Why the Professor Became a Nurse

“You left teaching English for this?”

I’ve been asked the question so many times by so many people that it no longer surprises me. After all, who in their right mind would give up being an English professor who taught writing at Tufts University to become a nurse?

Other versions of the question are no more complimentary. A favorite of mine is “You couldn’t get a job, right?” And sometimes they really give me pause, like when another nurse asked me, “Why? Because you hated having summers off?” I hadn’t looked at it quite that way before, and the question made me stop and wonder whether I really was crazy, since people ask when they hear my story, “Are you crazy?” I’m not, but I made a midlife career change that many people, including a lot of nurses, do not understand, and certainly would not have made themselves. The why of my decision at times eluded even me. Nursing just felt right, but I don’t think even I fully understood my career change until the last night of the very last shift I would ever work as a nursing student.

That night an eleven-year-old leukemia patient who had a fever arrived on my floor at our children’s hospital. I had decided
to do my senior clinical at Children’s because I wasn’t sure if I wanted to work with kids or adults. In some ways I loved it there, but caring for kids when my own children were still young was hard, and ultimately I only applied for jobs with adult patients.

Still, there I was on my last night at Children’s with a new admission, a kid who’d been in and out of the hospital many times, at ten o’clock.

The patient, Sean, and his dad came up from the ED (emergency department). They talked and joked with each other, started watching movies on the TV in their room right away, and passed an enormous bag of potato chips back and forth. I got the impression they were trying to convince us, and more importantly themselves, that an impromptu hospital stay could be fun if you just had the right attitude.

Other nurses on the floor had warned me that this family was “difficult,” but they seemed OK. Sean’s dad had a bad back and asked a few times for more pillows since he would be sleeping on the chair in the room that folded out into a bed. I’m not sure why, but pillows are a rare commodity in hospitals. I searched both wings of the floor until I found some for him—even with a healthy back, those chair beds are not too comfortable. Sean, testing out some preteen behaviors, could be rude, so I teased him about saying “please” and “thank you” as I handed over cartons of apple juice. I described him to the resident as “cheeky,” but I liked him.

They’d ordered fluids for him and antibiotics—lots of antibiotics—and Sean and his father were concerned I was going to wake them repeatedly during the night since I would need to administer one drug after another. I told them I would do my best to let them sleep undisturbed—peaceful sleep is another
rare commodity in hospitals, and it’s important for healing as well as peace of mind.

Still, they finished the first movie and moved onto another, until finally around two o’clock in the morning they both fell asleep. They had turned off the TV and the light. Sean’s father had fallen asleep first, and then Sean, who’d been lying in the dark hospital room with his eyes wide open, keeping his thoughts to himself, dropped off to sleep, too. I went into the dark room and hung the drugs I needed to administer as quietly and quickly as I could without turning on a light. I had promised not to disturb them, and I meant to keep that promise.

Around 4:00 A.M. my preceptor, the nurse supervising me, told me Sean wanted a Tylenol. I went to see what was up. As soon as I walked into his room, he looked up at me in the darkness and said, “It feels like I can’t breathe. My chest hurts.” Alarms went off in my head, and I truly pictured myself as Tom, the cat in the Tom and Jerry cartoons, with little mallets alternately striking on opposite sides of my head, which had become one big metal bell. Oh, gee, that sounds bad, I thought to myself. What am I going to do about that? But then I did the things I most needed to do: made sure he could breathe and called the resident to tell him about Sean’s change in status.

I told my preceptor, Paula, what was up, and she told me to get a set of vitals. Hearing that, I felt stupid. I had gotten so used to taking vital signs—blood pressure, heart rate, respiratory rate, and temperature—that I had forgotten they matter, that in a situation like this the patient’s vital signs could give us valuable information about just how bad off he was. A low blood pressure and high heart rate would tell me he was in danger of being septic and going into shock. If his oxygen level was low, I would
know that his breathing difficulty had something to do with not getting enough oxygen into his lungs.

I grabbed the equipment to take a set of vitals, but when I got back to the room, I had to wait—Sean needed to go to the bathroom. I helped him walk around the bed with his IV (intravenous) pump, and halfway there, between the bed and the bathroom, his knees buckled. He cried out, “I can't see! I can't see!” I held him up, then picked him up and somehow got him into the bathroom and onto the toilet. While I was holding and carrying him, I wondered, a little angrily, why his dad wasn't helping me. Could he really sleep through all this? I wondered, because he did look asleep, even though we must have been loud in that small room.

Once I got Sean settled on the toilet, I took his blood pressure twice. I took it with the machines we have, and I took it manually, by pumping up the cuff myself and listening for the flow of blood. Taken both ways, on both arms, his pressure was 70 over 30, much too low. He wasn’t complaining anymore about loss of vision or not being able to breathe, and by this time the resident and the intern—the doctors in training who were taking care of him—were both in the room. The poor kid had to sit on the toilet while we all stood in the dark and talked about him. When I checked to make sure he was safe sitting on the toilet by himself, he yelled out, “Can't a man take a crap in peace?”

I most remember a swirl of activity. The resident, the more senior M.D. in the room, asked me to tell him exactly what happened when Sean said, “I can’t see,” and fell to his knees. I told the resident the story. He seemed stressed, or maybe I was just projecting my own feelings onto him. I’d seen sick people, sure, and sick kids, but never anyone who was this fragile, and the
nighttime and the darkness of the room gave the whole situation a surreal feeling. We increased the rate of Sean's IV fluids because upping the amount of fluid is usually the first course of action when patients are hypotensive. Putting more fluid in the veins is an easy way to increase blood pressure and cardiac output.

However, we couldn't get Sean's pressure up, and the doctors were worried that he was going septic. The resident called in the fellow (an M.D. training in the hospital's fellowship program) from the PICU (pediatric intensive care unit), and they talked over Sean's symptoms. The doctors asked me to keep taking blood pressures, but Sean never climbed much above his early low. I watched all this with only a vague understanding of what was going on. The resident and the fellow had a couple of huddled negotiations in the dark hallway; the fellow made a few phone calls, then they told me Sean would be sent to the PICU, that he needed the more intense technical support available there.

Things calmed down while we waited for the call to transfer Sean to intensive care. Around 5:30 in the morning I went to check on him. The room was still dark, Sean's father was still asleep, and I hoped Sean had fallen back asleep as well. But he was awake, and he had some questions. His earlier cheekiness was gone, and I found myself confronted by a very scared eleven-year-old boy.

“Why did my chest hurt?” he asked.

I sat down on the edge of his bed. Answers and pieces of answers swirled around in my head, but the truth was I really didn't know, and the doctors didn't either. So I told him that. “I don't know,” I said. “Maybe because you were having trouble breathing, your chest tightened up.”
He nodded, then asked, “How come I couldn’t see?”

I didn’t have an exact answer to that question either, but I did my best, slowing my answer down to match his deliberate pace. “It could be because your blood pressure was so low,” I told him. “Maybe that’s why you fell, too.”

He nodded again, then asked his last question, the hardest: “Why couldn’t I breathe?” Every answer I thought of to this question seemed overly technical, but also just inadequate. I’m sure his breathing trouble had something to do with his low blood pressure, but I didn’t have enough experience to know if hypotensive patients often felt short of breath. I couldn’t make sense of it in a simple way, so I told him that, too. “I’m not sure,” I said. “That’s why they’re sending you to the PICU, so they can find out why you felt like you couldn’t breathe.”

To me, all my answers sounded lame, but Sean seemed to find them comforting. He didn’t want a physiology lecture or a detailed explanation of why patients who are septic drop their pressure; he wanted to ask someone his very troubling questions, and he wanted answers that made sense to him. As soon as I finished giving my explanation for the third question, he stopped talking and relaxed back into bed.

This brief conversation could be categorized as “patient education” in a nurse’s note, but Sean and I exchanged something more substantial than information when we talked. He found a way to ask, “What’s wrong with me?” and “Am I going to die?” And I told him, “I don’t completely know, but whatever happens, I am here with you.” There we were, nurse and patient, talking quietly in a dark room, confronting the vagaries of life and death. For me, this moment finally put to rest any questions I had about why I quit being a professor and became a nurse instead.
Around 6:30 that morning the staff initiated the transfer to the PICU. My preceptor had taken over for me at this point. As a student I wasn’t allowed to take Sean up to the PICU on my own. Before they left, though, I went back into the room to say goodbye and to see if Sean had any more questions.

When I got to the room, I saw Sean’s father, and my question about why he had not helped me during the night was answered. His face held such an intense look of distress that I wanted to look away. His eyes were hollowed out, almost sunken, and he stood there, stooped and silent, as if his only choice in life was to keep receiving blow after blow and hope he could stand it. This is love, I thought, and all the agony that love can bring. “Do you have any questions?” I asked him gently. “Do you understand what’s happening?” That was all I could offer him. If only I could have wiped the slate of his face clean, taken the pain that was driving his shoulders in and down and thrown it out the window, but unfortunately I do not have that power. Sean’s father would have to bear this burden himself.

In answer to my questions, he shook his head no and stood silently in the room while the doctors and I talked to Sean, and Paula got him ready to go.

I looked at my watch and realized I needed to hang feeds for one of my babies. This little guy had been born with a multitude of birth defects, and he got his food through a tube in his stomach. New bags of food have to be hung at specified times, and his was due now. I felt reluctant to leave Sean, but he was in good hands, and I had to take care of another patient. I told Paula where I was going and went to get the new feeds out of the refrigerator. I went into the room and hung the new bag, checked the baby’s diaper, and threw the old bag of feeds away.
As I was leaving the room, another resident, one who had overheard me complain about Sean being cheeky, walked by and asked how he was doing. “Oh, he went to the PICU,” I told her.

“What?” she said, looking genuinely surprised.

“Yeah,” I said. “We just couldn't keep his pressure up.” I marveled at how this phrase, which I had never before used in my life, came out of my mouth. Did I just say that? I thought to myself. Wow, I sound like a nurse.

She stopped for a minute, then said, “Good job,” and kept on walking down the dark hall.

By eight o'clock Sean had gone off to the PICU, and I never saw him again. I ended up overstaying my final shift and missed out on a celebratory breakfast with my friends. I have no idea how things turned out for Sean, but I hope he and his dad are still watching movies and eating potato chips, and will be for many years to come.

When I finally got home that morning, much later than I intended, and so exhausted that sleep simply meant giving into gravity, it hit me that it was my own son's eleventh birthday. My child's biggest worry that day was, “Is mom going to be awake enough to make me a birthday cake?” Compared to Sean's biggest worry, my son's might seem irrelevant, but I didn't see it that way, and the contrast between the concerns of those two eleven-year-old boys reveals part of what I love about nursing. Doctors diagnose, treat, and prescribe—work central to healing—but nurses really do tend to the whole person. A birthday cake in its own way is as important as getting answers to scary questions about not being able to breathe. Explaining human physiology in a dark room in the middle of the night and making birthday
cakes both capture the essence of nursing: combining technical skill and knowledge with love.

After having my son, I realized I wanted a job where I was expected to care about people, not instruct and grade them. Then I had my twin daughters, and my world turned inside out and upside down with the physical challenges of the pregnancy. The midwives who helped me through the pregnancy left a lasting impression, and when I mentioned my admiration for them, a friend who's a nurse told me, “You could do that job.”

It had never occurred to me before. People like me go to medical school, I thought. They don’t become nurses. At that time I knew very little about what nurses really do, but my friend, who's also named Teresa, persisted. She was beginning a doctoral program in nursing, but she'd put in her time as a nurse practitioner, providing gynecological care to underserved teens in high school clinics. She talked about hospital nursing, how there were floor nurses who could “kick my ass” and what a huge advantage it was to be smart as a nurse. She also talked about patients in general, and without using the specific words, described for me the nurse's role as a “patient advocate,” a phrase like “to serve and protect” or “first do no harm” that is so integral to the job that it can be considered a professional mantra.

I was hooked. Just days after that conversation I decided to go to nursing school. Six years later, when my twins were eight, I got my bachelor’s in nursing degree, and a few months after graduation I passed the licensing exam to get the coveted R.N. It's a long story that involved my starting at the University of Pennsylvania, withdrawing when my husband's job in New Jersey imploded, and starting over again at the University of Pittsburgh after we moved there. During all that time, while I
T H E R E S A B R O W N

took science prerequisites at Rutgers, after beginning at Penn, and then enrolling at Pitt, my dedication to nursing never wavered. The more time that went by, the more I knew I had finally found a job that fit.

I tell people that “having kids changed my life,” and truly if I had not had children, I would never have become a nurse. So, how I got from the ivory tower to the hospital, from English to nursing, flows directly from my becoming a mom. Pregnancy and motherhood can feel alternately like a slog and a wondrous journey. With my twins I got a double dose of that agony and ecstasy, and I found it enriched my life when I had not known it was impoverished.

Contemporary writer Frank Bidart has a great two-line poem called “Catullus: Odi et Amo”:

I hate and love. Ignorant fish, who even wants the fly while writhing.

I first read this poem in a college poetry class and thought it said something so true about the kind of romances I tended to find myself in: wanting the men who made me miserable. Now, married, in my early forties with three kids, I see a deeper meaning. At this moment in my life, the poem describes the kind of work I want to do and why I want to do it. I love my kids, but like Sean’s father I know how painful and fraught that love can be. I care deeply for my patients, and I loathe their suffering and disease. Patients love the idea of being treated and cured, but they hate how those treatments can wrack their bodies more horribly than their disease ever did. I love the idea of helping patients, even when I don’t know exactly what’s wrong with them.
It's a simple enough idea: love what you do, even when you hate it. I never felt that way about being an English professor or even a teacher. I liked teaching, and at times I found it enjoyable enough, but I never felt passionately about it, for better or for worse.

So I gave up my summers off, and now I have to be at the hospital at 7:00 a.m. and work for twelve hours with no promise of a real break. But nursing stresses me out in a completely different and oddly more tolerable way than working as a professor ever did, I think because I find it so much more meaningful. Working as a floor nurse is messy and stressful, but I wouldn't exchange it for a dream classroom full of well-read, hardworking, intellectually curious college students—not in a million years, not ever. For where else can I go to sample daily the richness of life in all its profound chaos? Where else can I comfort a cheeky eleven-year-old boy who has to confront his own mortality earlier than any of us ever should?

This book is the story of how I learned to do a job I love and hate, and why I keep on doing it. The “writhing” that Frank Bidart described in “Odi et Amo” is just part of it, too—no one can fight for their life without having some suffering mixed in, at least not the way we practice medical oncology right now. And that’s where nurses come in. Doctors heal, or try to, but as nurses we step into the breach, figure out what needs to be done for any given patient today, on this shift, and then, with love and exasperation, do it as best we can.