The Pause

1. **Jonathan B. Bartels, RN, BSN**⇑

Jonathan Bartels is an emergency room nurse and palliative care liaison at University of Virginia Medical Center in Charlottesville. He and Dorrie Fontaine, dean of the School of Nursing at the University of Virginia, are founding members of the Compassionate Care Initiative at the University of Virginia.

Corresponding author: Jonathan B. Bartels, RN, BSN, University of Virginia Health System, 1215 Lee St, Charlottesville, VA 22903 (e-mail: jbb4x@hscmail.mcc.virginia.edu).

A young woman is wheeled into the trauma bay. She'd been crossing a busy intersection at night, clad entirely in black, and was hit by a sport utility vehicle moving at full tilt through the crosswalk. Smears of blood streak her face like war paint, and her arms are bent at unnatural angles. Her body lies exposed, her clothing in snipped tatters about her small frame as we do an initial physical assessment.

Airway, Breathing, Circulation

These are the final moments of her life, but no one knows that yet. She remains unresponsive, and given the number of blunt injuries she has most likely sustained, we decide to intubate. Intravenous access is established. Our FAST exam [focused assessment with sonography in trauma] is positive for massive abdominal bleeding. We speak in low staccato to one another, poised for what will happen next, willing her body to come back, her eyes to flutter open, our monitors and instruments to detect any surviving circuitry within her.

Then there is no blood pressure, then no pulse, and the monitor chirps asystole. The tension escalates as compressions begin, 100 deep beats per minute. Drugs and fluids are rapidly infused. We expertly move in a choreographed dance dedicated to saving lives. From the outside, it must look like chaos, but our dance in the emergency department is known. We have done this before, and each of us knows his or her step in this trauma bay by heart. We try to bring her life back for 45 minutes before we realize it's too late, and the code is called.

On this day, the day of the young woman, I remember defeat and exhaustion, but also more than that: a kind of vacancy, a space where the pull of emotion gets tamped down by time, fatigue, and grief, leaving an empty numbness in its place. It is as if our team lost the most important game of the year only to be told we're due to assemble at the 25-yard line once again. I watch my colleagues throw off their gloves and stride out of the room, leaving the naked, lifeless body on the table. Not a glance back, just a step back out into the world of the emergency department where patients stream in like locusts.

It isn't heartless: it's force-fed anguish. There is no time for a breath, or thought or tears. A death that gives us pause as humans leaves us as clinicians with no time to pause. Maybe, I think, that's the problem.

It was on the day of this girl's death that I changed my response to and ceremony around death. Her death wasn't our first, and it would not be the last, but I remember it because it did mark the end of the old way and the beginning of the new—our pause —and my determination to speak up, to ease up on the tamping down of emotion, to be brave.

Emulating our unsinkable chaplain and shedding whatever compunction I felt about changing our routine, I used the next difficult case—just days later—as a platform for a shift, this pause. However haltingly it began, somehow, it became ceremony. After a death in the emergency department, I would stand, ask that no one leave, and invite my peers to bear witness with me, to be together and present in a singular moment of grief and loss. I would ask each to, in their own way, offer silent recognition of the lost human life—someone's mother, father, sibling, or child—to remember that the person who had died loved and was loved, to understand that the person's passing deserved recognition, and to acknowledge that our own efforts, too, were worthy of honor.

Forty-five seconds, maybe a minute, a minute and a half. For us, pausing has made all the difference. This pause honors those lives that do not get saved and gives us a moment to contemplate the passage and bring the sacred into what is often a profane environment.<In so doing, we recognize this sad rite of passage.

Our pause, in its own way, breathes life back into what can feel like an airless, emotionless room where we work. With it, we stop and allow ourselves to be present in the natural, real events that have unfolded. We are together, yet apart. We recognize that stillness is very human, as is the desire to tamp down things that hurt, disappoint, and exhaust. But we become still. In my own practice, I am learning to try not to tamp my feelings down as much.

Around the University of Virginia, we talk about ways to keep ourselves resilient, to keep ourselves from squashing the very human elements that make the practice of medicine the noble and soulful profession it is. This intervention is inspired by the Compassionate Care Initiative. According to Bob Melody, RN, Clinical Nurse IV, the pause brings closure and creates an uplifting experience in a negative situation.

Like the very best ideas, the pause continues its spread quietly and purposefully throughout University of Virginia Medical Center. Last week, an anesthesiologist stopped after a failed resuscitation and requested that all present "stop and do a pause like they do in the [emergency department]." The head trauma surgeon now asks after a code for the staff to do "that thing." The practice is growing and gaining advocates. Our grass-roots ceremony is being repeated because it feels right.

Michael Day, RN, MSN, CCRN, heard about my description of the pause at a trauma nursing conference in April 2013 from a keynote speech on compassion in trauma care delivered by Dorrie Fontaine, dean of the University of Virginia School of Nursing. Michael is the trauma care coordinator at Providence Sacred Heart Medical Center and Children's Hospital in Spokane, Washington. He took the concept back to Spokane and met with the director of chaplaincy services and devised a plan to meet with each unit's manager and then with the staff to introduce the pause. Michael states that the staff where he works are extremely receptive to the pause.

The pause slows our racing minds, offering mental space so that we are not drawn into the vortex of failure versus success. We bear witness to a reality devoid of projections. We give ourselves the opportunity to forgive—and be forgiven. This practice removes the impotence that colors loss in health care. It empowers each individual to offer support without imposing beliefs on others. It is both communal and individual, and it allows for secular, religious, and humanistic perspectives. It is simplicity infused with complexity. We are called to bear witness to the reality of loss and the acceptance of reality.