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RESILIENCE AND LOSS: UN-CONCEAL GRIEF AND EMBRACE VULNERABILITY

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I vividly remember the first patient death that I witnessed. It occurred at 4 AM in the person's bedroom. I had known this gentleman and his wife not much more than a few hours, having started my shift at 7 PM. He was pale and gaunt and barely conscious. I introduced myself, told him who I was, and why I was there. I described everything I was doing as I provided care for him. He never spoke a word. His limbs were cold. His urine was dark. His lungs were congested. His breathing was loud. I notified his wife who had been resting in the adjacent room when he began to exhibit Cheyne-Stokes breathing. It was her grief that hit me the hardest. I stayed with her until the coroner arrived and the body was removed. I spoke to no one about this event and no one spoke to me about it. I assumed the lack of discourse was related to the autonomy and isolation of being a home care nurse. There have been many deaths since then in other settings and remarkably the aftermath has been more or less the same.

What follows stems from another event that took place during another night shift. It transpired in a hospital intensive care unit. I had developed a therapeutic connection with the wife of a dying man. Married for nearly six decades, she did not leave his bedside throughout the evening. Her love for him was breath-taking and her grief was an unremitting presence. I felt it – like a blunt, gnawing pain beneath my sternum.

My own purposeful withholding of tears engendered a pressure across my eyes and forehead. My whole being and spirit felt like it was being crushed as I imagined her grief.

An Unremitting Presence

the room is dark,
and somber
and utterly quiet, and still,

a lull in breathing
interrupted by a gasp and a gurgle
and a fluttering of his eyelids

her hand leeches
upon mine with bluish veins surfacing
and anguish-drenched eyes

I feel her kindness
towards him and a sadness Rush
in with an unremitting presence—

as his pulse wanders and pauses
his body fatigues, and drawing breath
becomes undeniably grueling

the frothing of his lungs
erupts a violent fear,
she has never felt

the forecast is palpable

as I suction his lungs,

one final time

engulfed by a deep-rooted despair

she presses her lips against his cheek,

grasping his hand

she is drained. and shattered.

but helps bathe his body, pulling

the blankets up to touch his collarbones

After this death, I walked out of the patient room and down the hallway. A couple of nurses asked, “Did he die?” Although their faces showed empathy, that was the end of the exchange. I suppose I too had asked this same question to other nurses and had given a similar empathetic look. On the rare occasion that a formal debriefing was implemented, no one showed up. Debriefing on the unit where I worked appeared to be reserved for the day shift and specific cases. Yet, most deaths that I have witnessed seemed to happen on the night shift.

In my view, such silent support is insufficient when dealing with repeated losses experienced by health care professionals. I recognize the protective mechanism underlying this silence considering that I too failed to participate in formal debriefings. Like many others, for years I ignored, suppressed, and masked my feelings of loss and grief. Talking about death and dying is a sensitive and sometimes emotional experience that can place those involved in a vulnerable position. However, denial of this vulnerability can lead to burnout[1]. Moreover, unprocessed loss and grief can be harmful and undermine one’s health and well-being[2]. Importantly, the toll of concealing or denying the emotional experience can negatively impact one’s professional capacity to provide competent care at end of life[3].

I have come to recognize that in order to deliver whole person care nurses and other healthcare professionals need to foster their own resilience. Becoming resilient and dealing with loss and grief as a health care professional can be approached through a myriad of ways including but not limited to: curricular changes where palliative care and topics pertaining to death and dying are better integrated into the curriculum[3]; coaching programs in which health care professionals provide mentorship and support to one

another[1]; and last, mindfulness that promotes increased awareness of the self, other, and context[4,5,6]. The latter approach has facilitated my capacity to becoming resilient, beginning the shift from suffering to healing, wholeness, and a sense of inner peace[5].

I write and compose poetry as a way of becoming mindful; thus, I witness my own sense of loss and grief. These narrative and arts-based activities provide an opportunity for me to be self-aware and, to some extent, notice the moments of beauty that can occur with death. The arts have also permitted me to achieve what Hutchinson and Dobkin call mindful congruence in which I strive to be fully present in the moment. I propose that we can lead by un-concealing our grief and embracing our vulnerability with colleagues and particularly while training students. When I share reflective narratives through venues such as this journal, and in the classroom, I hope to be a model for those who are and will be exposed to death and dying in their professional work. We may develop resiliency when we open ourselves to being fully present and mindful.■

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