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The Meaning of Caring for Someone Dying in the ICU: A Nurse's Experience

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Abstract

The mystery of death is part of the enigma of life itself. In nursing, being next to someone dying makes us more aware of our strengths and limitations while caring for someone who walks into the unknown. As nurses, we are affected by these experiences, so how do we deal with them? What is the essence of caring for someone dying in the ICU? What makes each experience unique? Through the experience of being with someone as they are dying, we discover our limits, our finiteness. We cannot deny death's disruptive and silent spirit that embodies us, yet death, like other aspects of life, is unique; it appears to teach us that life goes on, that life cannot wait for us.

Keywords: Enigma of Death, Nursing Care, Phenomenology of Practice, Intensive Care Unit, Being with someone.

Introduction

> *[T]he meaning of death does not begin in death. This invites us to think of death as a moment of death's signification, which is a meaning that overflows death. We must note carefully that 'to otherflow death' in no sense means surpassing or reducing it; it means that this overflowing has its signification, too.* (Lévinas, 1975, p. 104).

The mystery of death is part of the enigma of life itself. Levinas invites us to think about the death of the other person, emphasizing that the meaning of death does not begin with death. It is a moment of signification. Etymologically the word *signification* comes from Latin *significationem*, meaning a symbolic representation of something (Skeat, 1963). According to Levinas (1975), a symbolic representation of death is stronger than death per se as the person dying continues to demand the living "I" into ethical responsibility. When we experience someone's death, we are still tied to the other's face, which demands our attention and response. It is precisely that response to the face of the other that deters death's power over us (Arnett, 2003). However, our lived experience of death retains only an external perspective of a process that manifests itself when someone's life comes to an end (Lévinas, 1975). Death moves us into an emotional relationship with the other's death; it is a journey charged with sensibility and disquietude (Levinas, 1975). Responsibility for the other means thinking least about one's own death and most about the other's death, precisely when caring for the other's death takes precedence over

caring for one's own demise (Cohen, 2006, p. 25). Moral agency and moral responsibility are inescapable and non-exchangeable features in many disciplines, but they are particularly important in nursing. Placing the other before oneself means that caring for the other's suffering is at the core of our nursing practice. What happens is that nurses and patients move in and out of each other's lives so fast that sometimes we are not aware of how profoundly every encounter changes us. When such a unique interaction occurs, caring becomes a moment of mutual accomplishment between the nurse and the patient. At this moment, care itself is the bridge between two worlds. It is a moment with one goal—the recognition of the other through the vicarious experience of illness and, sometimes, the end of life (Camargo Plazas et al., 2012). Furthermore, through this human experience of accompanying someone's dying, we learn about fear or courage, compassion and solidarity and, most importantly, taking responsibility for the person who walks into the *unknown* world of death (Levinas, 1975). As in Levinas's description, in nursing, being next to someone dying makes us more aware of our strengths and limitations while caring for someone who walks into the unknown. As nurses, we are affected by these experiences, so how do we deal with them? What is the essence of caring for someone dying in the ICU? What makes each experience unique? Below is one of my stories from my time as an ICU nurse.

The Rhythm of the ICU

> *6:50 p.m. I am about to begin another12-hour night shift. As I wash my hands, I am forced to look into room 311, one of my assigned rooms this week. There, I see a man in his 50s or 60s. His face is sweaty and pale, and he does not look well. I glance at the monitor. Blood pressure is very low. Heart rate is normal; saturation is good. The patient is surrounded by the usual beeping alarms and flashing displays of the ICU's medical equipment. Medications are running through intravenous catheters and the central line in his bruised, swollen, stretched and shiny arms show edema. As I quickly scan the room, I see a ventilator, at least 10 IV pumps and a messy table full of empty bags of blood, plasma and medications. As may be expected, the outgoing nurse is focused on preparing more medication, checking the stocks and supplies. She moves from one side to another and then pauses for a moment to check her patient. This is the rhythm of the ICU.*

Etymologically, the word rhythm comes from the Latin *rhythmus,* meaning movement in time or measured flow, soul, disposition, symmetry and arrangement. In both music and art, rhythm is defined as a regular, strong, repeated pattern of movement or sound (Harding et al., 2019). It is an ordered repetition of contrasting elements in music, poetry, painting, sculpture and nature. Rhythm in art creates a visual tempo in artworks through the repetition of lines, shapes, colours and more, providing a path for the spectator's eye to follow (Hopsch & Lilja, 2017). As in art and music, the rhythm of the ICU is unique, having its own tempo. Sounds of beeps, buzzes, a blur of the scrubs and stethoscopes of the fast-moving staff, the rapid-fire exchanges of medical jargon, emotional outbursts from visitors mixed with rare periods of sombre silence are part of the rhythm of the ICU. As a nurse, I am used to the rhythm of the ICU; the sounds, smells and sights of the ICU do not scare me. The rhythm of the ICU is part of my life as a nurse, a part of what I

know is my work environment. Yet, this rhythm is sometimes intimidating for those who do not work there. Seeing a loved one—or anyone—surrounded by numerous machines, drips and a chorus of beeps and alarms coming from every direction can be too much for the unfamiliar visitor. The ICU can be a very daunting space. However, within this busy, complex and often hectic space, ICU nurses are ready to care for and build meaningful relationships with their patients. As in my story above, there is no such thing as a typical day for a critical care nurse. The characteristics of the critical care environment and how nurses embody their role and expectations are fundamental to understanding the experience of nursing the dying in the ICU.

Likewise, besides the rhythm and environment that are important in a practice profession is how we embody our role. In nursing, we begin to fulfill our role as caretakers when we wash our hands and accept and receive a report on our patients at the beginning of a shift. Washing our hands resembles a ritual act that prepares us to enter the world of nursing (Cameron, 1998). The action of washing our hands is simple but meaningful. In nursing, our hands are an essential tool for interacting with our patients. Hand hygiene in the ICU is more than scrubbing, rubbing, washing, feeling and touching conveys an ethical obligation to protect the health and safety of our patients (Chatfield et al., 2016; Lapao et al., 2016). Hand hygiene is the most effective activity to prevent nosocomial infections in healthcare settings. Our hands play a role in the incidence and the spread of infectious agents transmitted by touch. Washing our hands is important specially when caring for vulnerable patients in the ICU. What is the difference between cleaning my hands at home and washing my hands in the ICU? At home, I wash my hands after I have walked inside from the street. It is a mechanical action. The routine is simple: I simply rinse my hands, cover them with soap and rinse again—there's really nothing special about it. When we wash our hands at home, we are reflecting the straightforward intention to clean our skin to avoid acquiring any disease. In the ICU, hands must be free from rings, watches and bracelets. Nails are free from any nail enhancements, and nail polish must be from chips or cracks. When practicing hand hygiene, all skin on the forearm and hands should be free. Using lukewarm running water, we wet our hands and forearms and apply antibacterial soap. A good amount of soap is required to create lather for a five-minute scrub. We keep our hands above elbows, scrubbing each side of each finger, between fingers, under each nail, and then back and front of hands. We scrub the arms, using an up-and-down motion keeping our hands above the elbows at all times. Then, we repeat the process with the other hand and forearm. Next, we take paper towels to dry the skin, starting at the fingertips and working down toward the forearms using a dabbing motion (Lapao et al., 2016). It takes me a full ten minutes to wash and dry my hands in the ICU. Yet it is more than time: we care for our patients with our hands. Washing our hands in nursing is a ritual act in which we set ourselves aside to enter into one specific world (Cameron, 1998): the world of nursing.

> *As I wash my hands, I observe my surroundings. Observing is another simple action that helps me to continue embodying my role as a caretaker. What is special about observing in nursing? How different is observing in nursing from observing in our day-to-day life? When I was ten, I visited my grandmother at the hospital. That was my first experience as a hospital visitor. I wanted to see her. She had suffered a cardiovascular event, and I was worried about her. Before we arrived at the hospital, my mother explained what to expect about my*

> *grandmother's health and her room. My mom described everything we'd see there in terms of pumps, sounds, IV lines and nurses. When we arrived at her room, I saw her lying in a bed different from her own bed. She laughed and spoke normally. I did not perceive pumps, IV lines or even nurses. I only saw her speaking and laughing as she always did. The child I was at the time could not perceive my grandmother as a sick person. She was there, but I did not understand why. Later, when I left the room with my mom, I asked her, "Why is Granny here?" She was not in an unusual situation, as far as I could understand. Indeed, the situation was nothing special. However, nurses see patients differently from other people.*

Etymologically, the word observe comes from Latin *observare,* which means watch over or keep safe (Skeat, 1963). In nursing, we watch over our patients to keep them safe. Observation in nursing is an essential skill that requires knowledge and expertise. In nursing, observation helps us monitor our patients' progress and detect problems early. We observe our patients' need for us to understand them as persons with needs. As nurses, we are trained to see particular signs that something is wrong with them. For example, the sight of a pale and sweaty face alerts my instincts that something is wrong. Back in room 311, my eyes perform a quick scan, and both monitor and room confirm my suspicions that something is really wrong there. In nursing, we use our perceptions not only to distinguish one person from another but also to perceive how everything is with our patients. Through these experiences, we develop that intuitive feeling that is characteristic of nurses. I'm talking about a gut feeling, telling us that something is not right with our patients. Somehow, the act of nursing engages us in a special kind of observing beyond simply perception. This kind of knowledge in nursing can only be learned through experience (Benner, 2001). A nurse learns from continuous experience, developing an intuitive grasp of each situation. Through practice, we learn how to recognize the typical events that we may expect in a given situation and how plans need to be modified in response to this event (Benner, 2001). By embodying our nursing role, the chances of something new comes to presence, something not yet, only a promise at this time (Cameron, 1998, p. 131).

Being There

> *7:00 p.m. I am ready to start my shift. I enter room 311, and after greeting my colleague, I ask, "Who is he?" "Our new patient is Mr. Rodriguez. It is a sad story," she says. "This morning, he got up, as usual, and had breakfast with his wife. Suddenly, he got the worst abdominal pain. He came to emergency; they operated, but now he is beyond help. We cannot do anything for him. He is dying. He has a DNR order." As my colleague speaks, I stand beside the bed, looking at him. His hair is grey, his face pale and sweaty but with a touch of peace. He seems to be sleeping. As I keep looking at him, I ask, "What about the family? Where are they? Do they understand the situation?" She responds, "Dr. Perez has spoken with them. His wife was very sad. But she knows what to expect. They may be at home now. She left a phone number, just in case." As she speaks, I find myself thinking about my own family. I cannot imagine how difficult this situation must be for Mr. Rodriguez's family. I take his hand. It is cold, clammy and*

> *sweaty. I say hi to him. I introduce myself. But I don't know if he can hear me. I watch the monitor. Blood pressure and heart rate are unchanged. Perhaps he is waiting for something or someone.*

In nursing, we always start our encounters with a patient by asking for their identity. Who is he? It is a way to recognize the other person as a human being who requires our full attention. This simple question makes it possible to put a name to the other's face. My colleague, in answering the question, "Who is he?" responds with a name and a complete description of the patient's health problem. In nursing, the answer to the question encompasses identification and a comprehensive description of the person's situation. Hence, who he is in nursing is not a question that can be answered with a name alone. Instead, I'm talking about comprehensive information about someone's identity and their health problem. Our responsibility as nurses emerges from the recognition of the other (Lavoei et al., 2006). "To receive recognition literally means to be known" (van Manen, 2003, p. 38) because that person becomes an individual who requires all my attention, knowledge, support and effort in a vulnerable moment.

The reality is tangible. His sweaty, cold hand shows me a reality. He is dying. However, I feel neither afraid nor powerless. I feel that I can be with him. I am his nurse, and I can talk to him. Our moment together is not surrounded by sorrow. Instead, this moment represents company and respect for the other's situation. As Olson (1993) says, "Care is the being of being there" (p. 145). *Being there* is my responsibility as a nurse. I cannot change his situation, but I can be there during his last moments of life. My company means being there unconditionally, both for him and with him. In those moments, approaching includes a feeling of unity as human beings. Doing our best in health care goes beyond science or knowledge. Our best includes simple actions of care and respect for the other human being (Gadow, 1990). Care and respect are responses to persons, both in the richness of distinguishing detail and in the shared humanity that they encompass and is encompassed in them (Dillon, 1992, p. 119). In the daily work of nursing, care projects the nurse into the immediate presence of the patient's affliction in a way that may even involve suffering as an inescapable element of practice. Through this experience, he is teaching me the meaning of compassion and nursing care.

As I start asking routine questions about Mr. Rodriguez's primary contact, should something happen, I look at his face, seeing its fundamental nakedness and vulnerability, making me aware of an already existing ethical responsibility (Levinas, 2002). It is a moment of recognition. Who has not experienced some identification with another's problems? For a moment, he is not Mr. Rodriguez, lying in this bed with a medical order not to resuscitate. Instantly, his situation makes me think of my own family. He could be my father. Death links two people in one experience: his family and my family are the objects of my reflection in this moment. How would I deal with that? My perception of his condition makes me feel empathy for his family. I try to approach and understand his situation. He has a story that makes his experience unique. I hear his story, and every word of his story becomes part of our story now. Being with others is not merely a relation of pure glance (Lavoie et al., 2006). This perception is like putting oneself in someone else's place. There is a sense of solidarity. How is it possible to be touched by a situation that is not intimate or personal? Moreover, what is it like to approach the subject on a personal level when a loved one is dying? On a personal level, I have felt sorrow and

hopelessness. Even though I wanted to offer my grandmother comfort from my perspective as a nurse in her last moments, I could not. I could only say, "Hi, Grandma." Even I was astonished that I could not comprehend she was dying. Even though we were not close, the moment of her death was different from Mr. Rodriguez's death. I felt sad and powerless. Her death showed me how difficult it is to accept the death of a loved one. With Mr. Rodriguez, I must be with him. I must let him know that I am here for him during his last moments of life.

Life Goes On: Talking about Death

> *After checking my other patient, I am called to the phone. It is Mr. Rodriguez's wife. My heart skips a beat, and my mouth is dry. I do not know what to say. She asks about her husband, saying, "Is he OK?" I hear myself mechanically repeating the information I was given. I take a deep breath and look at one of my hands, seeing it tremble gently. I stare at the floor as if I am trying to talk to it. At last, I tell her, "If you want to come here and stay with him, I can authorize your entry to the unit." I hang up and quickly scan my surroundings. I still feel my hands trembling, and my mouth is dry as I walk through the corridor outside Mr. Rodriguez's room. All is unchanged in the ICU. As usual, there are beeping alarms, nurses, therapists, and doctors discussing other patients, all in their own world. I wonder if anyone except me is concerned about this particular patient. I walk to the window. As I look outside, I see sheets of rain sweeping sideways. A dark, chilly and biting wind weaves through the corridor. I shiver and pull my jacket tighter as I look outside. The rain brings a unique silence for reflection. My thoughts at this moment are simple: life goes on. It does not care who is in its way, who falls and gets trampled. Yet, here in room 311, it is a different night. Intense. Bright. And strangely silent. Mr. Rodriguez's heart is fighting for his life. The heart rate continues at 70.*

When I receive the call from Mr. Rodriguez's wife, I feel uncomfortable and overwhelmed by the information I must provide. I lose my sense of control. My conversation with her is limited to repeating the doctor's prognosis, but certainly, I want to say more to her. Yet, the words do not flow because the instant of recognition of death is a strange and unique moment. In the ICU, conversations with family are limited to brief personal encounters or telephone calls. But here, beyond a telephone call, the presence of the patient's wife makes it almost impossible to talk about death. The words do not flow. Nevertheless, she is waiting for my answers, and more than that, she wants an opportunity to resolve her doubts about her husband's condition. Why? What is she expecting? What am I expecting of this encounter? The seconds pass like hours, and the moment to assume the responsibility to talk about death stretches into an eternity. It is our responsibility, a responsibility that is very difficult to accept. We are not prepared to face this kind of situation or talk about it. When someone asks me, "*Is my father OK*?" I hesitate because this question does not have an easy answer in the ICU. However, death is a part of our care. Once, a patient said to his daughter, "*Do you know, honey, what you will do, if something happens to me tonight? You know what to say to everybody?*" At that moment, she was surprised by his words. She was not prepared for that conversation. She avoided his eyes. She tried to change the topic of the conversation. As human beings,

we leave, missing those precious last moments with the person who is trying to say goodbye because we are afraid. We do not want to confront the unpredictable. We are born, grow up, and organize ourselves to live. We are afraid of death because we do not know what happens after death. But in the end, death is the only certainty for all human beings. Although we are mortals and we are aware of that, death is one of the inevitabilities in our life that we cannot control. To recognize the face of death in someone else is to recognize our own mortality. We think that we are prepared for anything. But life changes the rules of the game repeatedly. Now, we are here. In the next minute, we do not know what is going to happen to us.

How uncomfortable are we when we are talking about death in the ICU? Talking about death means establishing a distinction between hopefulness and hopelessness; as a nurse, being a bearer of bad news for the family is the hardest part of the job. In critical care units, the word death has a different meaning. The goal of a critical nurse is to prevent death or delay it for another day (Wim, 2009). As nurses, we can see on any given day our patients at their frailest and most vulnerable, or in their strongest and most determined moments. In the ICU, a narrow line separates life and death. However, we never know where and when an unexpected encounter with death will become a reality. As such, there is not a set way to have a conversation about death. It is always a matter of foreseeing what one cannot see coming (Derrida, 1995, p. 40).

In our surroundings, everybody is busy with other activities. No one perceives that something is occurring in room 311. Another life is leaving us. At the same time, these surroundings are different. It seems as if the colour of death is reflected in the place where we are. Now my room is silent and bright. Nevertheless, death becomes significant. Different. I look at my surroundings, finding a contrast between the darkness outside and the brightness and intensity of the room. Both inside and outside have an indifference to this man's death in common. The precise meaning of death is very difficult to describe when we limit ourselves to considering the word death as a general theme. However, death, as with other aspects of life, is unique. The face of death is always changing, and the experience in that final moment becomes an individual experience. In the ICU, the meaning of death is implied in different experiences that enrich nurses' professional and personal lives because each experience is unique and helps us to confront our fears and because, somehow, when we look into a patient's face, we become aware of our own mortality. However, we cannot stop life; it just flows unstoppably. In life, nothing is permanent, neither the good nor the bad. Everybody has time and is part of a life cycle. For everyone, when the time comes, one must let go. This is a hard reality, a part of existence, and a part of life.

Do our vocabulary and thoughts consistently avoid or omit the word death? By their nature, talks about death are disruptive. The word forces us to recognize our mortality. Derrida (1995) writes, "A quiver can of course manifest fear, anguish, apprehension of death; as when one quivers in advance, in anticipation of what is to come" (p. 53). Death shows us our vulnerability and our end. How can I think of death when I am alive? Death means the end of the world as I know it, the closing of the window of life. The world we know disappears before our eyes. We spend all of our lives focusing on how to live. Yet, it seems that we hardly think about how to die. Speaking about death seems to break our daily routine, making it impossible to move forward. We do not recognize how

impermanent life is, nor that, no matter how much we take our lives for granted, sooner or later, we are going to die.

Nursing the Dying

> *An hour later, a woman is in his room: his wife. We exit the room to talk. She says, "I know you are his nurse.… I just want to ask how he is. Is he suffering? Is he dying tonight?" I look at her, seeing the sadness in her eyes. She is suffering. I feel the night's chill. The seconds pass like hours. I hear myself awkwardly saying, "Mr. Rodriguez's condition is poor, as Dr. Perez told you today. I don't think he is going to make it through the night. Do you want to see him?" She says, "Yes." We return to his room. She looks at him, delicately caresses his face and hand and kisses his forehead. Then she turns to me and asks, "Can he hear me? Is he in pain?" I say, "Right now, he does not have any pain. It may help to talk to him." She continues rubbing his hand. She kisses his forehead again and looks at the monitor. His blood pressure reads 40/23. His heart rate has begun to decrease. She looks up to me and says, "I do not want to be here when he dies. Please take care of him." She suddenly turns and leaves the room. Now, I am here with him. Alone with him. I approach him. This is one of his most intimate life moments. I hold his clammy, cold hand and watch his face, feeling sad and somehow calm. As I look at him, I hear my mother's words: "When someone is dying, their facial features become more defined." I look at him, and now, I recognize death. I glance at the monitor and confirm. Blood pressure is 0/0. Heart rate 45, 42, 30, 25.… 9:30 p.m. He is not suffering any longer.*

The more I care for Mr. Rodriguez, the more I worry, and the more I worry, the stronger becomes my desire to care (van Manen, 2002, p. 272). Caring expresses itself as a natural phenomenon, neither imposed nor contrived; it simply appears, connecting two people in a unique moment that emerges from empathy, creating bonds and connections in a singular way. From there, the other becomes part of our world because, as nurses, we open up our eyes to the experience of the other. As ICU nurses, we prepare for unexpected encounters with the vulnerable, the very ill and the dying. When the encounter takes place, the vulnerability acquires a face and identity, thus creating in nurses a moral responsibility for the other (Levinas, 2002). Throughout his work, Levinas returns to the metaphor of the face of the other, discussing how and where responsibility enters into our lives (Dussel, 1985). Subsequently, ethical responsibility encompasses acting toward the other as other, in which the recognition of the other is based on face-to-face interaction beyond physical facts or requirements pre-established by symmetrical relationships (Levinas, 1985). As a consequence, interaction implies being part of the other's world, and the interchange of experience always falls under parameters of mutual respect and recognition. As Dussel (1999) points out, "[A] priori responsibility…places us in a position of having charge of the victim who unexpectedly appears before us" (p. 126). It seems that the responsibility for and the ethical treatment of the other never ceases. Why? Perhaps because as human beings, we have a filial bond, a fundamental need to form relationships in order to survive, a phenomenon that Dussel calls sensibility, a pre-opening to the other's world. This sensibility enables the encounter with the other person in a meaningful way.

In nursing, our responsibility emerges from the recognition of the other (Lavoei et al., 2006). Mr. Rodriguez's face exposes itself to the world "without defence" (Levinas, 1985, p. 86). His face, which mere minutes ago was foreign to me, becomes familiar, and we are ready to share his last moments alive (Levinas, 2002). From one who was strange, what has he become? He is not 311's patient anymore. My responsibility as a nurse is revealed: that person requires my utmost attention. As Levinas (1985) describes it, "[T]he face is meaning all by itself" (p. 8). Mr. Rodriguez's face creates a responsibility that cannot be delegated, and our relationship now is centred in terms of proximity because of the character of my obligation as a nurse (Lavoie et al., 2006). Mr. Rodriguez's presence compels me to do something for him (Levinas, 2002). Levinas (1985) writes that compassion is at the heart of each relationship. It is the ability to respond in a situation, an ability that technology cannot confer. Indeed, feeling touched by Mr. Rodriguez's vulnerability, I have decided to share this time with him, caring for him in a real way in his last moments of life. As van Manen (2002) states, "In the encounter with the other, in this greeting, in this face, we experience and understand the purely ethical before we have involved ourselves in ethics as a form of thinking and reasoning" (p. 273). Responsibility means that our life is tied to another life in a way that is impossible to break and forget. Why? Perhaps it is that as human beings, we have a filial bond, a basic need to form relationships in order to survive. As nurses, we open up our eyes to the experience of the other. It is a relationship of recognition. Although he cannot share his feelings or thoughts, the peace in his face shows me another face of dying. I recognize that Mr. Rodriguez's face is teaching me about the uniqueness of the moment of his death.

As human beings, we each live as a part of groups; we spent a lot of time in various groups, such as our families and friends. However, the most important instances of life are lived in complete solitude: one such is birth, and the other moment is our death. As Derrida (1995) says, I can share my life, my dreams, my grief and all the things that join me with another person, but the moment of death is a moment to be alone, a moment that leaves the word share behind. Where and when it arrives is impossible to foretell. Moreover, dying is more than a simple step in life; death is part of us as humans. As his nurse, I can simply be with him. I can share those last moments with Mr. Rodriguez. I can rub his skin, monitor his vital signs—but I cannot die with him. I cannot feel what he is feeling now in these last moments. I am merely an observer of his last moments. Although I am with him, at the same time, he is alone. As a nurse, I cannot intersect death; I might, perhaps, feel some of the same feelings when I die, but my experience is different from his experience. Once again, I look at him and touch him, and a feeling of sadness comes with these actions because he is dying and I am aware of that. Despite my wide experience in the ICU as a nurse, this moment is different and unique. As Derrida (1995) points out, "I am still afraid of what already makes me afraid, of what I can neither see nor foresee" (p. 54). It is difficult to face something that I really do not know, something I can see with my eyes but that is beyond my own humanity. I am not easily able to give up the need to speak to, touch and hear the person who is dying, especially if that person is a loved one.

Nursing of the Dead

> *Mr. Rodriguez is dead now; I turn off the monitor, ventilator, and IV pumps one by one. I inform Dr. Perez about the patient's death. We close the room. Outside, his wife waits for news. I call her. She looks at me and understands that he is gone. I say, "I am sorry." She walks into room 311, and husband and wife spend one last moment together. After a while, she lets us know that we can carry out his last offices. For this process, I put on a pair of gloves and an apron. Another nurse will assist me in the process. Mechanically, I start cutting stitches as needed, remove tubes and lines and clean and cover. These intrusive elements, now unnecessary, are removed. We close his mouth and eyelids and continue to wrap his body until he is completely covered. His hands and feet feel like ice. Then, I look at his face. He seems to be in a pleasant dream. Mr. Rodriguez's body is relaxed, and it seems as if all his worries have been left behind. He is ready now for the last encounter with his entire family. Wife, daughter, son, sisters and brother come into room 311. Everybody cries as they surround him, but no one touches him. I am outside room 311, watching. After a while, his family knows that it is time to let him go of the ICU. Then his wife turns to me, takes my hand and says, "Thank you." For a moment, it's hard to get out any words. Then I say, "I am sorry for your loss. If you need anything, please let me know." At that moment, I watch how his body leaves the ICU. Before returning to my other patient, I make a last scan around room 311. It is now empty and messy. Now it is very real that he is gone.*

Caring does not stop with the other's death. I am now in charge of caring for his dead body. Cleaning and removing all unnecessary elements, taking all the dirty linen away and washing his body is part of my duty as a nurse. It is more than a procedure or a set of steps prescribed in a nursing book; post-mortem care is really our last nursing act of intimacy with our patients. As with many other acts in nursing, afterlife care is not a lofty achievement or a mundane list of skills or intricate cognitive reasonings (Cameron, 1998). Rather, it is the practice of the hidden or unpresentable work of nurses (Cameron, 1998; Wolf, 1991). Post-mortem care is a moment that includes removing all the invasive elements from his body, washing and positioning the body, closing the eyelids, positioning the jaw, wrapping the patient in a shroud and preparing the body for viewing by the family (Swardt & Fouche, 2017). Through this last interaction, we wash away all traces of suffering and some of the profane aspects of death (Wolf, 1991, p.75). Nursing of the dead is private bodywork. Now he is ready for the last encounter with loved ones.

Caring for someone who is dying entails caring for a mourning family as well. Interactions with the family can be overwhelming, but they are important. We offer feelings of sympathy and grief to the family as they try to understand and cope with their loss. Although I did not know much about Mr. Rodriguez and his family, through my practice, I have become extremely close to other patients and their families when they stayed for extended periods in different wards. How different are those experiences? Juan Diaz was one of those patients. I came to know him and his family while he was in my ward for a long time due to complications with his COPD and diabetes. Thus, I was his nurse for almost three months. I got to know his wife, children and extended family in a

particular way. We had long conversations about his life before and after he was diagnosed with diabetes, chronic pulmonary obstructive disease and heart failure. Every time I thought he was going home, a new complication arose. However, it never occurred to me that he was going to die. He was relatively fine the day before he passed. That was our last time together. I remember him joking and laughing that day. He was dreaming, as always, that he was going home the following week. The next day, I was working in a different ward when I heard a "Code Blue" called. I could not hear the room number in the announcement, but somehow, I knew the code was about him. Once I finished my work, I ran downstairs to see what had happened. Juan had developed an arrhythmia and died. He was alone. I felt sad for him and his family because I could not talk with or see them after his death. In Mr. Rodriguez's case, I looked at him and touched him, and a feeling of sadness came with those actions because he was dying and I was aware of that. But it was different with Juan because I did not know he was dying. I did not have the chance to say goodbye to him or his family.

Sadly, death is not a surprising event for healthcare professionals; we have learned to accept that all lives end in death. Yet we never know where and when an encounter with death will become a reality, as with Mr. Rodriguez or Juan's story. Through time, I learned that each encounter in nursing is unique, with its own tempo, individual characteristics and growth in wisdom (Bergum, 1989). Although caring for someone as they are dying is part of our nursing practice, I do not think anything can prepare us for seeing a patient die. In nursing school, we learned how to assist patients in their transition to death, how to provide palliative care, how to carry out post-mortem care, and how to assist family members in the process of grieving, but we seldom learn how to deal with our feelings of sadness and loss. Inside, I have also grieved a little bit with each of the deaths of my patients (King & Thomas, 2013). I have felt a little bit caught up in the moment and somehow struck by the solemnity of each situation. Even so, I have learned to stop grieving with them, so that I can focus on my next patient. Whether death is expected, unexpected, peaceful or painful, every experience is different (Wolf, 1991). It is an intimate moment.

Final Reflection

> *And when your sorrow is comforted (time soothes all sorrows) you will be content that you have known me.* — (de Saint-Exupéry, 1943)

As a novice nurse, I heard many other nurses say that the first patient passing away is the hardest, but over time coping becomes easier. Several years have passed since my first patient died, and still, the experience of caring for someone dying has not gotten any easier. Many times, I have felt ill-equipped to discuss the sensitive topic of death with a patient or family member. The result of nursing care is not only the culmination of diverse techniques but also the combination of nurses' skillful practices and deep emotions for their patients (Schultz & Carnevale, 1996). Through the experience of being with someone as they are dying, we discover our limits, our finiteness. We cannot deny death's disruptive and silent spirit that embodies us, yet death, like other aspects of life, is unique; it appears to teach us that life goes on, that life cannot wait for us. Hence, seeing in others the reality of vulnerability helps us understand that we are as vulnerable as they.

Now, several years after the death of Mr. Rodriguez, I find myself reflecting on the experience of caring for him. Our encounter lasted only two and a half hours, but it was meaningful, nonetheless. Caring for him made me reflect on the meaning of providing nursing care for someone going through the process of dying: a reflection that I did not have before. Death is a part of life, and when the time comes, we must let go. For nurses, it is necessary to take every part of life as it comes because life is composed of situations in which it is necessary to learn, teach and let go. Everybody lives in a constant state of change; being too strongly attached makes us forget the real commitment of nursing, which is to care, share, learn and let the person go when their time comes. We need to be open to learning to gain wisdom. Nothing is permanent; we only need to open ourselves to enjoying the good and the bad. From both, we can learn valuable experiences. In short, Mr. Rodriguez changed my way of perceiving care. Let me dig inside of his death to understand what it is. My care for him was unlimited and unrestricted, something that created unyielding bonds. For me, as a nurse, that is the wisdom of nursing: first, recognize the imperfection, and then continue growing from that point.

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