A nurse's experience in Iraq

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Abstract

- In April 2005, I deployed to the Australian Medical Detachment at Balad, Iraq, as a nurse in the intensive care unit (ICU) of the 332nd Expeditionary Medical Group Air Force Theatre Hospital.
- The experience was physically and emotionally draining. Despite my previous experience in the infantry and as a critical care nurse, I was not prepared for the experience.
- The ICU had three wards: one for US personnel, who were quickly evacuated to Germany; one for Iraqis, who often had long stays; and an overflow ward.
- Sometimes stress meant that corners were cut, either intentionally or unintentionally. I saw disappointing practices that the pace of the situation and continual flow of casualties did not lend itself to addressing properly.
- To cope, I found myself dehumanising, focussing only on the immediate task. On return to Australia, I found the dehumanising remained, affecting my work and personal relationships.
- Nevertheless, I feel the deployment was positive, and I would deploy again.

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In late March 2005, I was told that I was to deploy to Balad, Iraq, as a Critical Care Nurse. I had 21 days notice of deployment. With Easter and weekends, this was a very short time. I was deploying alone, after 18 months in the Royal Australian Army Nursing Corps (RAANC), having spent many years in the infantry. Coming from the tight-knit bonds of an infantry section, to deploy on my own and work in a critical care environment with people I had never met, was a daunting task. Reports of injuries and the strain — both physical and mental — had circulated via email within RAANC, and nothing suggested that deploying to a war zone was going to be pleasant or glorifying.

As a critical care nurse, I like to think that I have been exposed to many things, that I feel comfortable with a diversity of critical care presentations and would be able to cope with whatever came through the door. However, from the moment that I met my first patient, I knew that nothing could have prepared me for what I was about to do. This was not a deficit in my training or experience, but simply a matter of volume of patients and extreme injuries in extreme conditions. There is no training substitute for the experience of real time casualties of war.

Balad

The Australian Medical Detachment at Balad consists of about 20 Australians attached to the United States 332nd Expeditionary Medical Group Air Force Theatre Hospital at "Camp Anaconda". The detachment consists of medics, nurses, doctors and surgeons, in a tri-Service effort. As an emergency nurse with critical care qualifications in emergency and intensive care unit (ICU) nursing, I deployed as an ICU nurse.

The ICU was part of a larger hospital of up to 80 beds — a herringbone of tents and containers on a concrete slab. There were three ICU wards. One was for the US and coalition forces, where a stay could be a few hours or up 3 days before evacuation to Germany. Another was for Iraqi patients, where patients often stayed for weeks. From here they could be discharged to wards or to a Baghdad hospital. The third ward was for overflow.

ICU beds were stretchers, sometimes only a metre apart. There were no privacy curtains. Infective patients were isolated by hanging a sheet from the tent roof. Oxygen was supplied by bottles and at best the concentration was 93%. The number of ventilators on the one O_2 line caused regular drops in the O_2 supply pressure. Paediatric patients had to be ventilated with volume cycle ventilation, as the oxygen supply system could not cope with pressure cycled ventilators.

Orientation

I was given a short tour of the facility, its layout and administration. I was then given my first patient as an orientation to the general ICU process. It was a relatively simple day by Balad standards, and I was soon left alone. My preceptor took one look at me and said, "Well, if you are orientating, you can have my patient. I've got laundry to do."

The patient was a US soldier who had been a gunner in the turret of a 9-tonne vehicle involved in a complete rollover accident at about 80 miles per hour. This type of accident was

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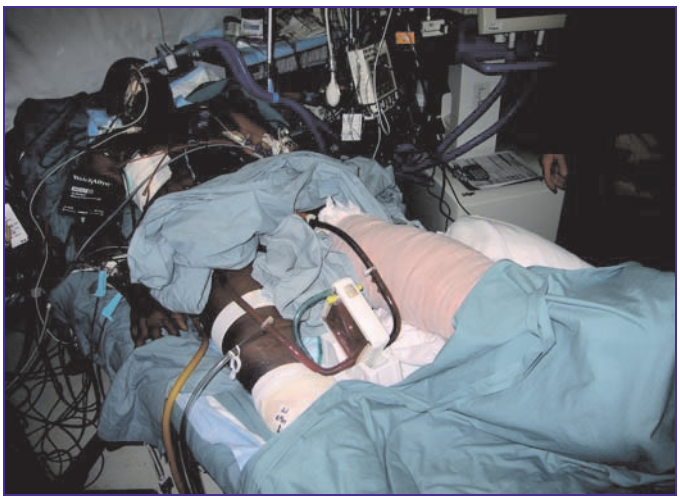
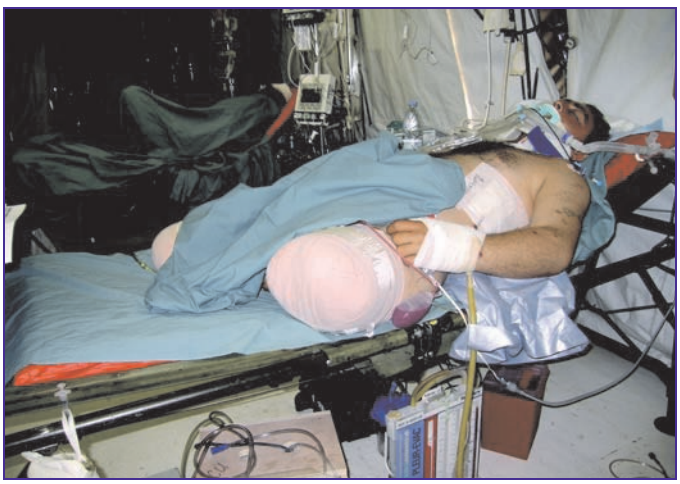
common, as drivers often travelled at high speed to limit their exposure to improvised explosive devices (IEDs), ambush, or small arms fire. His injuries included pneumothorax, fractures to the femur, ulnar, and radius. The arm injuries had severed his ulnar and radial arteries, and it was thought that the ulnar and radial nerves had also been severed.

Grafting and reconstruction had given him circulation in his hand, and after a few hours he was able to be extubated. Towards the end of my 12-hour shift, there was some movement in his thumb — it meant the difference between recovering use or facing amputation on his arrival in Germany.

This was one of the few patients that I had the opportunity to extubate and converse with. I soon learned that extubation and conversation with patients in the ICU would be rare. Often the only people we saw extubated in the ICU were long-term Iraqi patients and the dying.

In orientation, I learned that the usual staffing ratio in the ICU was one nurse to two patients. The shift supervisor, who also had a patient load at times, allocated the patients as fairly as possible, but nurses were usually looking after two intubated patients. The 12-hour shifts with the same patients were physically and emotionally draining. Arrangements were made wherever possible to provide some respite for staff, even if it was just allocation of different patients.





Two Iraqi patients. One with a craniotomy after suffering a penetrating head injury from a gunshot, the other a bilateral amputee with bilateral pneumothoraces, the result of an improvised explosive device. This was a typical patient load in the ICU.

Iraqi patients in the ICU

My first Iraqi patient highlighted very early some of the shortcoming and difficulties of working in a combat hospital. He was a policeman who had sustained four gunshot wounds to the back. His injuries included bilateral pneumothoraces, perforated bowel, lacerated kidney and liver, ruptured duodenum, perforated stomach, the possibility of anoxic brain injury, and an *Acetebacter* infection.

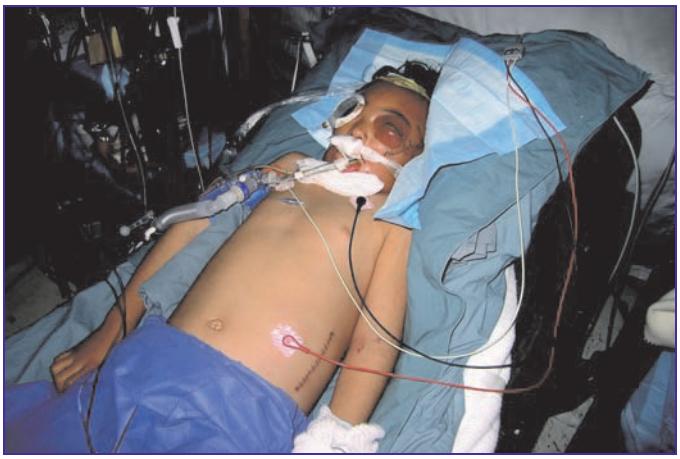
This patient was one of the hospital's longest staying, and his recovery was slow and at times demoralising. His brothers visited him frequently; although he had a tracheostomy, he was able to communicate on paper. At one stage, his condition deteriorated until communication was no longer possible, and his brothers stopped visiting. Patient washes were difficult and were substituted with a rubdown using pre-packaged moist towels on some shifts. The patient developed a full thickness sacral ulcer which became infected.

Over time, with intensive care, regular physiotherapy and debridement of the pressure ulcers, the patient began to respond and improve. He was weaned from the tracheostomy and transferred to the step-down ward, where he communicated with staff in English. His wife, children and parents were dead; the hospital was the only home he had left.

Amira

Amira was a 3-year-old girl who had a respiratory infection. She had been discharged from an Iraqi hospital, as they could do nothing more for her. She was brought to Balad and accepted into the ICU. The fact that she was not a war casualty was controversial. As a combat hospital, the facility was not resourced to accommodate non-battle casualties. We were fortunate to have a paediatric surgeon; however, the nursing staff had minimal experience with paediatric ICU patients, and at times caring for Amira became a strain on all involved.

Although the aim of Amira's care was mainly to palliate and maintain comfort, there was a constant danger of sudden deterioration requiring emergency resuscitation and stabilisation. Her father was full of hope for his daughter, but she had a raging respiratory infection, was febrile, sometimes able to breathe spontaneously but at other times dependent on the ventilator. She was extremely emaciated, and had pressure sores on her sacrum, head and shoulders. On one occasion, changing the endotracheal tube tapes and dressings on her head revealed lice.



Basima, following craniotomy and eye enucleation. The scar on the left flank was made for the storage of the bone flap in the peritoneum.

Throughout Amira's stay, we were torn between the need to palliate and maintain comfort for this child, while being constantly reminded that the hospital's mission was treatment of war casualties. This conflict affected staff morale, and nurses would often ask not to be allocated to care for Amira as it was too stressful. When she was eventually discharged, we knew her death would soon follow. The staff felt sadness for the inevitability of the situation, but also relieved that she was gone from the ICU.

Basima

As soon as Amira had gone, 10-year-old Basima replaced her. Basima was a girl of a Bedouin family, living with her four mothers and 23 brothers and sisters. She had sustained a gunshot wound to the head. The bullet entered the right temporal periorbital region, exiting through the left temple. It passed through the frontal lobe and destroyed the left eye. The condition of the right eye would not be known for another week.

I received her from theatre, where she had been taken to undergo a craniotomy. Keeping in mind the need to educate Amira's father only days earlier, I consciously involved Basima's father in her care. While I managed the critical nursing responsibilities, her father washed her and learned how to change sheets and put on nappies. Basima's father was understandably concerned about her vision. Interpreters explained to him that the left eye was gone and we were unsure about the right eye. Nevertheless, every time the eye drops were administered, he would ask the same question in broken English and sign language: "Will she be able to see?"

Unfortunately, Basima lost the other eye. Although blind, she played purposefully with toys that I gave her. Eventually, the tubes were removed and most of the antibiotics ceased, and discharge was getting closer. She still required high flow oxygen via a tracheostomy. However, one day when her father stepped out, she was dressed and sat out of bed. When he returned, he was reduced to tears of joy. For the first time, he had seen her dressed, like a girl, sitting in a chair holding a doll. As the tears fell, he waved his arm in a blessing towards me and the ICU doctor, and he picked up an Australian flag which was hanging on a nearby wall, draped it around himself, and kissed the Southern Cross.

Nursing practice

Sometimes stress meant that corners were cut, either intentionally or unintentionally. I saw disappointing practices that the pace of the situation and continual flow of casualties did not lend itself to addressing properly. Perhaps, if time had been taken to provide ongoing education and reinforcement of best practice, things would have been different and patient outcomes improved. Too often the words "we're in a war zone" were used as an excuse for poor nursing practice. It was a war zone, but that was no excuse. We were still in a hospital and could still practise nursing to the best standard possible.

Pressure sores were endemic in the ICU, partly because of the bedding (stretched canvas and thin inflatable mattresses), but also because of inadequate pressure area care and the lack of regular repositioning. When being rolled for pressure area care, patients were rolled from their back toward the ventilator and to their back again, rather than moving the ventilator or the tubing so that the patient could be rolled the full 180 degrees. This meant patients received no real pressure area relief at all. A pillow or a rolled blanket under the shoulder was all the padding a patient received, and often, unless a real effort was made, this did not take any weight off the sacrum.

Water was available with a tap in each of the ICUs, and hot water courtesy of the microwave. Despite this, patients were not washed every shift or even every day. Yet the resources were available if people were willing to make the effort.

One of the saddest examples of nursing practice I witnessed was with a patient who had suffered blast injuries. He was left

unattended with a cervical collar *in situ* and on C-spine precautions. This patient required a chest x-ray. As the patient was lying supine, a nurse came and stood at the head end of the bed, slid him up the bed and sat him upright. His head slumped forward, and she propped it up again. We all know it takes one nurse to hold and stabilise the tracheal tube, one to stabilise the neck, and two to slide the patient — but "we're in a war zone". I will never know if that patient suffered C-spine fractures or a transection.

Deaths in the ICU

The dying often came to the ICU, where they were usually left in the care of the chaplain or a nurse. Sometimes extubated, these patients had unrecoverable injuries and were palliated in the ICU, sometimes for hours until they died. Iraqi or American, they were not to die alone.

One particular patient suffered horrendous injuries in a blast. We did not know his name, or if he was Iraqi military or civilian. His face was burnt, left eye missing, both legs were traumatically amputated above the knee, and abdominal wounds resulted in a laparotomy. Having come straight from theatre, he began to bleed.

He was given whatever blood products were available, until our supplies were running out, and a call went out for a blood drive — any suitable donors were asked to go to pathology. As more casualties were expected to arrive, the patient's viability and the strain on resources were considered, and the decision was made to allow the patient to die.

I assisted with the layout of the body and preparation for the mortuary. Whenever he was rolled to clean the blood that he was lying in, the contents of his peritoneum fell onto the bed, with more blood. I decided that it just was not right to send a man away "with his guts hanging out".

I never asked for permission or advice, I just began to suture. I had never done this before and people asked me why. Perhaps I did not know myself.

We all react differently in these situations. Once the abdomen had been closed, the stumps dressed, and the body bag zipped, a US major brought me the identification tags: *Name: Unknown.*

I attached one tag to the bag and opened it to put the second around the man's neck. Having just dressed both the amputation stumps herself, the Major now insisted that the second tag was to go on the toe. She was so insistent on tagging the toe that she sought confirmation from a more senior officer.

Coping within myself

I cared for more patients than I could ever remember. After some time, they tended to blend into each other, impossible to remember individually. This was partly a coping mechanism and partly because the injuries sustained were so similar.

We all develop coping mechanisms to allow us to do our jobs and to protect ourselves. I found as I was looking at the wounded I began to wonder about their future. I wondered what lifestyle they would return to, would they be able to enjoy the things enjoyed before being wounded? Will the loss of a limb mean the end of those moments previously enjoyed? What of lifestyle? Would they still be able to live in their home, move around the garden, or would they be dependent on their family for everything? Is their marriage strong enough to survive this, or will they be forsaken, a burden on their families?

As I thought about these patients, I began to relate myself to the patient. If that were me, could I ride my horse, go hunting and manage the farm, or would it be all over for me? Would I want to live if I lost all of those things I enjoyed? Perhaps not, so I would wonder, "am I doing this man any favours?"

My main mechanism to stop me becoming too involved with the patients was to dehumanise. I looked at a patient and saw only the wound and the immediate needs. At times this was difficult, and it goes against all holistic teachings of nursing. To stop me considering a patient's future, I forgot my own future and concentrated on the task at hand. Thoughts of home and what I wanted to be doing back home were forced away; slowly I dehumanised myself.

Coming home

I arrived home much the way I deployed, the only member of the detachment on my flight to Melbourne. I barely had the chance to say goodbye to those I had deployed with. I woke up at home, and life was exactly as I had left it, Iraq forgotten. It was as though I had never left home. I could not believe the difficulty I had remembering the deployment and the ease I had fitting back into a normal life. I wished my return from East Timor were as easy.

Within 2 weeks, I hit the wall. My forgetting the deployment was another coping mechanism, just like dehumanising people in Iraq. Now Balad had become numb to me, but it was too great an event to just wash out of my mind. Slowly, things came back to me and troubled me.

First, insignificant things upset me. Nostalgic movies turned me into a crying wreck as all the withheld emotion began to pour out. I felt helpless, as others were still there working with the wounded, without me. I wanted to be back there, not necessarily as a nurse — just back there, in any capacity.

I didn't change into a pacifist. Instead, although horrified at the suffering one can put upon another, I wanted to do the same to those who had caused it. I was seeking a reckoning for all the suffering.

I returned to work in the emergency department 2 weeks after my return home. My colleagues and I immediately noticed another problem — the dehumanising remained. I never compared the patients I saw in the emergency

department with those I saw in Balad, but the suffering of people presenting to the emergency department was lost upon me. I felt no reason to care for these people; they were of no value and no interest to me.

My coldness was reflected in my relationships with people. My wife felt I was cold and drained of any emotion. Although my love for my friends and family remained the same, I could not show it. I knew in myself that I was becoming numb to everything. My nursing practice was dangerous, as I just did not care.

For the first 2 weeks, I could speak freely of the experience in Iraq as if I was relaying a story I had heard. After that, I avoided conversation and anything else related to Iraq. I was disappointed in myself, as I knew that people wanted to know, people were genuinely interested, and the stories of people need to be told.

We all joined the Army for our own reasons. I never saw any point in joining the Army if I was not going to deploy. Deploying to Iraq provided a learning experience for me in both nursing and in the military. Where I take that experience now is entirely up to me, but I did not deploy for an education.

My deployment was not for career advancement, recognition and personal satisfaction, or to meet new people. I deployed because I felt that it was the right thing to do. Despite the difficulties of coming home and the many negative things that I saw and took part in, I feel that the deployment was a positive thing. People are alive today who would otherwise be dead. Given the opportunity, knowing all that I know now, would I go again?

Of course.

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