"What Do Nurses Do in America?"

Reminiscing about her tour in a Montagnard hospital in Vietnam, this nurse wonders what all the fuss over medications, charts, and protocol is all about here in the States.

HILARY SMITH

"Ya Hilary! New patient!"

It was evening at the Minh-Quy Hospital, the busy, bustling, crowded hospital that is the only major medical resource for thousands of Montagnard hill tribe people in Vietnam. A young man, slender, brown-skinned, clad only in a loin cloth, leant against a stretcher in the entranceway while around him his naked children tumbled on the floor and a ragged crowd of friends and relatives gathered to watch the action. "What is it, Gabrielle?" I asked the Montagnard nurse who had first drawn the young man to my attention. "What's wrong with him?"

Sister Gabrielle, one of Minh-Quy's best nurses, frowned in an effort to find the English words. "He . . . What is English little insect with many legs?"

"Centipede? A centipede bite?"

"Not bite, Ya Hilary. He only touch centipede. Not bite."

As so often during my early days at Minh-Quy I was stymied. Somehow my instructors in medical-surgical nursing had never seen fit to discuss the care and treatment of the patient suffering from centipede contact. Gabrielle, seeing my indecision, came to my rescue. With all the diffidence of the experienced nurse gentling along the raw young intern, she asked, "You want Prednisone? Darvon?"

"Uh, is that what Ya Tih gives?" I asked. It was Ya Tih—the Big Grandmother of the Montagnards, Dr. Pat Smith—who had built this hospital in the jungle for the aboriginal tribes. If I had learned nothing else in my brief time at Minh-Quy I had learned that Dr. Smith's medical judgment was invariably sound.

"Maybe just Darvon," said Gabrielle. "I think Prednisone only for snake bite."

"All right," I said. "Where's his chart?"

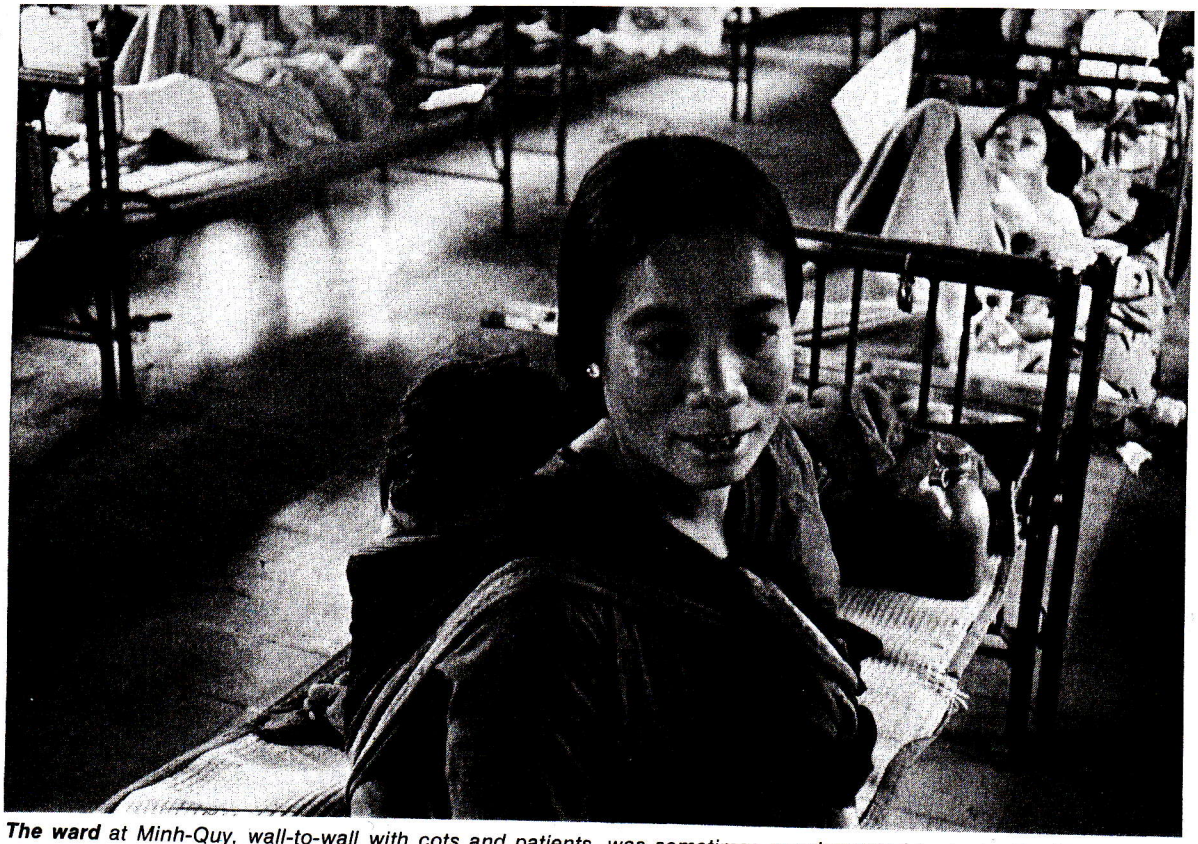
"No chart," said Gabrielle, gesturing towards the clinic building which housed our records and had long since been locked for the night. "We find chart tomorrow." And she hurried off to get the Darvon.

The young man and his family slept that night curled on the floor under the Minh-Quy stretcher. In the morning he had vanished. "Oh," said the night staff when I questioned them, "He much better today. He go home to village."

I was reminded of this incident the other morning as I prepared to go home from night duty on a surgical floor at the American medical center I work in today. A patient in obvious good health some days after his hernia repair asked if he couldn't have a little Maalox from the floor stock. And I, who had once given out Darvon on the authority of an aboriginal nurse with less than six years of formal schooling, hesitated, hedged, and finally suggested he ask the doctors to write an order for antacids when they made rounds.

The two hospitals, Minh-Quy and the modern one in which I now work, have some things in common. Both, for instance, practice sophisticated modern medicine and both set high standards for care. In other respects they are poles apart. The medical center is departmentalized, computerized, hierarchical. We all have our roles and heaven help the nurse who infringes on the prerogatives of the attendings, the house staff, the medical students, or the technicians assigned to our myriad distinct departments. By contrast, Minh-Quy when I knew it was simply two large rooms jammed with wall-to-wall cots and patients, plus a couple of tents to house the overflow. Often the census ran as high as 200, with another 150 or more appearing daily for the afternoon clinics. One or, at best, two physicians might be responsible for the care of all these people, and many of the patients were desperately ill. Under such circumstances it would have made no sense for the nurses to ask for a written order for Maalox—or for Darvon or indeed for any number of medications about which we felt competent to use our judgment. When faced with diseases easily diagnosed and treated by a standard regimen (the various forms of plague or malaria, for instance), a nurse could start treatment just as well as a physician and thereby save the doctor's time and energy for the more obscure diagnostic puzzles that came along. Montagnard and Western staff alike sought their level and set their own limits at Minh-Quy. Gabrielle would ask my advice on one case, I hers on another, while a third might

HILARY SMITH, R.N., M.A.T., home from Vietnam is now a staff nurse in the ICU at the Medical Center Hospital of Vermont, Burlington. In addition, she spends an evening a week as a patient advocate at the local free clinic. She explains that "ya" is an honorific, literally meaning grandmother, used in much the same way as our southern "ma'am" as a title of respect.

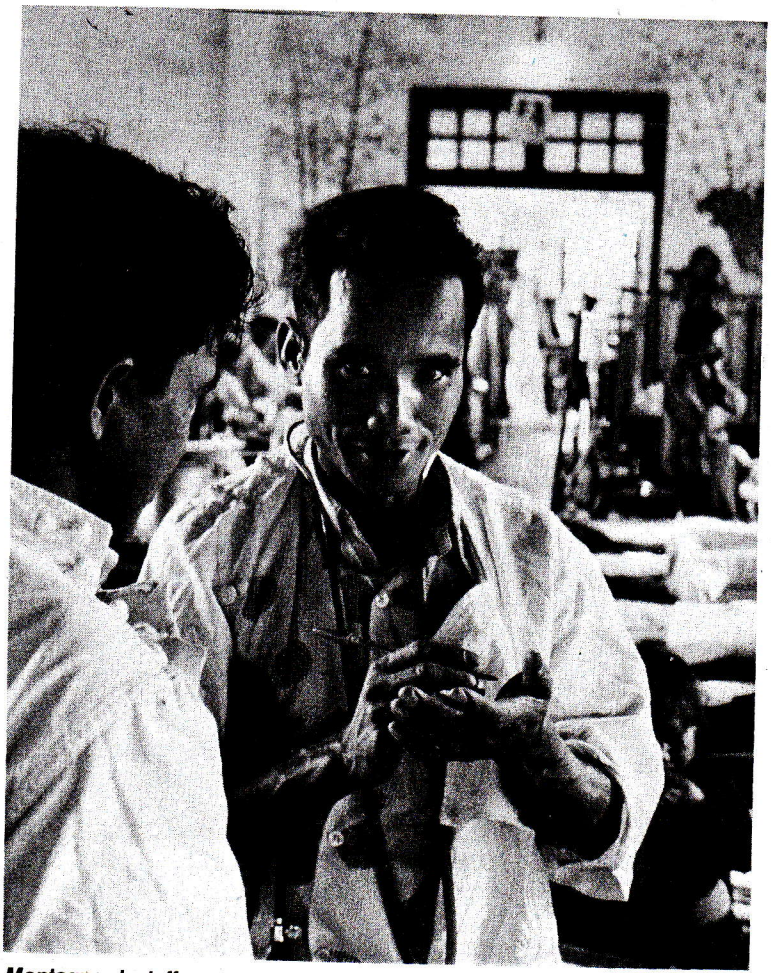


***The ward** at Minh-Quy, wall-to-wall with cots and patients, was sometimes supplemented by tents. Families helped.*

send us both to Dr. Smith for guidance.

If it made no sense for the doctors at Minh-Quy to dissipate their energies in routine diagnosis and treatment, it was equally absurd to expect them to perform all the procedures that are usually delegated to interns in Western hospitals. When I first came to Minh-Quy I was distressed to find that, compared to the Montagnard staff, some of whom were illiterate and none of whom had had more than six years schooling, my technical skills were negligible. I had never done a cut-down, never even started an I.V., never attended a delivery, never opened an abcess, never sutured a laceration or debrided a wound, never performed a spinal tap or a paracenthesis, never put on a cast or set up traction. The Montagnards did all these things as a matter of routine. Montagnards tend to have great manual dexterity. With supervision from someone who knew some theory and could exercise judgment, why shouldn't they learn and use such skills? What would have become of our 200 patients had we insisted that these procedures were the prerogative of physicians alone?

Recently I had a chance to discuss the position of nurse practitioners



***Montagnard staff nurses** had great skill even though few of them had had more than six years of formal schooling.*

with a nurse involved in their training. "Of course," she said, "The great danger is of the nurse practitioner becoming merely an apprentice, forgetting her specific nursing role." Did we forget our nursing role at Minh-Quy? Were we merely apprentices? I think not, although certainly we depended heavily on families to supplement our nursing efforts.

Families helped with the bed baths, families fed their relatives, families observed and reported to us the condition of our patients. After all, even the trained nurse rarely observes a sick child as closely as do the child's anxious parents. But we made and daily acted on decisions on such matters as skin care and hygiene, social and emotional needs, patient teaching, patient activity. Like nurses the world over we watched outputs and monitored I.V.'s and evaluated fluid and nutritional status and reported progress in wound healing. No, I do not think we were apprentices. But of necessity we assumed a broad role, a role expanded even beyond that of the nurse practitioners now emerging in America. The conditions and requirements of the hospital itself and of the primitive society it served forced this, just as the conditions of Western hospitals and the sophistication of the society they serve often tend to restrict the nurse's role.

Of necessity, physicians at Minh-Quy delegated responsibility. Of necessity, the society tolerated such delegation of responsibility. And, of necessity, we few Western nurses in turn shared our responsibilities with a wide variety of lay or semi-trained individuals. We made use of the services of every person who came through the doors of Minh-Quy and did so not according to his written credentials, but according to his observed ability.

Ner was a case in point. Ner was village chief of Dak Ko'dem, a community far from Minh-Quy and riddled with tuberculosis. Our tents were overflowing with patients from Dak Ko'dem unable to return to the village because they required streptomycin injections twice weekly and the distance was too far for even a Montagnard, used to traveling long distances on foot. Ner came to us with multiple injuries from a mine explosion. While he was with us we taught him to use our T.B. outpatient records and to give injections. And when he was finally discharged he took with him several boxes of streptomycin and half the population of his village. Why not? It was a logical solution to the problem, and Ner had demonstrated to us a good understanding of sterile technique and of the drug he was to give. Is giving injections really so sacred?

I sometimes wonder whether the limitations placed on the Western nurse's role by the medical hierarchy on the one hand and by a medically sophisticated lay public on the other aren't responsible for our stubborn clinging to the few prerogatives (e.g., medications) we perceive as left to us and for our efforts to invest those prerogatives with a certain mystical aura.

A friend was recently hospitalized in New York City with a heel injury sustained when she was hit by a car. For the first ten days she was on I.V. antibiotics administered in the standard fashion via a three-way stopcock in her main I.V. line. Her greatest complaint was that the overburdened staff often failed to get to her in time to switch the stopcock. As a result the I.V. would plug and have to be irrigated or changed, both procedures involving some pain. My friend readily acknowledged that the nurses were overworked and really not to blame. "But why couldn't they have let me turn the stopcock for them?" she asked. "Lord knows, I would have taken the responsibility seriously: they were my veins."

Why not, indeed? Because it is easier to cling to the few technical skills we still possess than to become the patient teachers and patient advocates we tell ourselves we should be? Because we are threatened by a medical sophistication that seems to engender incident reports and malpractice suits? Because we see so clearly the risk involved in trusting, trusting each other, trusting our patients?

In some ways Minh-Quy is an anachronism, a hospital exhibiting in the twentieth century the kind of nursing effort that was possible and indeed necessary in an earlier era, a place where technical skills are widely shared on the basis of need and competence, where patient advocacy is one aspect of a widely diversified nursing role. Once at Minh-Quy I tried to express to Sister Gabrielle my gratitude and excitement over all that the hospital was teaching me. "Before I came here," I told her, "I never did any of the things I do now, the deliveries and I.V.'s and I&D's and suturing and LP's. . . ."

Gabrielle gave me a look of alert interest. "And in America?" she asked. "What do nurses do in America?"

It's a good question, Gabrielle. I could tell you about bed baths and medications and vital signs and dressings and you would reply, "But is that all?" I could tell you about data bases and care plans and patient care conferences and you would give me your look of stubborn perplexity and ask, "But why? Everyone knows these things. They are common sense. Why must you write them down?" I could tell you about monitors and respirators and dialysis units, and you might even suspect me of advocating witchcraft. I could tell you that in America there are doctors to do the things that you and I did at Minh-Quy and you would give me your luminous smile and declare, "Ah, America very good!"

You may be right, Gabrielle, but sometimes, as for instance when I am debating such weighty matters as whether or not to give a dose of Maalox without a written order, I find myself mourning for your less complicated world, where nursing care is directly based on need, on trust, and on ability.

YIN

What is the very essence of nursing? The author found her answer in a primitive Vietnamese hospital, in the person of a nurse named Yin.

BY HILARY SMITH

SPEAKING OUT

NURSES LEARN THEIR CRAFT in many ways, formal and informal. They learn from classes, lectures and discussions; from doctors, patients and relatives; perhaps most often from other nurses. One of my best teachers was a nurse named Yin who worked—and works today—at the Minh-Quy Hospital in Kontum, South Vietnam.

I first met Yin in 1971 when I joined the Minh-Quy staff for a year's experience in overseas nursing in an underdeveloped country. The hospital itself is one of the small miracles of Vietnam, a modern institution served by and serving some of the most primitive people left in our world, a sophisticated medical resource flourishing, against all odds, in a country torn by war and decimated by poverty and disease. It is the creation of Dr. Pat Smith, a native of Seattle who first came to Vietnam in 1959 and who stayed to build a hospital in the jungle for the Montagnard hill tribes. The Montagnards are the aborigines of Vietnam, a people displaced and dispossessed by war and by the more "civilized" Vietnamese, much as the American Indian has been displaced and dispossessed in our country. When Dr. Smith first came to Vietnam, virtually no health care was available to the Montagnards. The birth of a child was never celebrated until the child was 2 or 3 years old, since most children died in infancy, and a Montagnard considered himself old at 40 and lucky to have lived so long. Now there is Minh-Quy, and the Montagnards have learned that the common diseases of the Highlands—T.B., malaria, plague, gastroenteritis, typhoid, dysentery—can be cured. For the Montagnards, Dr. Smith and her staff are truly workers of miracles.

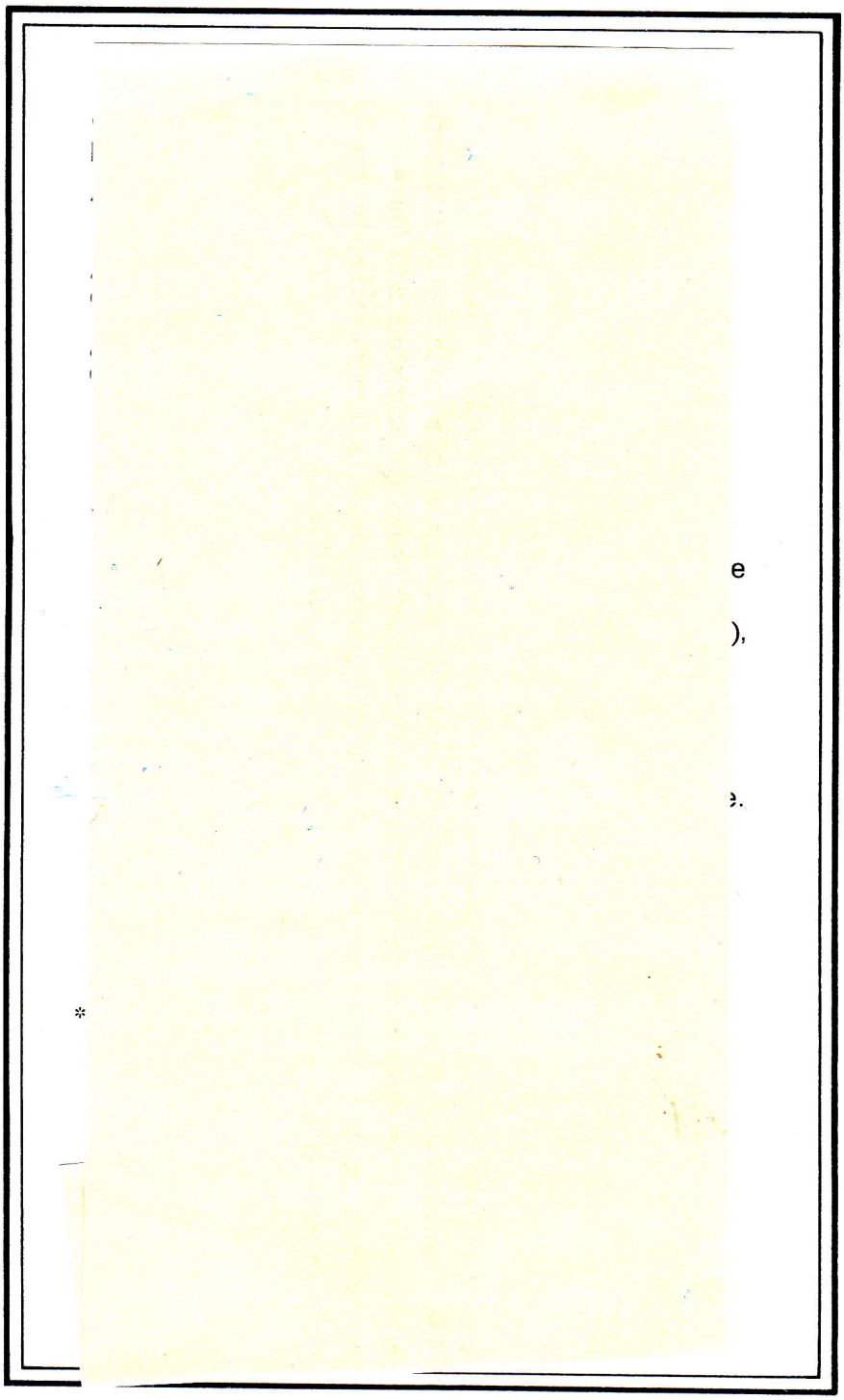
Yin is herself Montagnard. Like most Montagnards, she has lived all her life with overwhelming poverty and disease. And like most Montagnards, she has developed an ability to find life full of entertainments despite its deprivations. When you have nothing else you must have laughter, and Yin, like the vast majority of staff and patients at Minh-Quy, has laughter in abundance. At Minh-Quy there is none of the hushed solemnity of Western hospitals: the wards are aglow with cheerful activity. And any event, from the birth of a new child to an attempt at cardiac resuscitation, draws a large and interested audience much given to excited commentary and helpful advice. Yin herself presides at many a birth. She is an accomplished midwife, quick to spot potential problems, firm and reassuring with the straining mothers. But her primary job is simple bedside nursing, and at this she excels. When Yin finishes with morning care for a patient, that patient is clean and comfortable, hair neatly braided, mouth rinsed and teeth brushed, IV intact and running, Foley taped for proper drainage, back rubbed and powdered, any changes in condition observed and reported. Yin gives comprehensive nursing care—not in a bright and airy room with an electric Hi-Lo bed, a stack of fresh clean linen and a bedside stand full of gleaming disposables, but in a ward so crowded one can barely move between the ancient cots, where naked children tumble about the basin of bath water, and where an intact patient gown is a luxury. Out of seeming chaos, Yin creates her own brand of order and all her patients benefit.

Only a few of the Montagnard staff at Minh-Quy understand the importance of making rounds. Yin is one of these. One evening when I was at the hospital, I watched Yin start her shift with a quick and efficient tour of the crowded wards. The mother of a high-risk infant lay sleeping on the floor by the bassinettes, her 2-year-old son curled against her back. It was a chilly night and the boy was naked. Yin scooped him up in passing, and when she returned he was wrapped in a tattered sweater and a scrap of blanket. She set him down again beside his mother and the child, still sleeping, burrowed into his blanket to spend the night in unaccustomed warmth and luxury. He was not a patient. Technically he was no responsibility of Yin's. But he was present and in need, and that was enough for Yin: she seldom overlooked the needy.

One of Yin's neediest patients was Ymoi, a slight and fearful woman who looked on Minh-Quy with a mixture of deep suspicion and desperate hope. Ymoi was Jei, a member of one of the most primitive of the Montagnard tribes and a stranger to modern medicine. She came to the hospital with a leg infection over 2 years old, a purulent, funginating mass horrible to see. For her, Minh-Quy represented a last resort. Ritual sacrifice had failed her, and the standard local treatments—packing the wound with a mixture of dung and dried grasses, for instance—were no help. Ymoi came to Minh-Quy because there was nothing else left for her, and she came full of doubt and distrust. Her first few weeks at the hospital gave her little reassurance. We jabbed her with needles; we stuck a tubing in her arm that constantly got in her way; we subjected her to painful dressing changes and immobilized her leg in a cumbersome metal cage. None of it could have made any sense to Ymoi and, because she was Jei and spoke none of the local dialect, we could not communicate with her to offer reassurance. Then one day we moved her into a room full of strange machines, put a mask over her face, and forced her to go to sleep. When she awoke, her leg, drastically debrided under anesthesia, hurt worse than ever. But she must have thought

this was the definitive treatment, that now her leg would be whole and well again. Instead, 2 days later when the dressing was changed for the first time, she saw a hole more cavernous than ever, experienced overwhelming pain, and to her horror watched blood gush from the wound while an equally horrified staff worked desperately to locate and clamp off the bleeders unexpectedly revealed as the bandage came off. That was enough for Ymoi. At 4 o'clock the next morning, she pulled out her I.V., unwrapped the splint from her leg, gathered up her two young daughters and disappeared. It took us four days to track her down to a little hovel in the resettlement slums of Kontum City. The miracle was that she had neither bled to death nor developed sepsis in those four days. The leg looked as horrible and neglected as ever.

It was at this point that Yin took over Ymoi's care. Yin saw to it that any Jei who came through the hospital doors knew of Ymoi's situation and stopped to visit with her. Yin found toys for the two little daughters. Yin made sure that Ymoi was never overlooked at meal time. Yin bathed Ymoi and found a ribbon for her hair and, for the first time since coming to Minh-Quy, Ymoi looked pretty. Yin urged on us the importance of pain medication before each dressing change. Yin chatted to Ymoi in her own dialect—Bahnar—and Ymoi responded in Jei. Somehow, they understood each other. Slowly the look of panic fear disappeared from Ymoi's face. Slowly she learned to trust. One day she smiled. Another day she managed a few words in limping Bahnar, and Yin led the rest of the staff in fulsome praise for this accomplishment. Ymoi, Yin told us, was becoming wonderfully clever. Ymoi was a good patient.



Yin was right: Ymoi *was* a good patient, gentle, trusting, cheerful, enduring. She became a good patient because she had a good nurse, a nurse who recognized and met her needs, gave her support and understanding, watched over her with sympathy and compassion. Unfortunately Yin would never be able to find employment in a Western hospital. She is a superb nurse, but she is also illiterate. Like many Montagnards, Yin was never able to go to school. Her technical skills were learned on the Minh-Quy wards, her compassion and understanding came out of no textbook.

Sometimes as I sit at my desk compiling data bases and nursing care plans, checking diet orders and writing requisitions, surrounded by scraps of paper while others care for patients, I think of Yin with admiration and with envy. Yin herself bemoans her illiteracy. But in an odd, ironic way I think her fortunate. Scraps of paper will never come between Yin and her job: she looks directly after her patients and acts intelligently and humanely on what she sees. Of necessity, Yin has her professional priorities absolutely straight: patients first.

Most of us who do our nursing in Western hospitals deal with vast and complicated, departmentalized, often computerized, institutions. Whether we like it or not, the paperwork is unavoidable. But when it comes to choosing between a sick and troubled person and a piece of paper, I try always to remember the lesson I learned from Yin. Scraps of paper can always wait: patients come first.