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The Call of Nursing: Stories from the Frontlines of Nursing

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I worked in Women Care at a large hospital in Minneapolis which delivers more babies than any other hospital in the state. Women Care is a level IV obstetric care facility. Primarily I cared for high-risk mothers and babies there, including high-order multiples. In May 2010, I took a new position of OB Educator and since then I have obtained my BSN, PHN, and MSN Ed. degrees.

My mom had multiple sclerosis. She was diagnosed right after I was born, when she was about twenty-two. The diagnosis for MS back then was very hard to differentiate, and she had probably been sick with it prior to that for many years. As a child, I saw her have horrible symptoms. She would have paralysis. One day, all of a sudden, her hand would just develop contracture and she would become paralyzed on one side. Or I remember once, when I was five, she became blind. That lasted for about a month. MS is neurological. It can do anything to a person. The full gamut of anything that could go wrong did.

I think her condition made me resist wanting to be a nurse. I thought, *Maybe I shouldn't do this because it's too hard to care for somebody.* My perception of caring for sick and needy people was a little bit different because of those painful experiences with my mom. When you live with it, it's often harder than it is at a job, where you can go to work, deal with problems for eight hours, and then go home. A lot of depression and emotional issues accompany caregiving with your family. But also, when you grow up around somebody with a chronic disability, becoming a caregiver is how you survive, so that becomes a part of who you are, too.

When I was about twelve, I experienced a traumatic event with my mother. We were camping in northern Wisconsin. She was standing on the top step of our camper, and then she lost her balance. Vertigo was one of the primary symptoms of her MS, and she lost her balance frequently. She fell backwards and landed on her head only a few feet from where I stood, and lay there unconscious and unresponsive. All I could do was scream. I didn't know what else to do, and the fact that I didn't know what to do, or how to help her, became the most traumatic part of the experience for me.

I felt relatively helpless around my mom's disease until I was in ninth grade, and then things started to change. The high school I attended offered a program called OEC, Opportunities in Emergency Care, and through that program I obtained my EMT license when I was fifteen. After I got my license, I chose the postsecondary enrollment option, which is where you go to college instead of high school, and I took all my prerequisites for the nursing program. I did it half time for my junior year and full time for my senior year. So when I graduated from high school, I basically had my associate in science degree. That was great. Two years of college basically for free is a good thing.

Then I tried different things for a while to see what I wanted to do. I felt like I had to be sure. I tried everything. I even became an insurance agent. And then I finally decided to enroll in a private college. *Teaching would be a good career*, I thought. *That's still caring for people.* I had been running classes in first aid and EMS at the time and I enjoyed interacting with students. So I was studying to be a teacher when – the typical story – I met a guy, we decided to get married, and I had a baby.

During college and the early years of my marriage, I fell back on my EMT license, providing emergency medical services for employees at the *Minneapolis Star Tribune* newspaper. I worked the night shift, and my husband worked at his job during the day. There was always around-the-clock emergency care for all the staff and, at night, when all the presses ran, often I would be the only female in the building. There would be from 100 to 300 men in there, and I'd provide occupational health care and emergency support if they needed anything. They called me the nurse, and that role started to stick.

The *Star Tribune* would hire homeless people from the streets on Saturday nights. They were the ones who folded the advertisements into the Sunday paper. So Saturday night was always an interesting one at work because not only did you have regular staff there, but you also had all the homeless people with their many needs. For their breaks, where did they go? They went to the nurse's office, usually, or they tried to find a warm place to sleep. Sometimes it was just that they needed to talk to someone.

It was during that time I made my mind up about nursing. Being an EMT didn't pay very well and I decided that if I had to work and be

away from my kids, I needed to make it worth my while. So I enrolled in a distance education program. The only requirement that I had to take, in addition to the core nursing program, was microbiology. The *Star Tribune* actually supported me and paid for some of my education with excellent tuition reimbursement.

I worked nights, I went to school, and I had kids. That was my life. I didn't sleep much back then. I would get home usually around 4:00 a.m. and sleep until the kids got up, usually around 7:00, and that was it. Three hours a night, average, for many years. All the hard work paid off, though: I graduated in 1998, when I was twenty-five, and I got licensed in Minnesota as an RN soon after.

I stayed at the *Star Tribune* for – let me see, I think about this in babies – I was on my third baby at that point. So it must have been five or six years. Then I took an RN job at a county hospital out in the country. We moved quite a ways west of Minneapolis then, and in that hospital I was required to work in all areas of the hospital and in the ER. That's when I started doing OB care. I never thought for a minute that would be where I'd end up. I always thought it was going to be the ER because of my EMT experience. I fell into the OB thing and it just evolved into a kind of calling. You know I think it might have been because, when I had my first baby, I was so completely terrified. I didn't have anyone who really helped me through that, and I thought, *Well, I could help moms have their babies and make that process easier for them.* And the feedback I got from my patients was that I did help them. I'd get that hug afterwards, or they'd ask me to stay late after my shift, just to be with them. When that happens, it's obvious you're having a positive influence.

I remember my first week in the OB unit there I had a patient who was having her fifteenth baby. She was probably in the thirty-eight to forty-two range, so that would have meant she had a baby about every fifteen months or something. There are two religious groups out there, both of them Lutheran, that do not believe in using any form of birth control. That woman had a daughter who was across the hall in another delivery room, having her own baby, and they were both about to deliver at the same exact time – and this was in a tiny rural hospital. I

was trying to run back and forth to monitor both patients, and family members were all over the place, and I remember feeling kind of floored and wondering, *What do I do next*? So that was my introduction.

I grew up in the city, and I was used to ER-type work. It was really hard for me to stay out there in the country. There were moments of real activity, but often I longed for a faster pace. So I took a job with Women Care at a large hospital in Minneapolis. They handled more births than any other hospital in the state. Women Care was a Level IV obstetric care facility – that's the highest level OB care possible. From Minnesota, Wisconsin, the Dakotas, and Iowa, all the difficult cases were flown into us at that facility. We took care of quads, triplets, and even sextuplets. High-order multiples, unusual pregnancies – anything that normal places wouldn't treat, we dealt with there.

Perinatologists are specialists in high-risk, maternal-fetal medicine and, at that hospital, we had the largest group of them in the country. That's why we attracted so many complicated cases. Here's an alarming fact that underscores the sometimes hopeless, high-risk cases that were sent to us: there were so many deaths on our OB unit that they had to provide a chaplain specifically for our staff and patients.

Women Care was on the hospital's top two floors, on the fifth and sixth floors, and there were about 160 RNs working there. I think there were about forty or forty-five postpartum rooms, and sixteen labor rooms. We also had a high-risk ante-partum unit, which was where we would put patients who were either more stable or long-term, because a lot of women would stay with us for months before they delivered. And so they would be down on that unit, which could hold about fourteen patients.

When I started there, it was not uncommon to be assigned the whole wing of the postpartum unit, and that meant couplet care – moms and babies. So we would have to care for up to eight moms and babies – that meant at least sixteen RN head-to-toe assessments – and you had to chart on each one, along with doing all the nighttime stuff and feeding and bringing babies in and out of the nursery constantly. It was chaos.

But the nurses there were the best nurses I've ever worked with. You never had a shortage of help whenever you needed it. I'd put on the call

light and say, "I need help in here," and I'd have five people running right in. I was still the one responsible for doing the charting and all that, but I had tons of help whenever a situation was happening.

I was there when one of our high-order multiples was delivered prematurely, and that situation was wrong from the start. We're talking about very tiny babies. The mom was posting pictures on the Internet of her getting up, walking around, doing all this stuff, when she was supposed to be on bed rest. She was posting about how much money she would make when she signed an agreement with the news media. There we were, struggling to do everything we could to help her, and she should have been doing everything she could to maintain the health of her babies. That is not the kind of thing you want people doing. It seemed planned and purposeful. We all told her that there was a much greater chance of mortality the quicker she delivered.

I was blunt with her. I said, "Here's the deal. If you don't do what we're telling you, you're going to have these babies way too early. They're either going to be born and be underdeveloped and have multiple medical problems, or they're going to die. Your odds of your babies surviving at twenty-two weeks is about 20 percent. That's not including the problems with cerebral palsy and all the other things that can go along with that." She didn't listen.

She delivered at twenty-two weeks and five days, and her babies were micro-preemies – less than a pound. Out of the babies who were born, only one survived, and he was on a ventilator. If she wanted to sell her story to the news media and win her pot of gold and fifteen minutes of fame, what she found out was that nobody will buy a story where you have multiple funerals.

I could tell you hundreds of birth stories: a mother who had amniotic band syndrome, where part of the amnion leaked and wrapped around her baby's feet and hands, or another mom with aplastic anemia who went into a coma while pregnant, when her baby demised in utero. Although we performed a C-section to save her life, she didn't survive either. There are many, many others, but it becomes overwhelming to talk about them.

No matter what happened, though, most women wanted to have pictures of their lost babies as part of their mourning process. We worked with an organization called Now I Lay Me Down to Sleep, which had been started by a woman who was a professional photographer and whose own baby had died. Now that kind of job takes a really special person. Those photographers who came in were awesome. All of them had suffered a loss of their own, so they could relate to the grieving mothers. They were super sensitive to them.

Very rarely did I bring the job home with me, but it was so intense that there wasn't room for much else when I did get home. I was just exhausted from it, and occasionally I couldn't even sleep. My only coping strategy was to detach myself to a certain extent. I think I probably learned that in the EMT world because we were drilled, every single day, to put whatever we experienced aside and do our jobs – no matter what the sight or the smell or the sound.

More importantly, I have seen hundreds of healthy births, thank goodness. I have also seen many babies survive when they shouldn't have survived, and I considered them miracles. Thirty years ago, we didn't resuscitate babies if they were under thirty-two weeks. Now we do it at twenty-three weeks. So we're getting better at it. I know the smallest birth I participated in was a boy who weighed fourteen ounces. He came out crying, was put on a ventilator for about twenty-four hours, and then he was extubated. He breathed on his own and did fine.

However, enough chaos was finally enough. Now I work as an OB educator. I work with a group of general practice OB/GYNs, so it's not high-risk anymore. It's almost all normal risk. Patients find out they're pregnant, and they call the clinic for an appointment. Instead of seeing the doctor, they see me. I spend an hour with them, talking about pregnancy, about routine prenatal care, and explaining to them what they should do to have a safe and healthy baby. I hook them up with social workers if they need that. If it's an early pregnancy, the mom usually asks about nausea and vomiting. So we talk about those concerns, what you do for them, and which medications are safe in pregnancy. We talk about food safety because that's a big thing. When

you're pregnant you can't eat lunch meat and you can't eat sushi or things like that because of listeriosis – the bacteria that gives you what they sometimes call stomach flu.

I usually get them an ultrasound on that first day, and do their laboratory tests. I talk to them about nutrition. If your body mass index is over 30, you're at very high risk for diabetes – that's my standard. Any of my pregnant patients who have a BMI over 30 have to take a glucose test that same day, and most of them don't pass. Probably 50 percent of the patients I see have needed an early glucose test, and almost half of them are actually diabetic. So then they begin with insulin. It's NOT gestational – not because of the pregnancy – it's just that they're truly diabetic.

What happens is, when you're diabetic and you're pregnant, your blood sugar is high and your pancreas isn't pumping out enough insulin. Your baby tries to compensate, and tries to cover the maternally-induced high blood sugar that affects it. That's how you get those ten and twelve-pound babies. Then, once the baby is born, it's used to putting out all that insulin, but now it's not getting all those calories and all the glucose. It continues to put out that insulin if it has low blood sugar, and that can be very serious. The baby can end up on an IV. So it is a big deal. They've had to increase the hours of the registered dietician and another RN diabetes educator since I started because of the tests I've been doing, but we're seeing healthier pregnancies.

I can also offer genetic testing to my patients. Out here where I am, though, it's a conservative culture. Maybe 1-2 percent of our population wants it. People usually do genetic testing for a couple of reasons: they're either a Type A personality, or they're worried that something may be wrong with the fetus. And based on that genetic information, they could consider abortion. But if they're pro-life and conservative and don't believe in birth control, they don't choose that testing.

One nice surprise in this new job is that the clinic doctors know I've worked with the best perinatologists in the region, and they do rely on my high-risk labor and delivery experience. They'll come to me and ask, "Well, what about this doctor? What does he do normally?" There

have been a few high-risk situations that have occurred, and I've helped them coordinate care for those patients.

I love it when I see positive outcomes happen for my patients – when I see them making lifestyle changes that improve their health and that of their babies. And when they say, "Oh, you helped me so much the last time," it reminds me why I'm here and reassures me that what I'm doing is helping. It's that kind of reaffirmation that keeps me going.

Now is this current job something I want to do for the rest of my life? No way. It's not mentally challenging enough. But I have some more autonomy working as an educator and some extra time. Because of that extra time, I went back to school and I actually just graduated with my master's in nursing and education. Right now I'm being recruited by a couple of colleges. They want me to go and teach nursing. Most nurses are not trained in OB, so I would teach that at least, as well as anything related to reproduction or obstetrics. I love to teach, so I'll try it. And if that's not stimulating enough, I'll go back to working in a hospital.

I think nursing is a fabulous career. I believe nurses are trusted and respected more than doctors, even, but if you're going to go into this profession, you have to really care about people. Patients are putting their lives in your hands. You have to hold that responsibility close to your heart and really consider what's happening right now, every moment, every day. You have to resolve to do your absolute best for every single patient, no matter what.