George McCormick is a 64-year-old man with widely metastasized cancer. His comorbidities include Parkinson disease, and he previously had a 3-vessel coronary artery bypass graft. He was brought by ambulance to the emergency department 5 days ago after an episode of syncope. George, lying in a bed in the intensive care unit, appears cachectic, tired, and slightly jaundiced. He has lost 30 pounds over the past 4 months. His appetite has been poor, and the tasks of shopping for and preparing food have been increasingly challenging. George lives alone and has no family in the area.

Over the course of the day, George’s blood pressure has decreased, and he is nearly anuric. A fluid challenge was administered, but his hemodynamics and urine output have not improved. The team, anticipating vasopressor and continuous renal replacement therapy, places a central catheter. George is increasingly short of breath; a chest x-ray shows enlarging pleural effusions. George refuses noninvasive positive pressure ventilation, and a high-flow nasal cannula is put in place. A thoracic surgeon is consulted regarding thoracentesis versus chest tube placement. George wants to know when he can have more chemotherapy.

“Why are we doing this?” someone asks.

The Current Narrative

George is dying. Cancer will eventually claim his life, and that moment looms close. How close? Could the proposed plan of care see George through the immediate crisis? If so, are we just buying time? If not, are we just compounding George’s suffering? Is this the best use of critical care resources and expertise?

As a patient’s illness worsens, the critical care response becomes more aggressive in order to regulate or replace failing physiologic functions. Clinicians may feel caught on an increasingly slippery slope. It seems as though the patient for whom we have a duty to care is being exposed to greater burdens...
without a reasonable expectation of receiving the benefits that therapies are intended to provide. Core ethical principles of non-maleficence, beneficence, and justice seem to be compromised. A natural and appropriate response under such circumstances is to inquire, “Why are we doing this?” Depending on the tone of the question, we might legitimately be attempting to understand the rationale for the treatment plan. The question may also reflect clinicians’ attempts to create a coherent narrative about their work, their patients, and themselves. This question arises so frequently, however, that it may answer itself, reinforcing a sense of futility and helplessness.

Although the current narrative highlights typical ethical conflicts that occur in critical care, repeating the lament “Why are we doing this?” does little to relieve the distress and despair many critical care clinicians experience. Our current narrative risks leaving us stuck in the distress without a way forward. Feeling victimized, we may inadvertently disempower ourselves and our colleagues through negativity, anger, or unregulated moral outrage. Consider the language we use. Aggressive treatment is a term that describes what we provide to our patients. The narrative around cardiopulmonary resuscitation is described with words and phrases such as “painful,” “die a horrible death,” “break ribs,” “punctured lungs,” and “jump on his chest,” emphasizing the violence of the act. We use the term second victim to describe ourselves. In doing so, we reinforce narratives of harm and powerlessness. We frame our efforts in terms of our heroic attempts to sustain life and forestall death. When those efforts to rescue are ineffective, or when we believe we are using our skills in ways that are unjustified, we perceive that we have failed.

At the same time, we are reinforcing neuropathways associated with basic survival instincts that prepare us to respond to threats. Typical fight, flight, or freeze responses are activated. When our nervous system is hyper-aroused, we are more likely to react, become inflexible, and judge others. Less engagement of the neocortex can impair our communication and decision-making. The distress associated with the question “Why are we doing this?” manifests in the clinical interactions we have with team members and with patients and their families. Our ability to listen, discern, and flexibly respond is compromised. But not all critical care clinicians experience ethical conflicts the same way. What allows some critical care clinicians to respond to these inevitable ethical challenges without the pervasive despair associated with moral distress?

How might teams and individual clinicians move beyond this kind of helplessness to discover morally empowering responses to the question, “Why are we doing this?” For example, even when we do our best and make a choice to prioritize one ethical value above another, a moral remainder (or residue) of weighty unmet obligations remains. When we act against our conscience, the remainder may result in a cascade of moral suffering, including moral distress or injury, with all the sequelae that entails. Even when we feel as though we have little or no impact on the events, timeline, or persons involved in a narrative we perceive as morally threatening, we can restore moral agency by intentionally choosing our response. What moral remainder would we be willing and able to carry in this situation as a reflection of our deepest values? The answer may provide a way forward that preserves our integrity.

Shifting the Narrative

George has been living alone since his wife died 8 years ago. Although he had to retire this year because of his health, he still enjoys weekly poker nights with his former coworkers. Until recently he had maintained the activity regimen his cardiologist prescribed after George had a myocardial infarction. George’s daughter is expecting her third child in a few weeks. As George’s liver and kidney function worsen and his breathing becomes more tenuous, his opioid regimen is scaled back because of concerns for respiratory depression. George cannot get comfortable in the bed and is restless and irritable. His nurse advocates for him during afternoon rounds: “What about a palliative care consult? Maybe we can improve his symptoms and address goals of care?” The response: “We’re not there yet. I mean … he’s still full code. We’ll see how the next few days go.”

During the night, George speaks with his nurse about his situation. He knows he is dying. He expresses fear: “I’m at the mercy of this cancer. It’s not like having
heart trouble where you can eat well, try to take better care of yourself—maybe it works and maybe not, but you are doing something. I don’t want to die, but I know it’s going to happen anyway.”

When his nurse asks what might ease his mind or give him strength during this time, he says, “My wife. She did this 8 years back. So, I know it can be done.”

George and his nurse talk about what his wife’s death was like and what he might want for his own last day. “I want to go out in a blaze of glory!” he says. George tells the nurse that it gives him great comfort to imagine that, at the end, a code will be called and crowds of people will rush to his rescue. “I can go in peace knowing you folks are there.”

The next night, George’s heart stops.

The ethical conflicts we encounter during clinical practice sometimes cannot be resolved. George’s heart stopped before additional consultations or discussions could occur. Action must be taken. As already noted, when trying to steer people away from cardiopulmonary resuscitation, clinicians traditionally describe it as violent—a long way from “do no harm.” A clinician providing such an intervention might feel deeply conflicted or experience moral distress when its intended outcome seems unattainable. Likewise, a clinician may feel sadness, regret, and grief.8 Entering into these moments with patient after patient requires letting go of the expectation that such experiences will not hurt us or and those we serve. Our eyes tear up and our hearts break because despite our best efforts we cannot modify some aspects of the situation. If we were only technicians, adjusting machines and titrating infusions, we could take comfort in knowing that our patient has ideal tidal volumes and perfect blood pressure. That is not, however, how we experience our vocation, and so we feel the hurt and ask the tough questions in order to examine our ethical obligations, to question the wisdom of a decision or treatment plan, or to attempt to create meaning out of dissonance.9

Our narratives document our experiences and illuminate the assumptions and values that are important to us. Benner10 notes that “narrative accounts uncover meanings and feelings in ways that shed light on the contextual, relational, and configurational knowledge lived out in the practice.” They are vehicles for making sense of the extraordinary experiences inherent in clinical practice and integrating them into the greater landscape of our lives. Narrative creation is often retrospective; it occurs in stories shared among colleagues or in the journals kept by nursing students, for example. By selecting what aspects of a situation to carry forward and in what context we place them, we craft the lesson conveyed to the listener and to ourselves. Narrative can also be created in the moment by selectively attending to or discounting data and eliciting new information and understanding. The description of George that begins this article contains a typical narrative conveyed in bedside reports or during rounds. It feels familiar, with a predictably distressing end for all concerned. Reading it, one might recall similar situations and experience physical tension or feelings of frustration. The second installment of George’s story places the current acute episode within a lived context. As we gain a sense of his life, his hopes and fears, he becomes an individual for whom we can feel compassion.

Why are we doing this? Shifting the narrative means we have the opportunity to see things anew—to examine what else might be true in the situation we are embroiled in and to engage our moral imagination to uncover a path that preserves integrity despite the apparent incongruence and dissonance. We might begin by discerning how others involved in the situation might answer the question. How do the patient, their family, practitioners in various disciplines, or organizational leaders see the case? Where are we aligned and where are we not? Even when different parties share a core value, the ways they enact it may conflict. Like George, a patient may see each moment of life as precious and therefore elect an intervention that a clinician—grounded in the same respect for life—might see as devoid of meaning. Similarly, clinicians may believe their duty to care requires continuing a course of treatment that a family member, with a similar obligation, declines on the patient’s behalf. Instead of each intensifying their efforts to bring about potentially conflicting outcomes, we can recognize the limits of our singular vision and allow other perspectives to inform our moral reasoning. For instance, a family member may advocate for and bear witness to resuscitation—even
when success is unlikely—as an expression of fidelity to their own perceived moral duty to the patient. Such a family member might carry forward into their time of grief various moral remainders:

- “I spoke up for my dad when he could not speak for himself, even though I disagreed with him.”
- “My words mattered to his caregivers.”
- “I set aside what was familiar and comfortable to me in order to do what he wanted.”

Even in the absence of clinical benefit, healing may come.

As the discernment process identifies important values and new perspectives, alternative courses of action may emerge. A risk at this stage is that habitual responses may shift us back into the old narrative: “Yes, but if we can just get the family to…” We can acknowledge that impulse without indulging it. Instead, we might suspend our own expectations regarding the outcome. In doing so, we do not abdicate our responsibility for clinical judgment and moral reasoning. We remain firmly grounded in our intention to serve and by the core values identified earlier in the discernment process. These values include, for example, the imperatives not to harm and to do good. We are releasing attachment to a particular outcome as validation of our moral reasoning. George going home in hospice care, as opposed to dying in the intensive care unit, does not retroactively justify or discount the team’s approach or their values.

What key data points are we missing? Feeling pressured, we may draw on previous similar experiences and use those as shorthand for the present experience. Incorporating what we have learned from relevant precedents can be useful in thinking through alternate courses of action; we know, or imagine we know, the results of the previous choice. However, if we bring to bear unexamined moral distress, residue, or injury, we blind ourselves to salient features of this situation. Initially, George’s question regarding more chemotherapy may have triggered assumptions, based on past similar experiences, that George expects further curative treatments with an outcome of discharge to home. The late-night conversation between George and his nurse shifted the narrative from that clinical archetype to the story of this particular patient. As a moral agent within this new context, how might the nurse respond? What actions embody respect, no harm, and service? How do we enlarge our sphere of empathy to include, rather than exclude, others involved? How do we find the path of integrity in the midst of moral complexity?

A New Narrative

George’s nurse is at his bedside when his heart stops. George’s words—“I want to go out in a blaze of glory!”—hang in the room as she hits the code button. The code team runs in, drugs and devices are prepped with the usual cacophony of instructions and confirmations, and his nurse is on the bed performing cardiopulmonary resuscitation. With each compression, she prays for George:

- May you be free from suffering.
- May you be at peace.
- May you be held in safety.
- May you live and die with ease.

At the end of the code, George is pronounced dead and the team filters out. Eventually, George and his nurse are alone again. She sits at his side in silence and then offers an apology for any part of his dying that was frightening or hurtful, and she expresses her gratitude for their time together.

The nurse in this situation found a course of action that preserved integrity. The following moral remainders were carried forward:

- She showed respect for George as a person by taking time to listen to what was on his mind. She upheld the first provision of her code of ethics: to treat every person with respect and dignity regardless of any unique characteristics.¹¹
- She honored his dignity by caring for him in a way that reflected what mattered to him, even when it was contrary to what the nurse believed was justified.
- She was part of a team working together to honor George’s dying wish.
- She participated directly by performing cardiopulmonary resuscitation without expecting that it would have clinical benefit, but rather with the intent of offering George what he said he needed in order to “go in peace.”
- She provided spiritual support during and after his death, upholding the value of beneficence.
• Recognizing that the team’s actions on George’s behalf may have caused distress that George had not foreseen when imagining his death, she accepted responsibility for her part.

When she stood in her moral agency, the disempowerment that produces moral distress was absent. Her actions manifested respect for a value she and George shared: the preciousness of a human life. That shared value might generate different preferences for how life should end; this nurse might have chosen hospice care for herself, whereas George requested resuscitation. Pausing to differentiate preferences from values defused potential ethical conflict, and a new course of action emerged. Instead of continuing the narrative of disempowerment and despair, the nurse was able to create a new one. Such a new narrative does not merely overlook or deny the ethical tensions in the case, it finds the integrity in the midst of complexity. This nurse was able to release the grip of the dilemma by reframing her ethical obligations in ways that did not abandon what mattered most to her and by creating a ritual that allowed her to release the detrimental aspects of the moral remainder. Integrity sometimes requires us to fiercely defend our values and at other times to release the tension created by the dilemma in the service of a higher good. By engaging our moral efficacy, self-regulating, and grounding our actions in integrity, we are able to increase our moral resilience.12

Building our own moral resilience is an important aspect of creating a culture of integrity-preserving ethical practice; alone, it is insufficient to sustain persons in the midst of ethically challenging situations (or in the midst of moral adversity).13 Individual work must occur in parallel with organizational discernment. What patterns underlie ethical challenges? An organization must identify system attributes that positively and negatively affect ethical practice and clinician integrity. Once known, these processes, policies, and relationships can be redesigned to address gaps. Clinical criteria that trigger this type of inquiry, systems that monitor the ethical climate of the organization, and robust ethics infrastructures are needed to cultivate a culture that expects and rewards ethical behavior and action.14 Developing system-wide structures such as nurse-led ethics champion programs can empower nurses on the front lines to recognize, address, and learn from ethically troubling cases.15 Applying routine processes such as “the pause” intentionally shifts the focus away from the perceived ineffectiveness and despair that accompany a failed resuscitation attempt and toward honoring the person whose life just ended and the team’s best effort on that person’s behalf. “The pause” or similar processes can create a moment of connection to that person and among team members, and it has the potential to transform the narrative and the moral remainder in integrity-preserving ways. The tools we use to communicate what our patients are going through—rounds, handoffs, and reports—can incorporate their hopes and values alongside their laboratory test results. When such processes as the one below become routine, they become leverage for culture change.

Create a Pause Process With a Trusted Colleague

1. Notice when the typical narrative about ethically challenging cases arises. For example, notice when you or others ask, “Why are we doing this?” Allow it to be the catalyst for inquiry rather than repeating it without reflection.

2. Identify a coworker with whom you can partner and investigate alternative approaches to this kind of ethically challenging case.Pause to write the story in as much detail as you can. Allow yourself to receive whatever needs to be witnessed. Notice without judgment aspects of the case that drew you in or from which you pushed away. What sensations, feelings, and thoughts arise as you reflect on this case?

3. Share your story with your coworker. Pause to consider what values and principles may be involved. What is at stake for you and the persons involved? Then answer the question. Coworker pauses and says, “Thank you.” Coworker then pauses before asking the question again.

4. Share your story with your coworker. Ask “Why are we doing this?” and respond 3 more times, noting whether and how the answers evolve. Throughout the process, notice what is arising in your body, heart, and mind.

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With your partner, consider what else is possible: How might you shift the narrative? Are there ways that integrity could be preserved in this situation? What would you be doing differently? Write that story. You could also do this as a solo exercise, writing out all of the questions and responses.

This process can also be used to assess cases in the recent past, particularly ones from which you still carry moral residue or injury.

Conclusion

Moral adversity is unavoidable in critical care. Helplessness and futility are sticky. When they are the main characters in our nursing narrative, our distress can strangle our altruistic intentions. Although we cannot always shift the narrative, often the potential is there to shift from a pervasive tone of despair and disempowerment to one of empowered moral agency. A first step in that process is to wholeheartedly inquire, “Why are we doing this?” We should not be too quick to answer, pausing to inquire, what do we not see and whose voice do we not hear? What values are truly at stake? What moral remainder are we willing to carry? What can we live with? In finding this place, integrity can be preserved and moral resilience engaged. When we share these new narratives with others, they become media for organizational creativity and growth.

FINANCIAL DISCLOSURES

None reported.

REFERENCES