A Very Easy Death: A Philosophical Essay in Review

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Simone de Beauvoir (1965) writes “foreseeing is not knowing” (p. 96). Of the many profound statements de Beauvoir shares in the recount of her mother’s death, I found this statement most powerful. I was struck by the blunt reality of these words and left to ponder the meaning of understanding related to acquisition of knowledge and experiences of knowing. As a professional nurse and nurse educator, I am in the privileged position to share my knowledge, experience and understanding of the human condition with my colleagues and peers, students, patients and their families and friends. The purpose of this essay is to reflect and discuss a theme that emerged from the reading. For the purpose of this essay, I will reflect upon knowing as it relates to the reading and my personal and professional experiences.

Through reading A Very Easy Death, I came to appreciate again, that knowledge alone is not power and that knowing does not equate to understanding. Both online and during class, we have discussed how nurses are often seen as the gatekeepers of knowledge. If nurses and other health care professionals are viewed by and large as the keeper or holder of knowledge, I am also caused to reflect upon the power disparity that exists therefore between nurse and patient. However, as in Beauvoir’s writing, this power can be transferred or held by family members as well. From my professional practice experience there are numerous reasons why family members “keep” information from their loved ones. Protection is often at the center of this decision. However, protection of whom is not always clear. In Beauvoir’s case, she and her sister chose along with the doctor to withhold information in regard to their mother’s condition. This was done with good intent, to protect the patient from potential harm caused from knowing. In practice I have seen similar situations when information vital to the care and prognosis of the patient is withheld. I am reminded of an individual who was a recent immigrant to Canada and
had very limited English speaking skills. This patient was very ill with a life-threatening HIV/AIDS-related disease. The physicians shared with the patient, the information - knowledge - related to the disease processes and virus that had caused the health crisis. They had gone as far as explain to the patient and family that the infection how the virus had been contracted. However, the patient and family clearly did not understand this information. Again, as one of the nurses providing care for this individual, I found myself caring for a patient who was unable to process the knowledge that had been provided. A virus, in the perspective of this patient, was likened to that of a “cold” or common type illness one could surely be cured. The patient and family members were puzzled why the patient fell so very ill in this case; unable to comprehend that the condition would proceed toward an inevitable death. This family was left with their limited understanding. Perhaps this was in attempt to protect them from the gravity of the condition, justified from the point of view of health care providers, that this patient and family would not be able to come to an understanding anyway.

This brings to mind another experience, similar, yet different in many ways. Conversely, I have been a participant in care provided to an individual with grave illness who withheld information from family members. In this situation, information was withheld to protect the rights and confidentiality of the patient, but also protect family members from perceived harm, resultant from the knowledge of the actual diagnosis. This situation increased the complexity of care when many nursing measures and interventions were shrouded in a veil of secrecy. This individual was married, with children and grandchildren. The actual diagnosis and prognosis was far different from the information shared with the patient’s family members. As a very young, newly graduated nurse, this situation left me feeling uneasy and deceitful both to the family members but also the patient. I felt that my care was somehow lacking or insufficient in some
ways. As family members asked why certain procedures and tests were performed, I found myself in the midst of a lie: one served to protect the privacy of my patient, but one that served to potentially harm the family members who stood by, unknowingly watching their loved one die. I was one of the holders of information that prevented these family members the opportunity to face their greatest fear: death.

The last example is one of my own mother. A young woman just turned 50 who had experienced vague symptoms over the course of a few short months. These symptoms worsened to the point of hospitalization for diagnostic investigation. After multiple diagnostic tests and procedures, her internist informed me that her heart was grossly enlarged and dyskinetic: she suffered from left ventricular hypertrophy, cause unknown. The gravity of this preliminary diagnosis was a tremendous weight to carry. I found myself caught in a position of knowing and understanding the diagnosis, but aware too that the fine details had not been shared with my family. Was it my responsibility to inform my mother, the patient? Had her physician left this decision to me? I possessed the power of both knowledge and knowing, power that I had held many times as a nurse, but as a daughter became a burden I wanted to cast off. My mother was transferred to a larger centre for further investigation. Less than 12 hours after the transfer this vital woman, about to be a first-time grandmother coded on the unit and was found pulseless and breathless during morning rounds. After CPR and numerous defibrillations she was revived, but only barely holding on. I recall her look of confusion as she asked my father why she was so sick, similar to Simone’s own mother who “was there, present, conscious, and completely unaware of what she was living through” (de Beauvoir, 1965, p. 76). My father and brother did not understand the severity of her condition. Again, to protect the patient and family, I was caught in a lie as I withheld this from them. In a few short hours after her first code, my mother
too was “blown out like a candle” (de Beauvoir, 1965, p. 47). These quotes became significant as I recalled how I too had stood on the other side of the patient bed, as a daughter, not only a nurse, and lived the experience of knowing while others around me, with the same information as I, clearly did not know.

I have provided these experiences as examples of the power we place on knowledge. Knowing, is more than simple provision of information or knowledge. Patients and family members, while “adequately informed” are often unable to interpret the true meaning of the knowledge that we impart. This can be due to a multitude of factors from outright withholding of information, subtly in the way and degree to which we share information, a language barrier, or quite simply, the patient’s inability to process the severity of the prognosis during a critical period.

According to CARNA (2006) it is our professional responsibility to collaborate “with clients to achieve mutually agreed upon health outcomes within the context of care” (p. 11). Moreover, in attempt to support patients and families in decision making regarding care, the registered nurse is required to establish professional boundaries with patients and family members while developing therapeutic, caring and culturally safe relationships (CARN). While withholding information from family members and/or the patient themselves, am I practicing in a truly collaborative way? Am I genuinely able to develop caring, therapeutic relationships with patients and families while knowingly withholding or not fully disclosing pertinent information?
References


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http://www.nurses.ab.ca/Carna-Admin/Uploads/Entry-to-Practice%20Competencies.pdf