We can make our minds so like still waters that beings gather about us that they may see, it may be, their own images, and so live for a moment with a clearer, perhaps even with a fiercer life because of our quiet.

—W.B. Yeats, 1883

Presence has received significant attention in the nursing literature over the past several decades, but it remains difficult to translate into a meaningful paradigm for clinicians. Presence has been described as invisible and indivisible (Gilje, 1992), existential in scope (Doona, Haggerty, & Chase, 1997), “a moment of encounter that requires a lifetime of preparation” (Younger, 1995, p. 66), the most demanding aspect of caring (Davis, 1981), and having the power to “create order out of chaos” (McKeverg & Day, 1998, p. 96). Oncology practitioners understand that presence is essential to meaningful care (Block, 2001; King, 2001; Stanley, 2000). Patients with cancer recognize and value nursing presence across the illness continuum, but its significance increases as patients encounter the limits of treatment, face the realities of dying, and seek meaning in their lived experiences. If oncology nurses are to communicate the value of presence to healthcare systems that increasingly limit nursing time with patients, its meaning and worth must be understood. The purpose of this lecture is to review basic assumptions regarding the paradigm of nursing presence so that nurses may improve clinical practice and enhance patients’ experiences at the end of life.

As members of the Oncology Nursing Society, we should take great pride in the fact that we are addressing nursing presence. The selection of this topic for the Mara Mogensen Flaherty Memorial Lecture validates its significance and consequence. It emphasizes that nurses value the individual often found trembling behind this illness called cancer and reminds us that nurses will search for and within the patient until he or she is found, validated, and comforted. Today, we will briefly examine the meaning of suffering as it relates to the cancer experience, review some basic assumptions regarding the paradigm of nursing presence, and consider narratives that illustrate the experience of nursing presence.

Suffering and the Cancer Experience

The Nature of Suffering

Suffering has been described as the perception of impending destruction that extends beyond the physical and is connected to an experience that threatens a person’s sense of wholeness (Cassell, 1982). It has been further portrayed as an amendment of the self, a loss of one’s personhood and central purpose, and disclosure of an existence that no longer lays claim to control (Cassell; Ferrell, 1998; Stanley, 2000; Stoller-man, 1997; Younger, 1995). Suffering can devastate one’s ability to communicate when words that give meaning to experiences cannot be found. This silence broadens the chasm between those who suffer and those who do not know how or are afraid to enter that experience.

A Diagnosis of Cancer

Cancer amends peoples’ perspectives on the past, the present, and the future. Characterized by uncertainty and fear, patients describe feelings of anxiety, anger, depression, loss of control, helplessness, vulnerability, shame, qualms regarding dependence on others, and loss of dignity. Remen (1996) described cancer as an isolating experience, one of separation and loneliness.

The Progression of Illness

If cancer is unresponsive to treatment or recurs, a patient’s sense of an intact persona diminishes and distress (i.e., feelings of hopelessness or fatalism, futility, meaninglessness, sense of loss, unresolved grief, and fear of death) assumes an increasingly existential perspective. These inescapable feelings trigger attempts to integrate one’s personal world into a larger whole that provides meaning and solace.

Abandonment

People with a terminal illness frequently are allowed to fade from the line of vision of family members, friends, and society. The Western world has a high regard for youth and health, and these values separate the well from the sick. A curative medical model that negates hope when cure is impossible compounds this isolation. Physicians may abandon patients when no further curative treatment is available or when patients refuse further treatment, decline entrance into clinical trials, or choose alternative therapies. Remen (1996) likened these healthcare professionals to those who sit in the front row of life.