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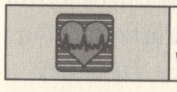
An ICU Nurse's Odyssey from London to Little Rock



SYLVIA M. BARCHUE

At the end of my three-year nursing program in London's Whittington Hospital, my job allocation officer asked me, "Where would you like to work?" Without a moment's hesitation, I said, "Ward 3." This was the gynecological floor, a unit with mostly healthy patients and a quick turnover. "I'm not surprised," said my AO. "You never missed one day of your GYN rotation."

The real reason I selected Gynecology was Sherry Brown. She was the unit's head nurse, and she made an excellent role model. At twenty-nine, Sherry was young and energetic. If we were short-staffed, Sherry would roll up her sleeves and get to work alongside her staff nurses. She also had an innate sense of fairness. Usually, if a patient was discharged, her nurse could eat the meal. In England, meals are served in specially heated carts, so the food stays warm. Sherry made sure that if one nurse got a free meal, all the

nurses got free meals. Her philosophy was always, "One for all and all for one."

We handled the entire spectrum of gynecological conditions. One of the most commonly performed procedures was the prostaglandin termination. It is a biochemical form of abortion in which the doctor inserts a Foley catheter into the patient's vagina and up to the uterus and injects an abortion-inducing agent called Prostin E_2. This procedure may strike some people today as barbaric, but in the late 1970s, prostaglandin terminations were considered safer than vacuum suctions, which, depending on the stage of pregnancy, could rupture the patient's uterus. The truth is, doing abortions sometimes made me uneasy, and to this day, I don't know how I feel about the whole subject.

One patient from Greece really irritated me. She was a beautiful woman with a low threshold for pain. After nearly thirty-six hours of labor and endless complaining, she dispelled the fetus into a disposable bedpan. As I removed the pan from her, she asked, "What sex is it?"

I got angry. I wanted to say, "If you're so interested in the sex, why didn't you keep the baby?" As a professional, however, I could not divulge my personal feelings. Instead, I said in a clipped voice, "Does it really matter now?" The woman could tell from my voice and the expression on my face that I would brook no more of her questions.

Once aborted, fetuses went straight into the incinerator. The Irish Catholic nurses told us we were committing murder and refused to participate. Their decision placed a burden on the rest of the nursing staff. We came up with a solution: We would let the doctors administer the Prostin.

The doctors, however, were not game for staying up all night until their patients aborted. They began the Prostin during the day, stopped it at night, and started it up again in the morning.

This meant that more women were in labor for longer than twenty-four hours. We ended up using a lot of Demerol to ease their pain.

During my stay in Gynecology, one of my colleagues entered the floor as a patient. When I finished my shift, I went home to change and then came back to visit her. While visiting, I heard a knock on the partition. I peeked around the corner and saw one of the student nurses, whom I'll call Katy, beckoning to me.

Outside my colleague's room, I said, "What's going on?"

"You have to give Miss So-and-So Ergometrine," Katy said. Ergometrine makes the uterus contract after an abortion.

"I'm not on duty," I said and pointed to my street clothes. "Who is supposed to be working now?"

"Cecelia," Katy said.

"Then tell Cecelia to give the Ergometrine."

"Cecelia's in the bathroom."

"What's she doing there?"

"Vomiting!"

"Is she sick?"

"She saw the fetus move!" Katy whispered.

After I got over my initial shock, I gave the medication to the patient and then hunted down Katy. "What did you do with the bedpan?" I asked.

She had taken it to the disposal area. "Go back and see if it's still moving," I said.

It turned out that this fetus was dead. But several weeks later, we aborted a fetus that lived. The doctor on duty at the time took it to the neonatal unit. It survived, grew into a baby, and, as I learned later, was put up for adoption.

One of the saddest abortion cases at Whittington Hospital involved a young girl from India. She had fallen in love with a young

man and wanted to marry him. As the parents of the would-be newlyweds studied their children's birth certificates, they discovered that bride and groom were actually half-siblings: They both had the same father. The girl had never known about her brother's existence until they began making wedding plans. By this time, she was pregnant with her brother's child. She had no choice but to abort.

The most bizarre case I saw was a seventeen-year-old girl with two vaginas. She was pregnant and required a curettage (a scraping process to remove tissue) in both of them.

Christmas Day was one of the most wonderful days at Whittington. The unit's three professors and their wives would join the nursing staff for Christmas dinner. The kitchen prepared turkey with all the fixings, and we each had a glass of wine with our meal. Christmas was the culmination of the staff's family feeling. In England, the hospital staff truly was a family. We did not bicker among ourselves. The nurses would not cut each other down either, as they do in the United States. And many nights while I was on duty, a doctor would bring me a cup of coffee. If I had to go to the bathroom, he would sit with my patient until I returned. I suspect that people outside the hospital world sensed our collegiality, because they treated us with respect. On a bus, for example, a person would give up his or her seat to a nurse.

One Christmas Day on ward 3, Sherry said, "Sylvia, there's a gift waiting for you in room one."

I thought it grand that I had two gifts, one under the tree and one in room one. What could be in room one? I opened the door and saw Sister Theresa in her bed, dead with a rose in her hands. Sister Theresa had come to ward 3 with uterine cancer. She was a petite French nun with whom I had struck up a friendship. In one

of our conversations, she had said, "Sylvia, if you find a good man, shoot him!"

"What do you mean, 'shoot him'?" I said.

"Shoot him before he changes," Sister Theresa said. *"They all do."*

This was strange advice coming from a nun who had spent most of her life in a convent. But Sister Theresa was full of unpredictable wisdom. As I looked at her for the last time, I understood why Sherry had asked me to prepare the body for the morgue. She knew I had developed a close relationship with this patient, and I was the best candidate to shepherd Sister Theresa's body out of this world. Sherry had a dark sense of humor, but in her case, it only enhanced her humanity.

At Whittington, I used to mosey over to the intensive care unit whenever I had a chance. Although I learned a lot in Gynecology, particularly about ward management, I was drawn to the patients in the ICU. I loved trauma. It was exciting. I liked to work with patients who came in sick and, with exceptions, were better when they left. The best place in England to learn intensive care nursing was at Northwick Park Hospital, and when I was offered a job in its ICU, I was over the moon.

Northwick Park was a lovely world of its own. The hospital had a bank and shopping center, both accessible by a continuously moving, doorless contraption called a paternoster. The trains stopped on the hospital grounds, so getting to the theater district in London was easy. Northwick Park was designed with not only quality health care in mind but also staff satisfaction. The place was a dream.

Hollywood had just finished filming *The Omen* at Northwick Park several weeks before I arrived. As I entered these famous

grounds, I thought, "Here I go again. I am the only black person in this group of lily-white people." But I had nothing to fear. I am not being obtuse when I say that I never experienced any hostility toward me because I am a native of St. Vincent in the West Indies. Indeed, my friends in nursing school called me a black-skinned, blue-eyed lady because I always got along with everybody. I believe that my professionalism and competence have shielded me from the feelings of insecurity that plague many other black people.

My ICU education at Northwick Park was extensive. The ICU encompassed pediatric, surgical, and medical units. On the same floor were a coronary care unit, the emergency room, and the operating room, and I spent about a month in each one. Having all the critical care areas next to each other allowed the staff to have a "Code T" system. Every day, one nurse in the ICU was responsible for carrying a beeper around. The minute the beeper went off, indicating a crisis situation, this nurse had to do whatever was necessary to help resuscitate the patient in distress. After the patient was stabilized, the nurse transported him or her back to the ICU.

Northwick Park stood right on the corner of an interstate highway, so the staff saw a lot of motor vehicle accidents. I saw injuries there that I have seen nowhere else in the world. The strangest one was a seventeen-year-old boy who was brought into the emergency room with his head sliced open on the horizontal. His mother had gotten him a motorbike for his birthday, and he had cracked it up on the highway. The oddest thing was that the boy was conscious and talking. We could do nothing to save him, though, and he gradually faded away. He left behind a guilt-stricken mother and a father who blamed her for the death of their only child.

Even less traumatized patients stood a chance of dying when

you least expected it. One doctor at Northwick Park was a fiend about vigilance. If he came into the ICU and found a nurse with her back to his patient, he would ream her out the rest of the day. His motto was, "Never turn your back on a critically ill patient."

To illustrate how quickly a patient's condition can change: One night I was working in the coronary care unit. A doctor and I were having a discussion when all of a sudden the emergency room called to say we had a new patient. It was my turn to handle admissions, so I got up to await his entry. The patient was about forty-five years old and complained of chest pains. Just as I wrapped the blood pressure cuff on his arm, he gasped. The man had gone into cardiac arrest before my very eyes. I thought, "Oh, my God! I have never seen this before!" Fortunately, the doctor was on hand to help me begin resuscitation. If we had not been on the spot, the man might have been a goner.

After one year at Northwick Park, I had had so much experience I practically was ready to help set up an intensive care unit from scratch. I met an American hospital recruiter, and he offered me a job at an Arkansas hospital doing just that. I had passed my national exam, so I had nothing holding me back from going anywhere in the world. Taking my first U.S. job proved to be one of the best nursing experiences of my life.

I always say that my stint at St. Vincent's Infirmary in Little Rock made me an ICU nurse. For one thing, the nurses there at the time were some of the best I have seen anywhere. For another, I had the privilege of working with Dr. Charles Nathan, a real stickler for patient care. He had the reputation for being a difficult man, but I found he let me enact the ICU regimens I had learned in London. The only problem I encountered here was from my fellow black nurses. One of these nurses, whom I'll call Dana, had been at the hospital for nine years but was frustrated that she had

been passed over for promotions several times. She cited white racism as the reason for her slow progress. She seemed to resent the fact that even though I also was black, I was given responsibility for Dr. Nathan's open-heart patients soon after my orientation. Human nature being vulnerable to shabby displays of jealousy, Dana accused me of siding with the whites. I said, "That's crap. I want nothing more than to be a great critical care nurse, and I don't care what you guys think about that!"

The other black nurses told me I couldn't appreciate the horrors of American racism. They kept saying, "Sylvia, you weren't born in the South. You can't understand how we've been treated."

I felt that the black nurses did not push hard enough. In private conversations I would tell them as much. I said, "If you want to take care of the open-heart surgeries, you've got to be aggressive."

My work with Dr. Nathan was thrilling. Once an open-heart patient was assigned to me, the patient was mine from the moment he or she entered the ICU until I left for the day. I was responsible for monitoring the blood gases, determining the hematocrit, which is the ratio of the volume of red blood cells to a given volume of blood, and performing the lab work. If the patient's potassium level was low, for example, I had the authority to add more potassium to the IV fluids. And I had to know when the patient was ready for extubation, because it was also my job to remove breathing tubes from the trachea, or windpipe.

In the course of my American career, I have often wondered how the state of nursing came to be so chaotic. Did we nurses do it to ourselves? Although there are many nursing organizations, they cannot come together and agree on anything. Whose fault is that? We can't blame doctors, hospitals, or the health-care system for the inadequacies of our own profession.

Part of the problem may be that some nurses in this country

became nurses for financial reasons alone. They hold two, sometimes three jobs at a time. A mentally and physically exhausted nurse cannot possibly give good patient care.

You have to want to be a nurse to be a good nurse. These days a lot of nurses come out of nursing school with the desire to "coordinate care," "facilitate utilization," or "administer services." This is not what nursing is about. To be a nurse, you must get down to the nitty gritty. You have to do the dirty end of it first before you can become a glorified head nurse.

Today, as the head nurse in a Bronx surgical intensive care unit (SICU), I always advise my nurses to think of their patients as their mother or father. I hope they will give them the same care they would want for their own parents. Several years ago, I brought in four new R.N.s to work in the SICU despite a warning from colleagues that I was taking too great a gamble on inexperienced staff. The new nurses took my advice to heart and have become some of the best nurses I have ever known.

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