VINTAGE

Copyrighted material

Contents

Cover
About the Book
About the Author
Also by Christie Watson
Dedication
Title Page
Epigraph
Introduction: Worth Risking Life For

1 A Tree of Veins
2 Everything You Can Imagine is Real
3 The Origins of the World
4 At First the Infant
5 The Struggle for Existence
6 Somewhere Under My Left Ribs
7 To Live is So Startling
8 Small Things, with Great Love
9 O the Bones of the People
10 So We Beat On
11 At Close of Day
12 There Are Always Two Deaths
13 And the Flesh of the Child Grew Warm

Author's Note
Acknowledgements
Copyright

Copyrighted material

About the Book

Copyrighted material

About the Author

Copyrighted material

ALSO BY CHRISTIE WATSON

Tiny Sunbirds Far Away
Where Women are Kings

Copyrighted material

For Nurses

Copyrighted material

THE LANGUAGE OF KINDNESS

A Nurse's Story

Christie Watson

Chatto & Windus
LONDON

Copyrighted material

chest. I refused to go into the living room after my mum bought a stuffed chick from a car-boot sale and placed it amongst her ornaments, and instead ate my vegetarian dinner on the stairs in protest, saying, 'It's me or the chick. I cannot be associated with murder.'

My mum, with endless patience, constantly forgave my teenage angst, removed the chick, made me another cheese sandwich and gave me a hug. It was she who taught me the language of kindness, though I didn't appreciate it back then. The next day I stole a rat from school, to save it from dissection by the biology department. I called it Furter, and hoped it would live safely with my existing pet rat, Frank, which used to sit on my shoulder, its long tail swinging around me like a statement necklace. Of course, Frank ate Furter.

Swimmer, jazz trumpeter, travel agent, singer, scientist ... Astronomy was a possibility until, at the age of twelve, I discovered that my dad, who had taught me the name of every constellation, had made it all up. I didn't tell him, though; I still let him point upwards and tell me his stories, with his enthusiasm for narrative bursting into the sky. 'There – the shape of a hippo? You see it? That's called Oriel's Shoulder. And that is the Bluebell. You see the shape? The almost silver-blue colour of those particular stars? Fishermen believe that if you look to the stars hard enough, they will whisper the secrets of the earth. Like hearing the secrets of the sea inside a shell. If you listen hard, you can hear nothing and everything, all at the same time.'

I spent hours and hours looking at the stars to hear the secrets of the earth. At night I pulled out a cardboard box full of treasures from underneath my bed: old letters, a broken key ring, my dead grandfather's watch, a single drachma; chewing gum that I had retrieved from underneath a desk, and which had been in the mouth of a boy I liked; stones I had collected from various places, and a large shell. I would stand in my bedroom looking up towards the stars, holding the shell to my ear.

Copyrighted material

One night, burglars came to steal meat from our freezer, which we kept in the garden shed. Those were the days when people bought meat in bulk at car-boot sales, from men on giant lorries with loudspeakers and dirty white aprons. Those were the days when police would come at night to investigate frozen-chicken theft, and my star-watching was interrupted by police shouting. The universe had answered my shell-call: vegetarianism mattered. I am not sure which would have been a more unusual sight that night: a few young men carrying a frozen chicken and a giant packet of lamb chops, or a skinny teenager in a moonlit bedroom, with a large shell pressed against her ear.

What I would do – and who I would be – consumed me in a way that didn't seem to worry my friends. I didn't understand then that I wanted to live many lives, to experience different ways of living. I didn't know then that I would find exactly what I searched for (minus the swimsuit and the sun): that both nursing and writing are about stepping into other shoes all the time.

From the age of twelve I always had part-time jobs. I worked in a café cleaning the ovens – a disgusting job, with mean women who used to make the teabags last three cups. I did a milk round, carrying milk during the freezing winter, until I could no longer feel my fingers. I did a paper round, until I was found dumping papers in dog-shit alley. I didn't make any effort at school; I did no homework. My parents tried to expand my horizons, give me ideas about what I might do and a work ethic: 'Education is a ticket to anywhere. You have a brilliant brain, but you don't want to use it.' I was naturally bright but, despite the tools my parents gave me and their *joie de vivre*, my poor school-work ethic and my flightiness continued. They always encouraged me to read, and I was consumed by philosophy, looking for answers to my many questions: Sartre, Plato, Aristotle, Camus – I was hooked. A love of books was the best gift they ever gave me. I liked to roam and not be far from reading material; I hid books around the estate: *Little*

Copyrighted material

Women in the Black Alley; Dostoevsky behind Catweazel's bins; Dickens under Tinker's broken-down car.

I left school at sixteen and moved in with my twenty-something boyfriend and his four twenty-something male lodgers. It was unbelievably chaotic, but I was blissfully content working a stint at a video shop, handing out VHS videos to the Chinese takeaway next door in exchange for chicken chow mein, my vegetarianism now beginning to wane, as I concentrated on putting on 18-rated films in the shop and filling the place with my friends. I went to agricultural college to become a farmer and lasted two weeks. A BTEC in travel and tourism lasted a week. To say that I had no direction was an understatement.

I was truly devastated when, after turning up late for an interview, I did not get the job of children's entertainer at Pizza Hut. It was a shock when my relationship broke down, despite being only sixteen and completely naive. My pride meant that I would never go home. No job, no home. So I worked for Community Service Volunteers, which was the only agency I could find at the time that accepted sixteen-year-olds instead of eighteen-year-olds and provided accommodation. I was sent to a residential centre run by the Spastics Society (now called Scope), earning £20 pocket money a week by looking after adults with severe physical disabilities: helping them to toilet, eat and dress. It was the first time I felt as if I was doing something worthwhile. I had begun eating meat and I had a bigger cause. I shaved my head and lived in charity-shop clothes, spending all my pocket money on cider and tobacco. I had nothing, but I was happy. And it was the first time I'd been around nurses. I watched the qualified nurses with the kind of intensity that a child watches her parents when she's sick. My eyes didn't leave them. I had no language for what they were doing, or for their job.

'You should do nursing,' one of them said. 'They give you a bursary and somewhere to live.'

Copyrighted material

I went to the local library and discovered an entire building full of waifs and strays like me. I had been to my school library, and to the library in Stevenage, many times when I was much younger, but this library was about more than simply learning and borrowing books. It was a place of sanctuary. There was a homeless man asleep, and the librarians left him alone. A woman on a mobility scooter was being helped by a man who had a sign round his neck that said he had autism and was there to help, reaching a book on a top shelf for her. There were children running around freely, and groups of younger teenagers huddled together, laughing.

I found out about Mary Seacole, who – like Florence Nightingale – nursed soldiers during the Crimean War. She began experimenting in nursing by administering medicine to a doll, and then progressed to pets, before helping humans. I hadn't considered nursing as a profession before, but then I began remembering: my brother and I purposefully ripped the stuffing out of soft toys or pulled the glass eyes from dolls, so that I could fix them. I remembered my primary-school classmates queuing for an anaemia check-up; I must have bragged about my specialist knowledge, before lining them up outside school and pulling down their eyelids, one by one, to see if they needed to eat liver and onions; and the endless friends with sore throats whose necks I would gently press with my fingertips, as if on a clarinet. 'Lymph node.'

There wasn't much written about what nursing involved, or how to go about it, so I had no idea whether or not I'd be suitable. I discovered that nursing pre-dates the history books and has long existed in every culture. One of the earliest written texts relating to nursing is the *Charaka-saṃhita*, which was compiled in India around the first century BC and stated that nurses should be sympathetic towards everyone. And nursing has strong links with Islam. In the early seventh century, faithful Muslims became

Copyrighted material

nurses – the first professional nurse in the history of Islam, Rufaidah bint Sa'ad, was described as an ideal nurse, due to her compassion and empathy.

Sympathy, compassion, empathy: this is what history tells us makes a good nurse. I have often revisited in my head that trip to the library in Buckinghamshire, as those qualities seem to have been lacking all too often during my career – qualities that we've now forgotten or no longer value. But, at sixteen, I was full of hopeful energy and idealism. And when I turned seventeen I decided to go for it. No more career choice changes and flitting around; I would become a nurse. Plus, I knew there would be parties.

A few months later, I somehow slipped onto a nursing course, despite being younger by a couple of weeks than the official entry age of seventeen-and-a-half. I moved into nursing halls in Bedford. The halls were at the back of the hospital, a large block of flats filled with the sound of banging doors and occasional screaming laughter. Most of my corridor was made up of first-year nurses, with a few radiographers and physiotherapy students, plus the occasional doctor on rotation. The student nurses were almost all young and wild, and away from home for the first time. There were a significant number of Irish women ('we had two choices,' they'd tell me, 'nurse or nun'); and a small number of men (universally gay at the time). There was a laundry room downstairs, next to a stuffy television room with plastic-coated armchairs which the back of my legs stuck to, in the heat from the radiators on full blast twenty-four hours a day. I met a trainee psychiatrist in that television room, after inadvertently blurting out that I was stuck to the chair, and he became my boyfriend for a few years. My bedroom was next to the toilets and smelled of damp, and one of my friends once grew cress on the carpet. The kitchen was dirty and the fridge was full of out-of-date food, with a note on one

Copyrighted material

of nursing: philosophy, psychology, art, ethics and politics. We will meet people on the way: patients, relatives and staff – people you may recognise already. Because we are all nursed at some point in our lives. We are all nurses.

Copyrighted material

1

A Tree of Veins

Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care.

Article 25 of the Universal Declaration of Human Rights

I walk across the bridge towards its jagged-edged shadow, watch the pale-blue, almost green, grey light dancing on the water below: it is dawn. Everything is quiet. A full moon. A couple of women swerve past me, wearing party clothes and smudged mascara; a man in a sleeping bag is slumped against the wall, a coffee cup beside his head containing a few coins. There is hardly any traffic, but for a few black cabs and the occasional night bus. But there are other people like me heading to the hospital: a uniform of scuffed flat shoes, rucksack, pale face, bad posture.

I turn into the hospital grounds and walk past the small church in the courtyard, which is always open. Inside, it is dark and lit by dull lighting and candles, with a book full of messages and prayer requests on the altar. The saddest book you will ever read.

The staff are rushing in through the main entrance; some pushing bikes, others walking with purpose, trying not to catch the eye of anyone anxiously searching for information, carrying a letter and an overnight bag, holding the hand of a crying child or pushing an elderly relative in a wheelchair, a blanket tucked over their knees. At 9 a.m. there will be a volunteer to help the lost, wearing a banner that reads: ‘How Can I Help You?’ This is Ken, who is seventy and whose granddaughter was treated at the hospital for sepsis, following treatment for ovarian cancer; ‘I want

Copyrighted material

to help people like me. It's the little things.' He gives out maps of the hospital layout, directions and a smile. The map of the hospital is colour-coded, and there are coloured stripes on the floor for people to follow. At least once a day someone will sing and skip as they follow the yellow stripe: 'We're off to see the wizard ...'

I walk past the reception seating area, where even more people are huddled together: rich and poor, disabled and able-bodied, people of all races and cultures and ages. Often I see the same woman – wearing slippers and reeking of urine, sitting next to a trolley filled with plastic bags – muttering to herself. Sometimes she shouts out as if she's in pain, and a security guard's face will pop up at the hatch to check for disturbances, before disappearing again. But today she's not there. Instead I see an elderly woman wearing a thick red coat, despite the hospital heating. She looks up at me for a few seconds with frightened, sad eyes. She seems completely lost and alone despite the dozen or so people around her. Her hair, once curled, is now unwashed and half-flat; it reminds me of my nan's hair when she got sick, and how she hated not having a perfect blow-dry. She closes her eyes and rests her forehead on her hands.

I love walking through the hospital. Hospitals have always been places of sanctuary. King Pandukabhaya of Sri Lanka (who lived from 437 to 367 BC) built lying-in homes in various parts of his kingdom – the earliest evidence anywhere in the world of institutions dedicated specifically to the care of the sick. The earliest psychiatric hospital was in the Islamic world, built in Baghdad in 805 AD. These early hospitals were forbidden by law to turn away patients who were unable to pay for care. The Qalawun Hospital in thirteenth-century Egypt stated: 'All costs are to be borne by the hospital, whether the people come from afar or near, whether they are residents or foreigners, strong or weak, low or high, rich or poor, employed or unemployed, blind or sighted, physically or mentally ill, learned or illiterate.'

Copyrighted material

I walk on, past the gift shop where 'Congratulations' and 'With Sympathy' cards are separated by 'Get Well Soon'. I pass the tiny clothes shop where nobody ever buys clothes, but the shopkeeper tells good stories and knows everything that is happening in the hospital; on to the public toilets where patients collapse, inject heroin and, occasionally, are attacked – once even raped. Opposite the toilets are the newsagent's and the twenty-four-hour café, where sour milk from the broken coffee machine once flooded onto the lifesaving defibrillators stored in the basement below.

I turn the corner and glance back at the woman in the thick red coat, nearly colliding with a kitchen assistant pushing a giant metal trolley which smells of bleach, mould and aeroplane food. Left of the coffee shop are the lifts where there is always a cluster of people waiting. The hospital is built on expensive land and grows vertically; most of the wards are above the main veins and arteries of the ever-expanding hospital buildings. But the long wards with their many windows are still recognisable as having the same architectural layout that Florence Nightingale suggested, recognising the role of good architecture and hospital design in improving patients' health. She recommended that ward layouts comprised of long, narrow blocks with tall windows, maximising the fresh air and sunlight. In her correspondence between 1865 and 1868 with the Manchester architect Thomas Worthington, Nightingale also highlighted the practical needs of the nurses: 'Will the Scullery be sufficient accommodation for a nurse to sleep in, if necessary?'

I imagine her footsteps, and watch my own as I pass the patient transport area, where there is an entire room full of people waiting to go home, too sick to travel by public transport and too poor to go by taxi; none of them have relatives to collect them. The patients are sitting in wheelchairs and plastic chairs, wearing coats or dressing gowns and blankets, looking at the automatic doors for the face of a stranger; looking past the automatic doors at the sky

Copyrighted material

outside, its emptiness. The vending machine whirrs, untouched, behind the row of chairs. I wonder if these people – most of them elderly and frail – are hungry, or in pain, or frightened. I already know the answer. The waiting room to leave the hospital seems fuller than the waiting room to get in. Everything is relative. Patients may not feel lucky to suffer a serious injury and be fighting for their life in Accident and Emergency (A&E), but if they have family and friends with them, then maybe they are lucky.

The porters' lodge door opens and slams continually into a line of empty oxygen cylinders, looking like giant skittles. A woman with frizzy hair and drawn-on eyebrows has a Madonna-esque earpiece and microphone and a switchboard pad in front of her. She is someone I spend time trying to befriend. But despite my efforts she barks, 'Can I help you?' every time I say hello, as if I am a stranger. Still, I persist.

The pharmacy is next door: a giant sweet shop for adults. There are trays that pull out, and miles of lines of different tablets. The inside of the pharmacy is like a trading floor on Wall Street, down a low-lit staircase to the basement, where certain drugs are organised into emergency boxes, labelled whenever they are opened, to ensure they're not tampered with, then restocked and sealed. Many of the drugs are used in the UK without NICE (the National Institute for Health and Care Excellence) approval. This is not uncommon. In paediatric use in America, for example, only 20 to 30 per cent of drugs are FDA-approved.

Drug reps are salespeople, and they used to be a source of excitement in hospital. They are easy to spot; like the pharmacists, they are better dressed than the doctors. A uniform of designer clothing and the manner of a car salesman, plus the ability to get the attention of a busy consultant (and past the consultants' secretaries), mean that a good-looking undercover army of twenty- and thirty-year-old graduates, who didn't quite get the grades for medical school, regularly visit hospitals. A visit on the

Copyrighted material

and the hospital canteen where staff with hangovers are eating their fried breakfast.

The woman with the sad eyes wearing the red coat is tiny and frail-looking. She is even smaller when the coat comes off. She's wearing a floral shirt underneath that has the buttons done up wrong. Her skin is crinkled and dry, her hair white and patchy. Her eyes are rheumy and her lips cracked; her half-flat hair smells sour. A wedding ring hangs on a silver necklace just above her collarbone. Her eyes flick from person to person and she is shaking. She is in the canteen, conscious and sitting on a chair, already surrounded by some of the crash team: a senior doctor, a junior doctor, an anaesthetist and an SNP. They do not look worried. The SNP, Tife, is a friend. She was an A&E nurse for many years. It is always reassuring to see her: she is as calm as ever. She has somehow found a blanket, which you would imagine is easy but never is, and is kneeling in front of the patient attaching a small sensor to her finger to record her oxygen levels.

'Morning!' Tife says.

'Hi. Sorry – I was just getting changed.'

The crash trolley arrives with a porter. It is called for as soon as a crash bleep goes off, and generally arrives at the same time as the team. On it rests an enormous amount of kit – an entire ward on wheels. There's oxygen, suction, a defibrillator, emergency drugs, and large bags containing everything under the sun from glucose monitoring kits to breathing equipment.

'Betty here has a bit of chest pain. All the obs are fine. She's very cold. Can you get a Tempa-Dot?' She turns to the doctors. 'We'll get her to A&E, if you need to go.'

'She needs a twelve-lead ECG,' the doctor says, and leaves before she notices the junior doctor rolling his eyes and muttering, 'You think?' under his breath.

'Can I hand over to you?' he asks me as he runs. They have busy jobs as well as being on the crash team, and have to drop

Copyrighted material

everything when the bleep goes off, sometimes leaving patients in theatre with only junior staff.

I nod. 'Hi, Betty.' I reach for her hand. It is ice-cold. 'I'm Christie. I'll get you sitting up on the trolley and we'll go across to A&E. Nothing to worry about, but best to get you checked over. I think I saw you on my way in? In reception?'

'Betty came in to see Patient Liaison this morning, but was early, so she came for a coffee and had a bit of a tight chest. All her obs are fine, but she's had a rough time, haven't you, Betty?'

I notice her expression. Terrified.

'Betty lost her husband to a heart attack recently.'

'I'm very sorry to hear that,' I say, pulling the blanket closer around her. Her temperature is dangerously low. 'How's the pain now?'

She shakes her head. 'I don't want to cause any fuss,' she says. 'It's not bad. Probably something I ate.'

Betty does not look like a patient having a heart attack (myocardial infarction), though older women do not always exhibit the classic signs that you'd expect – chest pain, numbness, tightness, tingling, pins and needles – and occasionally feel no pain at all. Ischaemic heart disease is the most common cause of death in most Western countries, and a major cause of hospital admissions. We see lots of patients suffering heart attacks in hospitals, and many of them are not initially in hospital for that reason. They come for dental appointments or to visit a relative, or to have bloods taken, and the stress of the hospital environment seems to be enough to tip people over the edge. A heart attack is different from a cardiac arrest. A heart attack is caused by atherosclerosis, or hardening of the arteries – a restriction in blood supply to the tissues, and a shortage of oxygen and glucose needed to keep the tissue alive. A cardiac arrest results from the heart stopping entirely, from any cause. But Betty is not sweating

Copyrighted material

or grey, and although her pulse is thready (thin), it feels regular and is palpable.

With help from me and the porter, Betty slowly climbs onto the trolley and I sit her up, wrap as much of the blanket as I can around her thin shoulders, and over her face I put a non-rebreathing oxygen mask – a mask with a pillowy bag at the bottom, which keeps the oxygen concentration levels high. Oxygen is potentially dangerous in the treatment of heart attacks, as it can constrict already-constricted blood vessels. But in medical emergencies where a patient might be critically ill, oxygen is essential. It is also good if you are hungover. But it smells disgusting, it is drying, and having a face-mask placed over you means that you can't see properly and the fear escalates.

I try and reassure Betty. 'This will make you more comfortable.' I walk beside her as the porter pushes the trolley, thinking about how the hospital arteries are much like our own, as the smallest blockage causes us to stop and start until people move aside to let us through.

Arteries and veins have been misunderstood throughout history. In the second century AD, Galen, a Greek biologist and philosopher who practised medicine (he was a surgeon to gladiators), said that 'Throughout the body the animal arteries are mingled with veins, and veins with arteries.' There was a belief that veins contained natural spirits, and arteries contained animal spirits. During medieval times, arteries were thought to contain spiritual blood – the vital spirit. But although our understanding has clearly advanced beyond belief, there is always some truth in history. In studying the arteries, Galen further identified what remains true of arteries (and can be applied metaphorically to hospitals) today: 'It is a useful thing for all parts of the animal to be nourished'.

Tucked down the corridor to the right of us is the hospital cinema, showing the latest films for patients and relatives (and

Copyrighted material

apparently staff, though I've never known any staff member with the time to go there), with a special chair for the nurse, paid for by a charity, who is on hand for reassurance or to deal with emergencies. Next to that is the sexual-health clinic (always busy, standing room only). Betty and I carry on, past the ambulatory medical unit, where a crowd is gathered around a man using a wheelchair who has an unlit cigarette in his mouth and another behind his ear, and is swearing loudly. There is a drip-stand with a large cylinder of frothy clear fluid hanging behind him, running into a thin white tube that eventually burrows into the top of his chest like a misplaced umbilical cord.

'Nearly there,' I say.

These people, the chaos: the spiritual blood of the hospital. The branch- and twig-like arteries and veins leading towards the centre: A&E.

A&E is frightening. It reminds us that life is fragile – and what could be more frightening than that? A&E teaches us that we are vulnerable and, despite our best efforts, we can't predict who will trip on a pavement, causing a catastrophic bleed to the brain; whose roof will collapse, leading to the traumatic amputation of a limb, a broken neck, a broken back, bleeding to death; who will be part of a couple married for sixty years until the wife's dementia results in her injuring her husband. Or who will be in the wrong place at the wrong time: a man with a knife plunged into his heart by a teenage gang member; or a woman beaten and kicked in her pregnant stomach.

There is beauty in A&E, too: a togetherness, where all conflict is forgotten. There is no sleepwalking through the day, as an A&E nurse. Every day is intensely felt and examined, and truly lived. But my hand always shakes when I push open the door – even now, after many years as a nurse. I've never worked solely in A&E, although I spend a lot of time there, in my job as a resuscitation officer. Nursing requires fluidity, being able to adapt and push

Copyrighted material

energy in the direction where patients and colleagues need you, even if it is unfamiliar. Still, A&E scares me. Unlike the staff in the canteen who put out the call for Betty, the staff in A&E only put out a 2222 crash call to the resuscitation team if things are desperate, or if a trauma arrives that requires specialist doctors.

A&E is unpredictable. There are some traffic patterns though. During the week, the mornings are for mothers who have nursed their babies all night and, in the cold light of day, realise they are worse, not better. Daytimes are for accidents and injuries, and the evenings are for office workers who can't get a GP appointment and don't want to take time off work. Anything can happen on weekday nights, and people tend to come to A&E at night only if they are truly sick. Yet from Thursday evening through to Monday morning party-people fill the corridors, wild-eyed and twitching; there is a steady stream on Sunday mornings, and the later in the day they arrive, the sicker they are: young men and women who have been taking all manner of amphetamines, their pupils as big as the moon, or the alcoholic heroin users with eyes as small as pinpricks, not seeing, not letting in light.

A&E is full of police, shouting relatives, patients lined up with flimsy curtains separating them; an elderly person having a stroke next to an alcoholic, next to a pregnant woman with high blood pressure, next to a carpenter with a hand injury, next to a patient with first-presentation multiple sclerosis, next to a young person suffering from sickle-cell crisis or a child with sepsis. Heart attacks, brain aneurisms, strokes, pneumonia, diabetic ketoacidosis, encephalitis, malaria, asthma, liver failure, kidney stones, ectopic pregnancies, burns, assaults and mental-health crises ... dog-bitten, broken-boned, respiratory-failing, seizing, drug-overdosing, horse-kicked, mentally ill, impaled, shot and stabbed. Once, a head half-sawn off.

Betty's face is grimacing. She reaches out for my hand as we walk through the large waiting area, the patients sitting on plastic

Copyrighted material

non-judgemental employer. The staff come from every possible country, every background, and completely reflect the patients they serve. I've worked with nurses from all corners of the world; nurses who've been homeless themselves; one who worked as an escort to support her studies; nurses who have family members who are dying or who are themselves going through cancer; those who are caring, outside the work environment, for young children and elderly relatives; nurses who are gay, straight, non-binary, transgendered; who are refugees; who are from incredibly wealthy backgrounds or from the kind of council estates where police only travel in groups. Surely there are very few professions with such a diverse cast of characters.

There is movement in nursing, between wards and specialities, and in London there's a high turnover of staff moving between hospitals, but in other parts of the UK nurses tend to stay longer and put down permanent roots. 'I'll have to wait for someone to retire or die, if I want a promotion,' a friend moving to rural Cumbria tells me. But regardless of where the hospital is located, there is an army of people staffing the NHS to meet the needs of the masses: such as the women who make clothes for babies or work in the shop; the kitchen staff; the women from the linen room; the pharmacy assistants; the biomedical engineers.

Dozens of different languages and accents are spoken in A&E, and the list of interpreters behind the receptionist's desk is ever-growing. It rarely gets used. People often have a young relative with them, or there is a porter or cleaner from that particular part of the world. There are arguments against translation from non-experts; a suspicion, on the part of the nurses and doctors, that the words are being softened and not translated precisely, but it's quicker than finding an interpreter.

I wheel Betty on, past the separate children's A&E, the line of beds where there is a long rectangular desk, at the side of which lie piles of paperwork: Do Not Resuscitate forms, observation charts,

Copyrighted material

admission notes. There are shelves and glass doors behind which are cupboards full of equipment, laid out on large pull-out trays; and in front of the doors there are crash trolleys equipped with everything that might be needed, if someone has a cardiac arrest. Betty looks all around her, her head flicking from side to side. She holds her bag tight to her chest. Still, everyone we pass looks at me, and not at Betty. She remains invisible.

At the end of the resuscitation area there is a man on a trolley and two paramedics next to him, a prison officer beside them. There are police, too – but standing at the nurses' station, so they could be unrelated. 'We retrieved some items from the patient's person,' a paramedic once told me. 'We've double-bagged them.' Paramedics have an interesting way of speaking, using language in a slightly formal way, even when off-duty. I often wonder if this is to prevent them from laughing out loud, or crying or retching as they hand over. When I asked what she meant by 'double-bagged them', she said they were contaminated. 'He'd put them up his bum. The mobile phone. And the charger.'

There is a trauma team wearing tabards (a kind of apron) surrounding the next patient: Lead Consultant, Nurse One, Anaesthetist, Orthopaedic Surgeon, Nurse Two. I push Betty to one side. 'I'll leave you here for a minute with the porter, Jamie, okay? Be right back.'

Sandra, the nurse in charge of A&E, is easy to spot. She looks the most harassed and is walking quickly, eyes scanning everywhere. I am not sure why doctors and nurses end up working in A&E, but they are usually adrenaline-junkies. They are fit and unafraid, and they think on their feet, with a no-nonsense kind of intelligence. All the A&E nurses I know are incredibly sarcastic, though I'm not sure if this is a prerequisite for working there.

Sandra stops in front of a bed space where a large number of nurses and doctors are crowding around a patient who is crying.

Copyrighted material

I walk over. 'Hi, Sandra. I've got a patient, Betty – crash call to the canteen and she has chest pain. Where do you want her?'

Sandra nods at me. 'We're full. Obvs. But get her in bed space one for now?'

I glance at Betty, who is on the other side of the room, still holding her bag. The porter is chatting to her, though, and she has her eyes open. I'm glad she is not looking in this direction.

'Stabbed in three places,' Sandra says, her head nodding towards the crying sound. 'I haven't stopped all night.'

It occurs to me that she is on a night shift from the night before: fourteen hours so far on her feet. People wonder how nurses afford to live in London, but the truth is that they don't. Like Sandra, most of them travel in from outside the city, adding two or three hours to their twelve-and-a-half-hour night shift.

Two nurses are checking details on small packets of red blood cells. Another nurse has already stuck defibrillator pads to the patient's chest and is allocating tasks.

Sandra swoops forward to the stabbing victim as the machines start to alarm in front of her. I leave the bed space. 'Bed one,' she repeats.

The porter helps me slide Betty's trolley down to the other end of the cubicles.

We walk past a patient who is thrashing around and looks likely to hurt herself: she's on a makeshift bed, a safe place of pillows on the floor, until she can be nursed in a room with no sharp edges or items to cause harm. There is a special room in A&E for patients with mental-health problems, although it's inevitably full. Patients who are suffering from severe mental-health disorders have an unacceptable wait in Accident and Emergency – a patient can wait twelve hours, or even longer, and the environment of A&E is completely inappropriate for patients who are already vulnerable and disorientated.

Copyrighted material

The psychiatric liaison nurse in A&E is covered with tattoos and wears DM boots with frayed laces. She has an increasingly difficult job. The level of responsibility is overwhelming, and the system is failing. But still the psychiatric nurse has to be calm at all times. This patient is clearly very distressed and is punching the air, and the nurse is sitting on the floor next to her, talking in a soft, low voice. I wonder how many hours she'll be sitting there, occasionally being attacked, kicked and hit. According to NICE, the number of reported assaults against NHS staff in one year was 68,683, and 69 per cent occurred in mental-health settings. The word 'reported' is telling. Violence and aggression towards hospital staff is estimated to cost the NHS £69 million a year. What would happen if every nurse reported every incident? The nurse sitting on the floor will not be reporting the hours that she spends today being hit. She'll sit with the patient and will not judge, and she will ignore a couple of bruises.

'Look at that poor nurse,' says Betty as we push past. 'They don't pay you girls enough.'

We leave the resuscitation area, past the cubicles of A&E where Sandra is still busy, and go through to the Majors area, passing a line of patients on trolleys in the corridor, waiting to go to wards. They are all seriously ill and require a hospital bed, but there's no room on the wards; or they are waiting to be seen, having been triaged – assessed for the severity of their illness – and needing to be processed in four hours, although on days like this they can wait much, much longer. Or die, unnoticed, on trolleys.

The porter wheels Betty into the empty bed space, which is being cleaned. A nurse I don't recognise smiles at me as she wipes down the bed, chair, monitor and trolley. There is a whiteboard on the wall, and next to it a sink with a pack of gloves and space for a roll of aprons. Above the sink there's handwash and Hibiscrub, to minimise the risk of infection, and a gap where the alcohol gel used to be. I put on an apron, then help Betty slide over onto the

Copyrighted material

bed. The nurse rushes off before I can say anything. 'I'll get the twelve-lead,' she says.

Betty is getting worse. Her face looks concave and she is shivering, her teeth chattering. She is the colour of the sheet behind her head, it looks as though she is disappearing into a cloud.

I tuck the blanket around her, careful to move slowly: her skin is paper-thin and she has bruises at different stages patterning her arms like late-summer roses. The blanket is blue and a bit scratchy, but she is still shivering.

I check her temperature again, using a small machine that sits just inside her ear and beeps when it's ready. Betty's skin does not feel as cold now, but the elderly have means of disguising problems with their temperature. Sometimes a very low – rather than very high – temperature in elderly patients can indicate sepsis: a life-threatening infection. I've always been fascinated by temperature, and the tiny margin within which our bodies can operate. To maintain life we have to keep our core temperature within fairly tight parameters. But we can survive well in the freezing cold; patients who almost drown in winter shut their own brains down so effectively that it becomes a protective mechanism. The other extreme is malignant hyperthermia which can happen as a rare reaction to anaesthetic drugs, causing a rise in temperature until someone's brain is cooking on the inside.

Betty's temperature is not extreme, but it's still dangerously low. She's been at home, with no heating, I suspect. There are millions of people in the UK living in fuel poverty, who cannot pay their heating bills.

'Betty, I'm going to get you a bear-hugger. It blows hot air over you and warms you up a bit. It's very cosy. The other nurse is bringing a machine that measures your heart, to check everything is okay.'

Copyrighted material