THE HAUNTING

Thomas Schwarz

Following a tragic car accident, an emergency room nurse struggles to overcome posttraumatic stress disorder. When he takes a job in hospice, however, he finds his experience helps him identify with his patients and their loved ones.

Thirty-three years ago, on a lazy summer evening in an emergency room in the suburbs of New York, I chose my first dying patient. An older, more experienced nurse was instructing me in the art and science of triage; her hours of patient explanations and unfailingly accurate assessments could be boiled down to a simple dictum: the worst goes first. The tricky part was to determine within a few seconds, a minute at most, who was at death's door and who was merely impatient and whining the loudest. When it came time to step up and choose my first patient, I guessed right. Or maybe wrong. I'm still not sure.

Two patients had arrived simultaneously. My mentor deferred to me, and I chose the obese, late-middle-aged, wheelchair-bound patient because his complaint seemed benign. He'd told the admission clerk that he'd had a sore throat for several days. In fact, he had the perfect storm of alcoholism and long-term aspirin use for rheumatoid arthritis, the consequences of which were the bulging esophageal varices that tickled his throat like angry, red balloons, growing more taut with each heartbeat of unclotted blood. I didn't foresee that he would die momentarily. As I weaved his wheelchair through the corridor, cluttered with empty stretchers and portable X-ray machines, I asked about his pain. Or perhaps I asked his name, or how long he'd had the sore throat; it was many, many shifts ago, and I can't remember. But I remember the next moment clearly: he lifted his left hand to his throat, coughed deeply once, and turned in his seat to stare into my eyes as he vomited a wave of blood. It didn't have the "coffee grounds" appearance that

indicates that the blood has been partially digested in the patient's stomach. No, this bucket of blood—*frank red blood* is the accepted clinical description—came straight up and out of the hemorrhaging varices in explosive gushes that filled his lap and covered his crippled legs. He didn't speak a word. He was too shocked to call for help, not that any drug or procedure could have saved him. He held my eyes with his own, too surprised to be scared, as his barrel chest shuddered with each heave. His hands gripped the wheelchair arms as if he were trying to save himself from slipping away. Moments later, his eyelids relaxed, and an unexpected calmness overtook him. He slipped down in his seat, looking as if nothing in the world could bother him, as if everything would be all right. At last, everything was suddenly fine.

I was not fine. I'm sure I looked gray and shaky as I washed down the wheelchair, pushed the discretely draped patient to the morgue, and completed the paperwork. My ER nursing mentor and the ER physician reassured me, later, that nothing could have quelled his lethal cough or staunched its horrific consequences, but nothing they said could salve my fear that I had missed something. We were there to save lives, not to watch them slip through our fingers, right? Nonetheless, I told them I was OK. After we cleaned up the mess (we never knew the patient's name—he was simply called The Mess), everyone went back to work as if nothing unusual had happened. I didn't understand, at the time, that I wasn't OK. I'd begun the shift with a nursing diploma and a bucket of bravado that someone had kicked over. I'd helplessly watched a life end from an arm's length away. That was the beginning of a long line of endings. After our shift ended, the other nurses collegially took me to the Parkside Tavern and got me numbingly drunk. The next evening, it was business as usual for everyone—except me.

I was barely thirty years old. My parents were alive and well, and even my octogenarian grandparents were still around. I'd never seen someone die until that night. That patient was and to this day remains *my patient*, someone who played out his last few minutes like an actor on my busy ER stage. During my three years at the nursing school from which I'd only recently graduated, the only corpses I saw were on gurneys being wheeled downstairs

to the morgue. *Dead*, *dying*, and *death* were words wielded like riding crops by the nursing instructors, who harried the students constantly. A medication error—by far the most prevalent form of medical error, at nine hundred thousand per year—was the easiest way to kill someone, the instructors warned. But I don't recall any instructor who ever admitted that *our* patients might die. They prepared us for hemorrhages, heart attacks, psychiatric emergencies, and birthing catastrophes. We even practiced postmortem care by washing, wrapping, and toe-tagging a latex dummy. But grief, shock, guilt, loss, and uncertainty were not part of the syllabus. We were taught, like the uneasy British during World War II, to keep calm and carry on.

The older nurses, whose refusal to shed tears over appalling events or even to speak of them later, were the models by which I learned to cope with tragedies and incorporate them into my nursing worldview. The nurses seemed, if anything, angry. At what or whom, I hadn't a clue. I didn't want to come off as sensitive, weak, or clueless, so I never spoke of my emotions either. If they were untouched by all the tragedy around us, then by God, I was going to be so-armored, too! I was young and cocky, well trained, and at the top of my ER game. When the screaming started, I would tell myself, *The patients hurt; I don't. Panic is contagious. If I let the patients' feelings become mine, I won't be able to help anyone.* I never let them in. Efficient? Yes. Callow, detached? Maybe. Compassionate? Not yet. It was still a long road to that destination.

In the decades that followed, I honed my emergency skills and clinical knowledge in ERs large and small, urban and rural; I proved my mettle with the "knife and gun club" in the Columbia–Presbyterian Medical Center's emergency department in Manhattan; I learned to save victims of careless hunting accidents and ghastly tractor rollovers. In that adrenaline-fueled atmosphere, patients came and went in a caffeinated blur. There was never enough time to connect in a deep or lasting way. The emergency medical technicians who pushed their stretchers piled with unimaginable tragedy through our doors called their rapid pace scoop and run. In order to keep pace with them, we had our own coping axiom: treat 'em and street 'em.

We sent the more stable patients to the ICU or the general care floors; our primary objective was to not let a patient die.

I distinctly remember the scream of a particularly aggressive doctor. He was directing the care of a dying patient, and his realization of the futility of his team's efforts was mounting. "Not on my time, you bastard—you're not gonna die on me!" he shouted, staring at the cardiac monitor as if he could will its lethal pattern into lifesaving submission. Stunned, I thought this to be a pretty heartless way to treat someone whose life was sloshing in a crimson cascade onto the shoes of the collected trauma specialists who surrounded his stretcher.

I'm not so sure, now, who he was screaming at. His soon-to-be-lifeless patient? The ghosts of past patients who'd slipped from his expert, unrelenting grasp? Maybe a brother who'd been killed at Da Nang or in Detroit while he was still a biology undergrad? Or maybe he was just as scared as I was and, like me, had never spoken a word about his fear to anyone who could help him to sort it out. Maybe his senior resident had exorcised his empathy years ago with the dictum Never let them see you cry.

On a late June evening, seventeen years after I'd started my ER tour of duty, I joined my kids as they chased lightning bugs on our front lawn in rural New York. We shared a second bowl of ice cream after dinner and decided to indulge ourselves by going out to pick up more. For some inexplicable reason, I chose to drive them in our clunky Ford station wagon rather than in my preferred yellow Volkswagen Beetle.

I was turning into our driveway when a drunk and stoned kid on a low-slung, souped-up motorcycle—commonly and appropriately referred to as a crotch rocket—struck my door at more than a hundred miles per hour. We neither saw nor heard his approach, which was odd. Those engines emit a scream that would put a banshee to shame. In the first seconds after his impact, I had no idea why all the windows of my car had blown out. My sole concern was for my kids. "Are you all right?" I shouted. They were miraculously unhurt. Not so, for me. By instinctively bracing myself during the explosive impact, I'd torn several muscles and tendons loose from my right arm and lower left leg. My door wouldn't open, so I slid across the front

seat and flopped to the ground. Neither my arm nor leg hurt at that point; they were simply numb and limp.

But I had more on my mind than a diagnosis for this clinical oddity. Somewhere in the warm evening was the person who had watched all his twenty-four years pass before his eyes when his ecstatic speeding was halted by the broad side of my tan, forty-six-hundred-pound Ford LTD station wagon. I searched my garden for the dying motorcycle driver. After what felt like an hour of crawling through weeds, I found him more than fifty feet from the car he'd impaled with his now unrecognizably crumpled motorcycle. His arms and legs lay skewed in a grotesque resemblance to a swastika. I futilely administered my best one-armed CPR as I shouted at him, "You bastard, you're not gonna to die on me! Not in *my* garden!" Years would pass before the irony of this curse would become a moment of enlightenment in my therapeutic journey back to an existence free of pain and posttraumatic stress disorder.

Within a half hour, the local ambulance squad scooped me up and brought me to an ER—fortunately, not to the one where I worked. "What was his name?" I asked repeatedly. The New York state trooper who'd escorted our ambulances repeated the victim's name to me over and over. It wouldn't adhere to my racing brain. Blessedly, some of his words did stick: "It wasn't your fault."

I was undressed, questioned, scanned, X-rayed, and falsely reassured in the ER: "You're OK except for some soft tissue injuries." Nothing could have been further from the truth. Within hours, my shoulder froze; it would stay that way for more than a year. The muscles, tendons, and ligaments in my lower left leg had sustained innumerable microtears when I'd kicked the brake pedal into the firewall. I could wiggle my toes and walk gingerly, and the bones appeared whole on the X-rays. Hence the flippant diagnosis of soft tissue injuries. More important, the nerves from my knee to my toes were numb. My leg had mysteriously gone to sleep. When it began to wake up, a week later, I felt that burning, throbbing, exquisitely painful feeling that occurs when one's circulation returns a few minutes after its deprivation.

The agonizing sensation lasted for the entire summer, robbing me of rest; my usual resilience and sense of humor were displaced by an angry,

exhausted zombie nurse. Dozens of hours of agonizing physical therapy later, I could walk without pain and raise my right arm nearly as high and straight over my head as my left. Nearly, but not completely. The price was high, but I had unintentionally earned a measure of empathy that would one day make me a better nurse. But there was more to learn. Never again would I impatiently dismiss a patient's complaints by telling him, "it's just a soft tissue injury." I swore I'd throw the word *just* out of my vocabulary. "This injection will *just* feel like a mosquito bite"; "I'm *just* the nurse"; "You *just* have soft tissue injuries."

On the morning after the crash, not twenty-five yards from where it had occurred, I lay in bed, still dressed in the clothes I'd worn the night before. The summer sunrise soon warmed my bedroom until I began to sweat into the rumpled sheets. Limping outside, I looked down my driveway to the spot where my car had sat, wrecked and steaming, before it was towed away. The occasional commuter's car tooted to me as it whizzed past. Friends and neighbors hadn't yet read the *Poughkeepsie Journal*'s terse report of the tragedy.

I noticed a middle-aged man a few yards down the road. He scanned the ground carefully, periodically picking up something from the gravel margin of the narrow country road. He cradled in his hands a small collection of the shattered pieces of plastic, metal, and glass left behind after the motorcycle was carted away on the flatbed truck, along with my car. He introduced himself as the father of the boy who had died. He said he was sorry for what his son had done and that he'd been expecting it, helplessly waiting for this to happen for a long time. He had told his daughter, long ago, "Someday we're going to get a call about your brother." And last evening, he explained, the call came. His voice teetered on the edge of anguish. His eyes were red rimmed and brimming with hot tears that would soon course down his unshaven cheeks. I'd never seen eyes so tired. He hoped that none of us were injured.

"My kids are all right," I responded.

"Good," he said. "That's a relief."

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Over the following weeks and months, I came to understand that not all injuries are visible. Nor do all illnesses have scientific, rational roots. Some surround the heart like barbed wire, never admitting peace or happiness, never allowing the release of residual, unspoken, or misplaced guilt. My psychic pain began with simple, reasonable questions. Why hadn't I seen the motorcyclist in the rearview mirror before I turned into the driveway? Why did he choose to pass in front of and not behind me? Why didn't any of us hear his approach? I wouldn't voice those haunting questions to anyone for many months. Nor did I speak of the collision's deafening boom that replayed in my mind again and again. One night, I became stuck while driving around a busy rotary. I couldn't summon the courage to make a simple turnoff through the thin traffic, so I drove around and around, like a lost soul on a merry-go-round of the damned, for ten minutes. My wife sat silently, patiently, by my side until my hands were cold and clammy from tightly gripping the steering wheel. When I finally exited, I was nauseated and humiliated by my panic.

Worse, I began to experience this feeling whenever I learned that an ambulance was bringing a victim of a motor vehicle accident into my ER. I began to ceaselessly hear crash noises, to the exclusion of all other sounds or voices. My ER expertise was erased, my bravado smothered by my pounding heart. I couldn't evade a patient's pain or panic anymore. I now knew those feelings firsthand, and until I acknowledged them without immature judgment or callous dismissal, I couldn't be truly helpful. In the same vein, I wouldn't be free of my fears until I admitted to my therapist, Marion, my haunting uncertainty about the crash; I spent hours sifting through details and tangled emotions like an archeologist of the soul. She called it a tape loop that had to be cut. Or posttraumatic stress disorder, if you like. Unbroken sleep became my measure for success, a cause for celebration even more profound than my graduation from nursing school. I felt as though I were starting over again, a newbie nurse who now knew what he needed to be a really good nurse: empathy.

I'm out of the ER business now. As I like to explain with a smile, I'm not thirty anymore. The ER pace is far too fast, and those exhausting, necessary

trauma skills have outpaced my sixty-three-year-old self's endurance. My brain can't process clinical algorithms and medication dosages fast enough anymore. I can't watch patients die, suddenly and awfully, and later worry that my best wasn't good enough.

On April Fool's Day 2007, I began a new job as a hospice nurse. Saving lives is not an option in hospice, although some patients do defer signing a Do Not Resuscitate order, a tacit admission that they are not entirely ready to die. My job is to help patients pass peacefully and comfortably at home, as is their common preference. The upstate New York hospice agency where I am employed has a fairly steady population of approximately 150 patients, with a predictable winter holiday season rise and post–New Year's decrease—terminally ill patients frequently and inexplicably manage to hold on until the holidays have passed.

The majority of the nurses at our agency work the day shift, during which they provide hands-on care to patients, ensure that they have enough antianxiety and pain-relieving drugs to carry them through until the nurse's next visit, and listen to their final desires, hopes, and fears. I am a strictly nocturnal nurse, on the other hand, who works the sixteen hours from dusk until dawn. In effect, I'm the hospice emergency nurse. After the day-shift nurses have tucked in their patients and gone home to their own happy and healthy families, I wait for the calls from patients whose symptoms—pain, nausea, vomiting, and worst of all, terminal restlessness and agitation—have unexpectedly spun out of control. There's no telling when I'll be summoned. Though we'd like to think that there's some degree of predictability to death and dying, there simply isn't.

My calls come when the patient's caregiver, most often a well-intentioned but inexperienced, overwhelmed, and frightened family member, senses the fear of abandonment that the dying patient feels. Panic, as I said before, is the most contagious of all sicknesses. *Where's our nurse?* they cry. *I'm afraid to give him more morphine, his pain is out of control, and he keeps trying to pull off his clothes and climb out of bed! She's plucking at things on her sheets that aren't there. She takes her oxygen off and tries to yank the tubing out of her arm! She's talking to people who aren't here, who died years ago! He's gurgling, and there's white stuff bubbling out of*

his nose and mouth. What do I do? He stops breathing for minutes at a time. That can't be right. Is that normal? He's burning up. She's ice cold. My brother wants to take him to the emergency room. We can't wake him up! Please come as quickly as you can!

Finding my patient's home in the pitch black of a 2:00 a.m. visit is never very hard. It's the only house with every light ablaze and more parked cars than driveway space. I walk from my car to the front door with an air of calm and confidence; someone will be anxiously watching for my arrival. The least confident member of the family, who hopes I have some magic in my big, blue, nylon nursing bag, usually greets me. Inside, I kneel by the patient's bedside. At six foot four, I'm at an appropriate height, in that position, to look into his eyes and not down at him from on high. I hold his hand, smile, and tell him, "My name is Thom, and I'm your nurse. I'm going to do my best to help you right now. What's happening?" The patient is often too lost in his pain or anxiety to answer immediately. He needs to resurface from his awful depths. But I can predict one question that patients never ask, one question that families *always* ask, one question that I can't answer with 100 percent certainty: "When?"

Through my own trials, I now understand the ineffable dread, as well as their inescapable sense of responsibility, that evokes that question. So I sit still, calmly look them in the eyes, and tell them with honesty and certainty, "What you're doing is the best and hardest thing you'll ever do. I respect you for that. I can see that you're doing everything you can. You're doing fine."

Hospice and palliative care services have grown exponentially as our elderly population lives longer and patients with terminal illnesses are increasingly reluctant to die in a hospital or skilled nursing facility—the dreaded "nursing home dump" scenario. Specialized training and a growing body of scientific literature ensure that nurses like me are well prepared for the job. Or are we? When I asked a colleague with seventeen years of hospice experience, "How have you stayed with it for so long?" she smiled with gentle understanding at the deeper meaning of my question.

"If you make it past three years, you'll be fine and stay in it forever," she replied. I also heard her unspoken warning: don't feel bad if you want out after they've wrung every tear out of you.

Although I have already endured that existential loss of innocence, the truth about dying is revealed to me over and over again, night after night. More than three decades of watching countless lives slip away at arm's length has blessed me with the realization that you cannot beat death simply by leading a sane and healthy lifestyle. Everyone dies, and it's rarely easy or pretty. Everyone I've ever known, loved, kissed, sat next to on a bus, watched on TV, or hated in the third grade is going to die. Everyone. I am the midwife to the next life for some. And although hospice nurses are very adept at relieving patients' physical and psychic pains, we're rarely 100 percent successful. Someone's going to suffer. I have lost loved ones and many patients. And I, too, have been scared to death about death.

All too often, new graduates stay in nursing because the recession offers little else to support them. The nursing profession has long acknowledged but never overcome its crippling level of burnout. Mandatory overtime still exists. Nursing's self-help tools are pitiful, demeaning, and far from sufficient to help nurses to recognize and conquer the fear, insecurity, and sadness that rob us of rest, happiness at home, and even our initial, quixotic love of nursing. Our beloved profession becomes just a job all too soon. It needn't be so. Nurses needn't leave the profession, resort to unhealthy coping measures, or become the nurse whose care no one wants for his or her loved one. The tricky part is to learn to be compassionate *and* detached in the right ways and at the right moments. I graduated from nursing school many lifetimes ago. Every night I start again.

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