat groggy from her current dose. Yet the surgeon increases her dose to 100 mg on her request and becomes defensive when the staff nurse questions

her order. Everyone comes to the weekly meeting with ruffled feathers: "Who do you think you are to tell me what to order?" "Doctors have a God complex!"

The team first examines the plan for communication between nurses and doctors at early morning rounds. These rounds took place as scheduled, and there was some brief comment by a nurse on the patient's status and by the surgeon on the patient's request for more medication. The plan for these rounds was implemented. However, nurses and physicians all voice their frustration with "rounds on the run," which were scheduled at a time when nurses are too harried to communicate clearly. It further became clear that this time was chosen solely for the convenience of the doctors. The team determines that:

1. The current procedure for rounds is inadequate.
2. The manner of setting the time for these rounds was unbalanced.

A time is set that all agree to be fair, and motivation for the full communication of concerns from all disciplines is renewed. By the end of the meeting the resignation of two nurses has been avoided, and the offending surgeon is released from the rack.

DIVIDING THE EMOTIONAL WORK

A. *Each patient* has a variety of emotional *needs*.
Each staff member will experience a corresponding *role* with its own specific emotional balance in meeting each of these needs.

Patient's needs	*Staff members' role*
Relief of pain	Relieving pain
Painful procedures (e.g., debridement)	Causing necessary pain
Medical decisions	Medical authority
Coordination of treatments	Coordinator
Friendly contact	Visitor

B. Usually an implicit division of these needs and roles occurs according to the requirements of the medical treatment and the individual personalities and personal tastes of patients and staff. At times this may give one staff member most or all the roles in the care of the same patient. For example, a given patient may tolerate pain for procedures best from a staff member who meets most of his other needs. That staff member may be best able to tolerate the role of causing pain when it is balanced by the other roles he assumes for this same patient. At other times just the opposite may occur. A patient may not accept decisions or friendly contact from the one who performs painful procedures. A staff member may prefer to perform the role of treating with patients to whom he or she is not required to cause pain.

C. Clinical situations occur where it is best to plan an explicit diversion of needs and roles. This is especially true where each of the needs is felt very strongly by the patient, and the staff experiences each of their roles as an emotional drain. For example, a former narcotics addict has recovered from the acute phase of a 40% third degree burn. He becomes verbal and is felt to be manipulative, playing staff members off one against the other, refusing procedures unless his demands for increased narcotic analgesics are met. The staff is furious, guilty about their anger, and unable to respond to the patient's need for friendly talk. A plan is devised:

1. The nurse least furious with the patient is assigned to him solely for talking, support, and ventilation.
2. A second nurse is given sole authority regarding narcotic analgesia.
3. The surgical staff now feels less need to avoid the patient, since they can refer his demands for medication to the nurse who knows the situation best anyway and they do not feel trapped by his manipulations.
4. The social worker coordinates the above plan as well as disposition procedures.
5. The anger aroused in the staff has been seen as a sign for a need for systems planning and channeled there rather than condemned.

ICU NURSES

A. The role of the ICU nurses bears special attention for three reasons:
   1. Nurses have most prolonged, intense, and intimate exposure to the burned patient. Therefore, whatever the emotional responses evoked by a given patient, nurses will probably experience them at the earliest time and most intensely.
   2. Nurses form a subsystem. Nurses experiencing such responses interact more regularly and closely with each other than do other system members.
   3. Nurses are most isolated from system decisions. By virtue of their numbers and their physical work, they are more often "represented" than personally present at meetings. In our society, gender and professional roles may combine to give nurses a subordinate role, especially in areas of decision-making, authority, and coordination.

B. The dangers inherent in this role are clear:
   1. As the most emotionally aroused and most isolated system members, nurses are convenient recipients for the unwelcome emotional responses of all team members. For example, the anger felt by the entire staff at a young father of four whose burns resulted from a suicide attempt may be attributed solely to the nurses, who are accused of avoiding the patient, while other staff members deny this angry reaction in themselves.
   2. The tensions within the system are often played out at very close range in the nurses' own intense subsystem.
   3. Nurses tend to "burn out" much more quickly than other systems members. A system may passively accept such "inevitable" results as a way of equilibrating the unresolved feelings of other members who deny their own impulses to leave and feel heroic in their "lasting" on and on while nurses come and go.

C. Management of the nurses subsystem

ICU nurses should have a *regular weekly meeting* as part of their work. The meeting can be led by the psychiatrist, social worker, head nurse, or by the nurses themselves. The meeting has two goals:

1. Subsystem goals:
   a. By virtue of their close interpersonal and physical contact with burn patients, nurses will experience uncomfortable emotional responses strongly and consciously. For example, they may have upsetting dreams of their patients, become depressed at work, or react with anger toward some patients or each other. Nurses often feel — and are taught — that such reactions are "inappropriate" to their "professional" roles. By sharing these responses, nurses will help each other in the difficult task of accepting their "selves" and their reactions, allowing them more emotional freedom to respond humanly to patients.
   b. The meeting will serve as a forum for resolving subsystem problems, such as friction between nurses, reactions to resignations, isolation of individual nurses from others, etc.
2. Systems goals:
   a. Nurses will be the vanguard in experiencing and expressing emotional responses. Their responses will likely be similar to those of non nursing team members. Other system members can be helped in clarifying their own responses by being informed of the reactions of the nurses.
   b. Nurses can best formulate their own difficulties vis a vis other systems members. For example, nurses are distraught that surgical interns remove newly placed dressings to assess wound progress. They are angry that the interns, with little experience, assess the wounds inaccurately. An episode is discussed in which an intern and a nurse recently examined a wound together. The anxious, but also humorous, situation of the nurse feeling he had to defer to the intern and the intern feeling

she had to prove a nonexistent expertise to impress the nurse was reconstructed. Nurses supported each other in the importance of their roles as teachers. The surgical interns were approached and were relieved that nurses wanted to teach rather than to judge them. A plan for joint assessments of wounds during dressing changes was instituted by the team, with the head surgeon endorsing the role of nurses as teachers.

SYMPTOMS OF THE SYSTEM

Some common situations encountered in a Burn ICU are listed below. The usual approach would be to personalize the problem by identifying the patient or staff member whose own personal problem caused the difficulty. This usually causes great anxiety, and delay in finding any resolution. When these situations are considered as symptoms of the system, system members may welcome them as opportunities to reexamine the system's operations.

1. Staff splitting, e.g., surgeons and nurses in a battle of mutual frustrations.
2. A series of patients refusing to cooperate with treatment regimens or threatening to transfer to other facilities.
3. Patients receiving escalating doses of analgesics far beyond usual requirements.
4. Families of patients arguing with staff members.
5. Excessive "burn out" and turnover of nursing staff.

It is left to each specific system and its members to evolve unique applications for their own special symptoms.

9

Prevention

Joan E. Nicosia and Jane A. Petro

The best way to prevent a burn complication is to prevent the burn. Most burn injuries (about 60%) occur at home with an additional 20% sustained at work. Motor vehicles, recreation, marine, and airplane accidents account for the rest. Thus, attempts to decrease the incidence of burn injury must be directed at accident prevention, home safety, and product safety programs.

HOME SAFETY

The most frequent type of burn in the home is a **scald** injury, usually occurring in the kitchen or the bathroom. Scald injuries can be prevented.

1. The temperature of the water in the water heater should not exceed 120°F, especially in households with young children, epileptics, alcoholics, or handicapped individuals who may slip in the tub or shower. Prolonged contact with water at or above 111°F can cause a severe burn. A water heater set at about 120°F will produce water at the tap that is hot enough for bathing purposes, but not hot enough to inflict a burn injury. This low water heater temperature will also result in a decreased fuel consumption, saving both energy and money.
2. Small children should not be left unattended by an adult in bathtubs or even bathrooms. Children can easily be burned if they turn on the hot water.
3. Avoid putting hot liquids or food on a table covered with a long table cloth. A child may grab it pulling hot food or drink on top of him/her.
4. Place coffee and tea cups away from the table edge.
5. Do not drink hot liquids with an infant or toddler sitting in your lap. The child may try to grab it.

Other types of burn injuries occurring in the home are caused by **grease, flame, explosions, electricity, and smoke inhalation**.

6. Keep small children from playing on the kitchen floor while you are cooking.
7. Turn pothandles away from the stove edge.
8. Do not wear long, loose sleeves while cooking on a gas range.
9. Do not put cooking condiments in cabinets over a gas stove.

Manual of Burn Care

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