That December I had been thinking about death and dying. We were nearing the end of our gerontology rotation in nursing school, and through the lectures about hospice care and the reflective logs dealing with end-of-life issues, the matter had been creeping to the forefront of my mind. Reflecting on my own fleeting experiences with death – my grandmother dying of cancer when I was very young, and the loss of two high school friends to suicide in my late teens – I began to obsess over the notion that I was not “prepared” for death and grieving. I found the thought of confronting death, on both a personal and professional level, to be a terrifying notion.

As all nursing students seem to do, I began to feel very anxious about the possibility of being asked to do something I didn't know how to do. For any other skill, we read books and articles and hear lectures. We went to lab and practiced wound care techniques. We learned how to place nasogastric tubes. We even practiced patient teaching on our fellow students before we gained experience at teaching hospitals and nursing homes. What we didn’t study or practice in nursing school was how to deal with grieving in any meaningful way. As people who were being trained to work with the sick and the dying, this seemed like a serious flaw.

One December night during my clinical rotation, these issues were weighing on my mind. Perusing the list of patients on the floor that night, I noticed the description of a woman with metastatic breast cancer who had just been placed on in-patient hospice. My heart jumped into my throat. I grabbed her chart to read the nursing notes. This woman was “actively dying.” Despite having no experience with a dying patient before, and despite my worries that I wasn’t going to be of any help to this patient (or even worse - that I would do or say something harmful because I was untrained), I found myself wanting to work with her. My heart was racing as I signed my name under hers on the patient list.

Before going on the floor that night, I double-checked with my patient’s nurse and my clinical instructor to see if they thought it would be okay if I chose to take care of a woman on hospice care. I explained my worries – that I’d had very little personal experience with death and that I had never worked with a dying patient and their family before. Separately, they each repeated a mantra that was surprisingly comforting to me: “In most cases, just being there is enough.” My fears temporarily quieted, I decided that just being there was about my skill level, and I headed down the hall.
When I approached the patient’s room, I could hear her labored breathing in the hallway before I even had her in sight. I hesitated in the doorway, a strange mix of fear, compassion, and curiosity holding me to the threshold.

The patient was unresponsive to touch and sound. Her eyes and mouth were open. Here breathing was irregular with periods of apnea punctuated by sharp gasps of breath. It was hard for me to watch. I could only wonder how scary it must have been for her family. I checked the patient’s pulse and her breathing rate and assured her sister that these were normal signs of the dying process, and that she wasn’t exhibiting any signs of being in pain. I did my best to make the patient and her family comfortable. And then I left. I made sure to check back frequently to see if they needed anything but I tried to be as unobtrusive as possible. When the patient’s family left that night, they thanked me for being so kind. I felt like I hadn’t done much at all.

For the last hour of my shift, I pulled a chair up next to my patient’s bed. I was alone in the room, and I didn’t know if I was doing the right thing, but something told me to sit with her. I talked to her. I told her, “I’m just going to sit here with you.” I had no way of knowing if she could see me or hear me, so I sat there, my hand over hers, my other hand rubbing her shoulder gently. “I am here. You are being so brave.” What was she thinking? Was she scared? Was I helping her? Did she want someone else there with her? Did she want to be alone? I couldn’t ask her these questions, and she couldn’t answer, so I just sat with her.

Her breathing started to change. I knew something was happening. Between breaths, it seemed like she was struggling now to say something: her tongue and jaw were moving, where they hadn’t before. “You are so brave. It’s okay. I’m here with you.” My heart was racing. Suddenly, she lifted her head off of the pillow, let out a few moans, and took a few more quiet breaths. A single tear rolled down either side of her cheek. She relaxed her eyelids. And then she was gone.

I sat with her a few minutes longer. When I stood up, I realized that I was shaking – hands, knees, everything. The tears came. I grabbed a tissue from the box, but instead of wiping my own eyes, I used it to dry the tears from my patient’s face. At this point, my clinical instructor appeared in the doorway. “I think she passed on,” I whispered hoarsely.

The tears didn’t stop, not after I left the patient’s room, not while I walked home, not while I was in my bed that night. But the tears were not tears of sadness or fear or grief. My overwhelming feeling was gratitude. I was so grateful to have been there with this woman in the last moments of her life. I was grateful that she did not die alone. I was grateful that I had been thinking and writing about dying and grief. Had these issues not been on my mind, I probably would not have been brave enough to choose to work with a dying patient.

Anytime I find myself doubting my skills or qualifications, I think back to that night when I found the strength to hold a dying woman’s hand, and in doing so, experienced one of the most profound moments of my life. It also serves to remind me that while “just being there” seems like a simple thing, it can also be one of the most difficult skills that we as nurses must develop.