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Advocating for Peaceful Death with Dignity

By Lisa Ross BSN, RNC

Plato is often credited with saying that the most important thing to do in life is to practice dying. Let's face it, we are all dying. Many of us have problems talking about death and dying with our patients and so the conversation is avoided, but there are times when we, as nurses, just need to listen and in listening the answer becomes clear. It is always important for me to try to incorporate all aspects of holistic nursing into the daily care of patients, but it seems particularly important at the end of life. It is at the end of life when we really just need to be present, to listen, and to lead with our heart. Surprisingly, advocating for your patients and leading with your heart rather than your head may be met with resistance in this scientific world of western medicine, but I have found that my heart has been made bigger for the effort of trying. This is one of my experiences:

Joan was a 90 year old retired nurse, who was admitted to the Senior Behavioral Health unit due to her primary care physician's concern over her 17 pound weight loss and her "failure to thrive." She was kyphotic, to the extent, that if she attempted to sit upright in a chair, her face was practically on her lap. She suffered from severe back pain. She weighed only 75 pounds. Her admitting diagnosis was depression. Soon after arriving on our unit, her oxygen saturation began to drop into the 80s. An echocardiogram and chest x-ray were ordered and she was started on continuous oxygen.

When I first entered her room, I saw a cachectic woman lying in a fetal position on an air mattress. Her respiratory rate was 24-30 breaths per

minute. She begged me to leave her alone and let her stay in bed, but being the "good" psych nurse that I was I insisted she get up, knowing that the best thing for her "depression" would be socialization with her peers while eating in the common dining room. She reluctantly agreed. I remember lifting her to the chair, worried that her bones would break as I did so because she was so frail. She moaned with pain as I moved her. I offered her the PRN dose of oral Tylenol 650 mg that was ordered as her only means of pain control, but she declined stating, "I would think this type of thing would warrant more than Tylenol."

She went to the dining room, but refused to eat. I talked to her about the possibility of IV fluids if she continued to not eat or drink. "I have the right to refuse that. I was a nurse. I have read the Patient Bill of Rights," she told me. It was then that I realized she knew what she was talking about and what she wanted. She told me she wasn't particularly depressed, she just knew that she was dying and didn't see any reason to prolong the inevitable. She wanted to be on Hospice, she said, and to have her pain controlled. She said, "I've had a good life. Now, I just want a peaceful death."

Armed with this new knowledge, I raced into the Multidisciplinary treatment rounds believing that as soon as I brought this information to light the patient would be well on her way to the peaceful death she so desired. I presented what the patient had told me and was surprised by the reaction. I felt tears start to come to my eyes as the doctors politely listened to what I had to say and then went on to



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Lisa has been a nurse since 1985 and has been with UCSD since 2005. Lisa first worked in the PACU and then as a hospice nurse for many years. Lisa is currently with UCSD Senior Behavioral Health, where her focus is on blending holistic modalities with technologies like iPads to engage her patients and support the healing process.



discuss increasing her anti-depressant medication and considered starting Marinol to help stimulate her appetite. I left the room feeling defeated. I told the patient that I had expressed her wishes to the physician and I promised I would do all that I could to help her.

I was a Hospice nurse for many years before leaving to work in Psychiatry approximately 10 years ago. I had listened to countless patients as they told me they were dying and I held their hand as they took their last breath. I remember children, whose parents had decided not to tell them they were dying, telling me about going to Heaven, after their parents had left the room. The patient always seemed to know the end was near. I learned to listen to those patients. I learned many things from them...how to live and also how to die.

I sat with Joan throughout the morning as the doctors made their plans. She told me about her work as a nurse in the war. She told me, with tears in her eyes, about the men who had lost their limbs and how their losses were the hardest to reconcile. She told me about her life after the war and about her husband and children. She told me how wonderfully blessed she was. I just sat with her and held her hand. I let my compassion and empathy be conveyed

by my presence, or what some refer to as “holding space” with her. This was all I had to offer her at the moment.

It is sometimes hard to delineate between depression and end of life issues. I have seen patients who have begged for death and have even attempted to take their own lives in order to end their suffering. I have also seen those same patients recover from their depression and go on to find meaning and purpose in their lives and regret the feelings they had and the decisions they had made in the dark days before the depression was treated. What made me think Joan was different than these patients? I’m not sure. It was just a sense I had. I knew I had to listen and that I had to advocate for her right for a peaceful death.

The clinical care partner came to me. Joan’s blood pressure was 82/60. Her oxygen saturation was 77% on room air. I called the geriatric internist to let him know. He ordered a STAT chest x-ray. I told him that the patient did not want any more treatment and was asking for Hospice. He told me he would talk to the patient’s daughter. Within 10 minutes, he called back and cancelled the chest x-ray and told me to make the patient a “No Code/Comfort care” and refer her to Hospice. I went to Joan and told her

that her wishes to die peacefully and with dignity were going to be respected. She smiled broadly and said, “You know, I’m hungry for the first times in weeks. Can I have a turkey sandwich?”

I found out later from the internist that Joan’s echocardiogram showed her “mitral valve was wide open” and that she was in complete heart failure. He was not able to treat her because of her weight and low blood pressure and that essentially, fluid was “pouring into her lungs”. In other words, Joan was dying, just like she said. After a brief discussion, I was able to convince the internist that her pain did indeed warrant something stronger than Tylenol and she was started on Morphine. She went home with Hospice care the next day.

Is there a lesson to be learned in this? I think sometimes we get so involved in practicing medicine that we forget to practice dying as Plato advised. Sometimes, that’s all it is, just dying. Not depression, not failure to thrive, just the end of a great and wonderful existence that doesn’t need to be treated, but instead celebrated.