ARTICLES

Knowing one's death: philosophical considerations

SIBY K GEORGE

Abstract

Coming to know and accept one's impending death allows terminally ill persons to face their mortality without deception. While life as such is a constant race towards death, terminal illness brings one's own death closer to experience. Being in the face of death in this manner can be transformed into an ontologically rewarding experience. Research on medical practices of truth-telling in cases of terminal illness tends to show that there is healthy acceptance of impending death in western contexts, whereas in other contexts patients are more likely to do well when poor prognosis is concealed from them. This paper considers the case of knowing one's death in terminal illness, and explores responses to truth-telling and allied issues in non-western contexts like India from a philosophical/reflective rather than prescriptively ethical or empirically evidenced perspective. It argues that culturally contextualised, sensitive ways of helping patients know that they are terminally ill can lead to a more spontaneous and freer acceptance of death in nonwestern contexts.

Introduction: intimations of mortality

Anticipations of death as an ontological character of existence can both be dreadful as well as transformative. One's own mortality is not a general fact about death as the existentialist philosopher Kierkegaard reminds: "But for me, *my* dying is not at all a something in general; maybe for others my dying is a something in general" (1: p 140). However, the anticipation of our mortality takes a very different colour if we were to come to know of a poor prognosis pertaining to our own terminal condition. The very end of existence leaps backward to closeness. For Tolstoy's Ivan Ilyich, it was all right for Caesar to die as in the syllogism "All men are mortal; Caesar is a man; and therefore, Caesar is mortal." But not for Ivan Ilyich "with all my feelings and thoughts – it's different for me. It can't be me having to die. That would be too horrible" (2: p 563).According to the Swiss psychiatrist Elisabeth Kübler-Ross, patients pass through the stages of denial and isolation, anger, bargaining, and depression, before they settle down on acceptance of imminent death (3). Nurses caring for terminally ill patients testify that most of them never reach the final stage of Kübler-Ross's model (4: p 184).

On the Christmas Eve of 2010, my doctor at the Tata Hospital in Mumbai told me that my cancer's name was "multiple myeloma", that it was incurable though treatable, that I was to be prepared for several cycles of chemotherapy, an autologous stem cell transplant, and several fractions of radiotherapy. I heard the sobs of my wife in the doctor's office; I noticed the dead faces of my colleague-friends who accompanied us. Something surged up within me to say that death is not merely ontological and indefinite but concrete, near and rather definite. I spent hours on the internet that night, trying to figure out the time left. At 40, I was angry about the cold statistical information that the average age of diagnosis for my illness was about 70 years, that the average expected survival time after diagnosis was 2–4 years. I began to hear the death knell tolling not for a different person but for myself.

This paper is a reflective and philosophically suggestive account of the medical practice of disclosing to patients their terminal condition in a contextually, culturally sensitive manner. Its approach is not ethically prescriptive or empirically evidenced. In cases of terminal illness – whether strictly in terms of a timespan or more broadly in terms of the nature of the disease –patients have the time and occasion to know and accept their death, if they are so disposed. This is not the case with all settings of coming to know one's death. In a fatal accident, for example, there could be the momentary awareness of death before the person actually dies, but she may not have the time and disposition to accept imminent death. My concern in this paper is with the condition of terminal illness, which gives patients the occasion to come to know and to encounter their death. While my general theme is the culture of prognostic communication with specific reference to the Indian medical context, the philosophical perspective that I adopt is that of the German philosopher Martin Heidegger (1889–1976), in whose writings death as an inherent part of existence is a central theme (5). The above-mentioned biographical fact of living with multiple myeloma is also an important subtext of the following discussion.

Concretion of ontological mortality

We are constantly dying. As Shelley says in the poem "Death" (1820), "we are death" because death has set its "mark and seal on all we are and all we feel, on all we know and all we

Author: **Siby K George** (kgsiby@iitb.ac.in), Associate Professor of Philosophy, Department of Humanities and Social Sciences, Indian Institute of Technology Bombay, Powai, Mumbai, 400 076, INDIA

To cite: George SK. Knowing one's death: philosophical considerations. *Indian J Med Ethics*. 2017 Jan-Mar;2(1)NS: 6-14.

© *Indian Journal of Medical Ethics* 2017

fear" (6: p 204). However, as Heidegger argues, the ontological fact of death as constitutive of our existential projections of possibilities can be suppressed, and we can go on playing the various socially conformed roles unhindered. While nobody can be another's representative in death, our socially coded encounter with death is one of evasion. Heidegger observes that people often console the dying person, assuring them of escaping death and returning to "the tranquilised everydayness of the world of his concern" (5: p 297). This tranquilisation is not only for the sake of dying persons but also for the sake of persons consoling them. Like Ivan Ilyich's wife and acquaintances, everyone wants to forget death, which is considered a social disruption. During my own treatment period, I busied myself with crime fiction and thriller movies in an attempt to keep the mind off cancer.

But a very poor prognosis concretely brings the dying person face to face with death. We experience illness as opposed to wellness with a clinically harmless migraine, but with an undiagnosed, painless and terminal cancer we feel well. The disease called cancer becomes an illness when the terminality of the condition arrests our wellness, and impairs our projections of meaningful possibilities with respect to our world (7). Knowing one's death brings about anxiety and existential disruption.

The philosophical point here, as Heidegger explicates it, is this. We exist, first and foremost, not as enclosed, insulated spirits; not as discrete, rational subjects of neutral thoughts (Descartes' "thinking thing"); not as disengaged spectators of the world from nowhere (Adam Smith's "impartial spectator"). Rather, we exist originally as selves concerned about and engaged in a world of meaning. We begin with a prejudgement of phenomena (Gadamer's positive notion of "prejudice"). We are beings who are affected by our world, who have a pre-cognitive, pre-reflective understanding of it. We can have the objective-scientific view of things only as a process of disentangling ourselves from our interested, "prejudiced" engagements with the world through critical thinking and the methods of science. Our existence is also inescapably temporal, because at each moment of our wakeful life, we project possibilities of our future being, one kind or another, choosing from a range of them, not neutrally and disinterestedly, but on the basis of our involved sense of what we have been or what we have become – that is, our history. As the philosopher, Charles Taylor, comments, this is the existential structure of our mundane decisions like getting up when we are ill and walking towards the chemist's to pick up drugs, and of our more crucial decisions like opting to treat or not to treat a diagnosed terminal condition (8: p 47).

The implication of this philosophical point is that the sudden knowledge of the terminal condition may disrupt and render meaningless our existential projections towards the world of people we care about, things that matter to us, and meanings that sway us. A stronger expression to describe what is meant by existential disruption is sometimes used: the destruction of self. Human self is not a discrete, universal subject, hiding within an interior castle, but consists of the layers of meaning that attach humans to the world with others. Meanings that form us into selves come from outside us. Such is the sense of Heidegger's description of the human being as "being-in-the-world" and "*Dasein*" ("being-there"). The sudden awareness of one's imminent mortality renders pointless one's existential projections towards the world that forms one's selfhood (9).

Of course, the most acute form of destruction of the world-layeredness of the self is found in excruciating bodily pain as when a nail pierces one's feet. Nothing exists for one, for example, when the body is burning, except the burning body itself (10: p 51–2). However, the experience of overtly closing in on oneself without the urge to project and make real meaningful possibilities is characteristic also of the existential disruption caused by the sudden knowledge of one's impending death before one has come to accept it. But unlike in the case of excruciating bodily pain and nausea, the existential disruption in this instance is also aggravated by one's thoughts about those who matter like one's children, spouse or other dependants, as it was in my own case.

Knowledge of powerlessness

This being the likely immediate consequence of coming to know one is dying, we may ask: do patients need to know they are dying?

The ethical principles of autonomy or respect for the patient's choices, beneficence or care for the patient's well-being, non-maleficence or desistance from causing harm to the patient, and justice or fair treatment of all patients are the broad guidelines to decision-making among modern medical practitioners (11). Accordingly, if we go by the current best practices of the medical profession, it is pertinent to tell the truth to patients about their condition. The therapeutic privilege – the privilege to withhold truth or part of the truth from patients in order to prevent grievous harm to their person – is frowned upon due to the principle of autonomy, which is held in high esteem in modern global culture. The contention that therapeutic privilege is a benevolent deception for the sake of avoiding harm, that prognosis at best is an educated but uncertain guess, that medical condition is incomprehensible for lay patients, or that some patients may not want to know the truth about their illness are all considered illogical from the perspective of the ethics of autonomy (12,13).

However, this debate is not closed yet. In an April 2013 issue of the *BMJ* (*British Medical Journal*), the question for head to head debate was: "Do patients need to know they are terminally ill?" The favourable answer to this question hinged on the issue of informed consent, and the unfavourable one on the indefiniteness of medical knowledge (14, 15). Interestingly, the affirmative response to this question recognises that prognostic information *can be* withheld from terminally ill patients if such disclosure causes more serious harm to them than merely making them upset (which is to be expected), and that such information should be presented to the patient sensitively in a more generic rather than narrowly specific terms, acknowledging the uncertainty of prognosis, simply because it can never be fully accurate. Interestingly, again, the negative response to the question rejects paternalistic modes of treatment, and deceptive approaches to consoling the patient, while underlining the need to offer the best possible form of care to the patient and being honest with them on the ambiguities involved in the prognosis. The negative argument in a nutshell is, it is better to withhold such heart-wrenching information which is uncertain. The positive argument is, it is better to give such crucial information, even though it is uncertain, specifying its uncertainty clearly. The affirmative response also observes that prognostic information may be discussed with patients "*only* if they request for information," and that it should be shared in a way they understand, and in a manner that will ease their pain, keeping in mind their cultural sensitivities, beliefs, and preferences. Similarly, in the negative response, the most important point of emphasis is merely that terminally ill patients "do not necessarily need to know" of their condition in order for the medical profession to provide them with the best form of care. Both the responses have a clear understanding of the inaccurate nature of prognosis.

Looking back at Heidegger's meditations on death in connection with these considerations of medical ethics, let me reiterate: although dying is inherent to living, prognostic awareness of impending death disrupts existential projections. In my own case, coping was made possible, I must say, through the very "native" ways of support that came from friends and family. According to Heidegger, my death is ontologically certain for me, is indefinite as to when it shall befall me, is experienceable only for me – a point that I shall contest in the last but one section below – and is the definitive endpoint and the impotent limit point of all my existential projections. He argues that it is possible for individuals to own up their death or finitude and, thus, become authentic individuals, even in a condition that they normally consider hale and hearty, when they deliberately allow the limits death imposes on their possibilities to guide their actual existential choices. The point about prognostic information regarding terminal illness is that it concretely brings about the possibility of facing up to our finitude.

However, one may still evade death. One may become depressed by distressing prognostic information, may choose to refuse information, may refuse to believe information, or may dissimulate information, relying either on the indefiniteness of medical knowledge or the possibility of miracles, whether naturally or divinely ordained. Indeed, it is too easy to imagine how one would be in the face of terminal prognosis when one actually is not. No one can force on another the freedom to accept or deny imminent death. The medical profession and our social circle can only create an ambience for us to make smoother the transition from a less definite to a more definite and medically validated knowledge of our death, and to deal in a more meaningful way with the painful and traumatic conditions that could accompany such knowledge. Death is ontologically inherent to living. Not only are humans dying in this way; the whole of nature is similarly dying each moment. Finitude is constitutive of being real and existing. Human dying is different only in degrees because of the ineluctable awareness and anxious anticipation we have of our inherent vulnerability in the face of our finitude and the unavoidable suffering this gives rise to, as the Buddha taught (16). Terminal prognosis makes death concrete and makes us concretely powerless in its face.

It is not always or even usually the case that one comes to know about terminal illness only when the physician finally announces it. However, as a professional practice, the announcement is important. *How* the announcement is made is more important than *what* is announced. Leman-Stefanovic's Heideggerian study of people's experience of their impending death recognises that "those who suffer most in coming to terms with their illness, are those who are advised in a very sudden, cruel, and unfeeling fashion of the seriousness of their health problem" (4: p 166). Coming to terms with our mortality gives us the chance to take a final look back at our life, to reassess ourselves, to sort out our affairs one last time, to face up to the existential loneliness of dying, to gauge without deception the significance of the social circle we have shared, and to relate meaningfully with ourselves at least once in a whole lifetime. The mood and culture of the announcement, the emphasis placed on the indefiniteness of medical knowledge, and the continuing indefiniteness of the actual occurrence of death are to be underlined in the physician's actual communication with the patient on terminal illness.

When my doctor discussed the prognosis with me, five points of emphases resounded in my ears: that no reliably curative treatment was yet available for my illness; that it was nevertheless a reasonably treatable condition; that my age was in my favour; that my continuing to live and the quality of my life were important, given that treatments could improve over time; and that my response to treatment depended also on the peculiarities of my biological constitution, or on God if I were a believer. "Terminal illness" is not a clinically specific prognostic description, which could simply mean "incurable and life-threatening illness." But in countries such as the UK, the legal meaning of terminal illness is "a disease which is expected to cause death within six months" (14). Terminality in the latter sense would definitely be more disruptive of existential projections. However, my own encounter with a more unspecific sense of terminality also brought about a whole set of changes in my expectations from life. Even so, my doctor's approach towards me and my illness was crucial to the way I have so far managed to live with multiple myeloma.

In the affirmative response to the *BMJ*'s debate on whether terminally ill patients need to know the truth, a disquieting argument is that knowledge gives power. The two authors, both specialists in palliative medicine, emphasise that knowledge of our terminal condition gives us "power" to make informed decisions on treatment and care, on finances, on delegating authority over our affairs to others, and on choosing our place to die (14). However, their own text and that of their opponent in the debate as well as the existential-phenomenological perspective that I have been espousing here, in fact, point to the patient's actual coming to terms with human powerlessness in the face of death with the more definitive knowledge of her dying. The concrete recognition of human vulnerability and finitude, coupled with the indefiniteness of the hour of death even when death knocks at our door, makes us experience the phenomenon of death and our powerlessness in its face without deception. The Baconian language of knowledge as power and control even in the face of death betrays the Cartesian notion of the disengaged, detached subject that underlies modern medical practice. We should, rather, speak of the affected, vulnerable and social self of the dying person. Every decision, taken from the perspective of facing death squarely in the eye, is not a decision of power and control, but a truthful enactment of the inextricable contingency and powerlessness inherent in human decisions and projects as such.

Being in the face of death

If a person is not encountering death unexpectedly or violently, she has the time to face death. This is what we call "being in the face of death". Such being in the face of death most concretely may not be a happy and serene welcoming of death. Even in Kübler-Ross's oversimplified sequential stages of dying, "[a]cceptance should not be mistaken for a happy stage. It is almost void of feelings" (3: p 92).Facing death is a way of surmounting the horror of death, the futile flight from it, and restoring death to its truth. We orient ourselves to face death not because life is a burden, not because death is desirable; but because the truth of the matter is dying is central to living. Although it might be considered inordinately human-centric today, Heidegger calls humans "mortals" "because they can die... Only man dies. The animal perishes" (17: p 176). Without acceding to Heidegger's human-centrism, we could still accept that the degree of angst in the face of death is enormous. Being in the face of death is about acceptance of the reality of death without deception. Without acceptance, the horror of death and the meaninglessness that death brings to our self-understanding, which is thickly entangled with our world of meaning, cannot be surmounted. Surmounting what is destined, whether the existential phenomenon of death or the cultural phenomenon of technological modernity, Heidegger points out, is similar to the way "one gets over grief or pain" (18: p 39). Accepting and understanding a phenomenon, and facing its reality are important for overcoming the impact and power it can have over us. As event, our own death is meaningless since we cannot surmount it, and experience its impact over us. What can be surmounted is the denial, anger, distress, and terror that surge up within us when we are faced with death. This is also a personal lesson that I have learned in living with multiple myeloma.

The modern ethical model of autonomy and truth-telling, however, is often said to be undesirable in the context of seemingly more non-individualistic cultures of countries such as India and Japan, where relatives frequently dissuade medical practitioners from revealing poor prognoses to patients (19). Some studies on India have suggested that psychiatric morbidity conditions like severe depression and anxiety disorders are significantly less among cancer patients who do not know they are terminally ill and consider their treatment as curative (20). This is said to be different in the western context where diagnostic information is seldom withheld. A study of 200 terminally ill cancer patients in such a context of complete prognostic awareness suggested that depression was in fact decidedly more common among those who were in a denial mode with respect to their prognosis (21). Importantly, this study concluded that there is no correlation between prognostic awareness and hopelessness. While emphasising that hope and a sense of dying could coexist, the study did not elaborate on what it meant by hope. However, in the context of living with prognostic awareness, hope can be taken to mean making meaningful existential projections without despondency and depression in the background of a non-deceptive awareness of one's impending death.

Of course, in the Heideggerian sense, there could not be a more authentic existence than this mode of living, even as life is coming to its close and is no more going to play host to dramatic existential episodes of authentic resolve. Being truthful in the face of death is the final act of authenticity that we can perform. Because to live is to continuously die, wane, and lose, because existential projections are always contingent upon the impotent, contingent ground of death, being in the face of death without deception is the soberest form of coming face-to-face with life itself. As the Lebanese-American poet Kahlil Gibran writes: "You would know the secret of death. But how shall you find it unless you seek it in the heart of life?" (22: p 50).

But is it true that people who have not fully experienced the modern ethics of autonomy cannot look death squarely in the eye, cannot live with prognostic awareness without depression and death anxiety? In the above-mentioned study of 200 terminally ill patients in the western context of complete divulgence of prognostic information, those who accept their prognosis are compared with those who deny it. But in studies on non-western contexts, where the general practice is to withhold prognostic information as in India, it is not fair to compare the few patients to whom prognosis is revealed with most others from whom it is withheld. Such an analysis does not take stock of the sudden cultural change experienced by patients. Depression and anxiety in such cases could be arising more from cultural shock than from prognostic information per se. As Heidegger points out, "[a]nything at all can be proved, depending only on what presuppositions are made" (17: p 220). The presupposition here is that prognostic information is a neutral piece of knowledge, which acts upon people universally in the same way: it traumatises the psychologically weak, infantile non-moderns but enhances the autonomous individuation of well-formed moderns. What distressed and devastated the Indian patients of Kasturba Medical College, Manipal (20) was probably the cultural shock of dealing with the sudden and matter-of-fact death-notice served to them by modern medical practice. Under such circumstances, a sound social science research practice could be to be attentive to the kind of death narratives available among the patient's cultural community, and the way people in general in that community deal with the deaths of others and with their own, when imminent death is more-or-less clearly known through various informal and familiar ways.

Whose life is precariously closer to death than that of the world's most disadvantaged people? In the World Bank's record of the views of the poor about their own condition, published in the year 2000, rural Sri Lankans reportedly said: "Joining the army means certain death… Poor boys join the army. After all, do any from the wealthy class ever join the army?" (23: p 257). Who can be more resigned and at the same time hopeful in the face of death than the believer in the principle of karma? Researchers sometimes adversely read pessimism and fatalism in the Indian patients' resigned attitude – that everything did not depend on them – through the lens of the modern principles of self-determination and self-assurance (24, 25). Others argue more favourably that karma determines only the background of human freedom – thrownness in existentialist terms which means for Heidegger the inescapable human condition of finding ourselves in a world that matters to us – but not freedom itself (26). And yet others plead that rather than the merely fatalistic account of karma, one could look at it as a perspective that brings in "a sense of containment rather than control" (27: p 190), which can be seen really as the antidote to the modern ethical perspective of autonomy and self-determination. If being in the face of death means living in the awareness of dying without deception and without losing hope – that is, able still to make meaningful existential projections – then, it is the adherents of the compatibilist interpretation of karma, who are better placed to face death in the eye, than those who abide by the modern ethical principle of self-determination. The contingency and precariousness of life is certainly more real to the non-moderns than to the moderns, who are driven by the ideals of autonomy and self-sufficiency. A terminal or even chronic debilitative condition or invalidism, and the purposelessness that could arise from such a condition, are likely to damage the sense of self-worth of the Americans more than the Indians because of their modernist beliefs in individual sovereignty and autonomy, personal industry and responsibility – all of which are values emanating from the Protestant Ethic (28).

Hence, the Indian's or any non-westerner's being in the face of death can be reliably known only from much more sensitive studies. Only strongly modernised Indians, for whom the medical culture of announcing the prognosis to the patient does not appear culturally strange and shocking, can be studied compatibly with westerners. For most Indians, who are terminally ill, the knowledge of their death usually enters their consciousness much more subtly – maybe from overhearing conversations among doctors, nurses or relatives; maybe from the downcast mood of family and friends; maybe from inadvertently stumbling upon medical reports. Or, maybe, from gentle and often indirect communication of the physician with patients in the presence of their close relatives (29). Once this knowledge seeps in gradually into their consciousness, being in the face of death as a natural part of living is often borne by them with resignation and grace, without having to stop making meaningful existential projections.

A straightforward and blunt death announcement ritual in medical profession is a specific disciplining tactic followed in western society. The appeal of this medical ritual in its original form has faded today both in its initial context and outside it, although the spirit of the practice has become acceptable everywhere, evoking varied culturally sensitive approaches to its practice. Non-patronising medical practices can themselves vary. Rejection of patronising approaches to medical practice does not give us the right to force decisions from patients when they are not in a position to decide for themselves due to their medical condition. Patients who come to know they are dying without the death-announcement ritual can still be treated without a patronising attitude in many ways. These ways are more important than the announcement itself, though knowing that one is dying is itself significant.

A moving anecdote of such informal and indirect manner of coming to know one's being in the face of death and coming to terms with it was narrated to me recently by a friend, who witnessed his brother's encounter with terminal lung cancer. Just after schooling, his brother Arun became addicted to alcohol and smoking. Later as a small-time contractor, he became the sole breadwinner of the family of five. He was very fond of his family, but did not believe in thrift and saving, taking pride in living life as it came. At the age of 38, Arun came to know that his days were numbered from the whispers of his brother to visiting relatives. Without knowing Arun's presence, they were conversing in hushed tones about his poor lung cancer prognosis, which the doctor had discussed with his brother. My friend became numb, but Arun took the news stoically. He had already got wind of it from the mood of his family. During the 74 days that he lived after knowing that he would not live more than six months, he visited everyone he loved; he asked his brother to drive him to places he wanted to visit with his kids. He spent time with his little girls, playing their games, visiting the temple daily with them, and telling them stories on the way and back, despite bouts of coughing. Arun died, taking care not to spread gloom around him and deeply aware of his mortality. His wife and parents said that Arun lived the best part of his life in his last 74 days.

Sharing the pain of dying

I now want to raise two critiques of the Heideggerian account of death in relation to the above discussion on truth-telling concerning terminal illness: the neo-Marxist critique that it could be seen as an ideological glorification of death, and the critique that the pangs of being in the face of death can be borne because it is sharable as opposed to Heidegger's rule that "*[n]o one can take the Other's dying away from him*" (5: p 284).

(i) The philosophy of being in the face of death and living one's dying is sometimes criticised as the "ideological exhortation to death" (30: p 126). According to the Neo-Marxist humanist, Herbert Marcuse, death is a brute biological phenomenon, which has no ontological and moral power over us. He accuses philosophy, right from Plato to Heidegger, of projecting death as a constant source of anxiety, individual authenticity, ideal of personal honour, sacrifice, and courage, and as the glorified ontological basis of existence that emboldens the oppressors of humanity to use the threat of death as the tool for domination. The ontology of finitude, Marcuse argues, works as "the taboo on unmitigated hope." Marcuse's emancipatory humanism takes the threat of death as a spoiler of the human goals of freedom and pleasure. His technological optimism asks for the surpassing of death to the extent possible and for making final biological death painless and powerless.

However, the goal of overcoming the biological necessity of death as we find in the ideologies of Marcuse, Marxists, other modernists and also in much of modern medicine, may be seen as "the culmination of modernity's attempt to deny the body and its limits" (31: p 203). The postmodernist philosopher Michel Foucault, therefore, sees the technological triumph over death as leading to the subjection of life "to precise controls and comprehensive regulations" (32: p 137).Hence, neither is there a total triumph over death for humanity as we know it, nor is technologisation of dying a meaningful way of encountering our mortality. Technoscience has made the human today a cyborg – part organism, part machine – as the philosopher Donna Haraway has argued. While the cyborg is a metaphor for the boundary-blurring emancipatory mixtures that the technological world makes possible, it also is a product of technological determinism, militarism, patriarchal capitalism, and the denial of death (33). In an interview Haraway emphasised the postmodern rejection of all soothing master narratives that negate the radical finitude of our existence and experience. This rejection, according to her, leads to "[s]ome deep, inescapable sense of the fragility of the lives that we're leading – that we really do die, that we really do wound each other, that the earth really is finite…" (34: p 20).

Modern medical practices increasingly become ways of letting us not encounter and accept our most intimate vulnerability of being in the face of death. Technologisation of dying has "dehumanising effects… on the experiences of people whose lives are ending" (35: p 137). Inordinate prolongation of vegetative life with the support of technical systems leads to considering death as a technical matter of failure of modern technology and technology itself as capable of defeating fate and finitude (36).

Most Indians like to allow the dying person to die peacefully rather than endure a vegetative and mechanically sustained life (37,38). Sudden and painful deaths are culturally considered inauspicious; similarly, technologically propped up survival without reasonable chances of revival is also considered inauspicious. Among Hindus, there is even the practice of the dying person refusing to drink or eat, and the family going through the agony of watching them passing away slowly. Several studies agree that believers in the theory of karma find it easier to accept their death than westerners who "think that they are in control of their destiny" (39,40).

Being in the face of death does not necessarily mean disbelief in the religious sense of afterlife. The two can go together. Heidegger insists that his discussion of death is purely this-worldly. Death is a point of discussion only inasmuch as it "enters into" human existence as a possibility of its being (5: p 292). Afterlife is a theological article of faith, not an aspect of experience and knowledge. According to Heidegger, human finitude is dependent upon the temporal boundary of existential projections, which is death, and humans are capable of being in the face of death. This is why Jeff Malpas argues that an endlessly continuing life or immortality cannot be a single life but "a succession of lives" (41: p 120), as aptly conceived in the Indic notion of rebirth. The Judeo-Christian notion of life after death, too, has to be a qualitatively different life, which needs a separate principle of unity that is beyond human conceptualisation. Each life, as far as our knowledge of it goes, has to achieve its own focus and wholeness in order for it to be meaningful. It achieves unity and purpose by embracing a world of meaning, a sense of value, and "a grasp of the possibility of its own ending" (41: p 120). A concept of immortality as a timelessly extended single life cannot explain the concept of identity and selfhood. Hence, being in the face of death means experiencing the pain and trauma of dying in the awareness that death as the end of one's being in the present world of experience is imminent. What defeats being in the face of death is the disavowal of the impending closure of this-worldly existence. Even for a believer in afterlife, death is painful not mainly because bodily pain can accompany it, but because it brings about a definitive closure to one's world of meaning, and with it, one's being as one has known it. Being in the face of death without the termination of meaningful existential projection is a possibility, whether one believes in afterlife as many do in India, or in the impossibility of it as many do in the west.

(ii) Heidegger's conclusion that being in the face of death is unsharable seems to contradict his own philosophical insights and our experience, especially in non-individualistic cultures as in India. He emphasises that individuation or the attainment of authenticity does not isolate humans from their socially mediated sense of who they are (5: pp 224,344). However, he also stresses that all that can be shared about death is its absolute but indefinite certainty. He considers all other talk about death as inauthentic. That is, although human existence is constitutively social, its most certain and unsurpassable possibility – being in the face of death – is non-relational or asocial. That is why Marc Crépon remarks that if Heidegger remembers his own argument that humans are essentially being with others (social), he would not have concluded that dying is unshareable. Rather, he would have concluded that death marks the absolute limit of what humans can share. Crépon proposes that death as "the ultimate sharable" makes possible the existential mode of being for the other person and being against death "in opposing death, in uniting against it, in suffering its proximity collectively" (42: p 24).

The modern philosophical idea of the self as inscrutable interiority, which no one but oneself can have access to, came to be rejected in the second half of the twentieth century. Although abstract individualism is the philosophy that grounds modernity and its institutions, this philosophy of the self came to be punctured in the twentieth century by the insightful understandings of the way the self is constituted by social mediation. Despite being an important contributor to this transformation of our understanding of the human self, Heidegger still argued that the only absolutely individualising and non-relational experience for humans is being in the face of death. However, as the transformable and open way of being, the suffering self, which encounters its own death, is still social and open to others. Compassionate human company can both relieve the burden of dying and help accept death as inherent to living.

Sharing the pain of dying is an important aspect of many Indian contexts of terminal illness. This was the finding in a study of 68 Indian cancer patients (43). While resources and knowledge constraints impeded their treatment, the enabling factor was the support they received from their family and friends. A study of Taiwanese breast cancer patients also reported similar findings (44). The Indian sociologist, TN Madan, argues that modern medical practices sometimes take away both freedom and dignity of the dying person through excessive medicalisation of dying and disconnecting patients from their family and friends, which can be corrected by recognising alternative perspectives (45). He quotes the example of the Gandhian Vinoba Bhave, who refused treatment and nourishment after suffering a heart attack at the age of 87, and chose to die among his disciples in his ashram. There is also the Jain notion of Santhara. In an interesting comparative study of dying cancer patients in Kenya and Scotland, the research group found that despite the availability of resources in Scotland "the community may no longer have the capacity, or the belief in itself, to care for dying people and to cope with death" (46: p 370). Among Kenyan patients, on the other hand, they found that satisfactory levels of pain relief, dignity, privacy, nourishment, care, and medical technology were absent, but nonetheless, the fear of dying, anger, and alienation of the dying person were also absent. They received hope and support from their social circle. The researchers suggested that western medicine could learn the need to empower patients, families, and communities "to accommodate the distress of the dying" (46: p 370), just as the Kenyan medical system needed urgent improvements in medical technology and resources.

Conclusion: contextual medical decision-making

I end with a few concluding remarks. First of all, despite the above discussion on culturally contextualising the knowledge of being in the face of death, it is not helpful for medical practice to imagine culture in a rigid and fixed fashion because such view of culture is untrue. There is, for example, no monolithic Indian culture. This is not only because India is a curious amalgam of linguistic and religious identities, and caste and ethnic communities with distinctive cultures, histories, memories, and loyalties. As the philosopher Don Ihde argues, our postmodern technologically mediated world is shaped by pluriculturality (47). We are not merely multicultural nations with different cultural communities, co-existing in their separateness. Technologies such as television, internet, photography, mobile phones, and cinema bring distant and totally different worlds into our own, which gradually impinge on us and shape our world, transforming themselves as well in the process. Our worlds have become like our fusion music. Moreover, any aspect of the ways in which people around us experience their being in the face of death in India might be true of others elsewhere. Our discussions of contextualising medical approaches do not claim uniqueness for these contexts. Rather, they only claim that insightful contextualisation can make medical practice effective and humane. The possibility to change and adapt new practices of caring for the dying are not thereby ruled out. The argument is merely that new practices should always be contextualised.

Secondly, contextual medical decision-making cannot always be strictly and narrowly rule-bound by ethical or legal code. David Morris, an important scholar of medical humanities, argues that medical practice cannot be bound wholly by medical logos or the familiar rationality-based medical norms. He proposes that medical practice can be enriched by the notion of medical eros– many ways of expressing desire and emotion in the context of medicine, illness, pain, and death. He quotes the example of Dr Morton's dilemma in the biographical movie, *The Great Moment* (1944). If he divulged the composition of the anaesthetic agent letheon to his colleague, he would be relinquishing his gains from patenting it. If he conducted the surgery on the young woman patient in front of him using the anesthetic to relieve her pain, he would be going against the prevailing law. He finally decided to do both. "It is a decision in which medical eros in effect affirms the spirit of the law, while medical logos persists in blind, self-interested adherence to the letter. It is not entirely a happy ending. We already know that Morton's brave and lonely act of moral heroism will also entail the defeat of all his worldly hopes" (48: p 157). The medical practitioner's contextualised decisions discussed in this paper also benefit from an approach of balancing medical logos and medical eros. Life is enmeshed in spaces of illegality as the philosopher Foucault contends (49). These need not only be spaces for sabotaging the law, but could also be serious spaces of moral experiment for medical practitioners, who aim at conscientious defeat of medical logos in the face of the dilemmas presented by medical eros.

Thirdly, I want to return to the question of the necessity to tell terminally ill persons, especially from cultures where blunt truth-telling is not the norm, the truth about their condition. I have argued that patients should be sensitively and contextually made aware of their condition because it is the final opportunity they have to authentically own up their mortality, which indeed constitutes the ontological structure of existence even otherwise. Camilla Zimmermann suggests from a Foucauldian perspective that helping patients to participate in a certain way of dying – the acceptance of their mortality – is a positive and productive exercise of medical power to discipline and educate them (50). I have argued also that when terminally ill persons have the time, medical practitioners can more effectively use contextually sensitive and compassionate ways of helping them accept their mortality in contexts like that of India, where individualism and scientism have not still permeated enough culturally to make persons feel worthless and unfree in the face of death. The possibility of sharing the pain of being in the face of death with others and refusing the technologisation of dying are positive contextual features in this regard.

Lastly, although several thorny issues of medical ethics like passive and active euthanasia, and assisted dying are left unexplored in this paper, its critique of the technologisation of dying does support passive euthanasia or withdrawing treatment, which can hasten the death of terminally ill patients, as in the well-known case of Aruna Shanbaug, who survived in a persistent vegetative state for 42 years (51: p 32). The cultural context of the ideology of voluntary acceptance of death towards the end of one's life and the disavowal of the technologisation of dying according to the principles of the major Indic religions, in my view, supports passive euthanasia in fitting cases. A separate set of deeply problematic philosophical considerations are required to assess the ethical merit of the case of active euthanasia and assisted dying.

Note: *[1] For Heidegger the term "thrownness" stands for the inescapable human condition of finding themselves in a world that matters to them*

References

1. Kierkegaard S. *Concluding unscientific manuscript*. Hannay A (editor & translator). Cambridge: Cambridge University Press; 2009.
2. Tolstoy L. *The death of Ivan Ilyich and other stories*. London: Penguin; 2008.
3. Kübler-Ross E. *On death and dying: what the dying have to teach doctors, nurses, clergy and their own families*, 40th anniversary edition. Abingdon: Routledge; 2009.
4. Leman-Stefanovic I. *The event of death: a phenomenological enquiry*. Dordrecht: Martinus Nijhoff; 1987.
5. Heidegger M. *Being and time*. Macquarrie J, Robinson E (translators). London: Blackwell; 1962.
6. Shelley PB. *Prometheus unbound: a lyrical drama in four acts, with other poems.* Cambridge: Cambridge University Press; 2013.
7. George SK. Wellness in illness. *Samyukta: J Women's Studies*. 2011;XI(2):49–65.
8. Taylor C. *Sources of the self: the making of the modern identity*. Cambridge, MA: Harvard University Press; 1989.
9. George SK. The familiar stranger: on the loss of self in intense bodily pain. In: George SK, Jung PG (eds). *Cultural ontology of the self in pain*. New Delhi: Springer; 2016, p 51–74.
10. Arendt H. *The human condition*. Chicago: The University of Chicago Press; 1958.
11. Beauchamp TL, Childress JF. *Principles of biomedical ethics*.7th ed. Oxford: Oxford University Press; 2012.
12. Kling S. Truth telling in clinical practice: is it ever ok to lie to patients? *Current Allergy & Clinical Immunology*. 2012;25(1):34–36.
13. Edwin AK. Don't lie but don't tell the whole truth: the therapeutic privilege – is it ever justified? *Ghana Med J*. 2008;42(4):156–61.
14. Collis E, Seelman KE. Do patients need to know they are terminally ill? Yes. *BMJ*. 2013;346:f2589. doi: 10.1136/bmj.f2589.
15. Blackhall LJ. Do patients need to know they are terminally ill? No. *BMJ*. 2013;346:f2560.doi: 10.1136/bmj.f2560.
16. Russon J. Self and suffering in Buddhism and phenomenology: existential pain, compassion and the problems of institutional healthcare. In: George SK, Jung PG (eds). *Cultural ontology of the self in pain*. New Delhi: Springer; 2016, p 181–95.
17. Heidegger M. *Poetry, language, thought.* Hofstadter A (translator). New York: Harper & Row; 1971.
18. Heidegger M. *The question concerning technology and other essays*. Lovitt W (translator). New York: Harper & Row; 1977.
19. Applebaum AJ, Kolva EA, Kulikowski JR, Jacobs JD, DeRosa A, Lichtenthal WG, Olden ME, Rosenfeld B, Breitbart W. Conceptualizing prognostic awareness in advanced cancer: a systematic review. *J Health Psychol*. 2014;19(9):1103–19. doi: 10.1177/1359105313484782.
20. Alexander PJ, Dinesh N, Vidyasagar MS. Psychiatric morbidity among cancer patients and its relationship with awareness of illness and expectations about treatment outcome. *Acta Oncol*. 1993;32(6):623–6.
21. Chochinov, HM, Tataryn DJ, Wilson KG, Enns M, Lander S. Prognostic awareness and the terminally ill. *Psychosomatics*. 2000;41(6):500–4.
22. Gibran K. *The prophet*. Hertfordshire: Wordsworth; 1996.
23. Narayan D, Chambers R, Shah MK, Petesch P. *Voices of the poor: crying out for change*. New York: Oxford University Press; 2000.
24. Ejaz FK. Self-determination: lessons to be learned from social work practice in India. *Br J Social Wk*. 1991;21(2):127–42.
25. Kishore J, Ahmad I, Kaur R, Mohanta PK. Beliefs and perceptions about cancers among patients attending radiotherapy OPD in Delhi, India. *Asian Pac J Cancer Prev*. 2008;9(1):155–8.
26. Wadia AR. Philosophical implications of the doctrine of karma. *Philosophy East and West*. 1965;15(2):145–52.
27. Bhaduri R. Self-determination: lessons to be learned from social work practice in India: a comment. *Br J Social Wk*. 1992;22(2):187–91.
28. Charmaz K. Loss of self: a fundamental form of suffering in the chronically ill. *Sociol Health Illn*.1983;5(2):168–95.
29. Chaturvedi SK, Loiselle CG, Chandra PS. Communication with relatives and collusion in palliative care: a cross-cultural perspective. *Indian J Palliative Care*. 2009;15(1):2–9.
30. Marcuse H. *Philosophy, psychoanalysis and emancipation. Collected papers of Herbert Marcuse, Vol. 5.* Kellner D, Pierce C (eds). Abingdon: Routledge; 2011.
31. Tierney TF. *The value of convenience: a genealogy of technical culture*. New York: State University of New York Press; 1993.
32. Foucault M. *The history of sexuality, Vol. 1: an introduction*. Hurley R (translator). New York: Pantheon Books; 1978.
33. Haraway DJ. *Simians, cyborgs, and women: the reinvention of nature*. New York: Routledge; 1991.
34. Penley C, Ross A, Haraway DJ. Cyborgs at large: interview with Donna Haraway. *Social Text*. 1990;25/26:8–23. doi: 10.2307/466237.
35. Benoliel JQ, Degner LF. Institutional dying: a convergence of cultural values, technology, and social organization. In: Wass H, Neimeyer RA (eds). *Dying: facing the fact*.3rd ed. Washington: Taylor & Francis; 1995, p. 117- 41.
36. Cassell EJ. Dying in a technological society. *Stud Hastings Cent*. 1974;2(2):31–6.
37. Desai PN. Medical ethics in India. *J Med Philos*. 1988;13(3):231–55.
38. Thrane S. Hindu end of life: death, dying, suffering, and karma. *J Hospice Palliative Nursing.* 2010;12(6):337–42.
39. Gupta R. Death beliefs and practices from an Asian Indian American Hindu perspective. *Death Stud*. 2011;35(3):244–66.
40. Laungani P. Death and bereavement in India and England: a comparative

analysis. *Mortality*. 1996;1:191–2012.
41. Malpas J. Death and the unity of a life. In: Malpas J, Solomon RC (eds). *Death and philosophy*. London: Routledge; 1998, p 108–20.
42. Crépon M. *The thought of death and the memory of war*. Loriaux M (translator). Minneapolis: University of Minnesota Press; 2013.
43. Sanghamitra P, Hussain MA, Chauhan AS, Mallick D, Nayak S. Patient navigation pathway and barriers to treatment seeking in cancer in India: a qualitative inquiry. *Cancer Epidemiol*. 2013;37(6):973–8. doi: 10.1016/j.canep.2013.09.018.
44. Lu MH, Lin HR, Lee MD. The experiences among older Taiwanese women facing a new diagnosis of breast cancer. *Cancer Nurs*. 2010;33(5):398–405. doi: 10.1097/NCC.0b013e3181d72c45.
45. Madan TN. Dying with dignity. *Soc Sci Med*. 1992;35(4):425–32.
46. Murray SA, Grant E, Grant A, Kendall M. Dying from cancer in developed and developing countries: lessons from two qualitative interview studies of patients and their carers. *BMJ*. 2003;326(7385):368.
47. Ihde D. Technology and the lifeworld: from garden to earth. Bloomington: Indiana University Press; 1990.
48. Morris DB. The infinite faces of pain: narrative, eros, and ethics. In: George SK, Jung PG (eds). *Cultural ontology of the self in pain*. New Delhi: Springer; 2016, p 139–64.
49. Foucault M. *Discipline and punish: the birth of the prison*. Sheridan A (translator). New York: Vintage; 1977.
50. Zimmermann C. Acceptance of dying: a discourse analysis of palliative care literature. *Soc Sci Med*. 2012;75(1):217–24.
51. Gursahani R, Mani RK. India: not a country to die in. *Indian J Med Ethics*. 2016;13(1):30–5.

Ethical attitudes of nursing students at Shahid Beheshti University of Medical Sciences, Iran

SOOLMAZ MOOSAVI, FARIBA BORHANI, MOHADDESEH MOHSENPOUR

Abstract

Introduction: *An ethical attitude denotes motivation and commitment in practice and is an important aspect of human communication. Values guide the efforts of human beings towards helping those in need, and an ethical attitude revives values and turns them into action. As a result, an ethical attitude and a sense of responsibility have direct effects on ethical action and ultimately, on the outcome of patient care.*

Method: *This descriptive cross-sectional study was conducted over a four-month period in 2014 to assess the ethical attitude of nursing students at Shahid Beheshti University of Medical Sciences. All the third-year and senior nursing students were selected through census sampling. They were requested to complete Ruth Elder's (6) ethical attitude questionnaire. The data obtained were analysed in SPSS-18.*

Results: *A total of 257 nursing students participated in the study. The mean (±SD) of the participants' ethical attitude was 0.95±0.45, with the total mean ranging from -2 to +2. There was a significant relationship between the morality dimension of ethical attitude and gender, with the mean obtained in the former being greater for female than male students ($p<0.05$ and $t=8.45$).*

Conclusion: *Educational institutions should take the emotional attributes of students into consideration and foster positive emotions in them, since attitudes affect the students' future relationships and performance. University curricula should aim to simultaneously develop ethical intentions and actions in nursing students.*

Authors: **Soolmaz Moosavi** (moosavi.soolmaz@yahoo.com) PhD student of Nursing, Medical Ethics and Law Research Center, Shahid Beheshti University of Medical Sciences, Valiasr Street, Tehran, IRAN; **Fariba Borhani** (faribaborhani@msn.com), Associate Professor, School of Nursing and Midwifery, Medical Ethics and Law Research Center, Shahid Beheshti University of Medical Sciences, Valiasr Street, Tehran, IRAN; **Mohaddeseh Mohsenpour** (corresponding author – mohsenpour_m81@yahoo.com), Assistant Professor, Department of Nursing, University of Social Welfare and Rehabilitation Sciences, Tehran, Iran.

To cite: Moosavi S, Borhani F, Mohsenpour M. Ethical attitude of nursing students at Shahid Beheshti University of Medical Sciences. *Indian J Med Ethics*. 2017 Jan-Mar;2(1)NS:14-20.

Published online on September 7, 2016

© *Indian Journal of Medical Ethics* 2016

Introduction

An attitude is a combination of beliefs and emotions, and a mental and nervous preparation which is organised through experience and which prepares the individual to perceive different people, objects, and groups in either a positive or negative light (1). An ethical attitude denotes motivation and commitment in practice and the capacity to respond to others. It is considered a significant aspect of human communication. Although it entails following the formal codes of professional ethics, an ethical attitude is more complicated than merely abiding by rules and ethical codes. An ethical attitude is important because rules and regulations alone cannot respond to challenging ethical predicaments. An ethical attitude can help find solutions to such predicaments and enable students to support patients under critical conditions (2-5).

The concept of patient care extends far beyond performing a series of procedures and following repetitive routine instructions to satisfy a set of needs. The patients and community expect nurses to display ethical and emotional attitudes, such as moral values, intimacy, empathy and connectedness, and ultimately, ethical performance (5-6).

As a symbol that indicates health sciences students' and health personnel's manner of dealing with the ethical aspect of patient care, an ethical attitude plays a significant role in creating a sense of accountability, altruism, respect and commitment towards the patient, and ultimately dictates ethical performance and the quality of patient care (5, 7-8).