David Thomas Peacock //

I wasn't prepared for so much death.

Before I became an emergency room nurse, I worked on a neurology unit with stroke patients. I loved that job. I gained a lot of clinical knowledge from my colleagues, but I learned even more about what it means to be a human faced with impossible tragedy from my patients and their families.

Strokes are, by definition, traumatic brain injuries. As such, the damage they inflict cuts to the very core of who we are as humans. The sequalae of these events is far-ranging, and will ripple out not only through the rest of the patient's life but also through the lives of everyone who loved or was touched by this person – including their caregivers. My work with these patients left me with an indelible impression of just how fragile our lives can be.

Occasionally a patient would go into cardiac arrest, and being a very curious nurse who wanted to learn as much as possible, I would always rush to the scene. I was struck by how chaotic it all seemed, with multiple doctors shouting out separate orders, and nurses scrambling to get the right equipment, meds, and establish IV access. An air of heightened anxiety was palpable – someone was dying, quickly, and everyone who responded wanted to save this person, but the whole experience was clearly outside the realm of their daily practice.

I remember thinking "*I want to work in an ER and learn exactly how to intervene when someone is in cardiac arrest*."

Well, I got my wish, and I love my job and am grateful to be working with a team of highly dedicated professionals who have taught me so much. I'll never forget the first arrest I watched as a new ER nurse: there was very little verbal communication and no one seemed excited, much less panicked. There was no "leader" assigning roles, instead everyone just coalesced into a team like a well-oiled machine, effortlessly sliding into whatever role needed to be filled. All necessary equipment was fetched and put in place by nursing, anticipating what medicine would need before it was even requested. I don't remember the outcome, I just remember being amazed at how smoothly the whole thing went.

But very early on, I began to realize that most people in cardiac arrest don't survive. This had a pretty obvious implication, since cardiac arrest is one of the most common "life and death" emergencies treated on a daily basis in virtually all ERs.

It means that you are very quickly going to take an active part in someone's death – and you are going to do it on a regular basis. Some shifts there might be none, others might have two or three. Suddenly you go from death being a rather isolated experience to death becoming a routine part of your job. And this isn't death from a distance, no, this is death up close and personal. Death as in one minute this human is alive and your hands are on them trying to keep them that way, and the next minute they are gone. Forever.

As part of the team attempting to resuscitate the patient, you innately understand that your job is not to become emotionally involved with what is happening. Sometimes there are spouses, life partners, loved ones, or family in the room while the team works to save the patient. At that moment, they don't need to see your emotional involvement, they need to see a group of highly skilled professionals doing everything they can to save their loved one. And they will never forget what they see.

I often think of the ER as the last stop for those in dire need of medical care. In a true emergency, it's the final destination before their ultimate medical disposition. There are only three ways the patient will leave – they are either discharged back to wherever they came from, they are admitted to the hospital, or they are wrapped in a body bag and transported to the morgue.

Although your best chance of surviving a cardiac arrest is in the ER, the reality is that the overwhelming majority don't survive. So this leaves the ER nurse (or doc) with a bit of a dilemma: How do you handle so much death? Unsurprisingly, there is no simple answer to this question, and in most ERs, it is left to the individual to figure this out on their own. How they do so is a measure of their humanity. Of course, some people are going to be better at this than others, yet for the most part, it's a topic that's not discussed.

Ultimately, it takes a toll on everyone, whether they admit it to themselves or not.

In order to deal with this tragedy on a daily basis without burning out, one is faced with two adaptive strategies: either become tough or become hard. Here's my distinction: *Tough means you can handle the worst that life has to offer and not lose your humanity. Hard means you can handle the worst that life has to offer, but the process of learning how to do so took your humanity with it*.

Obviously, we want to keep our humanity.

When I started working in the ER, I didn't fully understand the powerfully intimate human connection that happens between two people when one is in such a desperate state of vulnerable need and the other one is professionally trained to care for and alleviate suffering. I didn't understand what it would mean to take an active part in so much death.

With the exception of hospice (where death is the expected outcome), I'm not sure there are many other professions where death becomes such a routine part of your job. It's a great privilege to be part of a highly skilled team trained to save someone's life – but it feels strangely unnatural for another human to die while your hands are still on them, working to keep them alive. And when they're gone, you are expected to simply move on to your other patients, as if this is the most normal thing in the world.

But it's not normal.

I always try to take a moment after the team agrees to stop the code and call "a time of death," to quietly honor the life of this stranger in my mind. I have no idea who they were or what kind of person they had been. I just try to honor them as a human being who had lived a life and now their time was up.

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Image: The ambulance bay of the Allen Hospital – New York Presbyterian Medical Center at midnight.