

## Occasional essays

### Tales from the desert

A colleague and I were inspired to join the RAAF Specialist Reserves after our involvement in the Royal Darwin Hospital response to the Bali bombings. We wanted to be able to be part of a first response if disaster occurred in our region. We signed on in July 2004 and shortly thereafter received the call asking us to consider a 3-month deployment to Iraq. Intensivists were needed and in short supply. It wasn't what we had in mind when we decided to join up but it took less than 24 hours to make the decision to go and it's a decision I will never regret. My colleague deployed for the first 3 months from September to December 2004 and I deployed on Christmas Day and returned home at the end of March 2005. The deployment was a unique experience from both a work and personal perspective. It was a life-changing event.

Balad is a very large base north of Baghdad surrounded by farming land with a town in the distance. My first impression was that I had stepped onto a MASH set, complete with all the visual and sound effects. The hospital was a United States Air Force (USAF) tent facility and the Australians were embedded into the American structure. It took some time to adjust to the American hospital culture, though the Americans made some concessions to the Australian way of doing business. We practiced a mix of American and Australian medicine. We all learnt a lot from each other. The Americans really appreciated our contribution to the hospital staffing. The Aussie team consisted of a mix of doctors, nurses and medics – 20 of us in total. I learned in Balad what true Aussie mateship and the ANZAC spirit is all about – I made some very good friends during my 3 months there.

The hospital had an ED with 4 resuscitation beds, 6 assessment beds and an outpatient extension for overflow. There were 5 wards, each of 14 beds, 3 operating rooms (which could each take 2 tables in a mass casualty situation), 3 recovery beds, a radiology department with CT scanner (old, slow and clunky) and digital radiology (no films to be lost), a pharmacy department, a pathology department and an allied health department. We were one of two tertiary facilities in Iraq with all the basics available, but no bells and whistles – it was an interesting experience to learn what you can do without!

The ICU was 24 beds spread over 3 tents. There was a 10 bed Coalition ICU (mostly Americans) where patients were admitted from all over Iraq in order to be

stabilised for evacuation out of the country. Patients in this tent typically stayed less than 24 hours and were assessed, further resuscitated, arterial line and central venous catheter (CVC) inserted if not already done, further damage control surgery performed and then shipped out by the critical care air transport teams (CCATs). The organisation and execution of the evacuation was extremely well done - all the ICU doctors had to do was the clinical care and double-check all the paperwork was in order – the rest happened as if by magic!

There was a 10 bed Iraqi ICU where the patients stayed for the duration of their critical illness. These were the patients we managed day to day in consultation with the surgeons. These were the patients we got to know well. These patients were Iraqi National Guard (ING), Iraqi Army or Iraqi Police and Iraqi civilians from both sides of the conflict. There were a small but significant number of women and children admitted here as well. The third ICU tent had 4 beds for isolation / burns patients and 6 isolation ward beds.

On average there were 120 ICU admissions per month with about 80 ventilated patients. There were about 50 admissions to the Iraqi ward per month. There were surges in activity and quiet times much like ICU at home, except the surges were always due to a mass casualty event or events. The vast majority of the patients were trauma victims including those from gun shot wounds, vehicle improvised explosive devices or improvised explosive devices. A small number were motor vehicle trauma victims. The amount and nature of the trauma was very confronting and at times the sheer volume of human misery that we witnessed was overwhelming. Despite the horrors of war, I found great personal and professional satisfaction in the work - being able to make a difference to the critically ill who would likely have died without your care was what kept us going.

The ICU schedule was covered by 5 doctors working in shifts to cover the ICU 24/7. During a mass casualty event we would all be *on deck* for as long as we were needed. I was also the only doctor apart from one surgeon with significant paediatric experience, so I stayed in the hospital a lot when we had children in the unit. In my time off, I went to the gym, went shopping at the base store, sat around chatting with mates or caught up on sleep.

The day in ICU started with the ward round at 0730 when more than a dozen surgeons and others would review all the ICU patients – with less than a metre between stretchers you can imagine how crowded it was! The night ICU doctor presented the case and brought up issues for discussion that needed surgical input. The surgeons liked to know all the details about the patient and sometimes made suggestions about the

ICU management issues – it was interesting to see how the American open ICU system worked and it was a test of skill to institute a closed ICU system. The Australian intensivists established a reputation for being good clinicians and the surgeons were happy for us to run the ICU as more of a closed system as time went on. There were respiratory technicians, but they got used to the Australian doctors managing the ventilators and were keen to learn from us and were a useful resource when the nursing ratios shifted from 1:1 to 1:3 as we got busy. The ICU was extremely noisy with suction units that sound like train engines, helicopters landing outside your back tent flap and jets flying overhead. It was dusty and cramped and the walls flapped in the wind but it soon became home and it's amazing what you get used to. During *alarm reds* we had to work in Kevlar helmets and vests that are heavy and cumbersome – it certainly made me appreciate how tough the troops in the field have it – they have to wear it all the time!

Life outside the hospital was a challenge for me, coming from a very comfortable lifestyle in Darwin and with no military experience. There were times when I desperately missed home and particularly my husband but you get through those periods and learn to just get on with the job. We lived in trailers (dongas) and I had a room to myself (because of my rank), which was my sanctuary from the madness around me. There were portaloos scattered around with occasional blocks of flush toilets. It was a trial going to the loo in the middle of the night in below zero temperatures – particularly as there was a river of mud between my trailer and the nearest portaloos. The shower block was a 400 m walk through mud and stones – some days it was all too hard! I have never appreciated my bathroom and running water so much as I do now! The food was plentiful but not very palatable. I lived on food parcels from home – canned stew never tasted so good! Communication with home was by email and phone. Phones were scarce and

lines often crackly, but email was available on the computers at work, so this was the main form of communication with home. Operational security limited what one could tell the folks at home, so all of one's support came from the members of the team and I will be forever grateful to the other members of the first contingent who helped me get through my first deployment.

There is not much that can be said about security except stating the obvious. The violence in Iraq continues and Balad is not immune from that violence. It is in the public domain that Balad is the most mortared base in Iraq – it is right in the middle of the infamous Sunni triangle! The personal risk is very real but tends to remain in the background – a sort of subconscious awareness as you go about your routine. There were an average of 1 - 2 *alarm reds* daily but often you just heard the alarm and went through the drill – the times when the mortars landed close enough for us to hear the explosion were very sobering indeed. There were lots of controlled detonations of unexploded ordnances and sometimes these would occur without warning close by and scare the shit out of you. I still have a bad reaction to sudden loud noises – fireworks are no longer fun.

I am often asked if I had a good time. Good is not the word to describe this time in my life. It was a time of great personal growth. It was a time of professional satisfaction in doing a job that was making a difference to many people's lives. It was a time that made me realise how lucky I am in my life and how crazy the world can be for some people. It was a time I shall never forget and never regret.

#### DIANNE STEPHENS

*Intensive Care Unit, Royal Darwin Hospital, Darwin,  
NORTHERN TERRITORY*

## “The other side of the fence”: a patient's experience of intensive care

I was employed as a dialysis nurse in London while on a working holiday in 2000, when I had the opportunity to experience “the other side of the fence”.

I developed a flu-like illness one Monday while at work, and after 18 hours of worsening symptoms, my boyfriend, Aaron, returned home from a night shift and raised the alarm. I was rushed to the Emergency Depart-

ment with fulminant meningococcal septicaemia. In the emergency cubicle, my friend's partner, a doctor, was amongst the many in attendance. He left the room for two minutes to retrieve something and upon returning, saw my rash had spread.

Meningococcal septicaemia is caused by a bacterium. The bacterium can cause meningitis or septicaemia, which can kill within twenty four hours. Meningococcal septicaemia mimics the common flu so closely that the only real sign is the deadly rash, which continues to spread even after the bug itself is annihilated. The rash, which is actually blood under the skin, is the last symptom to appear. The toxins in the bacteria affect the capillary walls in the limbs and the major organs, including the kidneys, the heart, the brain

and the adrenal gland. It can cause deafness, and may result in multiple limb and digit amputations in severe cases. Some of those who contract this condition die, some are left with severe disabilities, both physical and mental, and others, with early intervention, survive with no ill effects. Chronic tiredness and memory problems may also be long term effects.

I spent 16 days in the intensive care unit. Initially two nurses were assigned to me, while I received full ventilatory and inotropic support. All staff and visitors wore plastic visors, hats, gloves and masks. I was not expected to survive. The black rash spread like wildfire, consuming my legs, my arms, my fingers, my toes, my nose, my cheeks and my ears. My parents flew from Perth, arriving in London two days later. The sight that greeted them was not attractive. My mother vomited and nearly fainted when she saw all that remained of my shrivelled legs: like burnt embers.

Bewildered, my parents were told of the diagnosis and prognosis. With nowhere to go, and numb with shock, they were invited to stay in the hospital. They spent a traumatic first night sleeping in a spare Intensive Care Unit (ICU) room which had no curtains and were exposed to the constant noises of a hospital ward after dark. The hospital subsequently arranged housing in the free accommodation for relatives, located on the hospital grounds.

As my friends, one-by-one, called into the flat, it was left to my boyfriend to impart the news. He had not met most of them, and, like my family, had no medical knowledge. Bad news travels fast and soon there was a crowd of visitors and many telephone calls to the typically understaffed ICU. This finally became too much for the nurses, and my parents suggested stopping all visitors. My brother in Australia copied an old group e-mail list I had sent him earlier and kept everyone updated electronically.

My memories of intensive care differ greatly from those of my family and friends who supported me during my hospitalisation. As the life-supporting medications began to be reduced, the hallucinations blurred with reality, blending and mixing. My memories were tinged with intense fear, and my hurtful angry words to my family were fuelled by intense paranoia. Even to this day, those who saw and spoke to me do not fully understand my altered mental state. I still struggle to put my experience into words.

After five days, both my lower limbs were amputated below the knee and I slowly began to improve. I was moved into a four-bedded room in the ICU. When I awoke from sedation, the nurse called my parents. In a narcotic induced haze, I had no concept of the extent of the rash and its implications. I have no distinct recollection of noting the absence of my legs, nor do I recall being at all shocked regarding the loss. Perhaps

the medication altered my reality so severely that I did not take it seriously. My mother insists my lack of surprise was a result of her persistent communications during the period of sedation. "I told you, before and after!" she tells me.

I did not know that the rash had extended under my thighs or over most of my bottom, or that it had spread to my face. My arms and fingers were barely visible and were coated in a vinyl-like thick black rash. I was unable to move at all.

My parents came. I talked to them but they could not understand a word I said, as the endotracheal tube remained in my mouth. Mum tells me I talked until ten in the evening, well after visiting hours, and finally they had to go. Before they left, I asked for Aaron. The following morning I must have overheard the staff talking about a tracheotomy; whether for me or for another patient I cannot be sure. I had been on a ventilator for two weeks and it was probably time to consider more permanent options. My parents came. I tried to tell them. I began to get increasingly distressed, but they could not understand me. To me a tracheotomy meant brain damage and or disability. A tracheotomy suggested terrifying implications revolving around permanence and an inability to care for myself. I knew very little about operating a ventilator, and this powerlessness created fear. Mum began eliminating the possibilities with me as she and my father tried to comprehend my distress.

"Are you hot?"

"Are you in pain?"

"Do you need to be moved?"

Finally mum guessed the tracheotomy. I nodded frantically. She told the staff of my concerns, and so they agreed to remove the endotracheal tube and allow me to try to breathe on my own. The tube was removed. I do not recall this. I breathed.

My first episode out of bed took place very early after awakening. My parents were coming to visit again and the nurse washed me nicely and dressed me in a nightgown. To surprise my parents, she decided to put me in a chair before they arrived, using a slide-board. I had used one myself for patients many, many times. I will never forget the sheer agony of that first transfer, and I never let a slide-board near me again! I became acutely aware of every nerve under that thick jet-black rash on my bottom and screamed.

Once sitting, I realised how very terrible sitting could be. I felt dizzy, aching and decidedly surreal. I had my first meal; a reheated frozen packet meal, with peas and mashed potato. When my parents arrived I felt very bad indeed. My skin throbbled and an acute giddiness beset me. For some odd reason I thought my brother, his wife, who is also a school-friend of mine, and their young baby who I had not yet met, were

outside the curtains. In reality, they were still in Australia.

My rebellious spirit re-emerged. My independent spirit has led me to many scrapes and miscommunications. At that time, I did not feel I needed my parents to be in London any longer, and told them of this. I was fine now! I didn't need any help. Nothing wrong here! They were devastated. My dad's blue eyes sparkled with tears.

The narcotics and sedatives had a powerful effect. They induced paralysing fear, paranoia and confusion. All my conversations were bizarre and only feebly based on reality. My reality was based on the same events, the same surroundings that everyone else saw, but was of another dimension, a terrifying and very real darker my world. My hallucinations revolved largely around nursing care. I knew I was in hospital and I even came to understand how unwell I was, including my limb loss. But on a functional level reality became distorted and skewed. I developed bonds with some nursing staff and deep-seated fear of others. I recall lying in the bed, watching a shift changeover in utter terror – for I knew the nurses were talking about me. I felt violated, vulnerable and very alone. My night shift nurse remained the same for several days at a time and I came to trust her implicitly. I was desperate to have my 'saviours' care for me, and petrified when left with any staff I felt unsafe with. There were so many unfamiliar faces coming and going. I was certain they were going to harm me. I was sure the patients around me were dying, and was frightened for my own life. Many of my hallucinations revolved around fire, presumably a result of my septic fever. I saw resuscitation equipment catch on fire during use on another patient. The nurses plotted to blow the ICU up, using Bunsen burners and gas. The cool water running over my necrotic tissue during a wash I mistook for a nurse 'saving' me from the ensuing fire. Following the fire I was moved to another fictitious unit, when in fact I simply changed rooms.

I mistakenly believed that one nurse overdosed my infusions with potassium – only a renal nurse could come up with that one! I thought I saw a nurse stabbing a patient, only to have cushion-stuffing spill from his belly. Nurses were conspiring to steal the narcotic analgesia and falsify my signature. I tried telling the nurses I 'trusted' about the conspiracies and elaborate plots taking place in the unit, but to no avail. I desperately tried to escape, tying a sheet to the bed rail and lowering myself down, and then crawling to the door .... But of course I could not move.

Aaron sat beside me, holding my hand one evening and I tried to tell him about the frightening events. "I've got to get out of here before I die." I informed him. "Out of the five people in this room, four died last night." He looked about him. There were four bedridden patients in

the room, all very much alive, thanks to modern technology. He said nothing. I became aware in my drugged state that my nurse seemed to be flustered about my infusion of fentanyl. "She's stuffed it up." I said to Aaron. "She's talking to another nurse about the titration." My nurse returned. "Your blood pressure is low, Lisa, so we are going to give you some Gelofusine®" she reached up to the drip stand beside me. "She's giving me 1:25 instead of 1:250 of fentanyl, that's why my blood pressure is low," I told Aaron. These figures popped into my head, the way good ideas occur in drunken sessions with friends. "How do you know?" he queried. "I heard her telling someone and she seems stressed." I was becoming frightened now. Aaron stayed for quite some time that night.

As my condition improved, the medical staff began to talk to me about a transfer to the ward. I was desperate to leave the ICU, to escape the imagined tyranny of the staff there. Friends came to visit me and stood at the end of my bed. I tried to reassure their shocked faces.

A physiotherapist came to see me in the days before I was transferred. She appeared at the foot of my bed after a long day of visitors, with doctors, nurses and hand therapists. "You don't know me, but I am the amputee physiotherapist. Is now a good time to have just a little chat?" "Well, not really. I've had a really long day and want to be left alone." "Well, I really don't have a lot of time, this won't take long." "No, I've had enough of visitors today. I can't take anymore!" I became aggressive with her, a rocky start for a very important relationship. "Could you come back later? She has had quite a bad day," my trusted nurse defended my case.

Later that day I was finally promised imminent transfer. The neurologist I saw murdered in one of my hallucinations had risen from the dead, and I now imagined him to be prone on a stretcher, waiting for some nursing care. Across the room the entrance to that "other" unit, within which I imagined such atrocities, was flooded with comings and goings. I lay paralysed with fear that they would find the record book for the narcotic analgesia.

Admission to the ward brought with it immense pain. My intravenous analgesia was removed in ICU, and I was commenced on oral morphine, which was useless in covering the pain caused by the black rash. I found myself arguing with the nursing staff in an attempt to have more pain relief. It wasn't until the grafting operations commenced a week later and I was given patient-controlled analgesia that I was able to gain effective control over the maddening pain.

After leaving intensive care, I spent another 4 months in the London hospital before returning to Australia. The rash had destroyed the skin on my arms,

under my thighs, and both my hands. The plastic surgeons gradually removed the dead skin surgically and replaced it with skin grafts. The ends of my index fingers were also removed. When I left ICU the frightening psychological experiences began to haunt me and a friend took me back to ICU to see the 'real' unit to superimpose it over the unit of my imaginings. It was smaller and safer than I recalled. I spoke to my nurses and discovered they were all very kind people. The nurse I remembered most readily explained how very common hallucinations were.

When I returned to Australia and left hospital, in an effort to purge the events of ICU and the subsequent hospitalisation, I wrote down every hallucination in sequence. This, and talking to my family and friends who were there during those first few weeks, allowed me to release them. I am astounded at my mind's ability

to manufacture such frightening events and still wonder where they came from.

Continuity of care was the most essential element of the intensive care experience. My time in intensive care was the most vulnerable and disempowered period of my life and unfamiliar nursing staff only served to terrify me.

#### **Acknowledgements**

I would like to thank the medical and nursing staff of the Royal London Hospital, Whitechapel, for saving my life, and the Intensive Care community of Western Australia for encouraging me to share my story

**LISA ELAINE WHITE**

*Department of Nephrology, Royal Perth Hospital,  
Perth, WESTERN AUSTRALIA*