

# Building Holistic Bridges from Life to Death

by JUDITH REDWING KEYSAR RN, BA



**H**ospice and palliative care are intrinsically holistic modalities because we cannot – and must not – separate the caring of the mind, body, and spirit when tending to the suffering of people who have serious illnesses or who are in the process of dying. Many interpretations of palliative care agree that it is about providing comfort, easing suffering, and assisting a person and his/her loved ones to achieve optimum quality of life.

Interdisciplinary teams provide palliative care to help people navigate the challenging territory of illness, decline, and eventual death. Palliative care is about encouraging people to live every moment until the last. It is the modality we can employ to help each other understand what it truly means to be “present” and to consider the fact that everything and everyone in this world is impermanent.

## HOW TO PRACTICE PALLIATIVE CARE

Although most of us imagine that we will live a healthy life until we are in our 80s or 90s and then peacefully die in our sleep, it just doesn't seem to happen that way most often. As Joan Didion (2005) tells us so eloquently in the opening lines of her book, *The Year of Magical Thinking*: “Life changes fast; Life changes in the instant; You sit down to dinner and life as you know it ends” (p. 3). Accepting our own impermanence as human beings here on earth must become an integral part of our holistic nursing theory and practice. Therefore, I offer three guides on how to practice palliative care.

### FIRST, Do No Harm.

These famous words of Hippocrates come to mind when assessing what is needed to provide comfort. It is so much more than vital signs, lung sounds, and heart rhythms because it takes time to know a person who is seriously ill.

If we enter a room with preconceived ideas of what “we” are going to do to make the situation better, we may be doing more harm than good. And, as we have learned in our holistic model of nursing, pain and disease can be signals of internal conflict (Ferguson, 1987). Therefore, it is important to spend time with the person who is ill and, if possible, with family and friends in order to understand what the issues are beyond a particular disease process.

Although pain can be alleviated with medications quite successfully, we also know that suffering is not just about

physical symptoms but involves our hearts and souls and our life stories, as the following case study demonstrates:

*Sally was wheeled into the ICU from the ER at change of shift one night when I was working as an ICU charge nurse. Aged 45, she was a home hospice patient dying of metastatic breast cancer, which was affecting her bones and liver. She arrived with her home infusion pump, which was giving her 650 mg of morphine/hour. This must be a mistake, I thought. Surely she could not be getting this much medicine and still be in pain. She was a small woman with long red hair and bright green eyes that looked at me with a sense of panic. “We’ll get you comfortable,” I assured her, as we gently slid her from the gurney into bed. Famous last words!*

*I called Sally’s doctor, only to find out that this was the correct dose and it was fine to increase it if she was not getting good relief. He also ordered Ativan IV prn and an increase in dosage on her Fentanyl patch. The Ativan helped her calm down, and I was able to leave the hospital feeling that she would get some rest that night.*

*An issue that complicated Sally’s story was her blood family’s anger at her for moving away from their hometown with a new husband, whom they did not like. This added to Sally’s intense fear about the dying process and anxiety about her pain and inability to breathe. I tried to assure her in many ways that we would give her enough medicine to ease her pain and that I would try to do whatever else I could to ease her suffering.*

*On the third morning when I came to work, Sally’s family and new husband Robert were at her bedside. Suddenly, I heard a shriek from her room: “Redwing, help me,” she cried out. I grabbed a syringe of Ativan and went running into her room. I stopped in my tracks when I saw that her morphine was at 850 mg/hr, her oxygen was at 6L, and she had been given Ativan twice in the last 5 hours. I put down the syringe, took her hand firmly in mine, and put my other hand on her chest near her heart. I took a long slow deep breath. Her family and husband became quiet and drew close to the bedside. Sally closed her eyes and finally, with everyone together in a moment of calm, she was able to let go.*

*In that moment, I understood that the drugs I could have given Sally had little use in easing her suffering. It was our moments of connection over the last couple of days that enabled her to trust me enough so that, at the moment when she knew she was dying, she called out for a hand to hold.*

## SECOND, Know Thyself

Many of us who teach about spiritual care believe that it is crucial to recognize and accept our own mortality if we are to be present and serve at the bedsides of those who are dying. Some of us have witnessed death many times in our professional lives, and some of us have also witnessed death in our personal lives, where our hearts are more involved. Often it is at the bedside of someone we care about where we are allowed glimpses into a deeper realm of spiritual transformation, for ourselves as well as for our loved one.

If we are to act as “healers” at the bedside, we must be willing to look within and understand where our own fears lie and what beliefs we carry with us about death and dying. To discern your beliefs, you might ask yourself these questions:

- Did you grow up with a strong religious faith?
- Do you believe that religion and spirituality are the same thing? If not, how are they different?
- Have you completed your own Advance Directive, and have you had a thorough discussion with your loved ones about what you would want at the end of your life? If not, what has prevented this?
- What was the first major loss in your life, and how did you deal with it? Try making a timeline of the losses in your life and examine which ones you have grieved and which ones you have not.
- Ask yourself the poignant questions that Angeles Arrien (1993) asks us in determining “soul loss”: “When did you stop singing? When did you stop dancing? When did you stop being enchanted by stories? And when did you stop being comfortable with the sweet territory of silence?” (p. 54).

If our own hearts and souls are not intact or in alignment, it is difficult for us to truly show up at the bedside of someone who is in the midst of the most profound spiritual transformation of life: death.

## THIRD: Practice Compassion

In her book, *Kitchen Table Wisdom*, Dr. Rachel Naomi Remen (1996) tells us, “The healing of suffering is compassion, not expertise” (p. 217). We foster compassion because we, too, have experienced suffering. Palliative care is about bringing that compassion to the bedside.

When I was the Nursing Director at Zen Hospice Project, I learned three simple tenets taught by Eric Poche, the Director of Volunteer Services, for how to be present at the bedside of those who are suffering: Sit, Breathe, Listen.

- **Sit:** Find your own seat or place of comfort that enables you to witness someone else’s suffering.
- **Breathe:** Deliberately notice your breath and allow space between words and actions for breath. Allow yourself to notice and be with the breathing of the person who

is suffering as well as your own.

- **Listen:** Pay attention to the words, sounds, stories, and breathing as well as to the story line between the words. Listen to the silence in the room. Listening is the gift we give to someone whose life story is about to end.

## BUILDING HOLISTIC BRIDGES

The philosophy of hospice includes palliative care, but palliative care does not necessarily include or preclude hospice. One of the many misinterpretations of palliative care is that it is only for people who are dying. I have encountered many nurses and physicians who say they will not refer to the hospital’s palliative care service because their patient is “not ready to die.” Palliative care serves people at any stage of an illness because there is just as great a need for clinicians to help ease suffering in people who are recently diagnosed, who are chronically ill, or who are being discharged from hospitals after complicated procedures as there is at the end of life.

Palliative care is a bridge that has long been needed in health care when cure is not possible. We must use our wisdom, compassion, and knowledge to attend to a person’s suffering and to assist him/her in achieving quality of life. As healer and author Deena Metzger said during a writing workshop (held in 1998 in San Francisco, Calif.), “Healing is a process and a practice.”

Holistic palliative care nursing is also a process and a practice. When we tap into our own true natures, open our hearts, and touch another human being with love in order to ease their suffering, we have truly become a way for grace to come through.

## References

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