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A meaningful closure

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I arrived at the ICU at 6:45 a.m. Opening the door I could feel the tension, reflected by the buzz of too many voices at this hour. I overheard the vascular surgery resident in discussion with the OR nurse “bed 2, new admission, 88-year-old male, fell, arrived 30 min ago. He fell because his abdominal aortic aneurysm started to leak. Let’s wait for the patient’s attending surgeon to arrive to discuss the surgical plan; meanwhile we’ll organize pre-op lines.”

I looked at Mr. R’s medical chart before introducing myself to him and his wife. “How are you feeling?” I ask; Mrs. R answered “He is not feeling too well; he fell; now we are waiting for Prof. Anner, our doctor.”

Prof. Anner entered the ICU with together with the anesthesia chief, and the ICU team geared up for the action plan. “I’ve been treating Mr. R for 20 years. Almost all vessels are stented or grafted. The aneurysm is inoperable”.

The announcement is received in dead silence by the team. We all knew the significance of such a statement. Mr. R.’s adult son David and daughter Sara arrived. Prof. Anner said “Julie what do you think? How much time does he have?” I saw an 88-year-old, totally conscious, calm man talking with his family; his heart rate (HR) was

98 bpm, and his blood pressure (BP) was 90/60 mmHg. I thought “A few hours Prof Anner said “20 minutes, tops”.” Together we entered Mr. R’s room.

Prof. Anner said “good morning Mr. R. How are you today? Do you remember our meetings in the clinic? We discussed your aneurysm, and I said it is like a balloon that will burst some day, and that when that day arrives, we will have no treatment options. That “some day” is today.” R nodded in silence. Prof. Anner continued: “I am here with you. I won’t leave you.”

Mr. R. said “yes, my family and I remember discussions; we talked about the implications.”

I was thinking fast. My research background in spiritual guidance and composure as nursing tools to assist patients and families with end-of-life (EOL) care is key to such situations. When someone dies in the presence of family, the death should be as dignified as possible. Such deaths are easier to cope with when the patient does not have blinking tubes sticking out of his body and appears as physically normal as possible. Using ritualistic caring practices reassures nurses that they are providing the best care possible for the dying person. I quickly reviewed what I knew about spirituality: the principle focal points are Meaning, Connection, Integrity, and Hope. The dying person can find meaning in many aspects, and family members need to feel that they are meaningful in the dying process.

How can I provide spiritual needs? Seeing Mr. R and son wearing skullcaps, signifying religious Jews, I asked David “Do you know which psalms your dad particularly likes?” Taking my cue, David closed his eyes and quietly sang a psalm. Mrs. R silently wept, calling to her husband. I then asked Sara, who was not wearing religious attire, if she could talk to her father about memorable experiences, birthdays, holidays, and/or personal experiences which she had shared with dad. Sara whispered in his ear, “last night we couldn’t help laughing at all the jokes you told.....” And the stories continued. The doctor and I

stood by and watched. Prof Anner's assurance to Mr. R and his family that he would be with them exemplified hope—they would not be abandoned. We followed the steadily decreasing HR and BP readings. Twenty minutes later the monitor showed a sea of flat waves.

We moved away from R's bed. His family kissed him and we all left to complete the paper work. We all went to a room where we could collect ourselves and discuss funeral arrangements, thereby moving to the next stage of grief. The family members thanked us, we hugged them, and they left.

This was an inspiring experience I will never forget and feel compelled to share. First, I was present in the ICU under very unusual circumstances where the treating surgeon and patient had previously discussed and agreed upon a medical reality—including EOL desires and possibilities. This is particularly remarkable as the wishes of

most ICU patients regarding EOL are unknown, causing the treating team to deliver extreme measures. My meeting Mr. R and his family was extraordinary in that I had no ethical conflict providing previously agreed-upon patient- and family-centered care. In this situation I was able to keep to my ideals of providing Meaning, Connection, Integrity, and Hope, which I believe is fundamental to providing holistic care. Secondly, I was able to identify my role and guide this family into their final, most crucial closure—you only get one chance to get it right. Thirdly, my sense of accomplishment in traveling the closing pathway of Mr. R's life was gratifying. Nurses, patients, and families need closure so the EOL pathway will be satisfying.

By 7:30 a.m. I completed the night shift handover for the rest of the patients that I would be treating that day.