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Telling the Truth

Barbara Ridley

Daisy died during the night. It wasn't unexpected. She'd been going downhill for days. The bronchitis developed into pneumonia and her frail little body was overwhelmed. Her kidneys shut down and those bright blue eyes sparkled no more. Back then—back there—ventilators and dialysis machines did exist in some remote section of the hospital, but no one considered calling them into service to treat a ninety-two-year-old admitted six months earlier with a fractured hip. This was London, 1976. Apart from a bit of IV fluids and antibiotics, Nature was allowed to take its course.

I wasn't there when Daisy died, but I knew the routine: the curtains would be drawn around the bed, and the neighboring patients, just six feet away in the long open ward, were expected not to notice that the rasping breathing had come to a halt. Two nurses—we always worked in pairs—would wheel in their cart and wash her one last time, turning and drying and wrapping in a silent, synchronized ritual. When they were done, they would leave the curtains closed and call for the

porter. It could take twenty minutes or longer for him to navigate the endless, straight corridors to reach MB1, the female orthopedic unit. Twenty minutes, during which the nurses would bustle about, changing dressings, emptying bedpans, and passing out pain medications, ignoring the curtained bed in the middle of the ward.

At three o'clock in the morning, there probably wasn't too much bustling. It was much more awkward at the peak of daytime activity. The porter would stand at the entrance to the ward, hovering in the shadows, waiting for someone to notice him. If Sister was on duty, she would be there to greet him and would stand with him until the nurses stopped, finished whatever they were doing, and drew the curtains around every single bed. We were supposed to smile inanely as we enclosed patients and visitors alike, with no explanation, only instructions not to move. Then we would stand to attention in a line down the length of the ward while the porter made his entrance with his special gurney, a sort of coffin on wheels.

Once he left, the curtains were opened again—except for those around the bed of the recently departed. Two nurses would wash the bed and apply clean sheets, still behind closed drapes. The clean, empty bed might not be unveiled for another hour or more. And then no one was supposed to acknowledge that anything unusual had occurred.

“What happened to Daisy?” Lillian asked me the following morning.

Lillian was an anomaly on the unit. She wasn't demented. Yet she was on the long-term “chronic”

side of the ward, which was full of old ladies going nowhere, most of them utterly confused. We helped them out of bed each morning and wheeled them down to the day room at the far end of the unit, where they took their meals. Lillian and Daisy had sat next to each other every day for months. Daisy faded in and out of making sense, but Lillian was sharp as a button. She'd had a stroke, I believe, but it hadn't affected her mind.

"What happened to Daisy?"

I knew what I was supposed to say: "She was transferred to the ward upstairs."

But I just couldn't do it. Every day for the past eight months, I'd helped Lillian with bathing, dressing, cutting her meat, walking her to the bathroom. She'd told me about her career as a primary school teacher. We'd talked about her two cats, now staying with her niece in Cornwall. She was an avid reader and had played the flute. We discussed the "troubles" in Ulster, the death of Mao, the election of Jimmy Carter. Yes, she must have had a stroke. I'm not sure what she was doing on the orthopedic ward, but I clearly remember her stiff hemiplegic gait, left arm dangling at her side, as we slowly made our way down the ward and passed the empty bed.

"What happened to Daisy?"

"She died," I said.

"Oh, no. I'm sorry to hear that. I hope she didn't suffer too much."

"I think she went in her sleep."

"Was somebody with her?"

Daisy had no family, no visitors. But I knew that one of the nurses would have sat with her while she was dying. Staff Nurse Balewa was in charge that night; she probably held Daisy's hand herself.

"One of the nurses was with her."

Lillian was seventy-eight years old. She had heard of people dying before. She missed Daisy at lunch but sat next to Louise instead.

Later that afternoon, Sister Thomas summoned me into her office. Sister's office: a glass-enclosed sanctuary in the middle of the ward—separating the section for acute orthopedic patients from the long-term boarders. The nurses gathered here for report at the beginning of each shift.

Sister bellowed from her doorway, "Miller! Come here!"

We all went by our surnames. I was still using my married name then. On good days, it would be "Nurse Miller."

This was not a good day.

"Yes, Sister."

When I say *Sister*, Americans assume I'm talking about nuns. But they weren't nuns. *Sister* was what the Head Nurse was called in England back then. They weren't nuns at all. More like army sergeants. Sister Thomas was the Senior Sister. She was West Indian. The Junior Sister, who was actually several years her senior in age, was Sister O'Brien, Irish. They hated each other.

"Miller!"

She used a high-pitched screech whenever she was angry. She was angry a lot of the time.

Especially with me. I think she may have hated me even more than she hated Sister O'Brien.

"Did you tell Lillian Jenkins that Daisy Worthington had died?"

Caught red-handed. Lillian must have unwittingly ratted on me.

"Yes, Sister."

"I have told you before that you must never, ever, answer patients' questions. You are to refer them all to me. You must never, ever, tell a patient that another patient has died. You must never, ever"

This was her favorite phrase. She used it a lot with me. She went on and on. And she ended up, as she often did, threatening to report me to the School of Nursing, where I was due to start my nurse training in a few months. I was an auxiliary nurse: a nurse's aide. The lowest on the totem pole. But I had been accepted into the training program to become a real nurse—to start in the New Year.

"You'll never make a nurse," she said.

I did everything wrong in her eyes. I didn't make the beds with all the pillowcase openings facing away from the ward's main entrance. I scrubbed the bedpans in the wrong way. I scrubbed the bedpans in the wrong order. I scrubbed the bedpans at the wrong time. Sister O'Brien wanted me to do it before the other nurses wheeled patients down to the big open bathroom, to be hoisted into the tub baths. But Sister Thomas wanted me to wait until after.

Why did I put up with it? All my friends wanted to know. None of them were nurses. They were school teachers, social workers, aspiring writ-

ers or photographers, academics or perpetual students, or full-time political activists.

“How can a feminist be a nurse?” one asked.

It wasn't as if I'd always wanted to be a nurse growing up. I had never considered it. But when I graduated from college with a degree in sociology in 1971, there was no work. I drifted through temporary jobs waiting tables, stuffing envelopes, and once even going door-to-door for a sociology research survey. When that all dried up too, and I was getting divorced and needed money, I took a job in the local hospital in the sterilization department. It was like factory work, except we cleaned and packed sterile instrument trays for surgery and procedure trays for the hospital units.

It was just a job, but it gave me my first glimpse of hospital life. And I was fascinated. We were all “girls” in the department—some, women in their fifties—except for the boss and the two men who delivered the sterile packs to the clinical areas of the hospital. When one of the men was on vacation and the boss asked for a volunteer to take his place, I jumped at the chance. As I stuffed dressing packs and catheterization trays into the racks in the storage room on each ward, I stole furtive glances at the nurses in their competent crisp uniforms, calmly going about the business of tending to the sick, and I wanted to be like them.

I had one friend who had entertained the notion of nursing school. She, like me, was an unemployed college graduate. All the nurse training programs in those days were attached to hospitals. The student nurses spent six weeks a year in the

classroom, but the rest of the time they served as cheap labour for the hospital, staffing every department, working all shifts. The programs were not academic in focus. Most of the students were eighteen, new immigrants from Jamaica or Dublin. When my friend applied, and owned up to her college degree, she was turned down because she was “over-qualified.”

So I lied on my application. I explained the gaps in employment by saying I’d been a housewife. This was the seventies; they believed me. I was accepted. But there was a long waiting list to start. I had to wait over a year.

That was how I ended up on MB1. As an auxiliary nurse. With a brown gingham uniform, not blue like the real nurses. And with no belt or stripes on my cap. Those came with increasing rank: Student Nurse Year One, Two, or Three; Enrolled Nurse; Staff Nurse; Sister.

“Nurse Miller, go and help Staff with the dressing on Mrs. Perkins.”

Staff Nurse Mahoney was already at the bedside, meticulously opening packages of paraffin gauze and laying out her forceps and sterile scissors. Sister Thomas liked to banish me to cleaning missions in the bathrooms during the “overlap,” the three hours in the afternoon when both the early and late shift nurses were on the ward. But Sister O’Brien, when she was in a good mood, let me help with the complicated or labor-intensive tasks that were saved for that time of day: washing the hair of a patient confined to bed in trac-

tion, changing the lining on a halo jacket, or attending to large-scale wounds.

Ethel Perkins had a very large wound. Her leg had been mangled somehow; I don't recall the details, a car accident, I believe. I do remember that the attending surgeon thought she would require an above-knee amputation. But one of the young house doctors had advocated for trying to save it. It smelled terrible and looked worse. The wound had to be cleaned at an awkward angle, with one nurse elevating the ankle, and two others at the top end trying to keep the patient still and calm.

It turned out I was good at that. If I rubbed her temples and sang nursery rhymes, she would relax a little. And if I spoon-fed her, encouraging her to take each additional mouthful, one by one, she took in enough protein for her wounds to begin to heal. If I offered her a bedpan every hour-and-a-half, she would avoid soiling the bed and contaminating the dressings. We saved that leg.

I had a lot of patience, because what was the point of being there if I did not? I was shocked at the attitude of some of the more jaded nurses. I remember one enrolled nurse in particular, I think her name was Evelyn, who screamed at Daisy each time she wet the bed. I was the complete opposite. No, it was never too much trouble to get another bedpan, another cup of tea, another box of Kleenex, to re-position the pillows one more time. It was all very straightforward: smile and be kind, and the patients adored you. My personal life might be a mess, but this was guaranteed instant approval.

My own grandmother had died a couple of years before this, suddenly over a weekend, before I had a chance to say goodbye. On my last quick visit home, a few months before her death, I had not even bothered to go across the street to see her. The least I could do was take good care of other people's grandmothers.

On Christmas morning, I was up early, before dawn. It was still pitch black in the deserted streets of North London as I cycled to work: no buses, no newspaper delivery, everything stopped for Christmas Day. Just the milkman out making his rounds.

"Merry Christmas, Nurse!" he waved.

We had all volunteered to come in an hour early to let the night shift go home. Both sisters were on duty; neither wanted to let the other get all the credit or have all the fun, and for once they were able to shelve their animosity towards each other. Everyone pitched in to complete the morning routine as quickly as possible, the full bed bath replaced with a "quick spit and polish." The nurses then sat down to a cooked breakfast prepared by the sisters themselves. Stuffed with scrambled eggs, bacon, and toast, we were out on the ward again getting the patients ready for lunch. Instead of using the day room, we set up tables in the middle of the ward so that the bed-bound patients could join in the festivities. We hung tinsel and jingle bells from the traction weights. There was plenty of food and drink—yes, even alcohol flowing freely—and gifts and carol singing and charades. The nurses covered their caps with those colored paper hats from Christmas crackers. All the doc-

tors came in with their families and Sister O'Brien danced a jig with the Senior Registrar. The patients laughed and cried with delight. By one o'clock, the day shift nurses were told to take off. My housemates were still rousing themselves by the time I got home. I'd already had a great Christmas.

One month later, I started my training in the same hospital, a huge, rambling complex with three additional satellite facilities in other parts of the borough. After a brief introductory course, we were out on the units, with thirteen-week rotations in every specialty, including obstetrics, pediatrics, psychiatry, and emergency. But I never returned to MB1. I occasionally ran into Sister Thomas in the corridors; she ignored me.

We learned most of the technical skills by the old *see one, do one, teach one* method. As a second-year student, I was expected to show the first-years how to insert a Foley catheter or a naso-gastric tube. We didn't cover nursing theory and we skimmed on microbiology, but it was an excellent clinical education. By the time I was a third-year student, I was used to being "in charge," especially at night, and had already experienced my fair share of drama.

One memorable night, I was in charge of two second-year students and an auxiliary nurse taking care of twenty-five sick children. The Night Sister carried the narcotic keys as I was not yet qualified to hold them. She had ten wards to cover and made her rounds as best she could, the echo of her footsteps in the dimly-lit halls heralding her return. In the middle of the night, I became worried about

an eight-year-old who'd had his tonsils removed the day before. He didn't look good to me. I didn't like the sound of his shallow breathing; I noticed he was swallowing constantly in quick involuntary movements, and his pulse was weak, thready. I knew he was bleeding. I positioned him on his side to prevent aspiration and tried to reach the house doctor. No response. I instructed one of the students to stay at the bedside and maintain the patient in position, while sending the other off to search the halls for Sister. I kept up constant efforts to reach the doctor on the phone. By five o'clock, we were preparing the patient for emergency surgery. Sister told me my prompt intervention had saved that boy's life. It wasn't until I got home and tried to sleep—never easy after night shift—that my heart pounded in my chest, the “what-ifs” swirling around my brain.

Some of the sisters were wonderful: wise sages who took their teaching responsibilities seriously. Others were dragons in the Sister Thomas mould. On one of my first days in the theatre (the operating room), I was working as assistant scrub nurse with the sister, who spent most of the day yelling at me. She was especially exasperated with me for not knowing which instrument to pass her when the surgeon asked for a Volkman's, a McEwan's, or a Langenbeck's. She wanted me to guess which forceps or retractor was which, and rolled her eyes and clucked behind her surgical mask when I inevitably got it wrong.

The last case of the day was a minor orthopedic case, a screw removal from an ankle. She told

me to stand to the side and not get in the way. The surgeon opened up the foot and exposed the repaired ankle. Six screws could be clearly seen protruding from the joint.

“Phillips!” he demanded.

Sister hesitated, hand hovering over the sterile tray.

“I said Phillips, Sister.”

I could see the Phillips screwdriver in the center of the tray. I pointed at it but she ignored me.

“Come on, Sister, we haven’t got all day.”

She couldn’t find it.

“I think it’s that one, Sister,” I said.

She glared at me. The surgeon reached across and grabbed it himself.

“You should listen to your student nurse, Sister. She obviously knows more about carpentry than you do.”

She made my life miserable after that. I decided I didn’t like the operating room anyway. I preferred my patients to be awake.

In addition to working forty-plus hours a week on rotating shifts, we had to study. I had a university degree, but I had shunned most science classes in school, and I certainly had to apply myself to memorize the bones and the muscles, the stomach enzymes and the cranial nerves, to understand lab values and medications, and to prepare for tests. We also had to write extensive essays—case studies on selected patients under our care. It didn’t take me long to figure out what they wanted: a detailed review of every system of the body and how to address the nursing needs associated with each. We had individual tutors to whom we submitted

these case studies. I had Mrs. Papadopulos: Greek, tiny, white-haired, she seemed ancient to me. I suppose she was in her sixties. At the bottom of one of my essays, she wrote: “You will make an excellent Ward Sister one day.”

But my life took a different turn. I ended up in California. After many bureaucratic delays, I was finally cleared to take the State Boards and qualify for my California license. I took a job at a large inner-city public hospital and assumed it would be similar to working in London. But I hated it. I wasn't daunted by having to learn American terminology and different brand names for most of the medications. But I found it disconcerting to work in isolation, with each patient sequestered away in individual rooms. The other nurses, and especially the nurses' aides, were reluctant to help with anyone who wasn't “their patient.” I missed the camaraderie of the big open wards and the team spirit that I'd taken for granted. When I worked Christmas Day, I was expecting something akin to what I remembered from England. Instead, it was dour and depressing. No senior staff came in. The kitchen closed early. When we had new patients admitted late in the day, we had nothing to feed them. We sent their family members out to get Chinese food.

I thought I was going to have to give up working as a nurse in the U.S. But then I stumbled upon rehabilitation nursing. I met someone at a party who told me about a spinal cord injury rehab unit. They were hiring, and I got the job. I immediately felt at home. The nurses worked in a team with

physical and occupational therapists, with physicians, psychologists, social workers, and recreation therapists. Nurses had to work together; it took two or three people to turn a patient in a halo vest, transfer a quadriplegic onto the commode, manoeuvre a patient on a ventilator into a wheelchair. Patients were grouped in four-bed rooms, and encouraged to interact with each other in the gym and the dining room. We had holiday parties and outings into the community. We endeavoured to create an environment where the patients could come to terms with their disability and move on with their lives.

That was thirty years ago. I've been a rehabilitation nurse ever since, witnessing patients cope with devastating injuries in myriad different ways. I went back to school; my undergraduate degree was finally useful. I didn't have to hide it; it enabled me to enter directly into a Master's of Science in Nursing program at UCSF. Deep in the stacks, I discovered hundreds of journals devoted to analysis and research on clinical issues closely related to the work I'd been doing for the past ten years. I loved it. It was as if disparate sides of my life were merging into one. Two papers I wrote in graduate school were published in peer-reviewed academic journals. I went on to become a clinical nurse specialist and then later a nurse practitioner.

Nowadays, many of my patients are like Rodney, paralyzed by a bullet on the killing fields of Oakland. He's been discharged from the hospital and is working in physical therapy. His legs have started to jerk at night.

“My legs are moving again,” he tells me.

I examine him and confirm my suspicions: these are involuntary spasms, and unfortunately no predictor of return to purposeful movement. I have to tell him. I know he’s been told before, but he will have to hear it many times before it sinks in: he is unlikely to ever walk again.

“What about stem cells and that shit?” he says, avoiding eye contact.

Yes, maybe. He is very young after all. I won’t squash all hope. But I can’t sugar-coat it either. He deserves the truth. I tell him stem cell treatment is not going to be available any time soon. And I can’t see it being covered on MediCal. I suggest we focus instead—for right now—on increasing his upper body strength, preventing skin and bladder complications, getting him decent equipment and figuring out what he’s going to do with the rest of his life. I promise to help him work on these things.

Out in the waiting area, as I tell him when to schedule his next appointment, I notice Carlos. Another paraplegic, injured four years ago. Carlos plays wheelchair basketball and is taking classes at the community college; he volunteers at a local radio station. I introduce him to Rodney. I pause briefly and remember my HIPPA Compliance training. Federal privacy guidelines supposedly forbid me to ever tell one patient anything about another. But that doesn’t always make sense to me. They’re soon telling each other everything anyway, swapping tips on catheters and wheelchair cush-

ions. I suggest Carlos invites Rodney to attend the spinal cord injury support group next week.

I think back to my days on MB1. I'm still doing things my way, Sister Thomas. And to tell you the truth: I'm a damned good nurse.

Barbara Ridley is a California nurse practitioner specializing in neurological disabilities. She is retiring later this year and will spend more time on creative writing. Email: ridleyb123@gmail.com